



What Physicians Need to Know When Documenting Patient Non-Compliance

By: *Rachel V. Rose, JD, MBA*

Overview

The fundamental aspects of the physician-patient relationship are “care and respect.”¹ At some point in nearly every physician’s career, the issue of dealing with a patient who exhibits inappropriate/disruptive/non-compliant patient behavior comes to the forefront. Here, the physician has two options – keep the patient as a client or dismiss the patient. According to the American College of Physicians (ACP), “[o]ur position on this [dismissing the patient] is in the ACP ethics manual. We see it as a last resort. Otherwise it can be seen as abandonment.”² Whether the patient stays or goes, a central issue that all physicians should continually bear in mind is comprehensive documentation. Hence, the purpose of this article is to provide physicians with some suggestions on both documenting patient non-compliance and patient dismissal.

Documenting Non-Compliance

Documenting non-compliant patient behavior should be no different than any other aspect of documentation in the medical record. In sum, it needs to be comprehensive and meet the standards of medical necessity. Under Nevada law, “[h]ealthcare records’ means any reports, notes, orders, photographs, X rays or other recorded data or information whether maintained in written, electronic or other form which is received or produced by a provider of healthcare, or any person employed by a provider of healthcare, and contains information relating to the medical history, examination, diagnosis or treatment of the patient.”³ This definition provides the basics of what should be included in a medical record.

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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

Board Elects New Officers

On September 11, 2015, the Board of Medical Examiners voted to retain its current President and Vice President, and to elect a new Secretary-Treasurer for a yearly cycle. Dr. Michael Fischer, Carson City, was retained as President; Dr. Theodore Berndt, Reno, was retained as Vice President; and Dr. Bashir Chowdhry, Las Vegas, was elected Secretary-Treasurer. The three officer positions comprise the Board's Executive Committee, which acts to review administrative, limited budget, and personnel matters not subject to the open meeting law, between Board meetings.

Federal Grant Awarded to Support State Medical Boards in Developing Infrastructure for Interstate Medical Licensure Compact

The Federation of State Medical Boards (FSMB) announced an award from the Health Resources and Services Administration (HRSA) to support state medical and osteopathic boards in establishing a commission to administer the Interstate Medical Licensure Compact (Compact) and to develop requirements for its technical infrastructure.

The Compact establishes a voluntary pathway that will significantly streamline the licensing process for physicians seeking to practice medicine in participating states, while expanding access to healthcare, especially to patients in underserved areas of the country. The Compact has been enacted in Nevada and 10 other states this year, and legislation has been introduced in an additional 8 states.

The HRSA grant will support the establishment of the Interstate Medical Licensure Compact Commission, which will create the bylaws, rules and processes that will be used by participating states when they begin expediting licensure for eligible physicians. The grant also will support development of specifications for technical infrastructure and educational outreach to expand interest and participation in the Compact.

Work to date on the Compact initiative has been funded in part by the FSMB's existing grant under HRSA's Licensure Portability Grant Program, which has supported a variety of initiatives by FSMB and state medical boards to enhance physician mobility between the states and address statutory and regulatory barriers to multi-state practice and telemedicine.

The final model Compact legislation was released in September 2014. Since then, 19 state legislatures have introduced the legislation and nearly 30 state medical and osteopathic boards have publicly expressed support for the Compact. The Compact has been endorsed by a broad coalition of healthcare stakeholders, including the American Medical Association (AMA).

The Nevada State Board of Medical Examiners (Board) appointed Executive Director Edward O. Cousineau, J.D., to serve as the Board's Commissioner to the FSMB Interstate Medical Licensure Compact Commission at its September 11, 2015 meeting.

For more information about the Interstate Medical Licensure Compact, visit: <http://licenseportability.org/>

To read the Interstate Medical Licensure Compact legislation: [http://licenseportability.org/assets/pdf/Interstate-Medical-Licensure-Compact-\(FINAL\).pdf](http://licenseportability.org/assets/pdf/Interstate-Medical-Licensure-Compact-(FINAL).pdf)

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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.

A more comprehensive approach to documentation is found in the Texas Medical Board rules for medical records:⁴

“165.1. Medical Records (a) Contents of Medical Record. Regardless of the medium utilized, each licensed physician of the board shall maintain an adequate medical record for each patient that is complete, contemporaneous and legible. For purposes of this section, an ‘adequate medical record’ should meet the following standards:

- (1) The documentation of each patient encounter should include:
 - (A) reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
 - (B) an assessment, clinical impression, or diagnosis;
 - (C) plan for care (including discharge plan if appropriate); and
 - (D) the date and legible identity of the observer.
- (2) Past and present diagnoses should be accessible to the treating and/or consulting physician.
- (3) The rationale for and results of diagnostic and other ancillary services should be included in the medical record.
- (4) The patient’s progress, including response to treatment, change in diagnosis, and patient’s non-compliance should be documented
- (5) Relevant risk factors should be identified.
- (6) The written plan for care should include when appropriate:
 - (A) treatments, medications (prescriptions and samples) specifying amount, frequency, number of refills, and dosage;
 - (B) any referrals and consultations;
 - (C) patient/family education; and,
 - (D) specific instructions for follow up.
- (7) Include any written consents for treatment or surgery requested from the patient/family by the physician.
- (8) Include a summary or documentation memorializing communications transmitted or received by the physician about which medical decision is made regarding the patient.
- (9) Billing codes, including CPT and ICD-9-CM codes, reported on health insurance claim forms or billing statements should be supported by the documentation in the medical record.
- (10) All non-biological populated fields, contained in a patient’s electronic medical record, must contain accurate data and information pertaining to the patient based on actual findings, assessments, evaluations, diagnostics or assessments as documented by the physician.
- (11) Any amendment, supplementation, change, or correction in a medical record not made contemporaneously with the act or observation shall be noted by indicating the time and date of the amendment, supplementation, change, or correction, and clearly indicating that there has been an amendment, supplementation, change, or correction.
- (12) Salient records received from another physician or healthcare provider involved in the care or treatment of the patient shall be maintained as part of the patient’s medical records.
- (13) The board acknowledges that the nature and amount of physician work and documentation varies by type of services, place of service and the patient’s status. Paragraphs (1)-(12) of this subsection may be modified to account for these variable circumstances in providing medical care.”⁵

If additional treatment is necessary from a specialist or testing needs to be performed, a patient form could be given and a follow-up letter sent, asking where and when the tests or the specialist visit was conducted.

Patient Dismissal

Three excellent resources physicians can consult when considering patient dismissal are: state medical boards, the ACP and the American Medical Association (AMA). These three entities offer guidance in both their ethics manuals, as well as legal/regulatory considerations. From there, it is incumbent on the physician to consult a lawyer, who is well versed in health law to make sure the risk of being sued has been mitigated as much as possible.

