NEVADA STATE BOARD OF MEDICAL EXAMINERS

NEWSLETTER

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Physician Suicide Letters - Answered

Guest Author: Pamela Wible, MD

I'm a family physician born into a family of physicians. My parents warned me not to pursue medicine. So, I went to medical school. Ten years later, I'm unhappy with the direction of my profession (and I'm not the only one). Then, I get this crazy idea: What if I ask for help? Not from the profession that wounded me, from random people on the street! So, I hold a town meeting and ask patients to help me—design an ideal medical clinic. I promise to do whatever they want as long as it's basically legal. That's going out on a limb!

I'm a go-out-on-a-limb kind of doctor. In med school, I protest the dog labs and I'm sent to the office of the Dean—who diagnoses me with "Bambi Syndrome." In residency, I'm caught giving patients recipes for kale salad. I'm sent to the office and reprimanded for not getting approval from the patient education committee. I'm still handing out unapproved kale salad recipes—now I'm taking on physician suicide in my newly released TEDMED talk.

We lose more than 400 doctors to suicide every year - that is an *entire* medical school gone. Given each physician may have a patient panel of nearly 2500 patients, this translates to more than one million Americans losing their doctors to suicide each year! And nobody tells patients the truth—the real reason they cannot see their doctors again. We can prevent the senseless deaths of our compassionate and brilliant doctors by breaking the silence on physician suicide.

I've been a doctor for twenty years. I've not lost a single patient to suicide. I've lost only colleagues, friends, lovers—ALL male physicians–to suicide.

Why?

There are answers. Finding them requires being willing to look at some very disturbing facts. It also requires the willingness to engage with people who have experienced and who continue to experience a great deal of pain. So I keep talking and writing—and listening for the truth. And because I'm listening with my heart and soul 24/7, my cell phone has turned into a suicide hotline. I've received hundreds of letters from suicidal physicians all over the world.

You may be wondering why so many people who want to help people end up killing themselves. That's why I wrote the book, *Physician Suicide Letters – Answered*.

I'm not a psychiatrist and have no formal training in suicide prevention. Yet, a number of medical students and physicians have told me that I helped to save their lives. How? By listening. By caring. By sharing my experiences and the experiences of others. Please read and share the following excerpts from *Physician Suicide Letters – Answered.* My hope is that sharing these letters will continue to help others find validation and inspiration to live.

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FEATURED IN THIS ISSUE:

ALSO IN THIS ISSUE:

MISSION STATEMENT

The Nevada State Board of Medical Examiners serves the state of Nevada by ensuring that only well-qualified, competent physicians, physician assistants, respiratory therapists and perfusionists receive licenses to practice in Nevada. The Board responds with expediency to complaints against our licensees by conducting fair, complete investigations that result in appropriate action. In all Board activities, the Board will place the interests of the public before the interests of the medical profession and encourage public input and involvement to help educate the public as we improve the quality of medical practice in Nevada.

BOARD NEWS

M. Neil Duxbury and April Mastroluca Join Board of Medical Examiners

Mr. M. Neil Duxbury and **Ms. April Mastroluca** were appointed by Governor Sandoval to positions on the Board of Medical Examiners effective December 11, 2015. The Board welcomes Mr. Duxbury and Ms. Mastroluca as public members.

Born in Reno, **Mr. Duxbury** was raised in northern Nevada and attended elementary, middle and high school in Washoe County before graduating from the University of Nevada, Reno with a Bachelor's Degree in Biology. During his college and post-college careers, Duxbury worked for the University of Nevada, Reno School of Medicine and the Veterans Administration Medical Center assisting with various medical research projects. He later assisted in medical research at the Karolinska Institutet in Stockholm, Sweden.

Duxbury, 52, is the founder and co-owner of Metropawn, the largest chain of privately owned pawn shops in the state. Metropawn has five locations in northern Nevada and three in southern Nevada. The company is entering its 24th year in business.

Duxbury is active in the community and supports such organizations as the Boys and Girls Club of Truckee Meadows, the University of Nevada-Reno, Bishop Manogue Catholic High School, and the Juvenile Diabetes Research Foundation. He has served as a member of the YMCA Capitol Campaign Committee, completed the Reno Chamber of Commerce Executive Training Program and was an active member of the Executive Association of Reno.

Duxbury lives with his wife and three daughters.

Ms. Mastroluca has spent many years dedicated to helping children and families.

A passion for working in the nonprofit industry began in 2002 when the Nevada Partnership for Homeless Youth hired Mastroluca to run the Safe Place Program. She was able to expand the program not only into the fire stations in southern Nevada, but she also worked to bring the program statewide by connecting with Children's Cabinet in Reno. Two years later, Mastroluca became the Fund Development Director for the Southern Nevada Chapter of the American Red Cross. Mastroluca then spent eight years as a National Service Representative for the National PTA. During her tenure with the PTA, Mastroluca worked with 23 states where she provided training, support, mentoring and coaching for volunteer leaders throughout the country on topics such as leadership development, membership recruitment, strategic planning, board development and advocacy. In June of 2014, Mastroluca was given the opportunity to bring her skills and knowledge home to Nevada when she accepted the position of Executive Director for the ALS Association Nevada Chapter.

Back home in Nevada, Mastroluca witnessed the struggle women and children faced in the absence of a Safe Haven Law in 2001. Mastroluca took action to help pass this critical legislation and once passed, led the effort to bring public awareness to this issue. This experience took Mastroluca to a new path of volunteerism: in 2008 she became a Nevada State Legislator, was re-elected twice and served until 2012. In December of 2012, Mastroluca presented her first TEDx talk at the FremontEastWomen Conference in Las Vegas, about her experience working on Safe Haven and serving in the Nevada Legislature.

