BOARD NEWS

Spring/Summer 2004

Dear Physical Therapists and Assistants:
(By: Sally B. Oxley PT, CHT, Board Chair)

The primary concern of this Board is and always will be to promote and protect the public health, safety, and welfare through the licensure of Physical Therapists. The purpose of an association, such as the West Virginia Physical Therapy Association, is the protection and furtherance of the profession and its members. Although the objectives of the WV Board and the WV Association are different, they are not adverse to each other as the ultimate goal is safe and competent Physical Therapy practice. I urge you to join and become an active part of your association with respect to the political issues that effect your profession and the lives of the people you serve. Your voice can be heard, and it has and will make a positive difference in the quality of life for the citizens of West Virginia:

Ben Franklin is quoted as saying, "We must a11 hang together or assuredly we will hang separately"

Regards,
Sally Oxley, Board Chair

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An Open Letter to Delegate Rick Staton of Wyoming County
(By: Cynthia Fox PT, Board Member & Frankie S. Cayton, Board Admini_stratdf)

(This letter was written in response to Mr. Staton's two attempts to introduce legislation that would have lowered the criteria for foreign-educated applicants applying for licensure in the State of WV.)

Dear Mr. Staton

During the past nine years, the WV Board of Physical Therapy has had **1,099** Physical Therapist applicants *who* successfully applied for and received a license to practice Physical Therapy in the State of WV. Each of those applicants went through a standardized process involving the careful evaluation of credentials not only for authenticity, but also for adherence to standards..

Educational credentials are examined as follows:

1. Domestically educated applicants must present transcripts from a CAPTE-accredited Physical Therapy Program. In essence, the awarding of CAPTE accreditation serves as an exhaustive evaluation of the Applicant's schooling as measured against published standards. Domestically educated applicants from unaccredited programs will not be considered for licensure in WV.
2. Foreign-educated applicants must have their school present transcripts to International Credentialing Association (1.C.A.), an independent credentialing agency with nearly 20 years experience in Physical Therapy credentials evaluation.

   We provide I.C.A. with the template to use for these evaluations. We have selected the "Course Work Evaluation Tool" developed by the Federation of State Boards of Physical Therapy (the umbrella organization of Physical Therapy Boards) who is also the developer of the National Phystcal Therapy Examination. This "Course Work Evaluation Tool" was modeled on theCAPTE requirements in place for U.S. Programs back when the B.S. Degree was the standard in U.S. **PT** education. There are no longer any B.S. Level programs in the U.S. as all programs have moved towards Masters and Doctorate

Level preparation. The Course Work Eva)uation Tool continues to measure foreign applicants against the B.S. Degree. It is used by at least 35 States.

3. Of the 1,130 people who haye applied for licensure since 1995, **1,099** applicants successfully met the credentialing criteria and were licensed. This. represents 97% of the applicants.

In response to your concerns, we have examined the files of all **31** people who failed to meet the criteria. Of these 31 applicants, nearly one third were U.S. citizens. Eight of these graduated from CAPTE-accredited programs and; therefore, passed the educational criteria. However, they did **NOT** pass the National Physical Therapy Examination (NPTE). This is an essential requirement for licensure.

Two of the remaining five were educated in foreign programs and, therefore, underwent an external review of their credentials by a reputable credential evaluation agency with findings as follows:

Applicant #1: With only two years of schooling, the credential evaluation. Aptly determined that this program was only equal to a two-year vocational training program; and was, therefore, not B.S. Degree equivalent.

Applicant #2: The credential evaluation clearly shows that the individual does have a B.S. Degree, but it is in Biology - - not in Physical Therapy. Therefore, the applicant is essentially missing large segments of clinically relevant education.

Applicant.#3: Never provided a transcript from a Physical Therapy School

Applicant #4 Refused to submit their credentials to be evaluated or authenticated

Applicant #5: Credential verification process revealed an active fraud investigation in Florida; as well as revocation of prior licenses in Missouri and Illinois as a result of a 1991 felony conviction.

The remaining 18 applicants were Australia (1); England (3);Indi4 So: Africa (3); and Switzerland (1).

Of these 9 failed to complete the application process as follow:

2 failed to pay the license fee
1 was unable to provide any documentation to prove she had attended a **PT** school
3 failed to provide transcripts of English proficiency testing
3 declined to submit their credentials to an evaluation

Of the remaining 9 applicants not of U.S. citizenry:

2 failed the National Physical Therapy Exam. One of these individuals bas failed the Exam 11 times to date
5 failed all or part of the English Proficiency Examinations. One of these applicants was unable to fill out the application form, and so should perhaps be grouped with the first contingent above. All of these 5 additionally had difficulties with their educational credentials - - one having only 2 years of college;' one having only 8 credits in general education; and all having serious deficits in subject matter.

The final 2applicams failed to gain licensure based solely on the education credential evaluation.

