

Primum

Arizona Medical Board and Arizona Regulatory Board of Physician Assistants

Inside this issue:

Guidelines for Supervision of Physician Assistants	3
Guidelines for Complementary or Alternative Medicine (CAM)	7-9
Guide to Choosing a Cosmetic Surgeon	10-11
National Study Group Seeks Solutions to License Barriers	12-13
Recent Medical Board Actions	14-15
Recent PA Board Actions	16
Reasons for Board Actions	16-17
Board News	18

Letter from the AMB Chair, by William R. Martin, III, M.D.

Many of us are faced today, as physicians and surgeons, with multiple questions.

We are constantly and continually confronted with issues of a medical-legal nature.

We are faced with financial concerns as reimbursement for many physician services continue to decline and as expenses sharply rise.

We are faced with ethical dilemmas regarding end of life issues and appropriate medical care. We are faced with our legal obligation, in many cases, to treat patients without regard to our personal and financial safety.

We are forced to work longer

hours and spend less time with our families and loved ones. In some cases, we are faced with leaving our beloved profession because of forces that are around us are no longer in our control and not amenable to our success.

When I reflect upon these issues I am reminded of one of the themes of the late Dr. Martin Luther King, Jr.'s last public speech before he was assassinated: "Dangerous Unselfishness".

For as long as I can remember, I have always been a great admirer of Dr. King. Whereas many have focused their attention on his life as a scholar and as a civil rights leader—I have

always been in awe of the man as a theologian. Many of his speeches have clearly stood the test of time. In my opinion, some are as applicable today as they were during one of the most turbulent times in our nation's history.

In "Dangerous Unselfishness" Dr. King eloquently relays the parable of the Good Samaritan. He shares the fact that the setting of the parable is the road from Jerusalem down to Jericho. Further, he notes that the road starts at about 1200 feet above sea level and ends, by way of car twenty minutes later, at about 2200 feet below sea level. He de-

(Continued on page 2)

Letter from the ARBoPA Chair, by Joan Reynolds, M.M.S., P.A.-C

October 6, 2007 marked the 40th anniversary of the Physician Assistant profession having graduated the first class from Duke University in October of 1967. Physician Assistants across the United States will celebrate with week long activities marking our profession. As members of this growing profession we have observed many changes and challenges.

Our profession has been extremely successful due to our unique approach for the best possible delivery of health care through the team approach with our physician colleagues. For those of us who have practiced for many years we have remained loyal to our contribu-

tions to this profession in many ways. Many of us have served on committees, boards and task force groups locally and through the AAPA to enhance our profession. Our PA colleagues have continued to educate PA students through their hard work in the academic portion of PA education. We are extremely fortunate to have two quality programs for PA education in Arizona. I have had the pleasure of working with many of our PA educators from both programs and can attest to their quality of students.

We will continue to develop and grow our numbers as the climate of health care continues

to change. It is crucial and our duty to continue to support this profession by participating in legislative issues, reimbursement improvements and positive regulatory changes. It is an honor to be a member of this profession and serve as the chair of the Arizona Regulatory Board of Physician Assistants.

I hope each of you were able to take time, the week of October 6-12th and focus on educating patients, health care providers and those in your communities about this terrific profession and our vision to continue to offer quality health care now and in the future.

PA Reynolds practices as a PA at Mayo Clinic in Scottsdale.



This article reflects the views of the author. Unless noted, it does not necessarily reflect the view of the Arizona Regulatory Board of Physician Assistants or any other member of the Arizona Regulatory Board of Physician Assistants

Letter from the Medical Board Chair, continued

(Continued from page 1)

scribes the road as being a “winding, (a) meandering”, and a “dangerous” path.

The parable as relayed by Dr. King was in the setting of many centuries ago. He states that there was a man who was hurt and in need of help lying in the middle of a treacherous road known as the “Bloody Pass”.

The road was a frequent site of and conducive for robberies and ambushes. The part of the road where the injured man was laying had several thick bushes on either side that could be used as cover for someone who might choose to ambush a “Good Samaritan” who was inclined to stop and to help someone.

Eventually, two men walking down the road came upon the injured and bleeding man on the ground. The first question that they asked was “If I stop to help this man,

what will happen to ME?” They were concerned that the man lying on the ground could be faking his ailments and putting them into harm’s way. These first two men kept walking and did not stop to help the injured man.

Then the Good Samaritan happened upon the man on the ground. The Good Samaritan also realized the inherent dangers that were possibly around him. He reversed the question, however. The Good Samaritan asked, “If I do not stop to help this man in need—what will happen to HIM?”

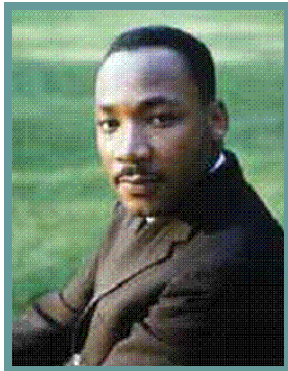
What I take from this parable is that there is still hope for physicians and surgeons. We STILL are members of one of the most honorable professions ever known to man. We STILL have the ability, with good training and regulation, to positively impact the lives of our patients, our families, and our communities.

Let us continue to be mindful of the parable of the Good Samaritan and be proud of the fact that we have reversed the question: “If I do NOT stop to help this patient of mine, what will happen to HIM?”

Let us stand tall today knowing that regardless of the many pressures that we find ourselves coping with—that we remain based on a firm foundation and in a profession known for doing GOOD! Although it may be “dangerous” let us continue to be “unselfish” in all that we do.

This article reflects the views of the author.

Unless noted, it does not necessarily reflect the view of the Arizona Medical Board or any other member of the Arizona Medical Board.



Dr. Martin Luther King, Jr.

Federation of State Medical Boards (FSMB) News



The “Ryan Haight Online Pharmacy Consumer Protection Act of 2007” (S.980), which would regulate the sale of controlled substances over the Internet, was reported favorably with amendments out of the U.S. Senate Committee on the Judiciary on Sept. 27. The bill amends the Controlled Substances Act and would:

- Bar the sale, distribution and delivery of a controlled substance via the Internet without a valid prescription,
- Require online pharmacies seeking to deliver controlled substances via the Internet to display information identifying the business, the pharmacist and any physician associated with the website,

- Increase penalties for illegal distributions of controlled substances categorized by the Drug Enforcement Administration as Schedule III, IV and V substances, and,

- Allow states to bring civil action on behalf of their residents in a U.S. district court to enjoin conduct that violates the Act .

During the past several years, FSMB staff, member medical boards and the FSMB’s government relations firm have worked to mobilize support for this and similar versions of the bill.

The United States Medical Licensing Examination (USMLE) continues to seek potential candidates to serve on USMLE test development committees and/or other

related USMLE activities.

The USMLE relies upon the work of nearly 300 physician and clinician volunteers in developing and maintaining the national licensing examination.

This “national faculty” draws upon physicians and clinicians from multiple backgrounds, including medical licensing boards, academia and private practice.

If you would like to participate, contact David Johnson, M.A., Director of FSMB Examination Services at djohnson@fsmb.org or (817) 868-4081.

You can get more information on the program by visiting the Web site, www.usmlc.org.

Medical Board and PA Board Adopt Guidelines on Supervision

Working with stakeholders, the Arizona Medical Board and the Arizona Regulatory Board of Physician Assistants have developed and adopted guidelines to help physicians and physician assistants understand the laws relating to supervision of PAs.

While investigating complaints regarding physician supervision of PAs, the Arizona Medical Board determined that much of the non-compliance with the law was due to physicians not fully understanding their legal responsibilities when they agreed to be the Supervising Physician (SP) for a PA. Therefore, in September of 2006, the Arizona Medical Board decided to undertake the project of developing guidelines to help physicians understand and comply with the law.

Subsequently, the Arizona Regulatory Board of Physician Assistants – which was in the middle of writing rules – also agreed that there was misunderstanding in the community regarding PAs relationships with their SPs. Thus, both Boards agreed to develop joint guidelines.

After more than a year of committee meetings involving stakeholders, the Arizona Medical Board and the Arizona Regulatory Board of Physician Assistants completed work on the draft guidelines. On October 11, 2007, the Arizona Medical Board adopted the guidelines at its regular meeting. On October 16, 2007, the PA Board adopted the same guidelines.