Volunteerism has always been important to Mastroluca. She currently serves on the advisory board of SAFY (Specialized Alternatives for Families and Youth), she is the 2016 President of AFP Las Vegas Chapter (Association of Fundraising Professionals) and a member of Leadership Henderson, class of 2016. In the past, Mastroluca has participated in Junior League, served as a Girl Scout and Boy Scout troop leader, served as President of Kesterson Elementary PTA and was on the Nevada PTA state board.

Mastroluca has a Certificate of Nonprofit Board Education from BoardSource. Previously, she completed the Emerging State Leaders Program at the Darden School of Business and the Western Legislative Academy from the Council of State Governments, West.

Today, Mastroluca fulfills her passion for working with people by helping non profits through coaching and training, and she is a frequent speaker and media contributor on educational and legislative issues.

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NOTIFICATION OF ADDRESS CHANGE, PRACTICE CLOSURE AND LOCATION OF RECORDS

Pursuant to NRS 630.254, all licensees of the Board are required to "maintain a permanent mailing address with the Board to which all communications from the Board to the licensee must be sent." A licensee must notify the Board in writing of a change of permanent mailing address within 30 days after the change. Failure to do so may result in the imposition of a fine or initiation of disciplinary proceedings against the licensee.

Please keep in mind the address you provide will be viewable by the public on the Board's website.

Additionally, if you close your practice in Nevada, you are required to notify the Board in writing within 14 days after the closure, and for a period of 5 years thereafter, keep the Board apprised of the location of the medical records of your patients.

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POST TRAUMATIC STUDENT DISORDER

Post traumatic student disorder is a normal reaction to a traumatic educational experience.

March 12, 2013

Dear Pamela,

I am a physician in the UK and things here appear to be the same [as in the US]. I have several colleagues who have committed suicide over the years and I feel lucky to have survived myself. I am particularly disturbed by the prevalence of PTSD among colleagues. Yes indeed I was traumatized in medical school and it continues to happen, but we get accustomed to it – to the point of becoming an abused class.

Christian

March 13, 2013

Dear Christian,

I was hoping it would be better elsewhere. Very disheartening. I always tell docs, "You can't be a victim and healer at the same time." Speaking the truth is the first step to healing. That so many caring young medical students graduate with PTSD is a crime against humanity. We pay more than $300,000 tuition for this abuse. What a racket!

Pamela

★ ★ ★

March 23, 2015

Pamela,

I am not surprised at the number of suicides among medical practitioners. I was a nurse for years and went back to school to be a physician assistant. There is so much abuse handed out in training. At the time I was in school, we still had some thirty-six-hour shifts. It was difficult. At least at the university that I attended they had a buddy program. All of the first-year students were given a third-year student to help show us around and be a mentor. The problem was before we even started our first classes. My mentor committed suicide. She was in her car on her way home still close to the hospital when she stopped at a red light then picked up a gun and shot herself in the head. The person behind her was a physician at the hospital. These things are not that unusual. It's a sad state of affairs.

Patricia

ANTI-MENTORS & TORMENTORS

Students describe medical school as an anti-mentorship program. They meet a lot of doctors they'd never want to become.

November 21, 2014

Dear Pamela,

Thanks for your fine work. It's nice to see such a serious problem discussed openly. I attended Harvard Medical School, made what the books assured me was a reliable suicide attempt, woke up thirty-six hours later. Blind luck. I was offered an antidepressant, time off doing research, and the choice to return or not. Nothing more. Studying was no big deal: that was like asking a fish to swim. Sleep deprivation was devastating, and I have come to see it as completely counterproductive as an educational strategy. It risks countless patients' lives and serves only as an advanced form of hazing, more thorough and relentless and of greater duration than any hazing I've found elsewhere. Other forms of bullying take on new toxicity when one is so weakened and vulnerable. So I got out. I'm a nurse and a teacher now. People often ask me "why" I 'm not a doctor. Why? Because I stood up for myself, at long last.

Glenn

EXISTENTIAL INQUIRY

Life is an enigma. So I went to medical school to see if I could make sense of things. Now I have more questions than answers.

April 5, 2014

Dear Pamela,

I suspect that you would be hard-pressed to find one of us who isn't at least sometimes suicidal. We're just not allowed to admit it as it would end our careers.

James

INVISIBLE DOCTORS

What does it mean when physicians are unable to be seen as human beings?

December 7, 2014

Pamela,

In anesthesiology, it seems we have a higher percentage of death by suicide than other medical specialties. My colleague took his own life over a year ago. I was basically okay until then, but it's how everyone reacted that really got me. The show must go on. We diverted patients the first night, probably because the ER had to see Joe when he came in. The next day all of us were back at

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work in the operating room. There was no time to grieve and we in the department were so stunned we did not know what we needed and what to ask for. It felt like abuse to not honor him or his colleagues with some rescheduling of operations. I will never be the same. I no longer see medicine as a force for good. It seems like it is a way for other people to make money off our talent, intelligence, education or determination.
He was my friend!
Bruce

December 7, 2014
Dear Bruce,

I'd love to speak with you. As helpers, we are not great at asking for help. Anesthesiologists are really high risk. Many reasons I'd like to share. Can you imagine if school shootings were handled the way doc suicides are? "Get back to class. Don't ask about Joe. Just do your algebra?" Let's talk soon.
Pamela

December 7, 2014
Pamela,

That would be excellent. Your article "Physician Suicide 101: Secrets, Lies & Solutions" [see resources] was one of the first reports I have seen which really and bravely addressed this epidemic. I was relieved to see it in print. After Joe died last year, one partner fell ill, and one left the practice. Joe had been on call the night before the morning he hanged himself. He did it while his wife was at the grocery store with their youngest child. I'm okay, but really disillusioned about the world I worked so hard to join. I'm infuriated at the state of affairs in medicine, and wish I could open my own clinic, but I'm in the wrong field.
Bruce

YOU ARE NOT ALONE

If you made it to medical school you're already in the top 1% of compassion, intelligence, and resilience. You have no resilience deficiency. You're not defective. You're responding normally to an abusive medical system. So are you peers (who are also hiding their tears).

