



The Duty to Report: An Overview of Sexual Misconduct and Physicians

By: Rachel V. Rose, JD, MBA

Overview

Imagine. As a patient, you consent to entrusting your body to physicians and hospital staff to undergo a surgical procedure. Have you ever read a consent form that says, "I allow any and all healthcare providers to violate me while I am anesthetized?" As an attorney who teaches bioethics, I can assure you that I have not. Now, imagine that after the consent form is signed, you hypothetically undergo a surgical procedure on your gallbladder, you wake up, the narcotics wear off, and you discover that you have been sexually assaulted. What do you do?¹

Take a moment and think about the last time you asked a physician when or if a substantial background check was run? Take another moment to think about the following questions: What are states doing to protect patients? What are the requirements for physician duty to report? The above stated phenomenon is not limited to sexual misconduct but may extend to prescribing issues, substance abuse issues, diminished capacity as well as hospitals and physicians "paving over" or "turning a blind eye" to these problems until a serious matter arises or a lawsuit is filed.

Over the past year, *The Atlanta Journal-Constitution (AJC)* has compiled an investigative series regarding the duty to report. The small number of states that have taken a hard line against reporting and deterring the aforementioned negative actions is deplorable. Nevada has taken steps to deter certain types of behavior and has enlisted the help of the courts to report the outcomes of cases. It should go without saying that there are many good physicians; however, it also can be difficult to report a fellow colleague. In bioethics, the virtue of courage is one piece of ethics practice physicians may use to address these types of struggles.²

The purpose of this article is to provide an analysis of the *AJC* series, as well as the requirements of Nevada statutes. Hopefully, this article will provide awareness and, in turn, lead to greater protections for patients and encourage physicians to report their colleagues in the spirit of upholding the Hippocratic Oath.³

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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

FSMB Survey Identifies Telemedicine as Most Important Regulatory Topic for State Medical Boards in 2016

Opioid prescribing, Interstate Medical Licensure Compact (IMLC), physician reentry into practice also listed among important regulatory topics

WASHINGTON, D.C. - The Federation of State Medical Boards (FSMB) announced that telemedicine is currently the most important medical regulatory topic to state medical boards. The announcement comes after analyzing results from the Federation's 2016 State Medical Board Survey. This year's survey, completed by 57 of the 70 state medical and osteopathic boards in the United States and its territories, identifies a number of important issue areas and topics impacting the work of boards as they carry out their mission to protect the public.

"The world of medical licensure and regulation is rapidly evolving, and it's important that we have our finger on the pulse of what's driving that change," said FSMB President and CEO Humayun J. Chaudhry, DO, MACP. "Increasing our awareness of which topics our member boards are most focused on enables us to become a more effective partner in providing them with the tools and resources they need to accomplish their mission."

The survey found that the top five most important medical regulatory topics to state medical boards in 2016 were:

- 1.) Telemedicine
- 2.) Resources related to opioid prescribing
- 3.) The Interstate Medical Licensure Compact (IMLC)
- 4.) Physician reentry into practice
- 5.) Medical marijuana

Each of the 57 participating medical boards was asked to choose five of the most important topics from a list of 15, including an "other" option. 75% of boards chose telemedicine as one of the most important topics to their board, making it the topic impacting the largest number of boards. 70% chose resources related to opioid prescribing, 47% chose the [Interstate Medical Licensure Compact \(IMLC\)](#), 44% chose physician reentry into practice, and 42% chose medical marijuana. Other notable topics were physician burnout (30%) and continuing medical education (CME) and compliance (21%).

One of the leading goals of the FSMB is to support its member boards through policy analysis and development on key issues impacting medical regulation. The FSMB periodically convenes representatives of state medical boards, together with experts in specific subject areas, to study and develop recommendations on issues pertinent to medical regulation. The Federation currently has official model [guidelines and policies](#) for all five of the medical regulatory topics that boards deemed most important in 2016:

- **Telemedicine:** ["Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine"](#)
- **Opioid prescribing:** [Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain](#) (FSMB's guidelines are being revised to reflect recent trends in opioid prescribing. The FSMB House of Delegates will vote on final passage of the revised guidelines in April 2017.)
- **Interstate Medical Licensure Compact (IMLC):** [Model Legislation](#)
- **Physician reentry:** [Report of the Special Committee on Reentry to Practice](#)
- **Medical marijuana:** [Model Guidelines for the Recommendation of Marijuana in Patient Care](#)

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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.

Analysis

Fundamentally, protection is defined as “prevention against injury.”⁴ In relation to the practice of medicine, this means protecting patients from harm, as well as protecting the professional as a whole. Given this notion, the series in the *AJC* piqued my interest. From there, a closer look was given at what Nevada requires versus other states. Overall, Nevada has more robust requirements than most states and, depending on the totality of the circumstances; a physician may have his or her license suspended or lose it altogether.