Introduction

Since Arizona established the Physician Assistant Practice Act (the Act) in 1973, the physician assistant practice in the community has evolved extensively. The notion of a PA working alongside a single physician in a private office has given way to PAs working with multiple physicians in large group practices, in busy emergency departments, or alone in an office separate from the physician's primary office. Interpreting and applying the Act in this ever-evolving environment requires balancing the need for the

evolution of safe healthcare practices with the requirement to maintain proper oversight of the profession. In analyzing the Act and the evolving community practices, the Arizona Medical Board (AMB) and the Arizona Regulatory Board of Physician Assistants (ARBOPA) identified seven areas of common misconceptions and concerns:

- I. The legal requirements for physician assistants to perform healthcare tasks;
- II. The meaning of the physician assistant's dependent relationship with a supervising physician;
- III. The role of the Notice of Supervision in establishing the physician assistant's practice parameters;
- IV. The supervising physician's responsibility for physician assistant supervision;
- V. The limited role of a supervising physician's agents in supervising physician assistants;
- VI. The context of the weekly meetings; and
- VII. The supervising physician and physician assistant's employment and business relationships.

Guidelines for Physician Supervision of Physician Assistants' Practices

I. The Legal Requirements for a Physician Assistant to Perform Health Care

Tasks:

In order for a physician assistant (PA) to perform healthcare tasks, the PA must hold a valid Arizona PA license¹; possess an ARBOPA approved Notice of Supervision form (NOS); and have an ARBOPA approved supervising physician (SP) immediately available for supervision at all times while the PA performs healthcare tasks. (A SP is not required to be physically present if the SP can be easily in contact with the PA by radio, telephone or telecommunication).

II. The Meaning of a Physician Assistant's Dependent Relationship with a Supervising Physician:

The Act prohibits PAs from practicing independently. A PA's ability to perform healthcare tasks is dependent on the PA establishing and maintaining a relationship with a SP. To establish this necessary dependent relationship, the PA must submit a notice of supervision to ARBOPA for approval.

All PAs must ensure that every patient he/she treats is a patient of either the SP or a physician approved by ARBOPA as the SP's agent (SPA). It is unreasonable to assume; however, that every patient the PA sees will have previously established a physician-patient relationship with either the SP or SPA. In the modern medical practice setting, patients routinely see a PA on their first visit to a practice setting before seeing a physician. In these instances, the PA's treatment of a patient creates the physician-patient relationship between the SP and the patient unless the PA identifies either another SP or an SPA in the patient's chart. The PA's treatment also creates a provider-patient relationship between the PA and the patient.

III. The Role of the Notice of Supervision in Establishing the Physician Assistant's Practice Parameters:

Prior to performing healthcare tasks, the physician and PA must submit a notice of supervision form to ARBOPA for approval. The physician and PA must carefully complete the notice of supervision because it establishes the parameters of the PA's ability to provide healthcare tasks by identifying the:

1. supervising physician,
2. healthcare tasks to be delegated to the PA,
3. agents who may supervise the PA when the supervising physician is not immediately available,
4. location where the PA may perform

(Continued on page 4)

PA Supervision Guidelines (continued)

(Continued from page 3)

the delegated healthcare tasks, and

5. guidelines for the supervising physician's and physician agent's supervision of the PA.

First, in completing the notice of supervision, the PA must identify the physician who will supervise the PA's performance of healthcare tasks. In order for a physician to qualify as a supervising physician, the physician must have a full, unrestricted Arizona license, must actually treat patients and must have at least one location where he/she sees patients.

Second, the physician must list on the notice of supervision the healthcare tasks delegated to the PA. The physician may only delegate those tasks the physician actually performs. The PA may only perform the healthcare tasks listed on the notice of supervision (after receiving ARBOPA approval). If the physician wishes to delegate additional tasks, the physician must first file an amended notice of supervision and receive ARBOPA approval for the added delegated tasks.

The physician must identify his/her field and type of practice on the notice of supervision. "Field of practice" is the physician's specialty, such as pediatrics or surgery. The field of practice limits the health care tasks a physician may delegate and supervise. For example, if the physician is a pediatrician, the physician cannot delegate or supervise adult patient healthcare tasks. "Type of practice" is the practice setting, such as hospital or office. The practice setting may also further limit the healthcare tasks a physician may delegate or supervise. For example, if the physician does not have hospital privileges, the physician may not delegate hospitalist healthcare tasks to or supervise a PA who works in a hospital.

Third, the physician may choose to

identify agents who will supervise the PA when the physician is not immediately available. While the Act does not require agents, a PA may only perform healthcare tasks when a physician approved by ARBOPA is available to supervise; therefore, SPs will usually identify at least one agent to supervise the PA when the SP is not immediately available.

Because the SP remains responsible for all acts of the PA even when the SPA supervises the PA, the physician should only choose as agents those physicians who will adequately supervise the PA. The PA can only perform those tasks delegated by the SP. The SPA, while supervising a PA, can restrict the PA's delegated tasks, but can never increase the delegated tasks. For example, if the SP delegates minor surgeries to the PA, but the SPA does not perform minor surgeries, then the PA cannot perform minor surgeries while supervised by the SPA. Conversely, if the SP does not delegate minor surgeries to the PA, then the SPA cannot allow the PA to perform minor surgeries even if the SPA performs minor surgeries.

To avoid limiting the PA's performance of healthcare tasks the physician should choose as an agent another physician in a similar field and type of practice. For instance, if the physician is a family medicine physician and chooses a pediatrician as the SPA, then when the SPA supervises the PA, the PA can only treat minors and would not be able to treat adult patients. Similarly, if the SP has hospital privileges, and the SPA does not, then the PA, while supervised by the SPA cannot see patients in the hospital.

Fourth, the physician must list on the notice of supervision all the practice locations where the PA will perform healthcare tasks. The PA can only practice at these locations. If the physician sees patients in more than one location, the physician must designate one place as the primary location for

seeing patients. The PA may work at offices that are geographically separate from the physician's primary place for seeing patients as long as the physician provides appropriate supervision and receives ARBOPA approval.

Fifth, the physician must submit with the notice of supervision the guidelines the physician will use to ensure timely and adequate supervision. The agent must also submit guidelines if the agent's guidelines differ from those of the physician. The guidelines must specify how the physician and agent will address supervision issues such as geographic separation, differences in employment, unique business arrangements, weekly meetings and any other unique issues that may affect supervision.

As the NOS establishes who supervises the PA, the tasks the PA may perform, where the PA may perform these tasks and how the SP will supervise the PA, the physician and PA must carefully consider the content of the notice of supervision before submitting it to ARBOPA for approval. The SP and PA may not deviate from the NOS without filing and receiving ARBOPA approval of an amended notice of supervision.

IV. The Supervising Physician's Responsibilities for Physician Assistant Supervision

The SP is responsible for all aspects of the PA's patient care, including the PA's quality of care, professional conduct and practice setting. The SP must ensure the PA has the skills and ability to safely perform all delegated healthcare tasks and that the PA's skills remain current with the evolving scientific literature and standards of care. In addition to the responsibility for the PA's quality of care, the SP is also responsible for the PA's professional conduct, such as appropriate patient interaction and compliance with all laws governing

(Continued on page 5)



"...the Physician and PA must carefully consider the content of the Notice of Supervision before submitting it to ARBOPA for approval."

PA Supervision Guidelines (continued)

(Continued from page 4)

the performance of health care tasks. The SP must monitor the PA's prescribing to ensure that it complies with the NOS and all laws and rules.

The SP is responsible for the quality of care the PA provides to all patients regardless of whether the SP has seen the patient. Appropriate supervision requires the SP review and discuss with the PA a number of charts based on the experience level of the PA, the duration of the working relationship, the practice environment, and as otherwise indicated by the standard of care. To meet this requirement the SP may choose to, for example, perform a daily chart review.

The PA should discuss with the SP patients seen for complicated or recurrent unresolved problems either at the time of the patient visit or during the weekly meeting as determined by the SP. This discussion should be documented in the patient chart or in another record maintained by the SP and PA.

Sometimes, a PA may practice in locations that are geographically separate from the primary place where the SP sees patients. This creates challenges for the SP to ensure proper supervision. In light of these challenges, a SP must be particularly diligent in following the requirements for proper supervision, including responsibility for the PA's practice setting. Accordingly, in addition to all the other requirements of supervision, proper supervision in this circumstance requires the SP visit these locations frequently enough to determine whether they comply with the standards for cleanliness, patient privacy and other aspects of an appropriately maintained clinical office.

A SP may not supervise more than two PA's at the same time. If the SP wants more than two PAs to work at the same time, there must

be at least one SP for every two PAs. A SP cannot use a SPA to supervise additional PAs to avoid this limitation.

V. The Supervising Physician Agent's Limited Role in Supervising Physician Assistants

The SP remains responsible for all aspects of the PA's patient care and conduct even when a SPA is supervising the PA. The SP is also responsible for the quality of supervision provided by an SPA. That the SP or the SPA does not employ the PA does not alter the requirements for appropriate PA supervision.