December 3, 2015
Dear Dr. Wible,

I'm not sure you read your Facebook messages but feel compelled to thank you. I was finishing term two of med school and had a bottle of Xanax in my hand. I was ready, as so many of us are. I took three then three more and came across this link, "How to graduate medical school without killing yourself" [see resources], which I believe may have saved my life and a couple of close friends who are also suffering. I'm near the top of my class and praying for death to escape the trap I'm locked into. I was in true delirium from lack of sleep and fear of failure. Studying in my sleep and waking up every hour in panic. Med school is doable but why must it be taught in this format? I read your stories and I'm just in shock how many others feel like I do or I feel like they do. Please keep sharing. You are saving lives, friend.
Chris

SURVIVAL STORIES

Having survived, I now serve others.

May 22, 2014
Dear Pamela,

I entered recovery in 1996 in a five-month recovery program. I used alcohol, narcotics, and most anything else to change the way I felt. Returning to work resulted in three trips to the psychiatric lockdown units. I spent a summer in bed. Didn't practice for a year. Was in my garage with a rope around my neck.

Therapy, support groups, medications, family love have helped control my diseases. I continue to see my psychiatrist quarterly and take my prescribed three antidepressants/mood stabilizers. Support meetings at least once weekly and retreat experiences quarterly. Actively pursue recovery and helping others.

Along the journey, I have bought my solo practice and just finished a two-year stint as Chief of Staff at our hospital. I take joy in attending support meetings in the same room where I chaired Med Exec meetings.

I share my experience, strength and hope very selectively with colleagues, patients and anyone else I think may benefit. I carry no shame but caution about public naïveté and professional ignorance.

I am forever grateful I removed the noose and got down off that ladder and have pursued life. It involves a lot of work, but I am rewarded daily.

Any way I can assist? The loss of an entire medical school on an annual basis is truly saddening. I am grateful to be the one who got off the ladder. Are there many stories of survival?
Mark

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COMMUNITY ACTION

Let's create a world where nobody has to write a suicide note.

September 6, 2014

Dear Pamela,

You were there for me when I needed you, and likely saved me from becoming yet another statistic. I have a rare heart disease, and the unrealistic pressure of my job was literally killing me. I had stopped all of my medications for nearly two weeks literally hoping for the inevitable. Instead, I just endured an accelerating pattern of angina, anxiety, and migraines, which just fueled my depression to put an end to it all.

I have started all of my medications and awaken each day grateful for the gift of life. In part, I owe that to you. For a time, my demons took charge and I was ready to concede defeat. Because you took the time to contact me on that pivotal day in my own tumultuous journey, I have the courage to go on. Day by day, one step at a time, I think I can. Thank you for being there for me and so many others in peril. Those of us who spend our lives on the edge, literally dying to heal.

Fondly,

Karyn

September 6, 2014

Karyn,

I am wondering what we can do as a community to save others in medicine. I think giving hope is often more important than any drug. What are your thoughts?

Pamela

September 6, 2014

Dear Pamela,

Suicide is rampant in our society itself, and none of us want to broach the topic. A frank discussion about suicide needs to be a mandatory part of the core curriculum in medical school. As a portion of that course, each student should meet with a guidance counselor or physician mentor, someone who will be available to them throughout their years of study.

We must remove the stigma of depression and mental illness and bring humanity back to the practice of medicine. As a profession, we must draw the line in the sand and say no to insurance and pharmaceutical companies. We can and must publicize the tragedy of American medicine and offer a better collaborative alternative to the cookie-cutter approach. Every protest movement begins with a single voice of reason. It always seems an insurmountable challenge. But one voice added to one voice and so on becomes an unstoppable movement of change and liberation for us all.

Karyn

I never went looking for suicides. These suicides found me. I have many suicide letters. My book contains only a small sample of letters from Canada, Egypt, India, South Africa, UK and the USA illustrating the cycle of abuse as a global phenomenon.

I invite you to take action – to do something, to join me. On behalf of those we've lost and those who are barely hanging on, I thank you for spreading your love and shining your light into this world. We need you.

What you can do now:

1) Read *Physician Suicide Letters—Answered*. Share with your colleagues.

2) View and share TEDMED talk - *Why Doctors Kill Themselves*.

3) View the film trailer for the forthcoming documentary on physician suicide. Sponsor the film.

4) Make physician wellness a priority in your organization. Need help? Contact me.