Applicant #1: 80% of his grades were D's and E's
Applicant #2: only had 3 years of schooling.

In neither case would these credentials be B.S. Degree equivalent.

In summary:

One third of applicants failed to complete the licensure process secondary to an unpaid fee, inability to

One third of applicants failed the National Physical Therapy Examination

One third of applicants failed to meet educational standards as outlined earlier; in some cases also failing to pass English Proficiency Exams

One was rejected because of encumbered licenses and a criminal history

Over the past nine years, only 9 individuals of the applicant pool has been disqualified for licensure based on educational credentials and English Proficiency. Clearly this has no significant impact on the-available pool of therapists.

We would also like to draw your attention to foreign born, foreign educated therapists who hold current WV licenses. Of these 112 licensees, about 60 are currently practicing in the State and they represent a diverse list of countries: Australia, Belgium, Canada, Chili, China, Egypt, Germany, Iceland, India, Ireland. the Netherlands, Norway, Pakistan, Philippines, Poland, So, Africa, Taiwan, the United Kingdom and Viet Nam. This represents approximately 12% of all Physical Therapists licensed in the State.

Finally, we need to return to the reason that the WV Board of Physical Therapy exists: TO PROTECT THE PUBLIC.

A Licensing Board that is unwilling to exclude anyone from licensure serves no purpose. It is in no one's best interest, including those who live in under served areas, to license unqualified individuals.

We have created a committee to examine our current educational criteria who will report to the Board at our next meeting. Our current licensure process takes approximately one month. We do not believe that the process should be expedited in such a way as to lower standards and endanger the public or erode public confidence in the licensees that are practicing.

We look forward to working with you and the WV Physical Therapy Association in collaborating future efforts to provide quality Physical Therapy services to the citizens of WV.

Respectfully Submitted,
Frankie S. Cayton, Administrator

H.B. 2122: Medical Professional Liability Reform

(By: Don R. Sensabaugh, Jr. & Michele Grinberg, Attorneys At Law)

Because of the incredible efforts of the CARE Coalition, individual lobbyists, and leadership in both houses as exemplified by Speaker Bob Kiss, Delegate John Amores, Senator Jeff Kessler and others, the Legislature took a step forward and passed significant tort reform in March 2003. The provisions apply to all'. "health care providers" in WV and, as such, apply to Physical Therapists, Physical Therapist Assistants and Aids with regard to any claims of negligent care and treatment. The provisions took effect on July 1,2003 and apply to all cases brought on or after July 1,2003. A copy of the full text of H.B. 2122, as signed by the Joint Conference CoIl1Jnittee, can be found on our website: (www.fsblaw.com) The following is a summary of the major tort reform provisions: contained in that legislation:

Cap on non-economic damages at $250,000 per occurrence (§55- 7B-8)

Lowers the existing one million dollar cap on awards for pain and suffering and other intangible losses to $250,999 per occurrence, regardless of the number of plaintiffs and defendants or distributes of an estate

In cases where plaintiff proves negligence/malpractice which results in (1) wrongful death or (2) permanent and substantial physical deformity or loss of use of limb or loss of a bodily organ system or (3) permanent physical or mental functional injuries that permanently prevent the injured person from being independently able to care for himself and perform life sustaining activities, the cap is lowered from one million dollars to a maximum of $500,000 per occurrence.

To qualify for this cap, a defendant must have at least one million dollars of professional liability coverage.

To account for inflation, the cap can be adjusted yearly by an amount equal to the CPl. The cap's increase over time cuts off at an amount equal to 50% greater than the original cap; i,e.,$375,000 per occurrence or $750,000 in cases of severe injury.

Cap on all trauma damages of $500,000 (§55-7B-9c)

Lawsuits filed as a result of good faith care or an emergency condition provided at designated trauma centers are subject to a $500,000 total cap on damages, exclusive of ,interest. Emergency condition is defined as any acute traumatic injury or acute medical condition which, according to standardized criteria for triage, involves a significant risk of death or the precipitation of significant complications or disabilities, impairment of bodily functions or with respect to a pregnant woman, significant risk to the health of the unborn child. The cap includes trauma care rendered by a licensed EMS agency. The cap does not protect medical care that is rendered in reckless disregard of risk of harm or in clear violation of established protocols. There is a rebuttable presumption that a medical condition that occurs during the follow-up care is related to the original emergency condition and therefore subject t!) the cap. The Office of Emergency Medical Services designates the trauma centers and may grant provisional status to a health care facility as it works through obtaining approval to be an officially designated trauma center. OEMS is also charged with developing written protocols specifying accepted triage standards.

Individual liability equal to percent of fault (55- 7B-9)

Eliminates the present rule where any defendant who is greater than 25% at fault can be required to pay the entire verdict (joint liability) and replaces it with individual defendant liability equal to their percentage of fault (several liability). The new rule takes effect upon creation of the patient injury compensation fund.