The Act authorizes a SPA to supervise a PA only when the SP is not immediately available. This legal condition greatly limits the SPA's role in supervising the PA, but it does not interfere with the PA's ability to consult with or work with the SPA.

In some settings, such as large group practices, PAs routinely treat a SPA's patients as well as the SP's patients. It would not be in the patient's best interest to require the PA to discuss patient care only with the SP who may have no treatment relationship with the patient. Also, even if the SP is available, the PA may consult with another physician regarding patient care. For instance, a PA may discuss a patient's film studies with a radiologist who is neither the SP nor SPA. However, the SP remains responsible for supervision.

In settings where the PA has many SPAs, the PA must clearly document in every patient chart which SPA was supervising the PA's care of the patient when the SP was not immediately available. The SPA must act within the SPA's scope of practice and actually perform the tasks that the PA is performing under the SPA's supervision. A SPA, while supervising a PA, has the identical responsibilities as the SP; however, the SPA's acceptance

of these responsibilities does not relieve the SP of these responsibilities.

VI. The Context of the Weekly Meeting

Supervising physicians and PAs must have at least one in-person weekly meeting to discuss patient management. As proof that the weekly meeting was indeed held, the SP should create a log containing the names of the patients discussed, the date, and the signature of the SP and PA. During the weekly meeting, the SP must discuss matters and review information necessary to sufficiently evaluate the PA's treatment of patients and the PA's general skills. The SP determines what must be discussed and reviewed during the weekly meeting. This includes discussing specific patient management, difficult or complex cases with recurrent or persistent unresolved problems, reviewing random or selected patient records and reviewing the PA's general medical knowledge and skills. During these weekly meetings, the SP must have access to the records of the patients discussed. During the weekly meeting, the SP and the PA do not need to discuss any patients that the SP and the PA discussed during the week or that they actually treated together. If the SP evaluates and collaborates in the treatment plan for each patient the PA treats during the week, the weekly meeting requirement is met and the SP and PA are not required to have an additional weekly meeting.

When the SP and PA cannot be physically in the same room for a weekly meeting, a live video conference or similar technology that allows for a face-to-face "in-person" discussion may be an adequate substitute; however, a telephonic conference or similar method that does not allow for a face-to-face discussion is not adequate. The remoteness of the of-

"A SP may not supervise more than two PA's at the same time."



(Continued on page 6)

PA Supervision Guidelines (continued)

(Continued from page 5)

office setting does not change the requirement for the weekly in-person meeting. The SP and the PA may choose to meet at some location convenient to both the SP and the PA other than the office. When meeting outside the office, the SP and the PA must ensure they meet at a location where they can easily discuss patient care without compromising patient privacy. If the SP and PA decide to use an alternative to an in person meeting, this alternative must be submitted to and approved by ARBOPA.

If the PA has more than one SP for a single practice setting, then the PA only needs to meet with one of the SPs during the weekly meeting, assuming that the SP has the authority to supervise all of the healthcare tasks the PA performed during the week. For example, if the PA works for large group practice with two SPs who have the ability to oversee all the care provided to all the patients, then the PA need only meet with one of the two SPs each week. If the PA has two SPs for two unrelated practice settings, then the PA must meet separately with each SP each week. For example, if the PA works part-time at an urgent care facility with one SP and works part-time at a psychiatric care facility with a different SP, then the PA must meet separately with each SP each week.

A SPA can only cover weekly meetings when the SP is absent due to vacation, illness or continuing education. If the SP is absent for any other reasons the SPA must have prior ARBOPA approval to meet

with the PA. If other reasons are anticipated that may cause a SP to be unavailable, these reasons can be identified in the supervision guidelines submitted with the NOS and receive prior ARBOPA approval.

VII. The Supervising Physician's and Physician Assistant's Employment and Business Relationships

Other than requiring notification when a Physician Assistant's employment is terminated, the Act is silent as to any requirements on the SP and the PA's employment or business relationship. Regardless of the employment or business relationship, that relationship may not interfere with the SP's ability to supervise the PA. This means that at all times the SP must have complete and unfettered access to the practice setting, the patients and the patient medical records.

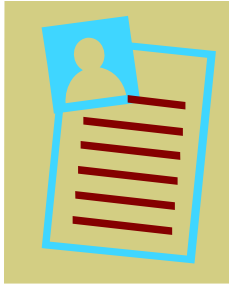
Occasionally, the SP may not employ the PA, but different organizations may employ the SP and PA. These alternative employment arrangements do not change the basic requirements of the Act. Regardless of employment, a PA may not practice independently. All acts of the PA are subject to the SP's supervision, and employment arrangements never relieve the SP of these legal responsibilities. Therefore, the PA and the PA's employer must never interfere with the SP's supervision of the PA, and cannot at anytime restrict the SP's access to the patients, the patient's records or the facility. If these conditions are not met, the SP must withdraw as the PA's supervising physician.

Likewise, a PA may see patients at an office not owned by the SP, but instead owned and controlled by a third party. Regardless of the business or facility ownership, the SP remains responsible for all aspects of the care the PA provides in the office. If the owner of the practice space interferes with the SP's or PA's efforts to conform the practice to required standards, the SP cannot allow a PA to continue working in that practice location. Regardless of the employment or business relationship, all patients the PA treats become the patients of the SP or SPA. Because the SP has personal responsibility for the care provided to the patients, the SP cannot allow any interference with his/her ability to supervise the PA.

Conclusion

The AMB and ARBOPA jointly produced these guidelines to provide guidance to physicians and physician assistants on complying with the Act. These guidelines will also help to communicate the legal requirements and expectations of physician supervision of physician assistants to the public and health-care businesses. These guidelines do not replace, augment or change the Act, but provide clarity to the AMB's and ARBOPA's interpretations and applications of the Act.

These guidelines are posted on both the [Arizona Medical Board](#) and the [Arizona Regulatory Board of Physician Assistants](#) Web sites.



"..at all times, the SP must have complete and unfettered access to the practice setting, the patients and the patient medical records."

Number of Licensed Physicians:

19,213



Number of Licensed PAs

1,634

Board Adopts Guidelines for Complementary or Alternative Medicine

The Arizona Medical Board adopted guidelines for MD's who incorporate or use Complementary or Alternative Medicine (CAM) in their practices. CAM refers to a broad range of healing philosophies, approaches and therapies that mainstream conventional medicine does not commonly use. Some of the more familiar CAM practices are acupuncture, homeopathy, naturopathy, and therapeutic massage.

The new guidelines are to assist physicians to use CAM in a manner that is consistent with the Arizona Medical Board's expectations for the safe practice of medicine and to inform the public of CAM and its legitimate use in our state. The Board emphasizes that it does not prohibit CAM but wants to ensure that physicians use CAM safely. The guidelines apply to all allopathic physicians (MD's) whether using CAM or not. The guidelines make it clear that the standard of care for physicians is the same whether using conventional medicine or CAM.

The Arizona Medical Board's Guidelines For Physicians Who Incorporate Or Use Complementary Or Alternative Medicine In Their Practice

Introduction

Increasingly, physicians are integrating complementary or alternative medicine (CAM) therapies into their practices or referring patients to CAM practitioners. CAM refers to a broad range of healing philosophies (schools of thought), approaches and therapies that mainstream Western (conventional) medicine does not commonly use, accept, study, understand, or make available. A few of the many CAM practices include the use of acupuncture, ayurveda, herbs, homeopathy, naturopathy, therapeutic massage, and traditional Oriental

medicine to promote well-being or treat health conditions.

The Arizona Medical Board (the Board) developed these guidelines for physicians who use CAM to assist them in doing so in a manner that is consistent with the Board's expectations and to inform the public of CAM and its uses in Arizona.

Preamble

The Board is responsible for regulating all physicians who hold an Arizona license to practice allopathic medicine. The Arizona Legislature and the Board have established standards that govern the practice of medicine. These standards allow physicians to exercise their professional judgment in treating patients and do not generally preclude the use of any treatment methods that are justifiably anticipated to benefit patients without undue risk. All physicians must meet these basic allopathic standards whether the physician practices allopathic medicine or some form of CAM or integrates both. All physicians, regardless of the type of medicine they practice, must practice in a manner that is safe and always with the patient's best interest in mind.

The standards used in evaluating health care practices must be consistent, whether such practices are regarded as conventional or CAM. The use of CAM is not in and of itself unprofessional conduct. Instead, the Board analyzes the physician's conduct and patient care in each case to determine if the physician's conduct constitutes a violation of the Medical Practice Act.