Pamela Wible, MD, is the founder of the Ideal Medical Care Movement and was named one of the 2015 Women Leaders in Medicine by the American Medical Student Association for her pioneering contributions to medical student and physician suicide prevention. She has been interviewed by CNN, ABC, CBS, and is a frequent guest on NPR. Dr. Wible lives in Eugene, Oregon, where she loves caring for patients as a solo family physician in a clinic designed entirely by her community. Contact Dr. Wible: http://www.idealmedicalcare.org/contact.php Website: www.idealmedicalcare.org

References and Resources

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(All book proceeds will be used to humanize our medical education system and help save the lives of suicidal medical students and doctors.)
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Physician Suicide: 101 Secrets, Lies & Solutions by Pamela Wible, MD
http://www.kevinmd.com/blog/2014/11/physician-suicide-101-secrets-lies-solutions.html

How to Graduate Medical School Without Killing Yourself by Pamela Wible, MD
http://www.idealmedicalcare.org/blog/how-to-graduate-medical-school-without-killing-yourself/

Five Ways to Evaluate Business Associate Agreement Indemnification Provisions

'Article originally appeared in January 22, 2016 edition of American Health Lawyers Association Weekly and reprinted with permission of author'

By Rachel V. Rose, JD, MBA

Data privacy extends across the globe and can impact a multitude of entities from providers to business associates to subcontractors. The Health Insurance Portability and Accountability Act (HIPAA) and the related final rules require that a Business Associate Agreement (BAA) be executed between the parties that create, receive, maintain, or transmit information.

Required under the Omnibus Rule, the BAA is a contract that should be given as much consideration as every other document that the parties execute. A crucial, yet optional provision is the indemnification clause. In essence, "[i]ndemnification is a contractual obligation by one party to pay or compensate for the losses or damages or liabilities incurred by another party to the contractor by some third person."[1] While not a required element, it is an important provision to consider in drafting a BAA. Here are five ways to assess the type of indemnification provision that hospitals, physicians, and business associates may wish to include in their BAAs.

Analysis

Use adequate due diligence to determine risk. The general premise associated with an indemnity clause is that it represents the transfer of risk between two contracting parties. But, before a hospital agrees to an indemnification provision, read it closely and consider the other party's state of compliance. The fundamental purpose of a BAA is to provide reasonable assurances to the other party that the relevant laws (i.e., HIPAA, the HITECH Act, and state and international laws) are complied with in relation to the creation, receipt, transmission, and storage of protected health information (PHI).[2] Before agreeing to indemnify a party, ask a series of five questions: (1) have you undergone a HIPAA risk assessment and risk analysis; (2) do you train all of your employees annually and within the requisite state law time frames; (3) do you obtain reasonable assurances from business associates and subcontractors that you work with; (4) is your data encrypted at rest and in transit; and (5) are your policies and procedures up to date? Asking these questions enables your organization to formulate more detailed questions before agreeing to enter into the business relationship and, more importantly, the type of indemnification clause your hospital may agree to.

Understand the types of possible indemnification provisions. An indemnitor is the party who is obligated to pay another. An indemnitee is the party who is entitled to receive the payment from the indemnitor.[3] In general, indemnification provisions fall into three categories: full indemnification of one party by another party; mutual indemnification; and limited indemnification (i.e., only certain acts or laws are considered).[4] Implied indemnification, that is when no provision exists in a contract, may be permissible under certain states' common law.

A related item is whether or not to use the phrase "hold harmless and indemnify" or simply "indemnify" or "hold harmless" independent of one another.[5] According to *Mellinkoff's Dictionary of American Legal Usage*, "indemnify" solely protects against losses, while "hold harmless" protects against losses and liabilities.[6] A California Court of Appeal case, *Rooz v. Kimmel*,[7] illustrates the importance of this nuance. In *Rooz*, the court was tasked with determining, "whether a hold harmless agreement absolved North American Title Company (North American) of liability for negligence when North American failed to record a deed of trust in a timely fashion. We conclude the trial court correctly found the hold harmless agreement protected North American."[8] Here, the parties executed a Master Agreement of Indemnification, which had the express language to "hold harmless, protect and indemnify."[9] Hence, all of the terms were present in the agreement, so the question of addressing a single term was not necessary.

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Appreciate the relationship between the parties and the nature of the services. There are four types of parties that could be related to the indemnification provision: covered entities, business associates, subcontractors, and third parties.[10] The nature of the relationship can determine the level of liability. For example, a large hospital utilizing technology companies to handle the IT operations related to PHI could have significant vulnerabilities in relation to the confidentiality, integrity, and availability of the data. And, oftentimes, these companies utilize subcontractors. Understanding the primary relationship, as well as secondary relationships and anticipating third-party liability can be helpful in determining what your risk tolerance is in relation to the indemnification provision.

Utilize counsel to determine the laws in your state regarding indemnification. Different states may have differing statutes and case law regarding the use and interpretation of indemnity clauses.[11] It is important that counsel look at both the statutes and the case law to determine how the contract needs to be worded for that particular state, in order to be upheld. In general, courts interpret clauses word by word and some words are acceptable in certain jurisdictions or may have differing meanings between the different states' interpretations.

Appreciate that not all states allow the recovery of attorneys' fees associated with indemnification provisions. In certain states, such as New York, an indemnity provision may include the right for the cost of reasonable attorneys' fees and the cost of defense, as part of the indemnified amount.[12] Illinois and other states require that these terms be expressly detailed in the contract, as well as the duty to defend.[13] Whether or not e-discovery and experts fees are covered is another consideration. And, under the California Civil Code,[14] unless a contrary intention is stated in the contract, the indemnitor has the immediate obligation to defend or fund the defense against all indemnified claims.

Conclusion

In sum, words matter. Hence, parties should review the indemnification provisions of a BAA and related contracts with a keen eye. Failure to do so can result in timely and costly litigation, as well as lack of protections.