The Atlanta Journal Constitution

“There is no other profession in which one passes so completely within the power and control of another as does the medical patient.” *Shea v. Board of Medical Examiners*, 81 Cal.App.3d 564, 578 (1978). The *AJC* five-part series entitled, *Doctors & Sex Abuse*, provides an in depth look at how well different states protect patients.⁵

In Part I of the *AJC*'s five part series, *License to Betray*, a variety of issues related to sex abuse by physicians were detailed. The reporters scoured over 100,000 records nationally and found profound evidence of misconduct. The goal of the *AJC* was to bring transparency to this issue. In turn, the hope is that more patients will be able to find a voice to expose these egregious acts.⁶

The second part of the *AJC*'s series focused on what happened when physicians were caught.⁷ For example, Dr. David Pavlakovic, a physician in Alabama, was deemed by law enforcement to have engaged in criminal acts. Yet, he still did not lose his license. “Effective July 8, the Commission suspended the license to practice medicine in Alabama of David J. Pavlakovic, MD, license number MD.22143, Birmingham, AL, until Sept. 1, 2009, and the license shall be placed on indefinite probation, subject to certain conditions.”⁸

Entitled, *State Secrets*, Part III builds on the two previous segments and illustrates cases where physicians were placed on probation but did not have to disclose it to their patients.⁹

“A southern California plastic surgeon calls himself an artist, one whose ‘gifted hands’ sculpt bodies to perfection. Sometimes, though, his hands strayed. So last year regulators placed him on probation for sexual misconduct with patients until 2020. But when patients come to his office for breast enlargements and tummy tucks, liposuction and eyelifts, he doesn’t have to tell them about his disciplinary status.”

Licensed since 2002, Dr. Mark Knight had an Accusation filed against him for battery and engaging in sexual misconduct with another patient during a post-operative visit. These two incidents occurred in 2007 and 2009, respectively.¹⁰ In light of these allegations, Dr. Knight surrendered his medical license on December 15, 2010. In 2015, Dr. Knight petitioned the California Medical Board to reinstate his license.¹¹ By producing clear and convincing evidence that he had changed, was genuinely remorseful for his actions and wished to make amends with the two victims that he harmed but had not done so for “medical/legal reasons” his license was reinstated in 2015 and was placed on probation for five years.¹² Unlike the physician in Alabama, Dr. Knight had to meet the stringent statutory standards before his license was reinstated.

Part IV of the investigation, *Failing Grades*, reflects a nationwide report card depicting faulty framework and gaps in discipline. Some highlights from the report card below are cause for alarm and include the following:

- Physicians who are convicted for sexual offenses – in Minnesota, they are banned from practicing medicine; yet, in 36 other states, no such ban exists.
- Women on state medical licensure boards – Iowa provides that half of the seats on the physician licensing board must be held by women; yet, most states have medical boards controlled by men.
- Citizens input in allowing physicians to stay in practice – approximately 25 states give citizens a significant say in the fate of physicians who harm patients.
- Criminal background checks – while Texas has a rigorous requirement for initial and continued background checks, 14 states still do not have this requirement.

Finally, Part V, *Hurt that doesn't heal*, focuses on the lifetime of trauma victims face. This portion of the AJC investigation includes interviews with several victims who agreed to go on record with their stories. "You have to speak out...We can't let them think that they can get away with this," said Maria Zito, sexual assault survivor. Pauline Trumpi Evans who has written three books as a result of her experiences explained, "I feel that I've done the best I could under the circumstances. I try to look at the fact that I did survive. I never had to be hospitalized or anything. I think some people it would have done in. I do look on myself as a survivor in some ways."¹³

Delaware General Assembly Representative, Kimberly Williams, summed up the underlying problem. "As a society, we don't take sexual misconduct, sexual assault and sexual abuse seriously enough. These are bad, bad crimes they are committing on people and we do not treat them that way."¹⁴ The 50 State Survey by the AJC reached the same conclusion in relation to patients. Hopefully, more will be done to deter and punish perpetrators and provide victims with both compensation and counseling for incidents that will affect them for a lifetime.



Nevada's Approach

In 2015, the Nevada State Legislature built upon previous legislation stemming back to 1977 that relates to a duty to file reports with the Nevada State Board of Medical Examiners. Specifically, NRS 630.307¹⁵ sets forth the following:

NRS 630.307 General requirements for filing complaint; medical facilities and societies required to report certain information concerning privileges and disciplinary action; administrative fine for failure to report; clerk of court required to report certain information concerning court actions; retention of complaints by Board.

1. Except as otherwise provided in subsection 2, any person may file with the Board a complaint against a physician, perfusionist, physician assistant or practitioner of respiratory care on a form provided by the Board. The form may be submitted in writing or electronically. If a complaint is submitted anonymously, the Board may accept the complaint but may refuse to consider the complaint if the lack of the identity of the complainant makes processing the complaint impossible or unfair to the person who is the subject of the complaint.

2. Any licensee, medical school or medical facility that becomes aware that a person practicing medicine, perfusion or respiratory care in this State has, is or is about to become engaged in conduct which constitutes grounds for initiating disciplinary action shall file a written complaint with the Board within 30 days after becoming aware of the conduct.

3. Except as otherwise provided in subsection 4, any hospital, clinic or other medical facility licensed in this State, or medical society, shall report to the Board any change in the privileges of a physician, perfusionist, physician assistant or practitioner of respiratory care to practice while the physician, perfusionist, physician assistant or practitioner of respiratory care is under investigation and the outcome of any disciplinary action taken by that facility or society against the physician, perfusionist, physician assistant or practitioner of respiratory care concerning the care of a patient or the competency of the physician, perfusionist, physician assistant or practitioner of respiratory care within 30 days after the change in privileges is made or disciplinary action is taken.