Guidelines

All licensed allopathic physicians, whether practicing conventional medicine or using CAM, must demonstrate a basic understanding of allopathic medicine and current medical scientific knowledge. If a physician uses CAM, the physician

must also be able to demonstrate a basic understanding of the treatment modalities connected with any method offered or used in the physician's medical practice. Whether using conventional, CAM or integrative medicine, all allopathic physicians must meet the basic allopathic standard of care for diagnosing, treating and monitoring patients regardless of the intended treatment modality.

I. Diagnosing, Treating and Monitoring

A. Diagnosing

The Board recognizes the difference between a physician's competency in meeting basic medicine requirements and a physician's skills in using a particular treatment modality. All physicians must take an appropriate history, review the patient's medical record, conduct a physical examination of the patient and obtain the necessary tests consistent with the allopathic standard of care to make an informed diagnosis regardless of the treatment modality employed to treat the illness or condition. In addition to the required conventional diagnostic methods, a physician may use additional safe and reliable methods to diagnose a patient's condition or illness.

B. Treating

After making an informed diagnosis, a physician may offer the patient conventional and/or CAM treatments as part of the treatment plan. The physician must tailor the treatment plan to meet the needs of the individual patient. The physician must design the treatment plan to timely and effectively treat the patient's diagnosis, provide for continued monitoring of the patient's condition or illness and perform all further testing, consultations, and referrals consistent with the standard of care. The treatment plan must establish how

(Continued on page 8)



"All physicians must meet these basic allopathic standards whether the physician practices allopathic medicine or some form of CAM or integrates both."

CAM Guidelines (continued)

(Continued from page 7)

“The physician must recognize when the prescribed treatment is failing to achieve the desired or expected results.”

the physician will evaluate the treatment’s progress and success, such as pain relief and/or improved physical and/or psychosocial function. The treatments offered should, at a minimum:

- have a favorable risk/benefit ratio compared to other treatments for the same condition;
- be based upon a well founded expectation that it will result in a favorable patient outcome, including preventive practices; and
- be based upon the expectation that a greater benefit will be achieved than can be expected with no treatment.

When analyzing a physician’s treatment of a patient, the Board will evaluate whether the physician is practicing appropriate medicine by considering, among other things, whether the treatment was:

- safe and demonstrably effective, *(having evidence of safety with demonstrable and credible scientific evidence of efficacy)*

- safe but not demonstrably effective,

(having evidence of safety, but with no or inadequate demonstrable and credible scientific evidence of efficacy)

- unsafe but demonstrably effective, or

(having evidence of significant side effects, but with demonstrable and credible scientific evidence of efficacy)

- unsafe and not demonstrably effective.

(proven or known to be unsafe with no demonstrable or credible evidence of efficacy)

The physician should consider treatments that are safe and demonstrably effective first when developing a treatment plan. The use of unsafe and not demonstrably effective treatments is experi-

mental in nature and a physician who wishes to use such a treatment should only do so under rigidly controlled conditions that meet all State and National standards and protocols for research including submission of the proposed treatment to an Institutional Review Board for approval.

C. Monitoring

When required by the standard of care, the physician must monitor the patient to determine if the treatment is successfully obtaining the expected results. All physicians must appropriately monitor a patient’s health by assessing the patient’s health, conducting additional physical examinations and/or obtaining additional tests consistent with the allopathic standard of care for patient monitoring. In addition to the required conventional monitoring methods, a physician may use additional reliable monitoring methods. The physician must recognize when the prescribed treatment is failing to achieve the desired or expected results. Once the physician determines the treatment is failing, the physician must:

- verify the accuracy of the original diagnosis and possibly modify the diagnosis,
- adjust the treatment plan, and/or
- refer the patient to another physician.

II. Informed Consent

When a physician uses CAM, in addition to the medical information required to be documented by the relevant standard of care, the medical record must also document the medical options the physician and patient discussed. The physician must document the information provided to the patient and the treatments the patient accepted and which treatments the patient rejected.

Physicians must always obtain a patient’s informed consent before treating the patient whether using conventional medicine, CAM or any experimental method. The patient’s informed consent must be in writing if the physician uses CAM, experimental methods or if required by the standard of care. In obtaining the patient’s informed consent, the physician, at a minimum, must provide the following information to the patient:

- The available treatment options and their known risks and benefits;
- The option of no treatment and its risks and benefits;
- The risks of early termination of a particular treatment;
- If the treatment will be performed at a different facility, the physician must identify the facility and explain any risks and benefits if there are any among the options of facilities;
- If the physician is recommending CAM or experimental treatments, the physician must also explain possible conventional treatments;
- The physician must inform the patient if the treatment is not scientifically established using conventional methods;
- The physician must also document and abide by any limitations the patient places on the consent.

III. Referral and Consultation

A physician who does not utilize CAM may refer patients to a CAM practitioner for additional evaluation and treatment in order to achieve treatment objectives or to comply with a patient’s request. The physician who refers the patient to specific practitioners is responsible for ensuring the referred to practitioner is licensed, if required, and practices competently and safely. In all situations where the referring physician con-

(Continued on page 9)



CAM Guidelines (continued)

(Continued from page 8)

continues to treat the patient, the referring physician remains responsible for monitoring the results from the referral and should schedule periodic reviews to ensure progress is being achieved. Patients should always advise their treating physician of any CAM treatments they receive and all CAM products they take or use.

IV. Claims

In advertising a practice or while consulting with a patient, a physician may not make false or fraudulent claims. A physician may not claim that a particular treatment can cure, alleviate or ameliorate a disease or condition unless the claim is supported by valid, conventional science. A physician's personal experience, patient testimony and other anecdotal evidence is not sufficient evidence to support a claim of a treatment's efficacy and safety. A physician may, however, inform the patients of his/her experiences with using a particular treatment. When advising patients on treatment options, a physician must disclose to the patient the physician's basis for making claims of the efficacy and safety of a particular treatment.

V. Products

Some physician practices have begun selling healthcare related products directly to patients. The law does not directly prohibit this practice, but any fraud or misrepresentations would violate the Medical Practice Act. Due to the potential for conflicts of interests, however, physicians should not sell, rent or lease health-related products or engage in exclusive distributorships and/or personal branding. If a physician chooses to make products directly available to patients, the physician must disclose to the patient that the physician has a financial interest in the goods or services. This does not prohibit physicians from distributing products to patients for free or at cost in order to make products readily available or otherwise dispensing prescription drugs and devices. In addition, this should not deter physicians from selling durable medical goods essential to the patient's care.

VI. Clinical Trials, Research and Experiments

As expected of those physicians using conventional medical practices, physicians providing CAM therapies while engaged in the clinical investigation of new drugs and procedures are obligated to maintain their ethical and professional responsibilities and meet all legal requirements governing research and clinical trials. Clinical investigations must be part of a systematic program competently designed, under accepted standards of scientific research, to produce data that are scientifically valid and sound. A clinical investigator should demonstrate the same concern and caution for the welfare, safety and comfort of the patient involved as is required of a

physician who is furnishing medical care to a patient independent of any clinical investigation. Furthermore, to ensure the risks to the patient are as low as possible and are worth any potential risks or benefits, researchers must abide by all federal guidelines and safeguards, such as approval and monitoring of the clinical trial by an Institutional Review Board, when applicable.

Conclusion

Legitimate standards of medical practice are rooted in competent and reliable scientific evidence. These standards, however, continually change as advances are made in scientific investigation and analysis. Some procedures that are initially considered unconventional gradually become conventional, while the scientific community may discard common conventional procedures.

Patients have a right to seek the treatment that is most appropriate for them. But the Board must protect the public by ensuring that allopathic physicians in all practices, whether conventional or CAM, comply with professional, ethical and established practice standards. The Board will continue to protect the public by ensuring that all allopathic physicians, whether practicing conventional medicine, CAM or both, meet the standards of care the community expects of allopathic practitioners.

These guidelines are available on the [Arizona Medical Board](http://www.azmd.gov) Web site.



“A physician’s personal experience, patient testimony and other anecdotal evidence is not sufficient evidence to support a claim of a treatment’s efficacy and safety.”

Boards’ Web Sites Packed with Information

The Arizona Medical Board and the Arizona Regulatory Board of Physician Assistants are making it easier for licensees to find important information on healthcare alerts, guidelines and even the latest Primum Newsletter. Newer items are highlighted by their placement

on the Boards’ homepages, just below the Welcoming Message.

Hyperlinks to files are included in the descriptions so that you need only click on them to go directly to them.

The Guidelines for PA Supervision

can be found on both Web sites in this way.

When the Department of Health Services issues a health alert, we will post it on both Web sites.

Check out www.azmd.gov and www.azpa.gov.