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[1] *See Weissman v. Sinorm Deli,* 88 N.Y.2d 437, 446 (N.Y. 1996); Cal. Civ. Code § 2772.
[2] 45 C.F.R. § 164.504(e)(1).
[3] Mary Brandt Jensen, *Determining the Obligation to Defend Under Indemnity Contracts Governed by Louisiana Law*, Louisiana State Law Review (Sept. 1986), *available at,* http://digitalcommons.law.lsu.edu/cgi/viewcontent.cgi?article=5009&context=lalrev (last accessed Nov. 12, 2015).
[4] Stafford Matthews, *Indemnification Clauses*, ACC New York (Nov. 14, 2013), *available at,* https://www.acc.com/chapters/gny/upload/Indemnification-Clauses-Stafford-Matthews-11-14-13.pdf.
[5] *See Are "Indemnify" and "Hold Harmless" the Same?, available at,* http://www.legalwritingpro.com/articles/D05-indemnify-hold-harmless.php (last accessed, Nov. 12, 2015).
[6] *Mellinkoff's Dictionary of American Legal Usage*, p.286 (1992).
[7] 55 Cal.App.4th 573 (1997).
[8] *Id.*
[9] Id.
[10] U.S. Department of Health and Human Services, Business Associate Contracts (Jan. 25, 2013), *available at*, http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/contractprov.html.
[11] *See An Overview of Indemnification and The Duty to Defend, available at,* http://docs.acec.org/pub/DA77E02A-C742-9915-1727-73DF2CCC23B9.
[12] *Gotham Partners, L.P. v. High River, L.P.,* Index No. 602582/04 (App. Div. 1st Dep't July 20, 2010).
[13] *Negro Nest, LLC v. Mid-Northern Management, Inc*., No. 4-04-0333, 2005 WL 3277959 (4thDist. 2005).
[14] Cal. Civ. Code §§ 2772-2784.5, *available at,* http://www.leginfo.ca.gov/cgibin/displaycode?section=civ&group=02001-03000&file=2772-2784.5.

Disclaimer: ***The opinions expressed in the article are those of the author, and do not necessarily reflect the opinions of the Board members or staff of the Nevada State Board of Medical Examiners.***

CDC Releases Guideline for Prescribing Opioids for Chronic Pain

Recommendations to improve patient care, safety, and help prevent opioid misuse and overdose

As part of the U.S. government's urgent response to the epidemic of overdose deaths, the Centers for Disease Control and Prevention (CDC) today is issuing new recommendations for prescribing opioid medications for chronic pain, excluding cancer, palliative, and end-of-life care. The *CDC Guideline for Prescribing Opioids for Chronic Pain, United States, 2016* will help primary care providers ensure the safest and most effective treatment for their patients.

The United States is currently experiencing an epidemic of prescription opioid overdose. Increased prescribing and sales of opioids - a quadrupling since 1999 - helped create and fuel this epidemic.

"More than 40 Americans die each day from prescription opioid overdoses, we must act now," said CDC Director Tom Frieden, MD, MPH "Overprescribing opioids—largely for chronic pain—is a key driver of America's drug-overdose epidemic. The guideline will give physicians and patients the information they need to make more informed decisions about treatment."

The guideline provides recommendations on the use of opioids in treating chronic pain (that is, pain lasting longer than three months or past the time of normal tissue healing). Chronic pain is a public health concern in the United States, and patients with chronic pain deserve safe and effective pain management. This new guideline is for primary care providers—who account for prescribing nearly half of all opioid prescriptions—treating adult patients for chronic pain in outpatient settings. It is not intended for guiding treatment of patients in active cancer treatment, palliative care, or end-of-life care.

While prescription opioids can be part of pain management, they have serious risks. The new guideline aims to improve the safety of prescribing and curtail the harms associated with opioid use, including opioid use disorder and overdose. The guideline also focuses on increasing the use of other effective treatments available for chronic pain, such as non-opioid medications or non-pharmacologic therapies.

By using the guideline, primary care physicians can determine if and when to start opioids to treat chronic pain. The guideline also offers specific information on medication selection, dosage, duration, and when and how to reassess progress and discontinue medication if needed. Using this guideline, providers and patients can work together to assess the benefits and risks of opioid use.

Among the 12 recommendations in the guideline, three principles are key to improving patient care:

- Non-opioid therapy is preferred for chronic pain outside of active cancer, palliative, and end-of-life care.
- When opioids are used, the lowest possible effective dosage should be prescribed to reduce risks of opioid use disorder and overdose.
- Providers should always exercise caution when prescribing opioids and monitor all patients closely.

"Doctors want to help patients in pain and are worried about opioid misuse and addiction," said Debra Houry, MD, MPH, director of CDC's National Center for Injury Prevention and Control. "This guideline will help equip them with the knowledge and guidance needed to talk with their patients about how to manage pain in the safest, most effective manner."

In developing the guideline, CDC followed a rigorous scientific process using the best available scientific evidence, consulting with experts, and listening to comments from the public and partner organizations. CDC is dedicated to working with partners to improve the evidence base and will refine the recommendations as new research becomes available.

CDC developed user-friendly materials to assist providers with implementing the recommendations, including a decision checklist. Materials and information for patients are available at www.cdc.gov/drugoverdose/prescribing/guideline.html.

CDC Releases Guideline for Prescribing Opioids for Chronic Pain

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CDC will continue to work with states, communities, and prescribers to prevent opioid misuse and overdose by tracking and monitoring the epidemic and helping states scale up effective prevention and treatment programs. CDC also continues to improve patient safety by equipping health care providers with data, tools, and guidance so they can make informed treatment decisions.

Health and Human Services (HHS) Secretary Sylvia Burwell has made addressing opioid misuse, dependence, and overdose a priority. Other work on this important issue is underway within HHS. The evidence-based HHS-wide opioid initiative focuses on three priority areas: informing opioid prescribing practices, increasing the use of naloxone (a rescue medication that can prevent death from overdose), and expanding access to and the use of Medication-Assisted Treatment to treat opioid use disorder.

