The UNIVERSITY of VERMONT
CENTER FOR HEALTH & WELLBEING

Vermont Board of Medical Practice
108 Cherry Street – PO Box 70
Burlington, VT 05402-0070

November 24, 2009

Re: Docket Number MPS 122-1109

Members of the Board,

I have received Ms. Nenninger's letter dated November 9, 2009. My response to her inquiry follows; before I address her questions, I believe that I can provide you with some helpful context about me and the Center for Health and Wellbeing.

A. My education, background and experience

I am a 1982 graduate of the University of Washington School of Medicine (Seattle) and completed my residency and chief residency in family medicine at Thomas Jefferson University in Philadelphia. I was certified by the American Board of Family Practice in 1986 and have maintained board certification since that time. In 1992, I began my practice in Vermont as a staff family medicine physician for Community Health Plan; my office was located in Hoosick Falls, New York and I admitted patients to Southwestern Vermont Medical Center. Prior to this I worked as a family physician at Princeton University, the Medical Center at Princeton (New Jersey) and Group Health Cooperative of Puget Sound (Olympia, Washington). In all of these positions I worked closely - and often in a supervisory or collaborative capacity - with physician assistants and nurse practitioners. These relationships were characterized by collegiality and professionalism, and consistently produced medical care of very high quality.

In 1996, I accepted a position with Fletcher Allen Health Care in Burlington; at that time, the University of Vermont contracted with FAHC for the services of the Medical Director. Eighty percent of my effort in this position was devoted to serving as Medical Director for the primary care and women's health offices of the Center for Health and Wellbeing. The remaining twenty percent of my work

involved practice as an attending physician at the Milton Family Practice Center and teaching students and residents in the Department of Family Medicine in ambulatory settings. In 2004, I became a full-time employee of the University of Vermont and have continued my affiliation with the College of Medicine and the Family Medicine residency to the present time. The Center for Health and Wellbeing serves as a clinical rotation site for nurse practitioner students, medical students, residents in the Departments of Pediatrics and Family Medicine and post-Masters Degree interns in counseling.

From 1996 until December 2008, I fulfilled the duties of Medical Director for the Center for Health and Wellbeing. The primary responsibilities of this position involve assuring that the care in the medical and women's health offices is of high caliber and meets appropriate standards. At an early point in my work as Medical Director, I wrote the Center's Peer Review and Quality Improvement policies and developed and implemented procedures for each of these programs. Beyond this, I served as clinical and administrative supervisor for the Center's physicians, physician assistants, and nurse practitioners. In this role I provided ongoing support and consultation for clinical issues and chaired regular meetings of the clinical staff. I served as UVM team physician for all of the University's athletes and intercollegiate teams from 1999 – 2008; I continue to cover contests on a regular basis and provide administrative supervision for the Center's Athletic Medicine unit, which includes the team physician and eight staff athletic trainers.

In August of 2007, I became the Director of the Center for Health and Wellbeing. In this position I have administrative and budgetary responsibility for each of the Center's individual units – Primary care, Women's Health, Counseling and Psychiatry, Athletic Medicine, Health Promotion and Administration. I report to the Assistant Vice President for Student and Campus Life at the University. In addition to my clinical activity and the work noted above, I am called upon to provide guidance and counsel to University leadership regarding issues affecting the physical and mental health of the roughly 13,000 undergraduate and graduate student communities. I serve as a member of the University's Emergency Operation Group which is responsible for responding to issues affecting the health and safety of the campus, and have for the last two years served as co-chair of the University's Pandemic Planning Task Force. I am available on a twenty-four hour basis for urgent clinical issues and for emergencies involving the campus. I continue to spend thirty percent of my time in clinical practice at the Center and maintain regular contact with our Physician Assistants and Nurse Practitioners. With the departure of our Medical Director this past summer, I continue to fill the responsibilities of this position as we engage in a search to fill this position. I continue to be a member of the medical staff at FAHC with active admitting privileges.