Medical Board Releases Guide for Choosing a Cosmetic Surgeon

Due to interest on the part of the public and the media, the Arizona Medical Board has prepared a Guide and a Checklist for people to use in choosing a physician for a cosmetic procedure.

Because most of these procedures are not covered by insurance, patients are on their own in finding the right physician for their desired procedure. The Guide explains how to choose a physician from the growing number of doctors who now offer them. The Arizona Medical Board recommends that patients carefully research the physician, the procedure, the location and the sedation that will be used before they have the procedure.

How to Choose a Physician for a Cosmetic Procedure or Plastic Surgery

The demand for cosmetic procedures and plastic surgery is rapidly growing. A large industry of professionals has also grown to meet this increased demand. The practice can be very lucrative as many of the procedures are paid for in cash rather than by insurance. Because most of these procedures are not covered by insurance, patients are on their own in finding the right physician to perform the desired procedure. When trying to decide which physician should perform the procedure, patients are motivated by cost, convenience of location and how soon the procedure can be scheduled. While these are legitimate and important considerations, they should not override the importance of choosing the right physician.

In Arizona, any licensed allopathic physician may perform any procedure that he or she is competent to perform. The law does not prohibit physicians from performing procedures that were not part of their formal training. There are very good reasons for this, but it does require patients to carefully research how a particular physician

received training in a particular procedure. The Arizona Medical Board requires all physicians to have the knowledge and skill to perform procedures within the community standard of care, whether the physician learned the procedure as part of the formal education or through informal education.

This leaves the patient with many options in choosing a physician to perform a procedure. Making the right choice can be challenging. To help in choosing the right physician, the Arizona Medical Board is offering this guidance document and attached checklist to assist patients in choosing the right physician to perform a particular procedure.

Getting started: Most patients begin their search for the right physician by asking friends, co-workers and family for suggestions. This may be a great way to identify potential physicians and obtain an actual account from a trusted source. However, the physician that was right for a friend or family member may not be the right physician for you. Each patient is unique. Differences in age, gender, build, weight and skin color can make a difference in choosing a physician. In addition, patients may ask their primary care physician or other healthcare providers for referrals.

Research: Once you have developed a list of potential physicians, you need to research the physicians. One of the best places to start this process is at the Arizona Medical Board's website, www.azmd.gov. The Arizona Medical Board maintains an on-line profile of every licensed allopathic physician. This profile will identify the status of the physician's license, list where the physician received formal training, identifies the field of medicine in which the physician received formal training, i.e. surgery, radiology, family practice, pediatrics, etc. The physi-

cian's profile also identifies if the physician is Board Certified in a particular specialty by a Board that is recognized by the American Board of Medical Specialties (ABMS). If such a Board does not certify the physician, the physician may list an area of practice in which the physician focuses. The web profile also shows whether the physician has been disciplined, paid on a malpractice claim or judgment or received a criminal conviction.

Training: You should carefully consider the potential physicians' training. There are several ways a physician can learn to perform a particular procedure. First, physicians can learn a procedure as part of the formal training during a residency or a fellowship. Second, physicians can learn a procedure informally after completing formal training from organizations that specialize in training physicians to perform particular procedures. Third, physicians can learn new procedures by being mentored or trained by other physicians. Regardless of the training method, physicians can become highly proficient and competent in performing a particular procedure.

Board Certified: If a physician is Board Certified by a Board recognized by the ABMS, this indicates that the physician has completed a residency or fellowship in a particular specialty and has passed examination at a level higher than that required for licensure. Additionally, some physician must re-qualify for Board Certification every few years to demonstrate continuing competency in the specialty. Not all Boards that certify physicians are recognized by the ABMS, and these Boards may not require the higher standards of training and examination, however, some non-ABMS Boards have high standards for certification. Therefore, if the physician is not Board certified by an ABMS Board, you need to research the Board to determine if

(Continued on page 11)



"Differences in age, gender, build, weight and skin color can make a difference in choosing a physician."

Guide for Choosing a Cosmetic Surgeon (continued)

(Continued from page 10)

it is a legitimate organization.

A number of physicians licensed to practice medicine in Arizona do cosmetic procedures successfully. Some of these physicians may not be Board Certified, but they have had adequate training and possess sufficient skills to perform procedures safely. Therefore, Board Certification alone does not demonstrate whether the physician is competent to perform a particular procedure, but it is one factor to consider.

Assessing the Physician: After selecting a potential physician, it is important that you assess the physician and the physician's staff during your first visit. When assessing the physician's office and staff, you should look for such things as cleanliness, politeness of staff, courtesy, privacy, etc. In general, you should feel comfortable with the practice upon walking in the door and being greeted by staff. When assessing the physician, you should consider if the physician answered all your questions and spent the time necessary to make you feel comfortable. You should ask general questions about the procedure: for instance, how many times has the physician performed the procedure, how did the physician learn to perform the procedure, will anyone other than the physician perform part of the procedure, what other similar procedures does the physician perform, does the physician have picture of the results of the same procedure on other patients.

Learning the Procedure: Once you are comfortable with the physician, you need to discuss the actual procedure. The physician should explain, in detail, what is involved with the procedure. The physician should explain the actual mechanics of the procedure, how long the procedure should take, how long recovery should take before dis-

charge and how long recovery should take post-discharge. The physician should also explain what to expect with regard to wound recovery and how much pain to expect and how to treat the pain and other post-procedure requirements. The physician should also explain what warning signs or concerns to watch for that might need immediate attention, such as bleeding, infection or excessive pain.

Very often, the sedation used during the procedure has more associated risks than the risks associated with the procedure. Therefore, it is very important that the physician explain if sedation will be used, and if so what type of sedative agent will be used. The physician should explain what level of consciousness will be maintained. Sedation can range from complete unconsciousness to alertness with a mild sedative affect. If the physician plans on using general anesthesia, then the procedure must be performed in a facility licensed by the Arizona Department of Health Service such as an outpatient surgical center or hospital. The physician should explain who would administer and monitor the sedation and their training, skills, knowledge, qualifications and licenses. The physician must also inform you of any other persons involved in the procedure, along with their purpose, training and skills.

Informed Consent: Physicians must have your informed consent prior to performing any procedure. Physicians must not only have consent for the procedure, but they must also obtain consent for every person who will be involved in the procedure and where the procedure will be performed. In order to obtain informed consent, the physician must provide you with sufficient information for you to make an informed decision. Ensuring that you receive sufficient information requires good communi-

cation between you and the physician. While the physician knows the risks and benefits of the procedure, knows the individuals who will help perform the procedures, and knows the location where the procedure will be performed, the physician cannot know every issue that may be of importance to you. So you must ask all questions necessary to ensure your comfort with having a particular procedure performed by a particular physician using particular staff at a particular location. You must also express any limitations or conditions you want to place on your consent.

Only after you feel completely comfortable with the procedure, the physician, the staff and the location, should you consent to proceeding with the procedure. While cosmetic procedures and some plastic surgeries may seem routine and very safe, these procedures do come with some level of risks. The skills of the physician and the physician's staff bear directly upon the risks of a particular procedure. So, it is critically important for your health and safety that you choose the right physician to perform the procedure, even

if it means paying more for the procedure at a less convenient location and at a later date.

The Arizona Medical Board has prepared a [checklist](#) for choosing a cosmetic surgeon.

The Guide is unique in that no other medical board has made this information available to consumers.

At the request of the Federation of State Medical Boards, the Arizona Medical Board has provided the FSMB with both the Guide and the Checklist for distribution to the other 69 medical boards in the United States and its territories.

"...it is important that the physician explain if sedation will be used, and if so what type of sedative agent will be used."



National Study Group Seeks Solutions to Licensure Barriers

The National Governors Association's State Alliance for e-Health has adopted two recommendations regarding licensure of physicians and other health care professionals submitted by the Health Care Practice Taskforce. The first is that state medical, nursing and pharmacy boards should work to implement online licensure applications. The second recommendation is that all State Medical Boards adopt the Federation of State Medical Board's Common Licensure Application Form (CLAF), with the understanding that individual states may include state specific requirements.

The Taskforce is discussing four more recommendations to the alliance:

1. Each health care professional board should develop, with its counterparts in other states, a nationwide core set of credentialing requirements that their respective applicants would have to meet in order to obtain a license.
2. Governors should require their medical, pharmacy and nursing regulatory boards utilize a single, centrally-coordinated credentials verification organization, like the Federation of State Medical Board's Credentials Verification Service (FCVS).
3. All state boards should require that applicants for initial professional state licensure undergo state and federal criminal background checks prior to obtaining a license.
4. All Health Care Practice Taskforce recommendations should be used as a model for other licensed health care professionals (e.g., physician assistants), contingent upon verification that there are no unique requirements applicable to those professions.