“Unilateral discontinuation of the patient-physician relationship by the physician should only be done in rare circumstances and only when other care is available and the patient’s health is not going to be harmed,” said Lois Snyder Sulmasy, JD, director of the American College of Physician’s Center for Ethics and Professionalism. “Our position on this is in the ACP ethics manual. We see it as a last resort. Otherwise it can be seen as abandonment.”⁶

But, what constitutes suitable grounds to terminate the patient from the practice?

- Failure to keep appointments,
- The patient is unable or unwilling to pay for services,
- The patient is non-compliant with clinical orders,
- The patient displays abusive and/or disruptive behavior, which puts the staff and the other patients in harm's way.⁷

These four items can serve as the starting point. Next, physicians must consider if they are dismissing the patient from the practice or in a hospital setting where the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1985 kicks in.⁸ First, a provider cannot simply "abandon" a patient during the course of treatment until the patient is stabilized. It is also important to consider how the legal burden shifts once a patient is admitted to a hospital. "[I]f it is determined that an [emergency medical condition] EMC exists, the hospital must provide treatment to stabilize the medical condition, or appropriately transfer the individual to another hospital. If the hospital admits the individual as an inpatient for further treatment, the hospital's EMTALA obligation ends. Once an individual is admitted as an inpatient, state tort and medical malpractice law then govern the legal adequacy of that care. EMTALA is not a federal malpractice statute, and is not meant to supplant available state malpractice and tort remedies."⁹ A physician's liability shifts as soon as the patient is no longer considered under treatment or observation in the emergency room.

Aside from having comprehensive policy and procedures, documenting the reasons for the dismissal, and appreciating the context of the treatment environment, the most crucial action the physician needs to take is informing the patient of the dismissal via certified mail/return receipt and email. It is also prudent to contact the medical malpractice insurance carrier. The key items physicians should have in the letter are:

- State the reason(s) objectively for the dismissal;
- Include the name of the provider (physician or insurance carrier) that you, the physician has contacted to take over the care;
- Include a copy of the HIPAA compliant medical records, along with the signed HIPAA release form; and
- Provide a timeframe that you will be discontinuing care. Be certain to check the individual state laws, but 30 days is a good standard to avoid abandonment charges.¹⁰

State laws may have additional obligations or the state medical board may also offer advice. Be sure to document any correspondence with any insurance carrier, regulatory or professional authority. Overall, following these steps may decrease the chance of a lawsuit and ensure that the patient receives care.

Conclusion

In sum, dismissing a patient is not a light undertaking. Care should be taken to have complete, comprehensive and detailed medical records, which can be used to form the basis of an objective dismissal. Taking all of the aforementioned steps will not guarantee a lawsuit will not be filed. It will, however, give the physician and/or the hospital a more defensible position.

About the Author

Rachel V. Rose, JD, MBA is a Principal with Rachel V. Rose – Attorney at Law, PLLC located in Houston, TX. Ms. Rose holds an MBA with minors in healthcare and entrepreneurship from Vanderbilt University, and a law degree from Stetson University College of Law, where she graduated with various honors, including the *National Scribes Award* and *The William F. Blews Pro Bono Service Award*. Ms. Rose is licensed in Texas. Currently, she is Vice Chair of Publications for the Federal Bar Association's Corporations and Associations Counsel Division, the Co-editor of the American Health Lawyers Association's *Enterprise Risk Management Handbook for Healthcare Entities* (2nd Edition) and Vice Chair of the Book Publication Committee for the Health Law Section of the American Bar Association and Co-author of the ABA's publication, *The ABCs of ACOs*. Ms. Rose is an Affiliated Member with the Baylor College of Medicine's Center for Medical Ethics and Health Policy. She can be reached at: rvrose@rvrose.com.

¹ American College of Physicians, *Ethics Manual*, https://www.acponline.org/running_practice/ethics/manual/manual6th.htm#initiating (last accessed, Sept. 9, 2015).

² T. D'Arrigo, *Dismissing Patients Always a Last Resort*, available at, <http://www.acpinternist.org/archives/2013/09/dismiss.htm>.

³ NRS 629.021.

⁴ See, <http://resources.tmlt.org/PDFs/ten-things-that-get-physicians-sued.pdf> (last accessed Sept. 8, 2015).

⁵ Texas Medical Board, Board Rules Chapter 165.1-165.5 Medical Records, available at, http://texreg.sos.state.tx.us/public/readtacSext.ViewTAC?tac_view=4&ti=22&pt=9&ch=165&rl=Y

⁶ *Ibid*.

⁷ Elizabeth Woodcock, *Dismissing a Patient from Your Practice is Probably an Infrequent Event, Yet it is One That You Must Take Seriously* (Jul. 31, 2014), available at, http://professional.medtronic.com/rm/pmr/compliance-risk/NHCP-PM-PATIENT-DISMISS-CR#_VeOjOITXKA.

⁸ EMTALA was enacted in 1986 under Section 1867 of the Social Security Act. (42 U.S.C. § 1395dd). EMTALA was passed as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Pub. L. 99-272). See also, [https://www.healthlawyers.org/hlresources/Health%20Law%20Wiki/Emergency%20Medical%20and%20Labor%20Treatment%20Act%20\(EMTALA\).aspx](https://www.healthlawyers.org/hlresources/Health%20Law%20Wiki/Emergency%20Medical%20and%20Labor%20Treatment%20Act%20(EMTALA).aspx).

⁹ See [https://www.healthlawyers.org/hlresources/Health%20Law%20Wiki/Emergency%20Medical%20and%20Labor%20Treatment%20Act%20\(EMTALA\).aspx](https://www.healthlawyers.org/hlresources/Health%20Law%20Wiki/Emergency%20Medical%20and%20Labor%20Treatment%20Act%20(EMTALA).aspx).

¹⁰ *Supra* n. 4.

Disclaimer: The opinions expressed in the Guest Contributor's 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.

Ethical Issues for the Nevada Practitioner

Guest Author: J. Ivan Lopez, MD, FAAN, FAHS

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There are few issues as complex and vexing for the medical practitioner as the subject of medical ethics. There is not a good definition of medical ethics, even if one looks in a dictionary. Nevertheless, we all can agree, in its essence, ethics is the business of being human (or humane), and medicine is, above all else, humane.

In the next few paragraphs, I will try to summarize a few ethical principles that apply to those of us who have the honor and privilege to serve the people of the state of Nevada.

Good ethics always begin with good medicine. Practitioners need to know science and evidence-based medicine in order to apply sound ethical principles when we deal with our patients. Good clinical medicine rests on a solid scientific basis.

There are various ethical theories, and most of us, who are engaged in the daily practice of medicine use them all in different combinations. It is very important for the practitioner to understand that we all have biases. They are rooted in our cultural background, our upbringing, our life experiences, and our medical knowledge.

Ethics based on common morality - the so-called principlist approach - would emphasize the patient's autonomy and the need to respect the right to make medical decisions for himself or herself.

A patient's rights impose a corresponding duty not only upon his or her physicians, but also upon the whole health system that provides care.

As physicians, we must act for the patient's benefit (beneficence) and we want to avoid undue, unnecessary risk (non-maleficence).