B. The Center for Heath and Wellbeing

The Center for Health and Wellbeing at the University of Vermont was created in 1996. While a minority of university health centers choose to undergo the accreditation process, the Center received its first full three-year accreditation by the Accreditation Association for Ambulatory Health Care (AAAHC)

in 2000 and has been reaccredited for full terms in 2003, 2006, and this year. I was active in the push for initial accreditation and have shouldered a significant role in the preparation process and site visits for each of these successful surveys.

In the most recent fiscal year the Primary Care and Women's Health offices recorded 13,500 visits while the Counseling and Psychiatry unit recorded 8,000 visits. The Center has a budget of 6. 4 million dollars and employs 70 staff members who represent a variety of professional backgrounds and cultures. Included in this number are two nurse practitioners, three physician assistants, four physicians, three psychiatrists, fourteen counselors (four of these individuals hold doctoral degrees and three are Licensed Alcohol and Drug Counselors), seven certified Athletic Trainers, and three individuals engaged in education and outreach related to three primary areas – alcohol and substance abuse, mental health, and sexual health. While the Center engages daily in the medical and counseling care of students in acute distress, it has a deep commitment to engaging and educating students about important issues related to the development and maintenance of excellent mental and physical health throughout their entire lives.

The Center's primary care office is typical of many medical offices. Students are seen by appointment or accommodated on a walk-in basis for the broad range of issues seen in a typical primary care office; clinicians typically see about 16 visits each day. The office is open six days each week and provides 24-hour call for students with urgent medical or counseling need – first line calls for students who require care outside of regular hours are taken by outside contracted service providers with backup by one of our physicians and counselors.

Problems frequently encountered in the medical offices include acute illness, orthopedic and dermatologic issues, and care related to sexual health. In line with the experience of most health centers devoted to the care of college and university students, the Center has in recent years noted a significant increase in the number of students presenting with significant mental health issues – namely depression, anxiety, and alcohol/substance abuse. This reality, along with the grave and potentially lethal consequences of suboptimal care for individuals afflicted with these disorders, makes it crucial that clinicians fully employ the expertise available in the Center as they care for individuals with serious and potentially lethal conditions. When they encounter challenging cases related to mental health or substance abuse, medical clinicians are expected to use our psychiatrists, general counselors, and licensed alcohol and drug counselors for consultation and referral and/or to seek expert opinion from the larger mental health and substance abuse treatment community in Burlington. Conversely, mental health professionals are expected to make appropriate use of medical clinicians on a regular basis in their care of students. This is not a casual expectation; I have emphasized it repeatedly in my communication with staff members and have worked to provide regular occasions for mental health and medical staff to meet and become well acquainted with one another on a professional level. Beyond enhancing professional relationships, these meetings are designed to provide opportunities to identify any 'seams' between the medical and counseling systems and to make them disappear. Our electronic health record, initiated in March 2008, allows clinical staff (medical and mental health) to view all clinical activity for students in

their care and thus insures that all information relevant to the management of an individual student's care is available to the clinicians at each of the Center's geographically dispersed points of care.

My responses to the specific questions raised in Ms. Nenninger's letter follow.

Your explanation of why Mr. Nobes' prescribing practices were not reviewed or followed by you during the time you were the Primary Supervising Physician.

I regret that for a period of time Mr. Nobes engaged in inappropriate prescriptive practices in his use of controlled substances with a handful of patients. In the following paragraphs I will address the reasons I believe this activity was able to take place and discuss the changes undertaken to prevent a recurrence of this behavior by any of our clinicians. Before doing so, I would like to put my supervision of Mr. Nobes and other providers at the Center into context.

A variety of systems employed at the Center – as well as the nature of the practice itself – provided me with what I believed to be a consistent and regular review of Mr. Nobes' clinical work during his tenure at the Center for Health and Wellbeing.