The Health Care Practice Taskforce is charged with identifying and addressing issues pertaining to "the regulatory, legal, and professional standards that have an impact on the practice of medicine and create barriers to interoperable, electronic health information exchange (eHIE)." In response to the charge, the taskforce held its first meeting in February of this year to examine licensure and liability issues. By March, testimony and discussions had moved licensure into the priority position.

A problem that has resonated throughout each meeting was how the licensure process is often a barrier to health care professionals who want to practice e-health across state lines in ways that would be classified as remote delivery of healthcare services, such as those defined as telehealth. Patients are now receiving more cross-state consultation with healthcare providers. As technology and procedures advance, consumers are pursuing specialty experts who reside in other states to provide direct consultation for a patient residing in another state. A more technology savvy healthcare consumer market is increasing the demand for Internet and e-mail consultative services. Hurricane Katrina focused attention on the nation's need to permit healthcare providers to practice medicine in different states or across bordering state lines at moment's notice.

The taskforce decided that it is necessary to promote a system that ensures qualified, licensed providers are able to satisfy the demand for cross-state consultation. As the healthcare industry moves toward a more interconnected environment, streamlining the licensure process will become increasingly vital to both licensed professionals and consumers.

Over time, the 70 boards of medicine in the United States and its territories have developed their own distinctive laws and regula-

tions to protect the public. As a result, there is a lack of uniformity in how Boards license qualified, competent practitioners. The length of time from the submission of an application to the issuance of a license varies from state to state. Should a physician wish to practice in more than one jurisdiction, he must obtain the licenses from each location and abide by the processes of the respective Boards, often requiring duplicative and time-consuming paperwork.

The taskforce examined individual state licensure rules and found a wide variation with respect to the requirements for obtaining a license. In the area of continuing medical education (CME), 51 Boards require anywhere from 12 hours (Alabama) to 50 hours (several states) of CME per year. Some states also mandate CME content, such as HIV/AIDS, risk management or medical ethics.

Another obstacle for a physician wishing to obtain multiple licenses is the fact that many states require the applicant to take a current licensing exam if seven years have elapsed since the physician passed the initial step of the United States Medical Licensing Examination.

The Medical Board of Ohio is part of a nationwide pilot program testing a common licensure application for physicians. The CLAF developed is an attempt to reduce the number of incomplete applications received by State Medical Boards; allow for the collection of uniform information; and add convenience for physicians applying for licensure in multiple states. Also utilizing the CLAF are Kentucky and New Hampshire. The Federation of State Medical Boards is currently working with additional Boards to convert their applications to the CLAF.

The North Carolina Medical Board recently implemented online licen-



(Continued on page 13)

Medical Practice Act and Interest Disclosure

Five medical device companies recently settled a Justice Department probe for more than \$300 million in fines. For the past two years, federal prosecutors have been investigating the companies who make artificial hips and knees. They claimed the device companies were paying surgeons to use and promote their products. It was the government's contention that doctors with so-called 'consulting arrangements' often failed to tell their patients about their connections with the companies.

A Phoenix TV station reports that, as part of the settlement, the companies had to list the names of the physicians and the amount of fees each received. The report says that Arizona surgeons had collected an estimated \$5.8 million in 'consulting agreements.'

The disclosure problem has come to the attention of Congress. On September 6th of this year, Iowa Republican Senator Chuck Grassley introduced the bipartisan "Physician Payments Sunshine Act." Aimed primarily at drug and medical device manufacturers, it would require them to disclose the names and office addresses of

doctors who receive gifts worth more than \$25. The bill exempts drug samples and funding for clinical trials.

The Wall Street Journal quoted Grassley as saying that "patients shouldn't be in the dark about whether their doctors are getting money from drug and device makers."

The same article reports that many physicians have invested in expensive equipment like magnetic resonance imaging or facilities such as surgery centers and diagnostic sites and have referred their patients to them. Proposed new Medicare rules against self-referrals go into effect in January 2008 nationally, but for some time now Arizona statutes have addressed this and other interest issues.

A portion of the Medical Practice Act concerns 'consulting' agreements or arrangements and other payments made to physicians. Arizona Revised Statutes § 32-1401(27)(ff) defines unprofessional conduct, in part, as "knowingly failing to disclose to a patient on a form that is prescribed by the board and that is

dated and signed by the patient or guardian acknowledging that the patient or guardian has read and understands that the doctor has a direct financial interest in a separate diagnostic or treatment agency or in non-routine goods or services that the patient is being prescribed and if the prescribed treatment, goods or services are available on a competitive basis."

The "Notice to Patients" form is available on the Arizona Medical Board Web site, www.azmd.gov. It explains the law to a patient. The form states that the medical practice is advising the patient that the doctor has a direct financial interest in the listed diagnostic or treatment agency or in the non routine goods or services named in the form.

A "Yes" or "No" is checked to say whether these services are available elsewhere on a competitive basis, and if so, which ones. The patient then signs and dates the form either for him- or herself or as a guardian. The statute specifically states that it "does not apply to a referral by one doctor of medicine to another doctor of medicine within a group of doctors of medicine practicing together."



National Study Group Seeks Solutions to Licensure Barriers

(Continued from page 12)

sure applications for MDs, reducing administrative errors and the timeframes for obtaining a license. So far, only North Carolina, Ohio, New Hampshire and Kentucky utilize online applications. While many states have "electronic applications," these are in fact files that must be downloaded, printed and mailed in.

The taskforce recognizes that the

need for cross-state licensure for telemedicine practice has the potential to create a backlash by state governments that may view common applications as the first step towards pre-empting their jurisdiction over professional licensure. The taskforce has not yet offered any suggestions for the type of mechanism that would enable multi-state telemedicine. It does understand that any physician practicing in multiple states

would still be subject to the statutes and regulations in each of the states.

The Health Care Practice Taskforce plans to continue examining general licensure models that may aid in reducing the barriers to interstate practice. It will also study liability issues that may arise in the e-health information exchange context as well as concerns with the exchange of state laboratory results.



Recent MB and ARBoPA Actions and Orders

The Arizona Medical Board and the Arizona Regulatory Board of Physician Assistants have legal authority to revoke, suspend, restrict, fine, reprimand or censure, require monitoring or additional education, or impose other remedial measures on the license of an allopathic physician (M.D.) or PA if the licensee has committed unprofessional conduct or is mentally or physically unable to safely engage in the practice of medicine.

State law also allows the Medical Board, at its discretion, to issue a non-disciplinary order for additional Continuing Medical Education courses.

The Boards have recently taken the following actions:

AMB

Melanie K. Kohout, M.D.

(Phoenix—Psychiatry)

Arizona License No. 23105

Accepted Consent Agreement for Revocation.

William V. Gaul, M.D.

(Sun City—Cardiovascular Disease, Internal Medicine, Interventional Cardiology)

Arizona License No. 13119

License revoked.

Cynthia J. Modny, M.D.

(Phoenix—Dermatology)

Arizona License No. 22577

Accepted Consent Agreement for surrender of active license.

King T. Leung, M.D.

(Apache Junction—Family Practice)

Arizona License No. 20262

Accepted Administrative Law Judge's Recommended Order for Revocation.

Thomas J. Grade, M.D.

(Gilbert—Anesthesiology, Internal Medicine, Pulmonary Disease, Pain Management)

Arizona License No. 10424

Accepted Administrative Law Judge's Recommended Order for Revocation.

Mary E. Groves, M.D.

(Chandler—Family Practice)

Arizona License No. 30315

Accepted Consent Agreement for surrender of active license.

Shelley L. Everly, M.D.

(Flagstaff—Psychiatry)

Arizona License No. 28385

Accepted Consent Agreement for surrender of active license.

James M. Tillinghast, M.D.

(Phoenix—Anesthesiology)

Arizona License No. 14418

Accepted Consent Agreement for surrender of active license.

Malcolm G. Wilkinson, M.D.

(Cottonwood—General Surgery)

Arizona License No. 21001

Ordered 15 years Probation with Practice Restriction from general surgery.

Venu G. Menon, M.D.

(Dayton, Ohio—Anesthesiology)

Arizona License No. 12360

Ordered Summary Suspension

(Continued on page 15)

Explanation of Terms

Revocation — Termination of a licensee's right to practice medicine or perform health care tasks in Arizona. A referral to a formal hearing is necessary.

Suspension — The Board may suspend a license for 12 months or less without a formal hearing. A suspension of more than 12 months may be issued after a formal hearing. A suspension may be used as a punishment to restrict financial gain.