We also have a duty to judiciously use our evermore limited resources in a practical way to try and benefit all of our patients under our care (principle of justice). Physicians who seek to accomplish the greatest good for the most people operate under the theory of utilitarianism. As an example of the application of this principle, there may be more benefit from removing a brain meningioma than by leaving it to grow larger and produce more impairment, and thus, leading to an even greater call upon society's limited resources.

The obligation-based theory states that we should treat all similar patients in a similar way. In this case, we would apply evidence-based medicine.

We must also distinguish between evidence-based medicine and evidence-only medicine. In the first scenario we apply published evidence to determine how best to treat our patients, understanding that there might be deviations depending on the circumstances. We would use wisdom, acquired through experience, to better benefit our patients. If we intend to practice evidence-only medicine, we would find that, in many circumstances, we have no scientific data to guide the medical decision-making process, and we would be left "paralyzed" and unable to make a decision that would benefit our patients without exposing them to undue risk.

At this point, it should be apparent that none of the individual theories thus far visited gets to the heart of what it means to be ethical.

Whatever theory or theories are used to guide our medical decision-making process, they must be clear and understandable, coherent and not self-contradictory in its elements, comprehensive in the sense that it should include more than one of the principles mentioned above, simple, straightforward, and practical.

We must remember that all ethics decisions must be based on knowledge of medicine and that we must always put the patient's benefit and welfare ahead of ours.

In the last few paragraphs I attempted to define a few ethical principles. We all use a combination of them in our daily practice of medicine. We must always remember to apply the old principle: First, do no harm.

Reference: McQuilen MP. What are Ethics? Continuum. 2003;9:11-15



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Drug Addiction in Healthcare Professionals

The abuse of prescription drugs—especially controlled substances—is a serious social and health problem in the United States today. People addicted to prescription medication come from all walks of life. However, the last people we would suspect of drug addiction are healthcare professionals—those people trusted with our well-being. Yet health care workers are as likely as anyone else to abuse drugs.

Even though the vast majority of DEA registered practitioners comply with the controlled substances law and regulations in a responsible and law-abiding manner, you should be cognizant of the fact that drug impaired health professionals are one source of controlled substances diversion. Many have easy access to controlled substance medications; and some will divert and abuse these drugs for reasons such as relief from stress, self-medication, or to improve work performance and alertness.

This guide will help you recognize the signs that may indicate that a colleague or coworker is diverting controlled substances to support a substance abuse problem.

What Are My Responsibilities?

You have a legal and ethical responsibility to uphold the law and to help protect society from drug abuse.

You have a professional responsibility to prescribe and dispense controlled substances appropriately, guarding against abuse while ensuring that patients have medication available when they need it.

You have a personal responsibility to protect your practice from becoming an easy target for drug diversion. You must become aware of the potential situations where drug diversion can occur and of safeguards that can be enacted to prevent this diversion.

How Do I Recognize a Drug-Impaired Coworker?

- Drug abusers often exhibit similar aberrant behavior. Certain signs and symptoms may indicate a drug addiction problem in a healthcare professional. Have you observed some of the following signs?
- Work absenteeism – absences without notification and an excessive number of sick days used;
- Frequent disappearances from the work site, having long unexplained absences, making improbable excuses and taking frequent or long trips to the bathroom or to the stockroom where drugs are kept;
- Excessive amounts of time spent near a drug supply. They volunteer for overtime and are at work when not scheduled to be there;
- Unreliability in keeping appointments and meeting deadlines;
- Work performance which alternates between periods of high and low productivity and may suffer from mistakes made due to inattention, poor judgment and bad decisions;
- Confusion, memory loss, and difficulty concentrating or recalling details and instructions. Ordinary tasks require greater effort and consume more time;
- Interpersonal relations with colleagues, staff and patients suffer. Rarely admits errors or accepts blame for errors or oversights;
- Heavy “wastage” of drugs;
- Sloppy recordkeeping, suspect ledger entries and drug shortages;
- Inappropriate prescriptions for large narcotic doses;
- Insistence on personal administration of injected narcotics to patients;
- Progressive deterioration in personal appearance and hygiene;
- Uncharacteristic deterioration of handwriting and charting;



- Wearing long sleeves when inappropriate;
- Personality change - mood swings, anxiety, depression, lack of impulse control, suicidal thoughts or gestures;
- Patient and staff complaints about healthcare provider's changing attitude/behavior; and
- Increasing personal and professional isolation.

Should I Become Involved?

Healthcare professionals often avoid dealing with drug impairment in their colleagues. There is a natural reluctance to approach a coworker suspected of drug addiction. There is the fear that speaking out could anger the coworker, resulting in retribution, or could result in a colleague's loss of professional practice.

Many employers or coworkers end up being "enablers" of healthcare practitioners whose professional competence has been impaired by drug abuse. Addicted colleagues are often given lighter work schedules, and excuses are made for their poor job performance. Excessive absences from the work site are often overlooked. Drug impaired coworkers are protected from the consequences of their behavior. This allows them to rationalize their addictive behavior or continue their denial that a problem even exists.

If you recognize the aforementioned signs or symptoms in a coworker, it's time to demonstrate concern. You may jeopardize a person's future if you cover up or don't report your concerns. Many well-educated, highly trained, and experienced healthcare practitioners lose their families, careers, and futures to substance abuse. Tragically, some healthcare workers have even lost their lives to their drug addiction because the people who saw the signs and symptoms of their drug use refused to get involved.

By becoming involved, you cannot only help someone who may be doing something illegal, but more importantly, your action could affect the safety and welfare of your addicted employee or coworker **AND** those patients or the public who may come in contact with him or her.

What If I Know That Drugs Are Being Sold or Stolen?

Drug abuse and drug dealing are serious problems that should be handled by qualified professionals. If you suspect that a drug deal is in progress, **do not** intervene on your own. Contact security or notify the police.

If you are a DEA registrant and become aware of a theft or significant loss involving controlled substances, you must immediately report the theft or loss to the nearest DEA office as well as your local police department.

What Can I Do to Help?

For some employees, the mere fact that their supervisor talks to them about their poor work performance is enough to help them change. For others, however, the problem may be more severe and require more drastic measures. The threat of losing a job may have more influence on a drug abuser than a spouse's threat to leave or a friend's decision to end a relationship. Many drug abusers will seek help for their problem if they believe their job is at stake, even though they have ignored such pleas from other people important in their life.

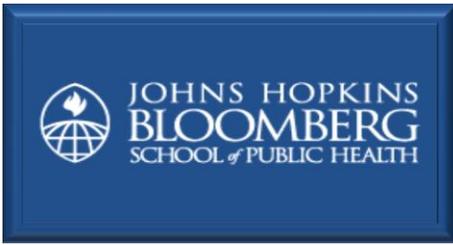
Drug addicts can recover, and effective help is available. Encourage your coworker or employee to seek drug treatment assistance. Treatment programs range from self-help to formal recovery programs. A number of state licensing boards, employee assistance programs, state diversion programs and peer assistance organizations will refer individuals and their families to appropriate counseling and treatment services. These services will maintain the confidentiality of those seeking assistance to the greatest extent possible.