Collateral payments to plaintiffs reduce awards by amounts paid (§55- 7B-9a)

This provision attempts to prevent so-called "double dipping" that existed before this legislation which allowed the Plaintiff to recover expenses such as medical bills and lost income that had already been paid by a "collateral source" like workers compensation, even if the plaintiff did not have to reimburse the collateral source.

Collateral sources include both private and governmental payers of medical and hospital expenses; etc. such as workers compensation, PEIA, health and accident insurance, casualty or property insurance, disability income, and Social Security Disability benefits which are obtained the same injury as alleged in the medical malpractice litigation. Collateral sources will be offset from the verdict before final judgment is entered. There is no offset if plaintiff individually purchased an individual disability or income replacement insurance policy or if the collateral source has a statutory or contractual right of subrogation.. Plaintiffs can be compensated for the premiums paid to secure benefits which are collateral sources. Collateral sources include both past and future benefits, as long 'itS the future benefits are reasonably certain to be paid and are reducible to a sum certain.

Patient Injury Compensation Fund (§29-12C-l)

The legislation establishes a Patient Injury Compensation Fund Study. A commission comprised of the director of the Board of Risk and Insurance Management (BRIM), the insurance commissioner and a governor's appointee will develop recommendations on the feasibility of creating a patient injury fund and will report back to the legislature in December 2003. This fund would cover only economic damages awarded by the jury but unpaid to plaintiff because either: (1) the economic damages exceed the trauma cap of $500,00; or, (2) because the elimination of joint liability in favor of liability only to the extent an individual is found to be at fault means some portion of the economic damages awarded remains unfounded. The fund will not provide for non-economic damages.

Medical injury litigation limited to injured patients (§55- 7B.9b)

Prior statutory language was interpreted by theWV Supreme Court to permit persons injured by patients to sue the patients health care profession. The new language limits injured persons or their legal representatives (who are not patients) to suits against health care professionals only when the health care services provided are proven to have been done in a willful and wanton manner or with reckless disregard of a foreseeable risk of harm.

Qualifications for Experts strengthened (§55- 7B- 7)

Witnesses, who parties want to call as experts at trial, must spend 60% of their time in active practice in the field or in teaching, in the same specialty for which they wish to render opinions when testifying. Expert witnesses must be licensed and in good standing by the licensing authority of a state and must have education and training in the particular area of medicine for which they intend to render opinions.

"Loss of Chance" Theory Requires Reasonable Proof (§55-7B-3(b»

Plaintiffs, pursuant to case law, can recover on a theory that a deviation from the medical standard of care decreased their chances of an improved recovery or survival. The statutory provision clarifies the proof required. Plaintiff must prove to a reasonable degree of medical probability that if the physician had followed the standard of care, it would have resulted in a greater than 25% chance that the patient woui4 have had an improved recovery of survived. In addition, it requires the acts of the physician to be a substantial factor in increasing the risk of harm to a patient.

Imputing liability through theory of "ostensible agency" eliminated (§55-7B-9(g))

Health care entities, pursuant to case law, can be held financially responsible for those whom the court found appeared to be the agents ("ostensible agents") of the entities or providers, in addition to the ostensible agents also being responsible. This provision eliminates the doctrine of "ostensible agency" as long as the "ostensible agents" carry $1 million in professional liability coverage.

This means that if a physical therapist has a contract with a hospital or other health care entity to provide physical therapy services, but is not an employee of the hospital, if the physical therapist maintains $1 million in liability insurance, the hospital is no longer liable for the therapists negligent acts or omissions. As a result hospitals or other health care entities will likely require independent contractor therapists to carry $1 million in liability insurance so the entities can avoid liability.

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Disciplinary Actions Taken By The Board:

David Lyle PT A

The Respondent violated the provisions of Chapter 30, Article 20, Section 10(3) of the Code of WV in that his conduct was unprofessional; and the provisions of Chapter 30, Article 20, Section 10(7) of the Code of WV in that he was grossly negligent in acting as a Physical Therapist Assistant by nor providing physical therapy treatments prescribed for and needed by the patient.

Mr. Lyle's PT A license was suspended through January **1,** 2004; he was also assessed administrative and procedural fees for the cost of investigating and conducting the hearing.

Ferdinand P. Soroneon

PT The Respondent violated the provisions of WV Code §30-2-3 and §16 C.S.R. 9 in that he allowed an unlicensed individual to work as an occupational therapist.

Mr. Sorongon's license was suspended for a period of 12 months; that period of suspension ending on March 3, 2004. For an additional period of 18 months from the date of said reinstatement, until September 3, 2005, Respondent shall practice physical therapy under the supervision of a licensed physical therapist. He was also assessed administrative and procedural fees for the cost of investigating and conducting the hearing.

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