4. A hospital, clinic or other medical facility licensed in this State, or medical society, shall report to the Board within 5 days after a change in the privileges of a physician, perfusionist, physician assistant or practitioner of respiratory care to practice that is based on:

(a) An investigation of the mental, medical or psychological competency of the physician, perfusionist, physician assistant or practitioner of respiratory care; or

(b) Suspected or alleged substance abuse in any form by the physician, perfusionist, physician assistant or practitioner of respiratory care.

5. The Board shall report any failure to comply with subsection 3 or 4 by a hospital, clinic or other medical facility licensed in this State to the Division of Public and Behavioral Health of the Department of Health and Human Services. If, after a hearing, the Division of Public and Behavioral Health determines that any such facility or society failed to comply with the requirements of this subsection, the Division may impose an administrative fine of not more than \$10,000 against the facility or society for each such failure to report. If the administrative fine is not paid when due, the fine must be recovered in a civil action brought by the Attorney General on behalf of the Division.

6. The clerk of every court shall report to the Board any finding, judgment or other determination of the court that a physician, perfusionist, physician assistant or practitioner of respiratory care:

(a) Is mentally ill;

(b) Is mentally incompetent;

(c) Has been convicted of a felony or any law governing controlled substances or dangerous drugs;

(d) Is guilty of abuse or fraud under any state or federal program providing medical assistance; or

(e) Is liable for damages for malpractice or negligence,

within 45 days after such a finding, judgment or determination is made.

7. The Board shall retain all complaints filed with the Board pursuant to this section for at least 10 years, including, without limitation, any complaints not acted upon.

In addition to the duties listed above, NRS 603.609 requires a similar obligation in relation to physician assistants and other ancillary care providers.¹⁶ And the Nevada State Board of Medical Examiners has a statutory obligation to investigate certain reports of malpractice under NRS 603.3069.¹⁷ While the patient protections are not nearly as express as Minnesota, Nevada fares better than other states.

Conclusion

In sum, there are not enough measures in place across the country to protect patients. Physicians faced with a dilemma of reporting a colleague or self-reporting should seek the advice of counsel, the chief of the medical staff or a state medical board. There is no doubt that reporting any sensitive issue takes courage. Yet, it is incumbent upon physicians, pursuant to the Hippocratic Oath, to make tough decisions in the interest of patient safety and the well-being of society. In some states, these disclosures are mandatory, while other states have a long way to go. Just remember, there is a duty to protect patients that comes before a duty to protect a colleague or oneself.

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¹ Rachel V. Rose, *HIPAA, Physicians and Photographs: Legal vs. Illegal*, Nevada State Board of Medical Examiners Newsletter, Vol. 54 (Mar. 2015), providing examples of criminal and civil actions where physicians were held liable for violating patients. http://medboard.nv.gov/uploadedFiles/medboardnv.gov/content/Resources/Newsletters/2015-03_Newsletter_Volume54.pdf (last accessed, Nov. 24, 2016).

² Manuel Velasquez, Claire Andre, Thomas Shanks, S.J., and Michael J. Meyer, *Ethics and Virtue, Issues in Ethics* Vol.1, N.3 (Spring 1988), available at <https://www.scu.edu/ethics/ethics-resources/ethical-decision-making/ethics-and-virtue/>

³ Peter Tyson, *The Hippocratic Oath Today*, PBS NOVA (Mar. 27, 2001), available at <http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html>.

⁴ See, <http://medical-dictionary.thefreedictionary.com/protectionism> (last accessed, Nov. 24, 2016).

⁵ Carrie Teegardin, *Failing Grades*, http://doctors.ajc.com/doctors_states_laws/?ecmp=doctorssexabuse_microsite_stories (last accessed, Nov. 24, 2016).

⁶ See http://doctors.ajc.com/video_AJC_editor_investigation/?ecmp=doctorssexabuse_microsite_nav (last accessed, Nov. 24, 2016).

⁷ See http://doctors.ajc.com/part_2_illness_or_crime/ (last accessed, Nov. 24, 2016).

⁸ Alabama Board of Medical Examiners, <http://www.albme.org/Documents/Newsletters/2009V24No3.pdf> (last accessed, Nov. 24, 2016).

⁹ See http://doctors.ajc.com/part_3_state_secrets/ (last accessed, Nov. 24, 2016).

¹⁰ *In the Matter of the Accusation Against Dr. Mark Anthony Knight, M.D.*, Case No. 06 2008-190093.

¹¹ See <http://www2.mbc.ca.gov/BreezePDL/document.aspx?path=%5CDIDOC%5C20150205%5CDMRAAEY2%5C&did=AAAEY150206001450257.DID&licenseType=A&licenseNumber=78828> (last accessed, Nov. 24, 2016).

¹² *Id.*

¹³ See http://doctors.ajc.com/doctors_states_laws/?ecmp=doctorssexabuse_microsite_stories (last accessed, Dec. 19, 2016).