*Department of Justice
Drug Enforcement Administration
Office of Diversion Control
Liaison and Policy Section
Washington, D.C. 20537*

It is not the intent of this publication to reduce or deny the use of controlled substances where medically indicated. Nothing in this guide should be construed as authorizing or permitting any person to do any act that is not authorized or permitted under federal or state laws.

Additional information on DEA's Diversion Control Program is available at: www.deadiversion.usdoj.gov

Study Finds Significant Differences in Frailty by Region and by Race Among Older Americans



SUBSTANTIAL DIFFERENCES BY INCOME ALSO FOUND

A large-scale survey of older Americans living at home or in assisted living settings found that 15 percent are frail, a diminished state that makes people more vulnerable to falls, chronic disease and disability, while another 45 percent are considered pre-frail, or at heightened risk of becoming physically diminished.

The Johns Hopkins Bloomberg School of Public Health study found frailty to be more prevalent in older people and more common among women and the poor. In addition, the study found wide regional differences in the U.S., with older people in central southern states more than three times as likely to be frail than those in the western states. The researchers also found significant racial differences, with blacks and Hispanics nearly twice as likely to be frail as whites.

The study is published in the September 2015 issue of *Journals of Gerontology: Medical Sciences*.

Frailty, once thought of as a generalized fragile state that befalls some people as they get older, is increasingly considered a medical process in and of itself. Frailty is thought to be exhibited by a set of symptoms including weakness, exhaustion and limited mobility. It often progresses separately from any underlying conditions, and is also common among patients with chronic diseases such as heart disease and diabetes, especially in their advanced stages.

Understanding frailty, and finding ways to prevent its onset or slow its progression, could improve older people's quality of life by extending their so-called robust years. It could also increase their chances of surviving surgery; for example, previous research has suggested that older, frail patients are less likely to survive major surgical procedures. Reducing frailty could lower healthcare costs, since frail persons are prone to falls and falls often lead to hospitalization. Hospital care is the largest component of Medicare spending.

Of their findings, the authors were most surprised by the significant racial and regional differences, says study leader Karen Bandeen-Roche, PhD, the Frank Hurley and Catharine Dorrier Professor and Chair of the Department of Biostatistics at the Johns Hopkins Bloomberg School of Public Health. The study is believed to be the first that examines regional differences in frailty in the U.S.

"We can't really explain the regional differences," says Bandeen-Roche, who also co-directs the Johns Hopkins Older Americans Independence Center and is a Core Faculty Member at the Johns Hopkins Center on Aging and Health. "We know there are health differences across the country, differences in diet and to some extent exercise habits. Observing the relatively low prevalence in the mountain west, you can imagine an active lifestyle might be a factor." As for the racial differences, Bandeen-Roche says it's too early to speculate, noting that they could be due to any number of factors, and merit further study.

For the study, researchers drew on interviews with 7,439 participants in the 2011 National Health and Aging Trends Study, a longitudinal study of people age 65 and older drawn from Medicare records. Participants, who resided either at home or in an assisted living facility, completed a two-hour, in-person interview that assessed frailty using several criteria: exhaustion, weakness, low physical activity, shrinking and low walking speed. Participants were also asked about their medical history and ability to perform daily tasks such as meal preparation and other household activities. The researchers assessed probable dementia with a combination of questions and cognitive tests.

Among the survey's other findings: Residents of assisted living facilities were more than twice as likely to be frail than those living in private homes. Prevalence increased with age, with 9 percent of those ages 65 to 69 found to be frail compared to 38 percent of those aged 90 or older. Among the frail, more than half had fallen in the previous year, and more than one-third had fallen several times, with 40 percent of those who had fallen being hospitalized.

As frailty becomes better understood, the researchers hope clinicians will develop recommendations that specifically address risks associated with frailty; for instance, having people engage in strengthening activities before major surgery. Such recommendations, if adapted by older people who have not yet slipped into advanced frailty, could help delay or even prevent its onset.

Aside from the 15 percent found to be frail, the researchers also found that 45 percent were what the authors deemed “pre-frail,” or older people who have begun to experience the same symptoms of frailty, but to a lesser extent. “It’s a question of degree,” Bandeen-Roche says. The so-called pre-frail are a prime target of study in order to help researchers understand the progression of frailty so doctors can develop recommendations – for instance, changes in diet or exercise – that could extend a person’s robust years.

“We would love for frailty assessment to become a standard component of assessment of older Americans,” Bandeen-Roche says. “Understanding frailty could potentially help us extend people’s quality of life into their later years.”

“**Frailty in Older Adults: A Nationally Representative Profile in the United States**” was written by Karen Bandeen-Roche, Christopher L. Seplaki, Jin Huang, Brian Buta, Rita R. Kalyani, Ravi Varadhan, Qian-Li Xue, Jeremy D. Walston and Judith D. Kasper.

This work was supported by the National Institutes of Health’s National Institute on Aging (U01-AG032947, P30-AG021334, and K01AG031332) and the National Institute of Diabetes and Digestive and Kidney Diseases (K23DK093583).

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HHS Announces Proposal to Update Rules Governing Research on Study Participants



Proposed changes enhance protections for individuals involved in research, while modernizing rules and improving efficiency

The U.S. Department of Health and Human Services has announced proposed revisions to the regulations that govern research on individuals who participate in research.

The current regulations that protect individuals who participate in research, which have been in place since 1991, are followed by 18 federal agencies and are often referred to as the Common Rule. They were developed at a time when research was predominantly conducted at universities, colleges and medical institutions, and each study generally took place at a single site. The expansion of research into new scientific disciplines, such as genomics, along with an increase in multisite studies and significant advances in technology, has highlighted the need to update the regulatory framework. Notably, a more participatory model of research has also emerged, with individuals looking for more active engagement with the research enterprise.

In July 2011, HHS issued an [Advance Notice of Proposed Rulemaking](#) to seek the public’s input on updating the Common Rule. The [Notice of Proposed Rulemaking](#) (NPRM) reflects that input and requests comments for HHS to consider as it drafts the final rule.

The protection of research participants is of paramount importance. Medical advances would not be possible without individuals who volunteer to participate in research. This NPRM proposes to modernize the current regulations by enhancing the ability of individuals to make informed decisions about participating in research, while reducing unnecessary burdens by streamlining the regulatory requirements for low-risk research.