These efforts build on work that began in 2010, when the President released his first National Drug Control Strategy, which emphasized the need for action to address opioid misuse and overdose, while ensuring that individuals with pain receive safe, effective treatment. Also in 2010, the Affordable Care Act improved access to substance use disorder treatment options by requiring coverage of substance use disorder services in the Health Insurance Marketplace and establishing important parity protections to ensure that substance use disorder coverage is comparable to medical and surgical care coverage. The next year, the White House released its national Prescription Drug Abuse Prevention Plan to outline goals for addressing prescription drug misuse and overdose. Since then, the Administration has supported and expanded community-based efforts to prevent drug use and pursue "smart on crime" approaches to drug enforcement, as well as efforts to improve prescribing practices for pain medication and increase access to treatment, to reduce overdose deaths and support the millions of Americans in recovery. Visit the full press release for more details.

Link for Digital Press Kit: http://www.cdc.gov/media/dpk/2016/dpk-opioid-prescription-guidelines.html **Contact:** Media Relations (404) 639-3286

For related information:

- JAMA Special Communication: CDC Guideline for Prescribing Opioids for Chronic Pain
- Guideline Resources
- Opioid Basics
- Prescription Opioids
- Overdose Prevention

FDA Drug Safety Communication: FDA warns about several safety issues with opioid pain medicines; requires label changes

The U.S. Food and Drug Administration (FDA) is warning about several safety issues with the entire class of opioid pain medicines. These safety risks are potentially harmful interactions with numerous other medications, problems with the adrenal glands, and decreased sex hormone levels. We are requiring changes to the labels of all opioid drugs to warn about these risks.

- Opioids can interact with antidepressants and migraine medicines to cause a serious central nervous system reaction called serotonin syndrome, in which high levels of the chemical serotonin build up in the brain and cause toxicity (see List of Serotonergic Medicines).
- Taking opioids may lead to a rare, but serious condition in which the adrenal glands do not produce adequate amounts of the hormone cortisol. Cortisol helps the body respond to stress.
- Long-term use of opioids may be associated with decreased sex hormone levels and symptoms such as reduced interest in sex, impotence, or infertility.

Opioids are a class of powerful narcotic pain medicines that are used to treat moderate to severe pain that may not respond well to other pain medicines (see List of Opioids). They can help manage pain when other treatments and medicines are not able to provide enough pain relief, but they also have serious risks including misuse and abuse, addiction, overdose, and death.

Additional Information - Recommendations and information for patients and health care professionals

Contact FDA: 855-543-DRUG (3784) and press 1 or druginfo@fda.hhs.gov

Report a Serious Problem to MedWatch: Complete and submit the report Online. Download form or call 1-800-332-1088.

HHS Awards $94 Million to Health Centers:
Will Help Treat Prescription Opioid Abuse and Heroin Epidemic in America

Health and Human Services (HHS) Secretary Sylvia M. Burwell has announced $94 million in Affordable Care Act (ACA) funding to 271 health centers in 45 states, the District of Columbia, and Puerto Rico to improve and expand the delivery of substance abuse services in health centers, with a specific focus on treatment of opioid use disorders in underserved populations.

"The opioid epidemic is one of the most pressing public health issues in the United States today," said Secretary Burwell. "Expanding access to Medication-Assisted Treatment (MAT) and integrating these services in health centers bolsters nationwide efforts to curb opioid misuse and abuse, supports approximately 124,000 new patients accessing substance use treatment for recovery and helps save lives."

The abuse of and addiction to opioids, such as heroin and prescription pain medication, is a serious and increasing public health problem. Approximately 4.5 million people in the United States were non-medical prescription pain reliever users in 2013, and an estimated 289,000 were current heroin users. HHS also estimates the number of unintentional overdose deaths from prescription pain medications has nearly quadrupled from 1999 to 2013, and deaths related to heroin increased 39 percent between 2012 and 2013.

Administered by the HHS Health Resources and Services Administration (HRSA), these awards to health centers across the country will increase the number of patients screened for substance use disorders and connected to treatment, increase the number of patients with access to MAT for opioid use and other substance use disorder treatment, and provide training and educational resources to help health professionals make informed prescribing decisions. This $94 million investment is expected to help awardees hire approximately 800 providers to treat nearly 124,000 new patients.

"Health centers treat some of the most at-risk patients in the country," said HRSA Acting Administrator Jim Macrae. "The awards position health centers to be at the forefront of the fight against opioid abuse in underserved communities."

Research demonstrates that a whole-patient approach to treatment through a combination of medication and counseling and behavioral therapies is most successful in treating opioid use disorders. In 2014, over 1.3 million people received behavioral health services at health centers, This represents a 75 percent increase since 2008 and was made possible with support from the ACA and the Recovery Act. Today's funding builds upon and leverages these previous investments by providing support to health centers to improve and expand the delivery of MAT substance abuse services in an integrated primary care/behavioral health model with a specific focus on treatment of opioid use disorders in underserved populations.

Today, over 1,300 health centers operate approximately 9,000 service delivery sites in every U.S. state, D.C., Puerto Rico, the Virgin Islands and the Pacific Basin; these health centers employ more than 170,000 staff who provides care for nearly 23 million patients. In 2014, health centers provided behavioral health services to more than 1.3 million patients, including those in need of substance abuse services.

"HRSA's innovative investment in the delivery of Medication-Assisted Treatment for substance use disorders affirms the importance of behavioral health to overall health," said Kana Enomoto, Acting Administrator of the Substance Abuse and Mental Health Services Administration.