Decree of Censure — Not defined in statute, but is identified as an "official action against the license..." A Decree of Censure may be issued by itself or in conjunction with terms of probation. A Decree of Censure may also include a requirement that restitution be paid to a patient.

Letter of Reprimand — A disciplinary order issued by the Board informing the licensee that his/her conduct violates state or federal law and may require the Board to monitor the license. It may be issued by itself or in conjunction with terms of probation.

Advisory Letter — Non-disciplinary letter that notifies a licensee that he/she has committed either a minor technical violation or that there is not enough evidence to take a disciplinary action.

Recent AMB Actions and Orders (continued)

(Continued from page 14)

Eli J. Hammer, M.D.

(Scottsdale– Family Practice)

Arizona License No. 17176

Ordered Summary Suspension, later stayed by court order.

Marvin L. Gibbs, M.D.

(Phoenix–OB-GYN)

Arizona License No. 13736

Accepted Administrative Law Judge's Recommended Order for Revocation.

Unen D. Hsu, M.D.

(Phoenix–Diabetes)

Arizona License No. 8373

Ordered 15 years Probation restricting him from prescribing narcotics.

David L. Greene, M.D.

(Phoenix–Orthopaedic Surgery)

Arizona License No. 32747

Emergency Summary Suspension.

Peter J. Normann, M.D.

(Anthem–Internal Medicine)

Arizona License No. 33254

Accepted the Administrative Law Judge's Recommended Order for Revocation.

Pamela A. Morford, M.D.

(OB-GYN, Gynecology)

Arizona License No. 17926

Ordered Consent Agreement for Surrender of active license.

Clarence E. Rodriguez, M.D.

(Mesa–Internal Medicine)

Arizona License No. 14409

Ordered Consent Agreement for Surrender of active license.

AMB Stats

At its two-day April 2007 meeting, the Arizona Medical Board approved:

- 3 Revocations
- 1 Surrender of active license
- 3 Disciplinary Probations
- 1 Decree of Censure
- 13 Letters of Reprimand
- 1 Referral to Formal Hearing
- 25 Advisory Letters
- 2 Orders for non-disciplinary CME
- 17 dismissals

At its one-day meeting on May 18, 2007, the Arizona Medical Board approved:

- 1 Summary Suspension
- 1 Disciplinary Probation
- 1 Decree of Censure
- 5 Letters of Reprimand
- 3 Advisory Letters
- 1 Dismissal

At Its two-day meeting in June 2007, the Arizona Medical Board approved:

- 3 Surrenders of active licenses
- 1 Suspension
- 1 Disciplinary Probation

- 1 Decree of Censure
- 16 Letters of Reprimand
- 2 Referrals to Formal Hearing
- 29 Advisory Letters
- 2 Orders for non-disciplinary CME
- 1 Dismissal
- 7 Upholding of Executive Director dismissals

At its two-day meeting in August 2007, the Arizona Medical Board approved:

- 2 Revocations
- 2 Surrenders of active licenses
- 1 Practice Restriction
- 3 Decrees of Censure
- 8 Letters of Reprimand
- 26 Advisory Letters
- 1 Dismissal
- 13 upholding of Executive Director dismissals

At its two-day October 2007 meeting, the Arizona Medical Board approved:

- 1 Revocation
- 2 Surrenders of active licenses
- 1 Decree of Censure
- 13 Letters of Reprimand
- 15 Advisory Letters
- 1 Order for non-disciplinary CME
- 15 Dismissals
- 15 Upholding of Executive Director dismissals

Reasons for Medical Board Actions

Knowing why physicians have come to the attention of the Arizona Medical Board may be helpful information to other licensees.

The Board ordered **Decrees of Censure** for

- Failure to timely see a critically ill patient and for making a misleading statement in the medical records;
- Improper diagnosis and treatment of patients with chronic pain, specifically the improper use of injections, improper combination of medications, improper procedural pre-medication, and inadequate understanding of anatomy;
- Releasing confidential Board information to the public;
- Inappropriate narcotic prescribing, and
- Multiple mishandled surgical complications and poor clinical judgment.

The Board ordered **Letters of Reprimand** in cases involving the following:

- Failure to appropriately manage an alcoholic with depression

and failure to maintain adequate medical records;

- Failure to timely diagnose and treat status epilepticus and for making a false or misleading statement to the Board;
- Failure to appropriately diagnose and treat discoid lupus, altering medical records and failure to maintain adequate medical records;
- Failure to appropriately perform a laparoscopic cholecystectomy and failure to correct all of the patient's injuries during the second operation;
- Failure to properly perform a cervical translaminal epidural steroid injection and for failure to properly sedate a patient during the procedure;
- Prescribing controlled substances to an immediate family member for prescribing non-controlled substances to a family member without conducting a physical examination and for failing to maintain adequate medical records;
- Failure to order a head CT and lumbar puncture for a patient

with altered level of consciousness and acute headache;

- Failure to provide adequate anesthesia during liposuction and adequately monitor the anesthesia when performing a liposuction procedure and for failure to maintain adequate medical records;
- Failure to adequately assess a patient with profoundly low platelets and hemolytic anemia and initiate treatment;
- Failure to diagnose a herniated disk in a timely manner and failure to maintain adequate medical records;
- Wrong site surgery;
- Failure to diagnose and treat an ankle fracture in a timely manner;
- Improper prescribing, inadequate examination of the patient, prescribing in excess of findings reported, failure to recognize or deal with evidence of narcotic abuse on several occasions;
- Performing surgery without adequate indications and lack of

Recent ARBoPA Actions and Orders

ARBoPA

During its meeting on May 16, 2007, the Arizona Regulatory Board of Physician Assistants took the following actions:

- 1 Surrender of active license
- 1 Probationary License
- 2 Letters of Reprimand
- 3 Advisory Letters

During its August 22, 2007 meeting, the Arizona Regulatory Board of Physician Assistants took the following actions:

- 1 Surrender of active license
- 2 Letters of Reprimand
- 2 Advisory Letters
- 1 Denial of License
- 1 Upholding of Executive Director's Denial of License.

Edward N. O'Bierne, P.A.-C

Arizona License No. 1911

Accepted Consent Agreement for Surrender of active license.

Kyle C. Denman, P.A.-C

Arizona License No. 2307

Accepted Consent Agreement for Surrender of active license.

informed consent;

- Improper methadone dosing and improvement management of accidental opiate overdose;
- Failure to appropriately communicate results of an abnormal lab test, delaying the diagnosis of prostate cancer;
- Failure to appropriately evaluate a patient with complaints of abdominal pain and performing unnecessary testing;
- Habitual intemperance and diversion of narcotics;
- Engaging in a sexual relationship with a patient and for making a false statement to the Board;
- Failing to obtain appropriate indications prior to performing bilateral mastectomies and for failure to maintain adequate medical records;
- Mismanagement of a chronic pain patient, predated prescriptions for narcotics, and prescribing narcotics without first conducting an evaluation and failure to maintain adequate medical records;
- Failure to adequately supervise Physician Assistants;
- Failing to appropriately evaluate and treat a patient with a horse bite injury to her hand and for failing to maintain adequate medical records;
- Performing a procedure to which the patient did not consent;
- Committing a misdemeanor involving moral turpitude, and;
- Failing to notify the Board of a change of address in a timely fashion and for an inadequate medical record.

The Board chose to issue non-disciplinary **Advisory Letters** in the following cases because the violation did not rise to the level of discipline or it was a one-time technical error.

- Altering medical records;
- Falsely representing Board certification;
- Failure to document a pre- and post-operative radial nerve examination;
- Violating a federal statute;
- Failure to read an x-ray properly;
- Inadequate charting of indications for a second surgery and failure to obtain informed consent for a second procedure;
- Failure to mention a sponge that was visible on x-ray;
- Improper reading of pathology slides;
- Inappropriately recommending spinal surgery and for inadequate medical records
- Failure to perform a dilated fundal examination in the post-operative period;
- Failure to retain records for the statutory period;
- Improper evaluation and biopsy of a mass identified on MRI and for failure to obtain the appropriate studies of the mass on the MRI;
- Incomprehensible operative note;
- Failure to document a neck examination;
- Failure to personally evaluate a patient with profound thrombocytopenia;
- Failure to properly supervise the

technical aspects of an interventional heart catheterization;

- Failure to obtain drugs from a neurologist prior to prescribing to a known active drug user;
- Failure to timely address corneal edema;
- Signing predated prescriptions;
- Improper monitoring of renal function in a diabetic;
- Poor charting and failure ensure timely biopsy of a suspicious lesion;
- Failure to re-evaluate a patient for chronic seizure disorder before initiating treatment;
- Failure to order imaging to locate an IUD after imaging showed the IUD was not in the uterus and there was no history of expulsion;
- Failure to adequately view the cecum during a colonoscopy;
- Failure to order baseline renal function studies;
- Failure to document the reason for not providing a patient with his medical records;
- Failure to provide medical records in a timely manner;
- Failure to timely anti-coagulate a patient;
- Failure to timely address weight loss and failure to enunciate a plan for anemia and PSA;
- Failure to personally evaluate prior to delivery of a VBAC patient being induced with prostaglandin gel;
- Failure to adequately supervise a medical assistant, and;
- Failure to recognize a pituitary lesion.