Changes proposed in the NPRM issued include:

- *Strengthened informed consent provisions to ensure that individuals have a clearer understanding of the study’s scope, including its risks and benefits, as well as alternatives to participating in the study.*
- *Requirements for administrative or IRB review that would align better with the risks of the proposed research, thus increasing efficiency.*
- *New data security and information protection standards that would reduce the potential for violations of privacy and confidentiality.*
- *Requirements for written consent for use of an individual’s biological samples, for example, blood or urine, for research with the option to consent to their future use for unspecified studies.*
- *Requirement, in most cases, to use a single institutional review board for multi-site research studies.*
- *The proposed rule would apply to all clinical trials, regardless of funding source, if they are conducted in a U.S. institution that receives funding for research involving human participants from a Common Rule agency.*

HHS will take public comment on this NPRM for 90 days, beginning Sept. 8.

View here: <https://www.federalregister.gov/articles/2015/09/08/2015-21756/federal-policy-for-the-protection-of-human-subjects>

Immediate Need for Healthcare Facilities to Review Procedures for Cleaning, Disinfecting and Sterilizing Reusable Medical Devices

Distributed via the CDC Health Alert Network



Summary

The Centers for Disease Control and Prevention (CDC) and U.S. Food and Drug Administration (FDA) are alerting healthcare providers and facilities about the public health need to properly maintain, clean, and disinfect or sterilize reusable medical devices. Recent infection control lapses due to non-compliance with recommended reprocessing procedures highlight a critical gap in patient safety. Healthcare facilities (e.g., hospitals, ambulatory surgical centers, clinics, and doctors' offices) that utilize reusable medical devices are urged to immediately review current reprocessing practices at their facility to ensure they (1) are complying with all steps as directed by the device manufacturers; and (2) have in place appropriate policies and procedures that are consistent with current standards and guidelines.

Background

Recent media reports describe instances of patients being notified that they may be at increased risk for infection due to lapses in basic cleaning, disinfection, and sterilization of medical devices. These events involved failures to follow manufacturers' reprocessing instructions for critical^[1] and semi-critical^[2] items and highlight the need for healthcare facilities to review policies and procedures that protect patients.

Recommendations

Healthcare facilities should arrange for a healthcare professional with expertise in device reprocessing to immediately assess their reprocessing procedures. This assessment should ensure that reprocessing is done correctly, including allowing enough time for reprocessing personnel to follow all steps recommended by the device manufacturer. The following actions should be performed:

Training

- Healthcare facilities should provide training to all personnel who reprocess medical devices.
 - Training should be required and provided:
 - Upon hire or prior to provision of services at the facility
 - At least once a year
 - When new devices or protocols are introduced, including changes in the manufacturer's instructions for use during the device's life cycle
 - Personnel should be required to demonstrate competency with device reprocessing (i.e., trainer observes correct technique) prior to being allowed to perform reprocessing independently.
 - Healthcare facilities should maintain current documentation of trainings and competencies.
 - If the healthcare facility hires a contractor for device reprocessing, the facility should verify that the contractor has an appropriate training program and that the training program includes the specific devices the healthcare facility uses.
 - Copies of manufacturers' instructions for operating and reprocessing each type of reusable device should be readily available to staff and inspectors. This file should include instructions for use of chemical disinfectants.

Audit and Feedback

- Healthcare facilities should regularly audit (monitor and document) adherence to cleaning, disinfection, sterilization, and device storage procedures. Audits should assess all reprocessing steps, including:
 - Performing prompt cleaning after use, prior to disinfection or sterilization procedures
 - Using disinfectants in accordance with manufacturers' instructions (e.g., dilution, contact time, storage, shelf-life)
 - Monitoring sterilizer performance (e.g., use of chemical and biological indicators, read-outs of sterilizer cycle parameters, appropriate record keeping)

- Monitoring automated endoscope reprocessor performance (e.g., print out of flow rate, time, and temperature, use of chemical indicators for monitoring high-level disinfectant concentration)
- Audits should be conducted in all areas of the facility where reprocessing occurs.
- Healthcare facilities should provide feedback from audits to personnel regarding their adherence to cleaning, disinfection, and sterilization procedures.

Infection Control Policies and Procedures

- Healthcare facilities should allow adequate time for reprocessing to ensure adherence to all steps recommended by the device manufacturer, including drying, proper storage, and transport of reprocessed devices.
 - Considerations should be made regarding scheduling of procedures and supply of devices to ensure adequate time is allotted for reprocessing.
- Healthcare facilities should have protocols to ensure that healthcare personnel can readily identify devices that have been properly reprocessed and are ready for patient use (e.g., tagging system, storage in a designated area).
- Healthcare facilities should have policies and procedures outlining facility response in the event of a recognized reprocessing error or failure. Healthcare personnel should assess the cause of the error or failure and the exposure event in order to determine the potential risk of infection. The procedure should include how patients who might have been exposed to an improperly reprocessed medical device would be identified, notified, and followed.
- Individuals responsible for infection prevention and reprocessing at the healthcare facility should be consulted whenever new devices will be purchased or introduced to ensure that infection control considerations are included in the purchasing decision as well as subsequent implementation of appropriate reprocessing policies and procedures and to ensure that the recommended reprocessing equipment is available at the healthcare facility.
- Healthcare facilities should maintain documentation of reprocessing activities, including maintenance records for reprocessing equipment (e.g., autoclaves, automated endoscope reprocessors, medical washers and washer-disinfectors, water treatment systems), sterilization records (physical, chemical, and biological indicator results), and records verifying high-level disinfectants were tested and replaced appropriately.
- Healthcare facilities should follow manufacturer recommendations for maintenance and repair of medical devices that are used to perform reprocessing functions as well as medical devices that are reprocessed. If healthcare facilities contract maintenance and repair of these devices to third-party vendors, healthcare facilities should verify that these vendors are approved or certified by the manufacturer to provide those services.

[1] **Critical items** (e.g., surgical instruments) are objects used to enter sterile tissue or the vascular system and must be cleaned and sterilized prior to reuse.

[2] **Semi-critical items** (e.g., endoscopes for upper endoscopy and colonoscopy, laryngoscope blades) are objects that contact mucous membranes or non-intact skin and require, at a minimum, cleaning and high-level disinfection prior to reuse.

Additional Information:

Examples of relevant guidance include CDC's Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008, available at:

http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf; and guidance from the Association for the Advancement of Medical Instrumentation (AAMI), available at <http://www.aami.org/standards/index.aspx>. Healthcare administrators should work with their infection prevention personnel and accreditation organizations to ensure that all recommendations are properly implemented to protect patients and personnel.

