

California and National News

California Nurses Association (A Union) Kills Nursing Reform Bill:

In 2009, the *ProPublica* non-profit, investigative journalism watchdog group along with the Los Angeles Times investigated the California nursing profession. It found that “the Board charged with overseeing California’s 350,000 registered nurses often takes years to act on complaints of egregious misconduct, leaving nurses accused of wrongdoing free to practice without restrictions. It’s a high-stakes gamble that no one will be hurt as nurses with histories of drug abuse, negligence, violence and incompetence continue to provide care across the state. While the inquiries drag on, many nurses maintain spotless records. New employers and patients have no way of knowing the risks.” This report led the “Governator” to replace most members of the state Board of Registered Nurses (BRN which oversees RNs) and order a review of patient safety controls for all licensed health professionals by the Department of Consumer Affairs. This led to Senator Gloria Negrete-McLeod (chair of the Senate Business and Professions and Economic Development Committee) introducing SB 1111, a proposal for broad revision of the disciplinary processes for virtually all categories of healing arts licentiates, and specifically requiring employers to report RNs who are guilty of misconduct to the state nursing board. The California Nurses Association (CNA) crushed this bill in committee. “The parallels with the California Teachers Association could not be more precise. Both the nurses union and the teachers union depict themselves as noble defenders of the public. The reality is that they are bare-knuckled special interest groups that use their clout to keep incompetents—and worse—on the job.” It seems doubtful that the vast majority of CNA members want their union to protect dangerous RNs from practicing.



*Adapted from the Union-Tribune Editorial Board, April 29, 2010
(www.signonsandiego.com/news/2010/apr/29/protect-patients-bah)*

California Nurses Association (CNA) Blocks Use Of Out-Of-State Volunteer Health Professionals To Provide Free Care To Indigents:

In light of the first *Newsbrief* found above in which the CNA opposed legislation stiffening regulation of RNs, the action by the very same CNA to prevent the use of out-of-state volunteer health professionals to provide free care to indigents seems more than a bit hypocritical and hollow. In fact, an updated *ProPublica* (see above) report revealed that the Board of Registered Nurses found that 3,500 California RNs previously had been punished for misconduct by *other* states, some even having their licenses revoked, while nonetheless retaining their *unblemished* California RN licenses! Yet, this same CNA union recently blocked

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Assemblywoman Karen Bass's proposed legislation to permit out-of-state volunteers to provide free care for indigents because, they cite, the lack of an oversight licensing body. The Tennessee-based, non-profit Remote Area Medical (RAM) organization has offered to staff large free clinics across the nation, therein showcasing the need for health care among the uninsured. The CNA claimed that the relaxing of state licensure requirements would be a threat to the quality of health care. Earlier this summer, Illinois passed a law to facilitate RAM to bring volunteers from any state to serve patients in Illinois. RAM, utilizing temporary licentiates, actually filled The Forum in Inglewood in 2009 as its volunteers rendered almost \$3 million of eye exams, mammograms and pap smears to 700 patients per day. However, earlier this year at another similar RAM event, hundreds of people were turned away for lack of health professionals, despite a doubling of room capacity. Dental care for the poor is another major need, especially since it was deleted from the Medi-Cal program. Note that there does, however, still exist an approximately 90-day process for obtaining temporary licensure for such volunteers in California.

Culled from multiple sources including a report by Christina Jewett at <http://californiawatch.org/watchblog>

Lawmakers in Most States Have Little Control Over Healthcare Premiums: As health care insurance premium hikes are in double digits, in some cases approaching 40 percent, the state regulators who are expected to serve as protectors for the public often can do little to control these rates. In many states the health insurance industry largely controls the regulatory process as they are heavy campaign contributors to those key legislators who are in positions of power to influence government oversight of premiums and review of state insurance regulations. Over \$42 million have been contributed by insurance companies and HMOs to state legislators since 2003. Consumer advocates and administration officials are attempting to encourage new state efforts to overcome this unlevel playing field, especially because the new federal healthcare law failed to give the federal government any meaningful power to regulate premiums, traditionally a state responsibility. Indeed, the oversight battle is at the state level. Of course, the insurance industry lobbyists are concerned that state regulators want to have the power to block rate hikes deemed unreasonable and unjustified by the states. Oregon is a prime example of a state with such authority (called "prior-authority approval") to determine the fate of proposed rate hikes, and indeed, has denied or modified 20 of 71 proposals in the individual and small group markets. Only 19 states have such authority, and although some other states can review premiums in limited circumstances, most have minimal legal authority to challenge the insurance companies. In California, Democratic Assemblyman Dave Jones is making his *third attempt in five years* to get passed a bill to give the insurance commissioner

“prior-authority approval.” His last failed attempt was in 2007 when blocked by four members of the Senate Health Committee, these four culprits having received more money from the state’s largest health insurers and their trade associations than any other state senators in the preceding six years! In fact, the California Department of Insurance belatedly permitted Anthem Blue Cross and Blue Shield of California a 13.4 percent to 18.5 percent average increase in premiums for individual policy holders only after these insurers had requested as much as a 39 percent increase. However, Blue Cross and Blue Shield later were forced to rescind that unimaginable amount when they were found (and admitted) to having made “errors” in their calculations. California law mandates that insurers can increase rates as long as 70 percent of premiums are spent on medical care, but even the figure of 70 percent is unconscionable low and needs to be increased toward the 90 percent level. Recently, the hand-tied Department of Insurance allowed Health Net to raise premiums by an average of 16 percent for their 38,000 individual policy holders, and Aetna an average of 19 percent for their 65,000.