¹⁴ See http://doctors.ajc.com/doctors_states_laws/?ecmp=doctorssexabuse_microsite_stories (last accessed, Nov. 24, 2016).

¹⁵ See <https://www.leg.state.nv.us/nrs/NRS-630.html#NRS630Sec307>. (Added to NRS by [1977, 824](#); [A 1985, 2239](#); [2001, 768](#); [2002 Special Session, 20](#); [2009, 880, 2964](#); [2011, 2862](#); [2015, 2775](#)).

¹⁶ *Id.*

¹⁷ *Id.*

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Do Flight Attendants Treat Heart Attacks?

10 Things to Know Before an Airline Emergency

Guest Author: **Pamela Wible, MD**

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Man collapses at 30,000 feet. Quick, who's in charge? Hint: it's not the doctor. Last month, [Dr. Tamika Cross was told to sit down](#) when she tried to help an unresponsive man. Why? Apparently the flight attendant was looking for an "actual" medical doctor, not a black woman. Turns out she's [not the only doc making headlines](#) for being turned down in a medical crisis. What in the world is going on up there? I interviewed pilots, flight attendants, and physicians to find out. Here's what I discovered:

1) A sick passenger can cost an airline \$100,000 - or more. Think - transoceanic [diversion](#) to nearest city, hundreds of grumpy people all needing hotels, meals, new flights. Plus, there may be a dead body on board, a legal investigation, and relatives to notify.

2) Medical kits may be unstocked. Should all FAA-approved flights have oxygen, epinephrine, a functioning defibrillator? Yes. Do they? Not always.

3) Flight attendants are underpaid. Guess how much these smiley greeters are paid to get you blankets, pillows, and help you to your seat? Nothing. They only get paid [when the plane is moving](#). Average starting salary: [\\$18 per flight hour](#). Yep, they eat airline food, get jet-lagged, and deal with rowdy passengers, terrorists, and medical emergencies—all for \$18 per hour. Shocking fact #2: A couple of young pilots told me they also started at \$18 per hour - hauling hundreds of humans at 500 mph! For big bucks, pilots fly FedEx cargo - hauling envelopes.

4) There's no place to put your body. No gurney. No exam room. No convenient spot to lie down. So you'll be on the galley floor (like both people I treated on planes).

5) You will disrupt drink service. Not only will your medical crisis be viewed by a bunch of gawkers with cell phones, you may anger the crew who can't wheel the snack cart over your body. Trust me. You will be in the way.

6) Flight attendants have limited medical skills. With just a GED or high school diploma, [3-8 weeks of flight training](#), and some CPR, these folks are handling medical catastrophes in the air. So, yes, the person who poured your soft drink may be treating your heart attack.

7) The flight attendant picks your doctor. If three docs respond to the call for help, how do they choose? Pilots, physicians, and passengers agree - pick the most qualified. Can a flight attendant actually judge the skills of an ob/gyn chief resident, an infectious disease fellow, and a retired rheumatologist? Maybe that's why 70% of flight attendants told me they take the first person who shows up - unless [implicit bias](#) selects the white guy over the black woman who arrives first.

8) The best doctor may be buzzed. Do we go with the sober rheumatologist or the chief resident post-Kahlua? Maybe the best doctor is a religious ICU nurse who does not drink.

9) Crew may obstruct care until doctor shows "credentials". Docs don't carry pocket-sized diplomas, yet crew must see credentials before accessing medical kits. Do you really want a doctor ruffling through her carry-on for a hospital badge while you're on the floor?

10) The doctor may still get sued. Liability varies by country. While the Good Samaritan law "should" protect you in the USA, nothing prevents a passenger (or next of kin) from [calling an attorney](#). Some airlines offer [indemnity](#), but only if the crew *initiates* the call for help (not if doctor proactively offers). Given poor medical outcomes in the friendly skies, do you think the average doc wants to [absorb all that liability](#)?

Frankly, I'm amazed anyone volunteers at all—and actually makes it to the passenger in time. How can two highly regulated industries intersect in such chaos? And what's the fix?

Besides the obvious (stock medical kits), here's my advice: 1) Mandate diversity training for crew—led by women physicians of color. (Contact [Artemis Medical Society](#)); 2) Prescreen for medical credentials. [Lufthansa](#) does this. Model what works; 3) Allow medical professionals to assemble themselves. Healthcare is a team sport.

One final request - Please thank any doc who willingly stands up to implicit bias, grabs a half-empty medical kit, and risks personal liability (while on vacation) to save lives - for no pay!

Question: If several docs respond to the call for a doctor on board, how do flight attendants pick the doctor?

	Most Qualified	First To Respond	Doc With Credentials	Assemble Themselves	Most Confident	The Man	No Idea
Pilots	100%						
Physicians	100%						
Flight Attendants	10%	70%	10%	10%			
Passengers	27%	17%	17%	13%	6%	10%	10%

On November 5, 2016, Pamela Wible, M.D., randomly interviewed 7 pilots, 10 flight attendants, and 30 passengers in the San Francisco and San Diego airports. Twenty doctors were also interviewed. Results compiled above.