Problems with medical device reprocessing should be reported to the FDA's MedWatch Adverse Event Reporting program either online at <https://www.accessdata.fda.gov/scripts/medwatch/>, by regular mail, or by fax. Download the form at:

<http://www.fda.gov/Safety/MedWatch/HowToReport/DownloadForms/default.htm> or call 1-800-332-1088 to request a reporting form, then complete and mail to address on the pre-addressed form, or submit by fax to 1-800-FDA-0178. Healthcare personnel employed by facilities that are subject to the FDA's user facility reporting requirements should follow the reporting procedures established by their facilities. Please see: <http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/PostmarketRequirements/ReportingAdverseEvents/ucm2005737.htm>

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national and international organizations.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Building the Empathetic Side of Practice

Special Website Enhances Provider Communication Skills

Free online CME Ethics and Professional Responsibility credit



MD Anderson

I*CARE

Interpersonal Communication and
Relationship Enhancement

Conveying bad news to a patient or a patient's family is one of the most challenging aspects of being a medical doctor. It's an emotional, stressful and sometimes uncomfortable situation for both the patient and physician to experience. Healthcare providers know that patients evaluate the effectiveness of their care based on factors that extend far beyond the purely clinical. How well clinicians communicate has a significant impact not only on patients' evaluation of their care and health outcomes but is also related to patients' quality

of life, psychological adjustment, compliance with care, and physician stress and burnout. Communication provides the basis for the establishment of trust and rapport between the patient and family and is necessary so that the patient and family can be appropriately informed about choices and educated about their care and the decisions they must make. Through The University of Texas MD Anderson Cancer Center's Interpersonal Communication And Relationship Enhancement (**I*CARE**) Program, doctors have access to numerous educational resources designed to help improve their communication skills, become more comfortable handling difficult discussions and can obtain [FREE online CME credit](#) for viewing these video demonstrations. **I*CARE** is the work of world-renowned communication skills experts [Walter F. Baile, M.D.](#), Professor, Department of Behavioral Science, the late [Robert F. Buckman, M.D., PhD.](#), Medical Oncologist and [Cathy Kirkwood, MPH](#), Project Director.

There is little hands-on communication skills training done in medical training programs, however skillful communication is a competency which can be taught and learned. The goal of the program is to be a resource for learning and teaching the skills necessary to manage challenging patient or family encounters and assist clinicians in extending their role beyond treating disease to establishing a therapeutic, supportive alliance with their patients. Since emotions play a powerful role in relationships with patients, there's a lot of anxiety and sadness in bringing bad news to someone. These modules show how to take the elephant in the room and shrink it down so it is a comfortable discussion for both parties by teaching how not to let your emotions get in the way and still tell the truth. The demonstrations cover a spectrum of conversations and teach effective responses to communication challenges to assist clinicians in sharpening their skills.

The site includes a module "[On Being An Oncologist](#)" where actors William Hurt and Megan Cole portray doctors and discuss their feelings about the stressors of caring for patients. The material in this video is based on focus groups conducted at MD Anderson by the Department of Faculty and Academic Development, where the program is housed. They teach [Fundamental Principles](#) of communication and each strategy is presented with explanations of what they are, how they work, as well as video vignettes that show a physician actually using them. The patients in these encounters are professional "standardized patient" actors, but the vignettes are unscripted, depicting situations that arise not only in the practice of oncology but in all clinical practices.

[Introduction to Basic Principles: CLASS-EVE-SPIKES-CONES](#)
[Non-Verbal Communication - In Depth](#)

The site also has [Advanced Skills](#) modules for having conversations about end of life, transition to palliative care, how to discuss options when treatments are no longer working and more specific topics such as:

["Crossroads"](#) - How to know when you've reached a point in conversation where these techniques are needed.
[Mr. Carter](#) - A man with lung cancer struggles to accept his illness (diagnosis, well-patient follow-up, recurrence transition to palliative care, end of life).

[Mrs. Anderson](#) - A patient with locally advanced breast cancer is followed from discussion of a clinical trial to the end of life and "saying goodbye."

[Mrs. Wright](#) - Guiding a patient with colon cancer through adjuvant chemotherapy, recurrence and palliative care.

["An Error Has Occurred..."](#) - A woman's son is told that his mother got the wrong dose of chemo.

["I'm Going To Mexico"](#) - A patient states that she is going for alternative treatment.

["My Mother's Not To Be Told"](#) - A patient's son demands that his mother not be told she has cancer.

["Don't Give Up On My Mother"](#) - A family member pleads for more treatment in the face of futility.

["Your Father Has Died"](#) - A physician announces a sudden death of a patient to his daughter.

["I Will Not Take Tamoxifen..."](#) - A patient has heard bad things about medicine she is prescribed.

["We'd Like To Discontinue Ventilation"](#) - A family is told that their loved-one is "brain dead."

["I'd Like More Information About Euthanasia"](#) - A patient expresses interest in assisted suicide.

["How Much Time Have I Got?"](#) - The doctor must respond to a difficult question about prognosis.

["The Patient Is Angry"](#) - A patient is very mad about a barium enema.

[Telephone Conversations](#) - Three situations that call for different strategies in giving test results.

[Genetic Counseling](#) - How to assess the need for genetic testing, evaluate the client and disclose the results.

[Culturally Competent Care](#) - Understanding how cultural competence builds trust and improves communication.

[Talking With Patients About Complementary Therapies](#) (No CME) – How to discuss these therapies with patients.

[Patients Talk About...Complementary Therapies And Cancer](#) (No CME) – Patient experiences to assist you in understanding why these therapies are important to them.

[What You Must Ask, And Why](#) (No CME) - The importance of communicating with patients about these therapies

Also included are materials on how to teach communication skills to others, [online lectures](#) from leaders in the field of clinical communication skills, and resources for both patients and providers. Free downloads of pocket guides to use as a quick review before having that difficult conversation are also available (hard copies are available upon request). The site has won numerous awards, including the **2005 International Health and Medical Media (FREDDIE)** award for the series "Complementary Therapies and Cancer", and three Telly awards, is accredited by Health on the Net Foundation (**HONcode**) and addresses the requirements of the Accreditation Council for Graduate Medical Education (**ACGME**) to obtain competencies in communication skills and professionalism.

Recognition and Awards

- 2013 [The University of Texas System Regents' Outstanding Teaching Award](#) – Walter F. Baile, M.D. - for delivery of the highest quality health education instruction
- 2012 eHealthcare Leadership Platinum Award - Best Health/Healthcare Content -Physician/Clinician Focused Site
- 2012 Distinguished Teaching Professor – Walter F. Baile, M.D. – Outstanding Contributions to Education
- 2012 [John P. McGovern Award](#) (American Medical Writers Association) - [Walter Baile, M.D.](#), [Cathy Kirkwood, MPH](#) - Excellence in Biomedical Communication Making a National/International Impact
- 2012 I*CARE listed on [iCollaborative](#) a service of [AAMC's MedEdPortal](#)
- 2010 [Lynn Payer Award](#) - Walter F. Baile, MD - Outstanding Contributions to the Literature, Theory, Practice and Teaching of Effective Healthcare Communication
- 2010 Silver People's [TELLY award](#) "[Crossroads](#)" and - [2 bronze awards](#) (Education, Training)
- 2005 International Health & Medical Media (FREDDIE) Award - "Important Conversations"
- ACGME Outcome Project
- [Health on the Net](#) - HON Foundation - [Verify here](#)
- [Healthlinks Select Site](#)

For more information on these programs and resources, contact [Cathy Kirkwood, MPH](#), Project Director, Academic Affairs at: icare@mdanderson.org.