Adapted from an article by Noam Levey, Los Angeles Times, August 12, 2010

Medical Liability Claim Frequency: A 2007-2008 Physician Snapshot: This “snapshot” of physicians’ experiences with medical liability claims, derived from the American Medical Association’s Physician Practice Information survey, describes differences according to a physician’s specialty, age, gender and practice arrangement. 42 percent of physicians had a medical liability claim filed against them at least once in their career; more than 20 percent were sued two or more times. 15 percent of young physicians (under 40 years old) and 60 percent of older (over 55 years old) reported claims, verifying the fact that older physicians have greater “exposure,” having practiced longer. However, in any single year, being sued is a rare event, only 5 percent of the surveyed physicians being sued in a given year. As expected, there also was wide variation across specialty, the greatest incidence being in general surgery and ob/gyn, nearly 70 percent of those physicians having been sued at least once, and 50 percent at least twice. Anesthesiology was not looked at specifically. Pediatricians and psychiatrists had the lowest incidence of claims. Of interest, before they turn 40, over 50 percent of ob/gyns already have been sued. 90 percent of general surgeons over 55 years old have been sued, and even among pediatricians, by the time they reach 55, over half have been sued. A gender difference was noted: twice as high in men than in women. However, this can at least partially be explained by male physicians being more concentrated in the specialties with the highest levels of claims and female physicians in those with the lowest levels. Moreover, women are newer entrants into the medical workforce, nearly one-third of men - but only 15 percent of women—being over 55 years old. Finally physicians who have an ownership

interest in a practice are more likely to be sued, but this may reflect the legal concept of vicarious liability and the Doctrine of Respondeat Superior, suggesting that some of the claims stem from care provided by employees.

American Medical Association Economic and Health Policy Research, August, 2010

Cash-Poor Governments Dumping Public Hospitals: Anticipating increasing debt and expected new federal health care law-mandated costs, numerous local governments are dropping public hospitals that tend to serve as the caregiver net of last resort. If these facilities are to be remaining open, for-profit chains are among the potential buyers, but, of course, if they, in turn, cannot make a profit, then they will close unprofitable services, fail to infuse needed capital, or simply close down. Over 20 percent of the nation's 5000 hospitals are government-owned, many in serious debt due to a rise in uninsured patients (industry closures), cuts in Medicare and Medicaid reimbursements, elevated health care costs, and payments on construction bonds sold in better financial times (also note that many have credit ratings that, in a tight credit market, impede their ability to borrow money). Furthermore, as many government-owned hospitals are solo operations, they don't benefit from economies of scale, nor are they likely to manage to their financial advantage the new federal health care law that mandates certain information technologies, quality accounting, bundled payments and care coordination.

Adapted from article by Suzanne Sataline, Wall Street Journal, August 30, 2010

Department of Insurance Seeks \$10 Billion Fine from PacifiCare: California regulators are imposing fines of up to \$9.9 billion from health insurer PacifiCare over allegations that it mismanaged and misplaced medical claims, "lost" thousands of patient documents, was negligent in paying physicians what they were rightfully owed, and failed to respond to complaints about their unlawful actions. These acts were found to have occurred after UnitedHealth Group Inc. (our nation's largest health insurance company by revenue) purchased PacifiCare, having violated state law about one million times from 2006 to 2008. Probably the largest fine sought against a health insurer, the Department of Insurance's general counsel said "this is about the intentional disregard for the interests of doctors, hospitals and patients in California, and the pursuit of cutting costs at any means possible. It is a story of intense corporate greed."

Adapted from article by Duke Helfand, Los Angeles Times, September 7, 2010

Physician Participation in Lethal Injection and an Inadequate Supply of Sodium Thiopental: New regulations promulgated by the California Department of Corrections and Rehabilitation and approved by the Office of Administrative Law, although not requiring a physician to administer

the lethal injection “cocktail,” would require a psychiatrist to certify (evaluate and declare) that an inmate is mentally competent to undergo execution (now that’s quite an “undertaking”). This disregard of the widely accepted ethical imperative against physician participation in execution represents a direct violation of the AMA, CMA and ASA ethical stances, yet such physician participation has been included in new CDCR regulations despite the strongly worded formal objections of organized medicine. In 2006, AB 1954, sponsored by the CMA, prohibited state or local government agencies from using a physician to participate in an execution. However, the bill was enmeshed in the controversy over capital punishment and experienced a rapid demise. And, now we have been informed that sodium thiopental, once one of the most readily available and most utilized anesthetic drugs, and one that is integral to the state-established lethal injection process, no longer may be available in ample supply, at least until 2011! As anticipated, the legal wrangling will continue well into the future.

ABA Numbers for Reporting CME credits!

CSA will report CME credits earned to the American Board of Anesthesiology. These credits will be counted as Lifelong Learning and Self-Assessment activities toward your Maintenance of Certification in Anesthesiology (MOCA) requirement. In order to report these credits, anesthesiologists need to provide their ABA number. To obtain an ABA number, visit www.theABA.org and create a personal portal account.