Pamela Wible, MD, is the founder of the Ideal Medical Care Movement and 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. 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: <http://www.idealmedicalcare.org/contact.php> Website: www.idealmedicalcare.org

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VA Study Finds EEG Can Help Distinguish Between PTSD and Mild Traumatic Brain Injury

WASHINGTON – A recent Veterans Administration (VA) study points to a possible breakthrough in differentiating between post-traumatic stress disorder (PTSD) and mild traumatic brain injury (mTBI), otherwise known as a concussion.

The two disorders often carry similar symptoms, such as irritability, restlessness, hypersensitivity to stimulation, memory loss, fatigue and dizziness. Scientists have tried to distinguish between mTBI and PTSD in hopes of improving treatment options for Veterans, but many symptom-based studies have been inconclusive because the chronic effects of the two conditions are so similar. If someone is rating high on an mTBI scale, for example, that person may also rate high for PTSD symptoms.

The researchers used electroencephalogram, or EEG, a test that measures electrical activity in the brain. The size and direction of the brain waves can signal abnormalities.

Analyzing a large set of EEGs given to military personnel from the wars in Iraq and Afghanistan, the researchers saw patterns of activity at different locations on the scalp for mTBI and PTSD. They saw brain waves moving slowly in opposite directions, likely coming from separate places in the brain.

The researchers emphasize that these effects don't pinpoint a region in the brain where the disorders differ. Rather, they show a pattern that distinguishes the disorders when the EEG results are averaged among a large group.

"When you're looking at an EEG, you can't easily tell where in the brain signals associated with TBI and PTSD are coming from," said Laura Manning Franke, Ph.D., the study's lead researcher and research psychologist at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia. "You get kind of a coarse measure – left, right, anterior, posterior. We had a different distribution, which suggests that different parts of the brain are involved. In order to determine what patterns are tracking their TBI and PTSD, you need an average to do that," Franke added.

The study linked mTBI with *increases* in low-frequency waves, especially in the prefrontal and right temporal regions of the brain, and PTSD with *decreases* in low-frequency waves, notably in the right temporoparietal region.

The differences in the levels of the waves may explain some of the symptoms of the two disorders, suggesting a decline in responsiveness for someone with mTBI, for example, and more anxiety for someone with PTSD.

Franke also noted that more low-frequency power has also been linked to cognitive disorders such as Alzheimer's disease and less low-frequency power to problems such as drug addiction. Additionally, spotting distinct patterns of mTBI and PTSD in separate parts of the brain is key for two reasons: the possibility these conditions can be confused with each other is reduced. That can help improve diagnosis and treatment and the patterns show that electrical activity appears to be affected long after combat-related mTBI, suggesting long-term changes in neural communication, the signaling between cells in the nervous system. "That could help, in part, explain the reason for persistent problems."

The study included 147 active-duty service members or Veterans who had been exposed to blasts in Iraq and Afghanistan. Of those, 115 had mTBI, which accounts for nearly 80 percent of all traumatic brain injuries. Forty of the participants had PTSD, and 35 had both conditions.

Despite the new findings, Franke and her team believe more work is needed to better explain the differences in the patterns of both conditions in the brain's electrical activity. Researchers need to analyze the differences in scans from larger numbers of patients.

Meanwhile, though, she said she hopes the research will play a role in helping medical professionals better diagnose someone's condition through an individual EEG—whether that person has PTSD, a brain injury, or a combination of the two.

"That's the holy grail," said Franke. "We want to use the EEG to differentiate the problems, but also to predict recovery and be able to measure how people are doing in a more biological way than just measuring symptoms, although those are still relevant. But symptoms are also problematic because they're influenced by so many things that aren't the disease that we're interested in."

For more information about VA research on PTSD and TBI, visit [Posttraumatic Stress Disorder](#) and [Traumatic Brain Injury](#). Information about Franke's study may be found at the [International Journal of Psychophysiology](#).



Are You Preparing to Leave, or Anticipating Going Back to, Clinical Practice? 6 Reasons Why It's a Good Idea to Talk with Your State Medical Board

1. Everyone needs a starting point.

Talking with your board can help you prepare to leave and/or come back to clinical practice by pointing you in the right direction for understanding requirements for notification of leave of absence, change of address, change of practice, availability of limited licenses, management of patient records, and other guidelines and requirements related to medical practice in your state.

2. Knowing what to expect is a good thing.

It is important to find out ahead of time about the process your state has in place for those who leave clinical practice and wish to return. Your board is a starting point for finding out what prerequisites, statutes, etc., your state has in place related to returning to practice as requirements may vary from state to state. Knowing as much detail as possible about your state's expectations and process for returning to practice will help facilitate your return.

3. Licensure is a privilege.

Often it is hard to get a license back once it has expired or has not been renewed. The burden of proof is on the physician to demonstrate that he or she has met the appropriate requirements for license reinstatement in order to reenter practice. Similarly, you should be aware of what requirements you must meet for license renewal should you choose to maintain your license while you are out of practice.

Contact information for the 70 State Medical and Osteopathic Boards in the U.S. is available at:
<http://www.fsmb.org/policy/contacts>



Talking with your board will help ensure that you understand what the specific requirements are for your state and will help in deciding which option is best for you.

4. There are financial costs.

Leaving clinical practice often means a change in income. Talking to your board about the costs associated with maintaining your license, or a limited license (if available), and fees that might be associated with reinstating a license will help you plan financially.