FSMB Offers Free CMEs for Medical Board Licensees



The FSMB announced that it is now providing accreditation services for continuing medical education programs offered by state medical and osteopathic boards. FSMB recently received provisional accreditation as a provider of CME by the Accreditation Council for Continuing Medical Education (ACCME).

ACCME provisional accreditation is the first tier of ACCME accreditation for initial applicants and is for a period of two years. ACCME accreditation seeks to assure both physicians and the public that CME activities provided by FSMB meet the high standards of the Essential Areas, Elements and Policies for Accreditation as specified by the ACCME. “The FSMB is pleased to now offer free CME accreditation as a service to state medical boards as they seek to provide educational programming to their licensees,” said Kelly Alfred, MS, Senior Director, FSMB Education Services.

For more information about accreditation services, please contact Ms. Alfred at kalfred@fsmb.org.

Free online CME for medical board licensees

In addition to providing accreditation services to medical boards, the FSMB also offers opportunities for the licensees of boards to earn free continuing medical education credits via the Education section of the FSMB website at www.fsmb.org. These offerings include:

Safe Prescribing of Extended Release/Long-Acting Opioids

The goal of this Risk Evaluation and Mitigation Strategy (REMS) activity is to reduce serious adverse outcomes resulting from inappropriate prescribing, misuse and abuse of extended-release or long-acting (ER/LA) opioid analgesics while maintaining patient access to pain medications. (Participants who complete all six modules earn three *AMA PRA Category 1 Credit(s)*TM or three *AOA Category 2B Credit(s)*.)

Internet Drug Sellers: What Providers Need to Know

Offered in collaboration with the Alliance for Safe Online Pharmacies, this program for physicians and pharmacists encourages participants to discuss the risks and patient safety issues involved with purchasing medications from a rogue Internet pharmacy. (Participants receive one hour of *AMA PRA Category 1 Credit(s)*TM or one contact hour of continuing pharmacy education.)

FSMB Policies on Responsible Opioid Prescribing and Office-Based Opioid Treatment

These learning activities educate state medical boards and the physicians and other healthcare providers they license on FSMB’s recently revised pain policies. (Participants receive one hour of *AMA PRA Category 1 Credit(s)*TM for each activity.)

“Responsible Opioid Prescribing: A Clinician’s Guide” – This book offers clinicians effective strategies for reducing the risk of addiction, abuse and diversion of opioids that they prescribe for their patients in pain. This new edition includes new information from FSMB’s *Model Guidelines*, FDA labeling, and preventing opioid overdose not available when the first edition was published in 2007. (Participants receive up to *7.25 hours of AMA PRA Category 1 Credit(s)*TM free; purchase price of book is \$16.95.)

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: Erin L. Albright, JD
General Counsel
Alexia M. Emmermann, JD
General Counsel

Licensing: Lynnette L. Daniels, Chief

Investigations: Pamela J. Castagnola, CMBI, Chief

2015 BME MEETING & HOLIDAY SCHEDULE

January 1 – New Year's Day holiday
January 19 – Martin Luther King, Jr. Day holiday
February 16 – Presidents' Day holiday
March 6-7 – Board meeting
May 25 – Memorial Day holiday
June 5-7 – Board meeting
July 3 – Independence Day holiday (observed)
September 7 – Labor Day holiday
September 11-12 – Board meeting
October 30 – Nevada Day holiday
November 11 – Veterans' Day holiday
November 26 & 27 – Thanksgiving/family day holiday
December 4-5 – Board meeting
December 25 – Christmas holiday

Nevada State Medical Association

3660 Baker Lane #101
Reno, NV 89509
775-825-6788
<http://www.nsmadocs.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

3660 Baker Lane #202
Reno, NV 89509
775-825-0278 phone
775-825-0785 fax
<http://www.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
www.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
www.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

BECKETT, Timothy D., M.D. (10395)

Henderson, Nevada

Summary: Alleged failure to disclose an arrest on license renewal application.

Charges: One violation of NRS 630.304(1) [obtaining, maintaining or renewing, a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading inaccurate or incomplete statement]; one violation of NRS 630.306(2)(a) [engaging in any conduct which is intended to deceive].

Disposition: On September 11, 2015, the Board accepted a Settlement Agreement by which it found Dr. Beckett violated NRS 630.304(1), as set forth in Count I of the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) \$1,000 fine; (3) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter. Count II of the Complaint was dismissed with prejudice.

BOYD, Susan L., M.D. (7944)

Las Vegas, Nevada

Summary: Alleged malpractice and failure to maintain appropriate medical records related to her 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 September 11, 2015, the Board accepted a Settlement Agreement by which it found Dr. Boyd violated NRS 630.301(4), as set forth in Count II of the First Amended Complaint, and imposed the following discipline against her: (1) \$2,000 fine; (2) 20 hours of CME, in addition to any CME requirements regularly imposed upon her as a condition of licensure in Nevada, on the topics of total abdominal hysterectomy (5 hours), vaginal hysterectomy (5 hours), laparoscopic vaginal hysterectomy (5 hours) and laparoscopic supracervical hysterectomy (5 hours); (3) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter; (4) reimbursement for reasonable costs and expenses incurred by the Board in monitoring her compliance with the Settlement Agreement.

KESHISHIAN, Ara, M.D. (9900)

Glendale, California

Summary: Disciplinary action taken against Dr. Keshishian's medical license in California.

Charges: One violation of NRS 630.301(3) [disciplinary action taken against his medical license in another state].

Disposition: On September 11, 2015, the Board accepted a Settlement Agreement by which it found Dr. Keshishian violated 630.301(3), as set forth in the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) \$2,500 fine; (3) reimbursement of the Board's costs and fees associated with investigation and prosecution of the matter. Dr. Keshishian's license is currently expired. Should he choose to reinstate his license, he shall be required to comply with additional terms.

LANDSMAN, Henry R., M.D. (4021)

Las Vegas, Nevada

Summary: Disciplinary action taken against Dr. Landsman's medical license in California, alleged failure to report said disciplinary action to the Nevada State Board of Medical Examiners and failure to disclose said disciplinary action on license renewal application.

Charges: One violation of NRS 630.304(1) [obtaining, maintaining or renewing, a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading inaccurate or incomplete statement]; one violation of NRS 630.306(2)(a) [engaging in any conduct which is intended to deceive]; one violation of NRS 630.306(11) [failure to report in writing, within 30 days, disciplinary action taken against him by another state]; one violation of NRS 630.301(3) [disciplinary action taken against his medical license in another state].

Disposition: On September 11, 2015, the Board accepted a Settlement Agreement by which it found Dr. Landsman violated NRS 630.306(11), as set forth in Count III of the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) \$1,000 fine; (3) reimbursement of the Board's costs and fees associated with investigation and prosecution of the matter. Counts I, II and IV of the Complaint were dismissed with prejudice.

LYNCH, Douglas S., PA-C (PA1486)

Las Vegas, Nevada

Summary: Alleged inability to practice medicine with reasonable skill and safety because of the use of drugs and rendering professional services to patients while in an impaired mental or physical condition.