Addressing the opioid crisis is a top priority for the Administration and the Department. HHS is focused on three key areas: improving opioid prescribing practices, increasing the use of naloxone, and increasing access to MAT. In addition, the President has made addressing the prescription opioid abuse and heroin epidemic a top priority and issued a Presidential Memorandum last year on improving access to MAT for opioid use disorders. Today's awards are an example of HHS taking every available step to expand access to MAT. Building on these efforts, the President's Budget includes a $1.1 billion initiative to help ensure that all individuals with opioid use disorders who want treatment are able to access it.

To view a list of the award winners, visit:
http://bphc.hrsa.gov/programopportunities/fundingopportunities/substanceabuse/fy16awards.html
For more information on HHS key areas of focus to address the opioid crisis, visit: http://www.hhs.gov/news/press/2015pres/03/20150326a.html
To learn more about HRSA's Health Center Program, visit: http://bphc.hrsa.gov/about/index.html
To find a health center in your area, visit: http://findahealthcenter.hrsa.gov/

VA Announces Additional Steps to Reduce Veteran Suicide

WASHINGTON – The Department of Veterans Affairs (VA) today announced new steps it is taking to reduce Veteran suicide. The steps follow a February 2 Summit, "Preventing Veteran Suicide – A Call to Action," that brought together stakeholders and thought leaders to discuss current research, approaches and best practices to address this important subject.

"We know that every day, approximately 22 Veterans take their lives and that is too many," said VA Under Secretary for Health, Dr. David Shulkin. "We take this issue seriously. While no one knows the subject of Veteran suicide better than VA, we also realize that caring for our Veterans is a shared responsibility. We all have an obligation to help Veterans suffering from the invisible wounds of military service that lead them to think suicide is their only option. We **must** and **will** do more, and this Summit, coupled with recent announcements about improvements to enhance and accelerate progress at the Veterans Crisis Line, shows that our work and commitment must continue."

Several changes and initiatives are being announced that strengthen VA's approach to Suicide Prevention. They include:

- Elevating VA's Suicide Prevention Program with additional resources to manage and strengthen current programs and initiatives;
- Meeting urgent mental health needs by providing Veterans with the goal of same-day evaluations and access by the end of calendar year 2016;
- Establishing a new standard of care by using measures of Veteran-reported symptoms to tailor mental health treatments to individual needs;
- Launching a new study, "Coming Home from Afghanistan and Iraq," to look at the impact of deployment and combat as it relates to suicide, mental health and well-being;
- Using predictive modeling to guide early interventions for suicide prevention;
- Using data on suicide attempts and overdoses for surveillance to guide strategies to prevent suicide;
- Increasing the availability of naloxone rescue kits throughout VA to prevent deaths from opioid overdoses;
- Enhancing Veteran mental health access by establishing three regional telemental health hubs; and
- Continuing to partner with the Department of Defense on suicide prevention and other efforts for a seamless transition from military service to civilian life.

Veterans Crisis Line
1-800-273-8255 PRESS 1

For information about VA initiatives to prevent Veteran suicide, visit: www.mentalhealth.va.gov/suicide_prevention/.

STATE OF NEVADA

BRIAN SANDOVAL
Governor

RICHARD WHITLEY, MS
Director

CODY L. PHINNEY, MPH
Administrator

LEON RAVIN, MD
Acting Chief Medical Officer

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Public and Behavioral Health

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Carson City, Nevada 89706
Telephone: (775) 684-4242 · Fax: (775) 684-4156

As of January 1, 2016, the State of Nevada, Office of Vital Records, requires the cause of death and certifier signature to be completed electronically per Nevada Administrative Code (NAC) 440.165. Since January 1, 2016 through mid-February 2016, our office has seen dramatic improvement with the overall completion of records.

At this point, the issue is physicians not completing the cause of death and signing the death certificate electronically in a timely manner. **This is a big issue for the family and friends of the decedent. They cannot receive a burial permit or death certificate without the certifier completing their portion of the death certificate. In some cases, services for the decedent have been postponed or held without the remains of the decedent.**

The Office of Vital Records is asking all physicians, who haven't signed up to be an electronic user, to do so immediately. If you have signed up, please make sure you access the system before you need to complete a death record.

Our office hasn't experienced any system issues. This system has been in place for approximately 9 years with several certifiers signing electronically for many years. Our office simply made it a requirement for all certifiers to sign electronically, since it has been in regulations for a few years.

The Office of Vital Records and the local health districts have provided assistance to many system users. Unfortunately, most of our assistance could have been prevented. Below, I have listed important bullet points to pay attention to:

- Please closely read the setup email and attached document previously sent to you. We are finding that most new applicants who cannot access the system haven't followed the login instructions or the location's firewall is blocking access to the system.
- Per NAC 440.160, the physician is required to sign within 48 hours of presentation of the certificate. The certificate is electronically presented when the certifier is assigned by the funeral home. The certifier should receive an email notification and be contacted by the funeral home. **Timely signing is crucial for family and friends,** but also affects the state of Nevada with timely reporting to the Centers for Disease Control (CDC).

Please contact the Office of Vital Records via email at ovrhelp@health.nv.gov or by phone at 775-684-4166 for any assistance with accessing the system.

You may also visit our website to review all information regarding this requirement.
http://dpbh.nv.gov/Programs/BirthDeath/dta/Publications/Vital_Records_Publications/

For training on using the system, please visit our website.
http://dpbh.nv.gov/Programs/BirthDeath/dta/Training/Birth/Death_Vital_Records_-_Training___Education/

Children YOUTH
with Special Health Care Needs

Nevada's Division of Public and Behavioral Health

ANNOUNCEMENT: Exciting News for Children and Youth with Special Health Care Needs (CYSHCN)…

A MEDICAL HOME PORTAL IS ON ITS WAY!