- As required by the Center's peer review process, a number of Mr. Nobes' charts were formally reviewed twice each year as part of the Center's peer review process. Ironically, because of his significant experience and generally stellar work, Mr. Nobes was responsible for organizing this process over the last several years. Procedurally, a number of clinical encounters (typically eight) are chosen for each clinician in the practice. These encounters are assigned to other clinicians for review using a standard format designed to evaluate the thoroughness and appropriate documentation of the patient's history, the documentation of an appropriate physical examination, and the arrival at an appropriate assessment and therapeutic plan. Each case is presented by the reviewing clinician to the Medical Director and the larger group of clinicians. One peer review session each year typically involves charts pulled on a random basis while the second session involves charts targeting a specific clinical issue – for example "pneumonitis" or "infectious mononucleosis." Issues noted in the course of this review are referred to the Medical Director and the Center's Quality Improvement Monitoring Committee (QIMC). Issues of a 'systems' nature which may potentially adversely impact the quality of care are resolved by the QIMC, while issues relating to the quality of care rendered by an individual clinician are brought to resolution by the Medical Director. The result of each clinician's peer review performance is noted in the annual performance review conducted by the Medical Director. Over the years Mr. Nobes' work was consistently noted to be of high quality. In my thirteen years of participation in this peer review process with Mr. Nobes, the only issue of note related to difficulty deciphering his penmanship.

- As previously noted, the Center has recently achieved its third full three year re-accreditation through the auspices of the Association for the Accreditation of Ambulatory Health Care

(AAAHC). In addition to a review of the policies and procedures related to the Center's administrative, budgetary, quality improvement, peer review, and patient/client safety activities, the Association requests a number of charts covering a variety of clinical issues at the time of their on-site visit and conducts a thorough review of these charts in order to ascertain that the care documented in these records meets an appropriately high standard. No problem with Mr. Nobes' care was ever suggested by these reviews.

- The clinical staff of the primary care and women's health offices meets for sixty minutes on a weekly basis. Approximately half of this meeting time is devoted to the presentation and discussion of challenging cases encountered by clinicians. Mr. Nobes was a regular contributor to these conversations and often brought cases to the group along with reference-based material pertinent to the diagnosis or therapeutic approach to the issue at hand. On no occasion did he bring any cases related to the pain management of particular patients or the appropriate use of opiate or anxiolytic medications.

- Regular individual meetings between Mr. Nobes and me in my role as his primary supervising physician allowed for a more detailed and thorough review of cases and charting. These meetings often served the additional purpose of allowing us to discuss issues related to Mr. Nobes' administrative roles including his supervision of our outpatient laboratory and work as peer review coordinator. A review of my calendar for the last three academic years records the following number of formal meetings with him by fiscal year.

June 2006 – June 2007	13
June 2007 – June 2008	20
June 2008 – June 2009	18

- My clinical work in this small practice alongside Mr. Nobes afforded me with what I believed to be an accurate insight into both the scope of his practice and his diagnostic and therapeutic approach to the issues presented to him. We shared many patients. I would thus see what he had done at a prior visit, and, in many cases, we would discuss a patient he was currently attending to that day. In the course of a day in practice, Mr. Nobes and I would have multiple opportunities to discuss clinical questions and dilemmas. Of note as well is the fact that, despite ongoing efforts to provide consistent continuity of care, students seem by nature inclined to seek care on an episodic basis and most often without any recollection as to whom they may have seen on a prior visit. In this situation it was a matter of course for me and for other clinicians to review the care provided by Mr. Nobes – often several times each day. Had I reviewed a case of inappropriate care on the part of PA Nobes, I would have followed up with him with appropriate urgency.

Moreover, I would have sought to ascertain whether a particular case was an 'outlier' or was part of a larger pattern of questionable care.

In addition to the issues inherent to the nature of this practice and the systems in place designed to insure quality of care, other important factors played an important role in my approach to the supervision of PA Nobes. First, over the course of thirteen years of clinical work with him I came to have a high degree of confidence in the quality of his clinical care. He was appropriate in his approach to clinical problems and used diagnostic and therapeutic resources in appropriate measure. Beyond this, I was entirely confident in his ability to know when a student was seriously ill and act in a manner so as to insure that the student received appropriate care in a timely fashion. The events of this spring aside, I do not have record or recollection of a single instance when his approach to a clinical scenario was of a nature requiring significant feedback or education.