5. Things change.

When you are out of clinical practice your usual methods for keeping up-to-date on clinical practice issues may change. Your board can provide information and guidance on how to stay current on regulatory changes that may affect your return to practice.

6. Lifelong learning is continuous.

Medical license renewal or maintenance of licensure is based on continuing professional development even if you are taking a leave from clinical practice. Your board may be able to direct you to resources that can help you with your professional development, as well as provide guidance on other requirements related to your medical license.

This resource guide was developed by The Physician Reentry into the Workforce Project and the Federation of State Medical Boards, which appreciate the input from the CMSS Workforce Leads Component Group.

INVESTIGATIVE COMMITTEE STATS

2015

Investigative Committee A, Year to Date

Total Cases Considered	387
Total Cases Authorized for Filing of Formal Complaint (to be Published)	17
Total Cases Authorized for Peer Review	27
Total Cases Requiring an Appearance	28
Total Cases Authorized for a Letter of Concern	117
Total Cases Authorized for Further Follow-up or Investigation	13
Total Cases Reviewed for Compliance	0
Total Cases Authorized for Closure	185

Investigative Committee B, Year to Date

Total Cases Considered	331
Total Cases Authorized for Filing of Formal Complaint (to be Published)	5
Total Cases Authorized for Peer Review	20
Total Cases Requiring an Appearance	8
Total Cases Authorized for a Letter of Concern	85
Total Cases Authorized for Further Follow-up or Investigation	7
Total Cases Reviewed for Compliance	0
Total Cases Authorized for Closure	206

INVESTIGATIVE COMMITTEE STATS

2016

Investigative Committee A, Year to Date

Total Cases Considered	553
Total Cases Authorized for Filing of Formal Complaint (to be Published)	37
Total Cases Authorized for Peer Review	56
Total Cases Requiring an Appearance	55
Total Cases Authorized for a Letter of Concern	101
Total Cases Authorized for Further Follow-up or Investigation	24
Total Cases Reviewed for Compliance	0
Total Cases Authorized for Closure	280

Investigative Committee B, Year to Date

Total Cases Considered	350
Total Cases Authorized for Filing of Formal Complaint (to be Published)	11
Total Cases Authorized for Peer Review	34
Total Cases Requiring an Appearance	19
Total Cases Authorized for a Letter of Concern	82
Total Cases Authorized for Further Follow-up or Investigation	8
Total Cases Reviewed for Compliance	0
Total Cases Authorized for Closure	196

LICENSING STATS

2015

In 2015, the Board issued the following total licenses:

- 599 physician licenses
- 136 limited licenses for residency training
- 112 physician assistant licenses
- 149 practitioner of respiratory care licenses
- 11 perfusionist licenses

LICENSING STATS

2016 – YEAR TO DATE (12/16/2016)

For the year to date, the Board has issued the following licenses:

- 635 physician licenses
- 171 limited licenses for residency training
- 98 physician assistant licenses
- 148 practitioner of respiratory care licenses
- 14 perfusionist licenses

Healthcare Providers Encouraged to Learn and Recognize Signs of Suicidal Thinking

Guest Author: Lesley Dickson, MD



Suicide is increasingly common in our society and is the 10th most common cause of death with the rate double that of homicide. More than 38,000 deaths by suicide occur each year, which equals about one every 15 minutes. Since many of those who commit suicide or make a serious attempt have been seen in the healthcare setting within a month of the suicide, physicians and other healthcare providers need to be alert to the signs of suicidal thinking and intervene to prevent its occurrence. Most individuals who survive a suicide attempt are glad they survived and many admit the decision was impulsive at the time. One study found that 1 in 4 said they deliberated less than 5 minutes while 13% said they deliberated more than a day.

Suicide is an act of desperation and frequently occurs in the context of a highly stressful life event such as a loss of an important person or relationship, a financial setback or trouble with the law. Exposure to other suicides, sensationalized accounts of suicide (contagion) and access to lethal means increases the risk. Nearly two thirds have communicated their suicidal intentions to another person but only about one sixth leave a note so that family are often left with no explanation. A study by the National Institute of Mental Health found that primary physicians saw 70% of elderly suicide victims within a month of their death. Suicide can occur at all stages of depression and patients remain at high risk after hospital or emergency room discharge. Thus good follow-up care is essential, a discussion of accessibility of weapons is important and families need to be engaged in the discharge plan.

To prevent suicide, we need to think about the possibility and then ask. The recently developed and validated Columbia-Suicide Severity Rating Scale lists 6 questions to ask; an answer of yes to number one or two leads to the other 4 questions. So, ask, “Have you wished you were dead or wish you could go to sleep and not wake up?” and “Have you actually had any thoughts of killing yourself?” Asking about suicide does not put the idea into someone’s head; instead asking opens the door for patients to feel free to discuss emotional issues.

The 2015 Nevada Legislative Session established the new Continuing Medical Education (CME) requirement for 2 hours in suicide prevention via [AB93](#). It is required for psychiatrists and all mental health professionals and strongly encouraged for other physicians and nurse practitioners. It also meets the 2 hours of Ethics requirement.