The CYSHCN program, which is the Maternal and Child Health Program of Nevada's Division of Public and Behavioral Health, is partnering with the University of Utah, Department of Pediatrics to create a customized web portal to provide easier access to resources and information on diagnoses and conditions, and allow physicians, professionals, families and communities to support local statewide services to work together. The website is designed to facilitate coordinated comprehensive care that leads to a healthier outcome for CYSHCN and their families. It is an online one-stop shop offering:

- Clinical decision support for primary care clinicians caring for children with chronic conditions;
- Information to support clinicians and parents responding to abnormal newborn screening tests;
- Information to support parents in caring for the CYSHCN, and for families, from birth or diagnosis through transition to adulthood, guiding them through the journey of raising a child with special needs, and partnering with health professionals;
- Information for clinicians to support their building a Medical Home, providing comprehensive care, integrating best practices, and partnering with families;
- Information about professional and community service providers to help CYSHCN and their families access services and to support robust referral practices; state information will be integrated into the content and will be searchable;
- Translation through the entire site by Google translate; and
- Automatic creation of custom lists of local services and resources for users, which can be edited, printed, saved and shared.

Nevada's Title V Maternal and Child Health Program, through this new partnership, will be better prepared to provide resources and educational materials in order to support, educate and empower families of CYSHCN throughout Nevada. The Medical Home Portal was established in 2002 through University of Utah, Department of Pediatrics with Montana, Idaho and New Mexico already successfully on board.

Currently, the Medical Home Portal can be accessed by going to www.medicalhomeportal.org, however Nevada will be linked in during the summer of 2016.

For any questions or further information please contact:

Laura Valentine, MS, Maternal and Child Health Program Manager

Email: lvalentine@health.nv.gov

(775) 684-5901

WHOM TO CALL IF YOU HAVE QUESTIONS

Management:	Edward O. Cousineau, JD Executive Director
	Todd C. Rich Deputy Executive Director
	Donya Jenkins Finance Manager
Administration:	Laurie L. Munson, Chief
Legal:	Robert Kilroy, JD General Counsel
Licensing:	Lynnette L. Daniels, Chief
Investigations:	Pamela J. Castagnola, CMBI, Chief

2016 BME MEETING & HOLIDAY SCHEDULE

January 1 – New Year's Day holiday
January 18 – Martin Luther King, Jr. Day holiday
February 15 – Presidents' Day holiday
March 4-5 – Board meeting
May 30 – Memorial Day holiday
June 3-4 – Board meeting
July 4 – Independence Day holiday
September 5 – Labor Day holiday
September 9-10 – Board meeting
October 28 – Nevada Day holiday
November 11 – Veterans' Day holiday
November 24 & 25 – Thanksgiving/Family Day holiday
December 2-3 – Board meeting (Las Vegas)
December 26 – Christmas holiday (observed)

Nevada State Medical Association
3700 Barron Way
Reno, NV 89511
775-825-6788
http://www.nvdoctors.org website

Clark County Medical Society
2590 East Russell Road
Las Vegas, NV 89120
702-739-9989 phone
702-739-6345 fax
http://www.clarkcountymedical.org website

Washoe County Medical Society
3700 Barron Way
Reno, NV 89511
775-825-0278 phone
775-825-0785 fax
http://wcmsnv.org website

Nevada State Board of Pharmacy
431 W. Plumb Lane
Reno, NV 89509
775-850-1440 phone
775-850-1444 fax
http://bop.nv.gov website
pharmacy@pharmacy.nv.gov email

Nevada State Board of Osteopathic Medicine
2275 Corporate Circle, Ste. 210
Henderson, NV 89074
702-732-2147 phone
702-732-2079 fax
http://bom.nv.gov website

Nevada State Board of Nursing
Las Vegas Office
4220 S. Maryland Pkwy, Bldg. B, Suite 300
Las Vegas, NV 89119
702-486-5800 phone
702-486-5803 fax
Reno Office
5011 Meadowood Mall Way, Suite 300,
Reno, NV 89502
775-687-7700 phone
775-687-7707 fax
http://nevadanursingboard.org website

Unless otherwise noted, Board meetings are held at the Reno office of the Nevada State Board of Medical Examiners and videoconferenced to the conference room at the offices of the Nevada State Board of Medical Examiners/Nevada State Board of Dental Examiners, 6010 S. Rainbow Blvd., Building A, Suite 1, in Las Vegas.

Hours of operation of the Board are 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding legal holidays.

DISCIPLINARY ACTION REPORT

GLASSMAN, Irwin G., M.D. (4299)
Las Vegas, Nevada

Summary: Alleged malpractice and failure to maintain appropriate medical records related to his treatment of a patient.

Charges: One violation of NRS 630.3062(1) [failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient]; one violation of NRS 630.301(4) [malpractice].

Disposition: On March 4, 2016, the Board accepted a Settlement Agreement by which it found Dr. Glassman violated NRS 630.301(4), as set forth in Count II of the Complaint, and imposed the following discipline against him: (1) 15 hours of CME, in addition to any CME requirements regularly imposed upon him as a condition of licensure in Nevada, on the topic of ectopic pregnancies, early pregnancies, complications, EHR and medical record keeping; (2) $1,500.00 fine; (3) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter. Count I of the Complaint was dismissed with prejudice.

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NEVADA STATE BOARD OF MEDICAL EXAMINERS

1105 Terminal Way, Ste. 301

Reno, NV 89502-2144