Further enhancing my confidence in Mr. Nobes' competence was the fact that he was vigorously engaged in professional activities of regional and national scope, endeavors of which I have been highly supportive. He has been an active member of the American College Health Association since 1989 and has been involved in the association's Clinical Medicine Section. He served on the Board of the New England College Health Association (NECHA - a regional unit of the American College Health Association) from 1998 until very recently. In this regional work he has been heavily involved in planning the annual NECHA educational and networking conferences and has been a regular presenter at these events. In 2002 he was named President of the Board of NECHA. In 2008 he was named a fellow of the American College Health Association, a status bestowed by the Association on individuals who have "given outstanding service to the organization and have demonstrated superior professional stature and performance in the college health field". Scarcely 200 individuals have achieved this status since its initiation in 1967.

Alcohol and substance abuse (including abuse of prescriptive medications) by college students is responsible for a tremendous amount of distress and injury to individuals and to university communities. In response to this unfortunate reality, the Center employs a three certified drug and alcohol counselors who work with students in need of assistance as well a full-time staff member whose duties are specifically devoted to outreach and education about this issue. With specific regard to Mr. Nobes' pattern of prescribing controlled substances, it was my very strong impression that in addition to the active support and supervision provided to him at the Center and our consistently strong emphasis on the importance of minimizing the damaging consequences of substance abuse, his active involvement in regional and national leadership activities in the field of college health would have served to enhance his awareness of the importance of prescribing controlled substances appropriately and with due caution.

While I am dismayed that the structures and systems put into place to insure quality care at the Center failed to allow us to discover the inappropriate instances of narcotic prescription by Mr. Nobes that I brought to your attention, I do believe there are important features specific to this practice that

contributed to this outcome. First, the number of questionable encounters represents a very small fraction of the number of students with whom Mr.Nobes interacted. In an average week he recorded approximately eighty visits, a minority of these representing follow up visits for a specific complaint. Additionally, it appears that students who were getting questionable medications from Mr. Nobes did not seek care from other clinicians at the Center. Once affiliated with Mr. Nobes, they had little incentive to seek out other clinicians with a request for narcotics as this might have endangered their continued supply. Fortunately, an important remedy to this situation has already been engaged in the form of the electronic record, which allows the medical director to rapidly survey the use of selected medications by specific clinicians.

Detail your understanding of the role of a PA Primary Supervising Physician.

I understand the role of the Primary Supervising Physician to encompass the following tasks:

- Maintain my qualifications to practice medicine of high quality and to supervise a Physician Assistant only in areas contained in my scope of expertise.
- With the full cooperation of and communication from the Physician Assistant, to work diligently to insure that patients under the care of this team receive care of high quality.
- Be available for consultation and review of work performed by the Physician Assistant.
- Conduct regular reviews of the Physician Assistant's work.
- Notify the Board of dissolution of the Physician Assistant's employment contract with me or should the scope of the Physician Assistant's practice change.
- Have read the statutes and Board Rules related to the supervision of Physician Assistants.

Your understanding of the Board Rules and VT Statutes regarding PA Supervision.

I have read the Vermont Statutes and Board Rules related to PA Supervision on many occasions and once again upon receiving the letter from Ms. Nenninger.

I understand the statutes to define the qualifications, role and scope of practice of the Physician Assistant, the identification of the Vermont Board of Medical Practice as the regulatory body for Physician Assistants in this state, the nature of the PA's supervision and the definition of misconduct and possible consequences for such behavior.

Plans to Avoid a Recurrence of this Issue

I would like the Board to know that I have given a tremendous amount of thought to the events which led me to report Mr. Nobes to the Board and remove him from employment at the Center for Health and Wellbeing. As a result of this reflection, I have undertaken the following steps.