The Nevada Psychiatric Association is sponsoring a 2 hour CME course Friday, February 17, 2017, 3:45 to 5:45pm at Bally’s Hotel in conjunction with the Annual Psychopharmacology Update. Registration information is located on page 11 of this newsletter.

[National Suicide Prevention Lifeline](#) - 1-800-273-TALK (8255) 24 hours a day, 7 days a week. The service is available to everyone. The deaf and hard of hearing can contact the Lifeline via TTY at 1-800-799-4889. All calls are confidential.





SUICIDE PREVENTION

EARN 2 HOURS CME MEETS REQUIREMENT OF AB93*

Friday, February 17, 2017 at Bally's Hotel in Las Vegas

3:45 – 4:45 PM: "Beating Back the Black Dog of Depression and Suicide" by Charles Nemeroff, MD, PhD, Leonard M. Miller Professor and Chairman of Psychiatry, University of Miami

4:45 – 5:45 PM "Physician Suicide: What You Can Do to Save a Life" by Michael, Myers, MD, Professor of Clinical Psychiatry, SUNY Downstate Medical Center, Brooklyn, New York

Offered as part of NPA's **22nd Annual Psychopharmacology Update course, February 15-18, 2017 at Bally's Hotel and Casino on the Las Vegas strip.**

Three options to meet this requirement:

- 1) Sign up for the whole Update course, February 16-18 at www.nvpsychiatry.org
- 2) Sign up for Friday, February 17, all day and 8 CME credits by going to www.nvpyschiatry.org.
- 3) Sign up for just the 2 hours in the afternoon at a prorated fee by going to <https://www.etches.com/2017suicideupdate>.

Online registration is now open. These two hours also meet the 2-hour ethics requirement. For any questions, please call 1-877-493-0007 or go to www.nvpsychiatry.org.

**Last year the 2015 Nevada Legislature passed a bill that requires every mental health provider to obtain 2 continuing education credits (CME) each licensing cycle, beginning this year, on Suicide Prevention. The 2 hours of CME can also count toward the Ethics requirement.*

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint providership of the University of Nevada, Reno School of Medicine and the Nevada Psychiatric Association. The University of Nevada, Reno School of Medicine is accredited by the ACCME to provide continuing medical education to physicians.

The University of Nevada, Reno School of Medicine designates this live activity for a maximum of 2.00 *AMA PRA Category 1 Credit(s)*[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This program meets the Nevada State Board of Medical Examiners' requirement **for 2 CME** credits in ethics and suicide prevention.

The University of Nevada, Reno School of Medicine approves this program for 2.00 hours of nursing continuing education credit.

Medication Assisted Treatment of the **Opioid** Dependent **Pregnant Woman** and her Newborn



CCMS 2017 CME Series

2.00 AMA PRA
Category 1 Credit(s)[™]

February 18, 2017
2:00PM - 4:00PM

Clark County Medical Society - Dr. Higgins Conference Room
2590 E Russell Road
Las Vegas, NV 89121

CCMS/NSMA and NPA Members: \$40
Nurse/Allied Health Professionals: \$40
Non-Members and/or Guest: \$60

Why you should attend... The purpose of this activity is to update physicians and nurse practitioners in the fields of Obstetrics and Pediatrics on the management of pregnant women who are opioid dependent and their newborns who need careful monitoring and detoxification from opioids. Special attention will be to the medication assisted treatments that are now being widely used and encouraged.

PROGRAM FORMAT

WELCOME

1:30PM - 2:00PM | Registration
2:00PM - 4:00PM | Program

A two hour presentation that will include a power point presentation followed by a roundtable discussion with facilitators of case material and problems in caring for this population.

Snack will be provided

PRESENTING SPEAKER & FACILITATORS

Elinore F. McCance-Katz, MD, PhD

Chief Medical Officer
Rhode Island Department of Behavioral Healthcare
Developmental Disabilities and Hospitals



Elinore McCance-Katz is the Chief Medical Officer for the Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals and she is the Medical Director/Acting Chief Executive Officer for the Eleanor Slater state hospital system in Rhode Island. Previously, she served as the first Chief Medical Officer for the Substance Abuse and Mental Health Services Administration (SAMHSA). She obtained her PhD from Yale University with a specialty in Infectious Disease Epidemiology and is a graduate of the University of Connecticut School of Medicine. She is board certified in General Psychiatry and Addiction Psychiatry. She is a Distinguished Fellow of the American Academy of Addiction Psychiatry with more than 25 years as a clinician, teacher, and clinical researcher. Prior to coming to SAMHSA, she served at the University of California, San Francisco as a Professor of Psychiatry, as the Medical Director for the California Department of Alcohol and Drug Programs, and as the Medical Director of SAMHSA's Clinical Support Systems for Buprenorphine (PCSS-B) and Opioids (PCSS-O). Dr. McCance-Katz has published extensively in the areas of clinical pharmacology, medications development for substance use disorders, drug-drug interactions, addiction psychiatry, and HIV infection in drug users. She served on the World Health Organization (WHO) committee that developed guidelines on the treatment of drug users living with HIV/AIDS. She has also been actively involved in the development and delivery of physician training on office-based treatment of opioid use disorders.