Executive Director Resigns, Takes Post with FSMB

Timothy C. Miller resigned as Executive Director of the Arizona Medical Board and the Arizona Regulatory Board of Physician Assistants, effective October 19th. He begins his new job as a Senior Director for the Federation of State Medical Boards (FSMB) in the areas of government relations, policy development and education in November and will be based in Dallas.

James H. Thompson, M.D., president and CEO of the FSMB, says, "We are pleased to have someone with Mr. Miller's years of experience join [us]. His unique expertise in both medical board leadership and health regulatory law will be a great asset to our member boards."

Mr. Miller, who is a member of the State Bar of Arizona, became the Boards' Executive Director in December 2004. Before joining the agency, he was the Chief of the Bureau of Consumer Rights within the Division of Behavioral Health Services at the Arizona Department of Health Services.

"My decision to accept the FSMB position was bittersweet," Mr. Miller said. "On one hand, my new position is a tremendous opportunity for me to work on health care regulation at a national level, but it's hard to leave such a dedicated staff—people I'm very fond and proud of."

Mr. Miller attended his final Arizona Medical Board meeting as Executive Director on October 10th and 11th.

Board Chair, William R. Martin III, M.D., presented him with a certificate from Arizona Governor Janet Napolitano marking his service as well as a plaque from the Board in appreciation of the work he did during his nearly three years in the post.

Dr. Martin credits Mr. Miller's vision and leadership for the progress the agency has made under his direction. "Thanks to Tim Miller, the Board has a bright future," Dr. Martin said. "We want to continue his proactive approach and look forward to working with his successor in this regard."

Mr. Miller leaves with a number of major

accomplishments in the agency's reorganization. These were key points in his vision for the Medical Board when he became Executive Director. Starting with three investigators, he expanded the Case Management



(L-R) William R. Martin III, M.D. and Timothy C. Miller

Office to 13. Hard work by the investigative team and Board Members resolved hundreds of backlogged, outstanding cases, some of which were dormant for more than a year.

Past Executive Directors

The position of Executive Director of the Arizona Medical Board evolved over a span of several years.

In 1961, the Board created the position of Secretary-Treasurer—a role that had previously been the task of one of the then-five Board members.

Originally hired by the Board in 1956, Paul R. Boykin rose to the post of Executive Secretary in July 1964, as the Arizona Medical Board and Arizona Medical Association separated. Until that time, the Executive Secretary of the Medical Board was also the Executive Secretary of the Association. Five years later in July 1969, the job title was changed to Executive Director. Mr. Boykin served in that position for another 11 years.

Boards Launch Search for New Executive Director

The Arizona Medical Board—with the support of the Arizona Department of Administration—advertised for candidates for the position of Executive Director in late September and early October.

Board Chair, William R. Martin III, M.D., appointed four other members of the Board to work with him on a committee to conduct the nationwide search for a replacement. Joan Reynolds, P.A.-C, Chair of the Arizona Regulatory Board of Physician Assistants, was also named to the committee.

The Executive Director Search Committee has been reviewing applications and resumes and plans to narrow down the list of candidates to eight or ten whom the committee will interview.

The committee decided to hold the first round of interviews on Wednesday, December 12th and the final round before the whole Board on Saturday, December 15th.

Douglas N. Cerf who had been Associate Executive Director for four years succeeded Mr. Boykin in June 1981.

Upon Mr. Cerf's death in 1994, Mark R. Speicher, the Assistant Executive Director, was chosen to replace him.

Donna Nerner served as Acting Executive Director from March to May 1998 when the Board hired Claudia Foutz to be Executive Director. After she resigned in June 2002, Barry A. Cassidy, P.A.-C, former Chair of the Arizona Regulatory Board of Physician Assistants, was named Executive Director.

Newest Medical Board Member Is an Ophthalmologist



Todd Lefkowitz, M.D.

Governor Janet Napolitano has appointed Todd Lefkowitz, M.D., to a five-year term as a physician member of the Arizona Medical Board.

Dr. Lefkowitz is Board-certified in ophthalmology and is the Medical and Surgical Director with Nationwide Vision Group in Phoenix.

He has had an Arizona medical license since 1983 when he became Chief of Ophthalmology at Luke Air Force Base.

Prior to his position with the U.S. Air Force, Dr. Lefkowitz received his medical degree from New York University School of Medicine.

Dr. Lefkowitz is a Fellow of the American Academy of Ophthalmology and holds

memberships in the Arizona Medical Association and the Arizona Ophthalmological Society, as well as both the American and European Societies of Cataract and Refractive Surgeons.

Before his appointment to the Medical Board, he reviewed cases as one of the Board's Outside Medical Consultants.

Dr. Lefkowitz is a former Executive Committee member of Physicians for the Phoenix Symphony. He has authored two books.

If his face seems familiar, you may be a diehard fan of the long-running television quiz show, "Jeopardy." He was so good at providing the correct questions to Alex Trebek's answers that he was a three-time Jeopardy champion in 1991.

Physician Assistant Joins ARBoPA



Kristin A. Neal, P.A.-C, M.P.H.

Governor Janet Napolitano has appointed Kristin A. Neal, P.A.-C, M.P.H., to a four-year term as a member of the Arizona Regulatory Board of Physician Assistants.

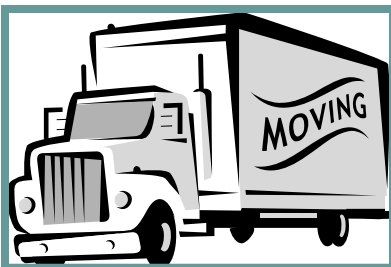
Ms. Neal works as a Physician Assistant in a Scottsdale family medicine practice and has had an Arizona license since 1999. She received her Physician Assistant education at Midwestern University in Glendale and her Master of Public Health from the University of Utah.

Ms. Neal currently serves as an Adjunct

Clinic Professor at Midwestern University. In her other professional activities, she has been the Clinical Editor for the Journal of the American Academy of Physician Assistants. And she has served as Chief Delegate for the Arizona Chapter of the Academy's House of Delegates and as Chair of the Legal and Legislative Affairs Committee for the Arizona State Association of Physician Assistants.

Ms. Neal replaces Albert Ray Tuttle, P.A.-C whose term had expired.

Moving? Make Sure You Tell Your Board



Your address and phone numbers are important if your regulatory board needs to contact you. Make sure you are meeting your legal requirements.

"The Board may assess the costs incurred by the Board in locating a licensee and in addition a penalty of not to exceed one hundred dollars against a license who fails to comply within 30 days from the date of change."

Physicians—A.R.S.§32-1435(A) and (B).

Physician Assistants—A.R.S.§32-2527(A) and (B).

You can find a "Change of Address" form under "Physician Center" on the Arizona Medical Board Web Site and under "PA Center" on the Arizona Regulatory Board of Physician Assistants site.

It is an act of unprofessional conduct not to inform your Board of an address change.

*Arizona Medical Board and Arizona
Regulatory Board of Physician Assistants*

9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Media Relations:

Roger Downey
Phone: 480-551-2713
Fax: 480-551-2828
E-mail: rdowney@azmd.gov

Public Information Dissemination

Lisa McGrane
Phone: 480-551-2724

Licensure

Suzann Grabe
Phone: 480-551-2756
Fax: 480-551-2704

Investigations

Fax: 480-551-2702

Medical Consultants

Christina Hedrei
Phone: 480-551-2728

Business Operations

Evangeline Webster
Phone: 480-551-2714
Fax: 480-551-2707

The Arizona Medical Board is committed to serving the public through the honest, fair, and judicious licensing and regulation of allopathic physicians (MDs). As it has in the past, the Arizona Medical Board will continue to gain public respect and trust by focusing on the issues that will shape positive healthcare environments.

As the utilization of physician extenders, such as physician assistants, continually increases, the Arizona Regulatory Board of Physician Assistants stays in touch with community needs and implements health care policy reforms to protect the public and provide guidance to its licensees. Within the last few years, the Board has systematically revised its laws and rules to stay abreast of healthcare trends.