- I have conducted a review of the prescription habits of all clinicians working at the Center with regard to controlled substances. I am confident that the prescription of these medications on the part of all clinicians is in line with an appropriate standard of care and, specifically, is in line with the expectations of the Board.
- I have raised the issue of pain management with the medical staff at the Center. We will complete and adopt a formal policy dealing with this issue by the end of this calendar year. Meanwhile the group is aware that they are bound by the following rules related to the prescription of controlled substances within the practice:
    - Clinicians will not prescribe narcotics for chronic pain unless the patient involved has been evaluated by a specialist in the field of pain medicine and such an approach is felt to be the appropriate course of action. The use of narcotic medication in such an instance will need to be in accord with the principles of their use as set forward by the Board and the use of a standard contract with the patient will be mandatory. Nurse practitioners and physician assistants need to consult with their collaborating or supervising physician in all such cases.
    - Clinicians will not refill controlled substances for patients for whom they are not the originating prescriber.
    - Clinicians will not refill prescriptions that are lost or stolen.
    - Narcotic medications will not be refilled after hours.
    - In all cases, clinicians will use narcotic medications as part of a step-wise plan to alleviate pain and will use non-narcotic medications as a first line response to pain.
    - The pattern of narcotic prescription for each clinician and for the practice as a whole will be reviewed semi-annually in conjunction with the peer review process. Apparent variance with an appropriate standard of care will be raised immediately with the clinician involved.
    - With regard to our peer review policies, it has not escaped me that Mr. Nobes was responsible for coordinating the 'pulling' of charts for review. I have changed our procedure in this regard so that henceforth charts will be pulled randomly by our practice operations manager.

As I deliberated about what course to pursue with regard to Mr. Nobes' future at the Center, I was impressed again that central to an effective Supervising Physician/Physician Assistant relationship is a profound commitment to candor, openness, and respect between these two individuals. The Physician Assistant must be able to accurately identify cases which are difficult for any number of reasons and must commit to bringing these cases up for supervision. The Supervising Physician must enter these conversations with an eye to first maintaining the safety of the patient, this followed closely by a stance toward the Physician Assistant which is both educational and respectful. In reviewing Mr. Nobes' care in the cases referred by me to the Board, it was clear to me that he was not fulfilling his part in this relationship by omitting these cases from our joint review and consultation. It was this 'disconnect' in

Mr. Nobes' approach to the supervisory relationship which persuaded me that I was no longer willing to supervise his practice.

Referencing my own actions in this course of events, I wish to note that I acted immediately and decisively upon learning of a potential problem involving Mr. Nobes' practice. I reviewed his pattern of narcotic and anxiolytic use and sought a review and consultation from an independent expert - even as I restricted Mr. Nobes' ability to prescribe these medications. I am aware that this pattern of prescriptive activity was harmful to individual patients and was a serious affront to the commitment to quality and dedication to students that characterizes the larger staff of the Center, and I take these realities directly to heart. At the same time, I believe that Mr. Nobes received supervision that was at all times active, competent and accessible, and am furthermore convinced that the structures in place at the Center – peer review, ongoing quality improvement activity, a professional environment which encourages consultation and continuing education, and individual supervision - serve as an excellent foundation ensuring both quality care and the effective supervision of all clinicians.

Moving forward, I believe it is important to assume an even more active stance in the supervisory relationship with Physician Assistants regarding the clear delineation of issues that must be brought to the attention of the Supervising Physician. While this understanding already exists in the realm of serious physical disease, the rapidly changing landscape we are witnessing in the issues and care of young university adults makes it important to specify more clearly what additional risks to health and life – addictive behavior, serious mental health issues, eating disorders, and more – must be brought to consultation between the PA and physician. Beyond this, it is my intent to formalize the review process in individual meetings between supervising physician and PA and will put into operation an expectation that these meetings take place at least biweekly with the review of a minimum of six charts chosen by both PA and supervising physician.

In closing, I wish to state my appreciation of the Board's consideration of this matter. I will be pleased to provide more information in person should this be helpful, and I will also be pleased to receive any input from the Board that will improve my supervision efforts.

Sincerely,

Jon Porter, MD

Director, University of Vermont Center for Health and Wellbeing