In Collaboration
with:



RESERVE Your SEAT Today! 702.739.9989 or Renee.hinostrosa@clarkcountymedical.org

MACRA, MIPS & You – WHAT'S NEXT?



CCMS 2017 CME Series

2.75 AMA PRA
Category 1 Credit(s)TM

January 10, 2017

6:00 PM - 9:00 PM

Statewide CME - simultaneously held at three (3) locations:

LAS VEGAS

Vegas PBS – Technology Campus
Events Center
3050 E. Flamingo Rd.
Las Vegas, Nevada 89121

RENO

University of Nevada, Reno
Center for Molecular Medicine | Room CMM
111
1664 N. Virginia Street
Reno Nevada 89121

ELKO

University of Nevada, Reno
Room GRIS 31
701 Walnut Street
Elko, NV 89801

Why you should attend... The purpose of this activity is to prepare Nevada Physicians & Clinicians for the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and Merit Based Incentive (MIPS) Payment System- Quality Payment Program that goes in to effect January 1, 2017. The program will highlight current Medicare payments for volume of services that are being replaced by payments for outcomes of care achieved through delivering higher quality, efficiency, and effectiveness of clinical practice, clinicians delivering higher value care- higher quality of care at lower cost- will receive higher reimbursements than those delivering lower value services, and current systems that do not adequately pay for coordination of care, clinical improvement activities, clinical information sharing, early preventive services and rapid access to care for those with higher needs but rather provides more incentives to deliver higher volume of discretionary procedures that marginally improve health and well being.

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WELCOME

Souzan El-Eid, MD

President, Clark County Medical Society

6:00 – 6:50 pm | Kelly Cleary
Policy, Law, and Regulation

6:50 – 7:15 pm | Q & A w/Kelly

7:15 – 7:30 pm | Break

7:30 – 8:15 pm | Jerry Reeves
Resources for Success

8:15 – 9:00 pm | Steve Phillips
Applying MIPS to Improve Health Outcomes

This seminar is brought to you by the following
State and County Medical Societies



Rural County Medical Societies:
Carson Douglas Counties, Central Counties, Elko County, White Pine County

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Kelly M. Cleary, JD

Counsel
Akin Gump Strauss Hauer & Feld LLP
Washington, D.C.



Jerry Reeves, MD

Senior Vice President
of Medical Affairs
HealthInsight in Nevada, Utah,
Oregon, and New Mexico



Steven L. Phillips, MD

Medical Director
Sanford for Center for Aging
University of Nevada, Reno



RESERVE Your SEAT Today! 702.739.9989 or Renee.hinostrosa@clarkcountymedical.org

**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

**2017 BME MEETING &
HOLIDAY SCHEDULE**

January 2 – New Year’s Day (observed)
January 16 – Martin Luther King, Jr. Day
February 20 – Presidents’ Day
March 3-4 – Board meeting
May 29 – Memorial Day
June 2-3 – Board meeting
July 4 – Independence Day
September 4 – Labor Day
September 8-9 – Board meeting
October 27 – Nevada Day
November 10 – Veterans’ Day (observed)
November 23 & 24 – Thanksgiving Day & Family Day
December 1-2 – Board meeting (Las Vegas)
December 25 – Christmas Day

Nevada State Medical Association

3700 Barron Way
Reno, NV 89511
775-825-6788
<http://www.nvdoctors.org>

Clark County Medical Society

2590 East Russell Road
Las Vegas, NV 89120
702-739-9989 phone
702-739-6345 fax
<http://www.clarkcountymedical.org>

Washoe County Medical Society

3700 Barron Way
Reno, NV 89511
775-825-0278 phone
775-825-0785 fax
<http://www.wcmsnv.org>

Nevada State Board of Pharmacy

431 W. Plumb Lane
Reno, NV 89509
775-850-1440 phone
775-850-1444 fax
[http://bop.nv.gov/
pharmacy@pharmacy.nv.gov](http://bop.nv.gov/pharmacy@pharmacy.nv.gov)

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

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

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

ARCOTTA, Karen F., M.D. (4896)

Las Vegas, Nevada

Summary: Alleged failure to provide adequate supervision of a physician assistant.

Charges: One violation of NAC 630.230(1)(i) [failure to provide adequate supervision of a physician assistant].

Disposition: On December 2, 2016, the Board accepted a Settlement Agreement by which it found Dr. Arcotta violated NAC 630.230(1)(i), as set forth in the Complaint, and imposed the following discipline against her: (1) 3 hours of CME, in addition to any CME requirements regularly imposed upon her as a condition of licensure in Nevada; (2) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter.

TAN, Lo Fu, M.D. (10849)

Henderson, Nevada

Summary: Alleged malpractice related to Dr. Tan's treatment of a patient.

Charges: One violation of NRS 630.301(4) [malpractice].

Disposition: On December 2, 2016, the Board accepted a Settlement Agreement by which it found Dr. Tan pled no contest to having violated NRS 630.301(4), as set forth in the Complaint, and imposed the following discipline against him: (1) 3 hours of CME, in addition to any CME requirements regularly imposed upon him as a condition of licensure in Nevada; (2) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter.

★ ★ ★

NEVADA STATE BOARD OF MEDICAL EXAMINERS

1105 Terminal Way, Ste. 301

Reno, NV 89502-2144