Charges: One violation of NRS 630.306(1) [inability to practice medicine with reasonable skill and safety because of illness, a mental or physical condition or the use of alcohol, drugs, narcotics or any other substance]; one violation of NAC 630.230(1)(c) [rendering professional services to a patient while under the influence of alcohol or any controlled substance or in any impaired mental or physical condition].

Disposition: On September 11, 2015, the Board accepted a Settlement Agreement by which it found Mr. Lynch violated NRS 630.306(1), as set forth in Count I of the Complaint, and imposed the following discipline against him: (1) the summary suspension imposed upon Mr. Lynch's license to practice medicine shall be lifted; (2) Mr. Lynch shall be placed on probation subject to various terms and conditions; (3) public reprimand; (4) 8 hours of CME, in addition to any CME requirements regularly imposed upon him as a condition of licensure in Nevada, on the topic of substance abuse; (5) reimbursement of the Board's costs and fees associated with investigation and prosecution of the matter; (6) reimbursement for reasonable costs and expenses incurred by the Board in monitoring his compliance with the Settlement Agreement. Count II of the Complaint was dismissed.

STARRITT, Rita E., M.D. (14540)

La Jolla, California

Summary: Disciplinary action taken against Dr. Starritt's medical licenses in California and Colorado.

Charges: Two violations of NRS 630.301(3) [disciplinary action taken against her medical license in another state].

Disposition: On September 11, 2015, the Board accepted a Settlement Agreement by which it found Dr. Starritt violated 630.301(3) (two counts), as set forth in the Complaint, and imposed the following discipline against her: (1)

she shall not act as an attending physician in Nevada, as set out in NRS Chapter 453A, for purposes related to medical marijuana authorizations until the same restriction is lifted from her Colorado medical license; (2) public reprimand; (3) 10 hours of CME, in addition to any CME requirements regularly imposed upon her as a condition of licensure in Nevada, on the topics of prescribing practices (4 hours), medical marijuana (4 hours) and record keeping (2 hours); (4) reimbursement of the Board's costs and fees associated with investigation and prosecution of the matter; (5) reimbursement for reasonable costs and expenses incurred by the Board in monitoring her compliance with the Settlement Agreement.

THOMPSON, Jan M., M.D. (8065)
Las Vegas, Nevada

Summary: Reasonable belief that the health, safety and welfare of the public was at imminent risk of harm.

Statutory Authority: NRS 630.326(1) [risk of imminent harm to the health, safety or welfare of the public or any patient served by the physician].

Action Taken: On September 15, 2015, the Investigative Committee summarily suspended Dr. Thompson's license until further order of the Investigative Committee or the Board of Medical Examiners.

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Public Reprimands Ordered by the Board

Timothy D. Beckett, M.D.

September 14, 2015

Timothy D. Beckett, M.D.
c/o Anastasia Noe, Esq.
Law Offices of Arthur W. Tuverson
7201 W. Lake Mead Blvd., Ste 570
Las Vegas, NV 89128

Dr. Beckett:

On September 11, 2015, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee in relation to the formal Complaint filed against you in Case Number 15-26736-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.304(1), obtaining, maintaining or renewing or attempting to obtain, maintain or renew a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading, inaccurate or incomplete statement. For this violation, you shall receive a public reprimand, pay a \$1,000 fine and pay the fees and costs related to the investigation and prosecution of this matter.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought professional disrespect upon you and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Michael J. Fischer, M.D., President
Nevada State Board of Medical Examiners

Ara Keshishian, M.D.

September 16, 2015

Ara Keshishian, M.D.
1808 Verdugo Blvd., Suite 413
Glendale, CA 91208

Dr. Keshishian:

On September 11, 2015, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee in relation to the

formal Complaint filed against you in Case Number 15-20508-1.

In accordance with the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.301(3) for disciplinary action taken against you by another state. For this violation, you shall be fined \$2,500, you shall be publicly reprimanded, and you shall pay the fees and costs related to the investigation and prosecution of this matter. Should you reinstate your license, which is currently expired, you shall also reimburse the Board any further costs incurred in monitoring your compliance with this Agreement, notify the Board when probation of your California license is complete, and issue a release granting the Board access to periodic reports filed with the Medical Board of California.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought professional disrespect upon you and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Michael J. Fischer, M.D., President
Nevada State Board of Medical Examiners

Henry Landsman, M.D.

September 14, 2015

Henry Landsman, M.D.
10055 Canyon Hills Ave.
Las Vegas, NV 89148

Dr. Landsman:

On September 11, 2015, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee in relation to the formal Complaint filed against you in Case Number 14-5951-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.306(11), failure to report to the Board, in writing, within 30 days, any disciplinary action taken against the licensee by another state. For this violation, you

shall receive a public reprimand, pay a \$1,000 fine and pay the fees and costs related to the investigation and prosecution of this matter.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought professional disrespect upon you and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Michael J. Fischer, M.D., President
Nevada State Board of Medical Examiners

Douglas Lynch, PA-C

September 16, 2015

Douglas Lynch, PA-C
1808 Crownhaven Ct.
Las Vegas, NV 89108

Mr. Lynch:

On September 11, 2015, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee in relation to the formal Complaint filed against you in Case Number 15-41732-1.

In accordance with the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.306(1) when you tested positive for an illicit drug. For this violation, your license shall be placed in a probationary status, you shall remain enrolled in a monitoring program for five years and comply with your monitors' recommendations, you shall complete eight hours of continuing medical education in addition to any CME requirements that are regularly imposed as a condition of licensure in the state of Nevada, you shall be publicly reprimanded, you shall pay the fees and costs related to the investigation and prosecution of this matter, and you shall pay any other reasonable costs incurred by the Board in monitoring your compliance with the Agreement.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought professional disrespect

upon you and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Michael J. Fischer, M.D., President
Nevada State Board of Medical Examiners

Rita Elaine Starritt, M.D.

September 16, 2015

Rita Elaine Starritt
5721 La Jolla Hermosa Avenue
La Jolla, CA 92037-7330

Dr. Starritt:

On September 11, 2015, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee in relation to the formal Complaint filed against you in Case Number 15-39985-1.

In accordance with the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.301(3) (2 counts) for disciplinary action taken against you by another state. For these violations, you shall not act as an attending physician in Nevada for purposes related to medical marijuana authorizations until this same restriction is lifted from your Colorado license, you shall be publicly reprimanded, you shall complete 10 hours of continuing medical education in addition to the CME requirements that are regularly imposed as a condition of licensure in the state of Nevada, and you shall pay the fees and costs related to the investigation and prosecution of this matter, as well as reimburse the Board any further costs incurred in monitoring your compliance with this Agreement.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought professional disrespect upon you and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Michael J. Fischer, M.D., President
Nevada State Board of Medical Examiners

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NEVADA STATE BOARD OF MEDICAL EXAMINERS

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