Commonwealth of Massachusetts

Board of Registration In Medicine

Annual Report
~ 2003 ~

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue
Boston, Massachusetts 02118

Mitt Romney
Governor

Kerry Healey
Lieutenant Governor

Martin Crane, MD
Chairman

Roscoe Trimmier, Esq.
Vice Chairman

Randy Wertheimer, MD
Secretary

Hon. E. George Daher
Public Member

Guy, Fish, MD
Physician Member

John Herman, MD
Physician Member

Asha Wallace, MD
Physician Member

His Excellency Mitt Romney
Governor of the Commonwealth
And the Honorable Members of the
General Court of Massachusetts

Dear Governor Romney
and Members of the General Court:

On behalf of the Board of Registration in Medicine, I am honored to announce the submission and availability of a report summarizing the Agency's activities for the calendar year 2003. The Board of Registration in Medicine continues to make tremendous strides in all areas of public protection and health care quality assurance.

The 2003 annual report can be found on line on the Board's web site at: www.massmedboard.org.

In the four years since the Board reorganized and revamped much of the way it operates, the number of annual disciplinary actions has increased sharply, up nearly 60 percent between 1999 and 2003. At the same time, since the Board tackled a longstanding problem of a large backlog of complaints, the time it takes for a patient to see a complaint resolved has dropped dramatically. Much of the Agency's improvement on these two critical areas of performance occurred in 2002, but efforts to make sure the fixes to the problems were not temporary were realized. In 2003, the Agency continued to achieve excellent marks in both areas.

With those areas no longer needing to be triaged, the Board was able to move ahead on several other important matters, including beefing up its renowned web site, www.massmedboard.org, which contains the first-in-the-nation Physician Profiles, and tackling head on the matter of reviewing a backlog of serious incident reports submitted by hospitals as part of the Agency's Patient Care Assessment program.

The year 2003 marked the first year the Board of Registration in Medicine came under the umbrella of the Department of Public Health, rather than the Office of Consumer Affairs. This collaboration has been marked by a great spirit of cooperation. Both agencies are united in a passion for protecting the public while at the same time supporting the practices of the physicians who provide the residents of Massachusetts with the world's highest quality health care.

It should be noted that the Board of Registration in Medicine, while now under the Department of Public Health's umbrella, continues to operate as an autonomous agency, and does not look to

taxpayer dollars to fund its important work. The Agency generates its own revenues, from licensing fees paid by physicians, to fund its budget.

In short, the Board of Registration in Medicine is efficient, consistent and stable as it continues to fine-tune its efforts to protect the public and serve the state's physicians.

The Board looks forward to working in cooperation with its many partners, including the administration and the legislature, to continue on its important mission.

I also express the Board's gratitude to our devoted staff for their tireless effort and dedication. And I personally want to thank my fellow Board members who volunteer long hours to make health care in Massachusetts safer and better.

Sincerely,

Martin Crane, MD

Martin Crane, MD
Board Chair
Massachusetts Board of Registration in Medicine

Board Of Registration In Medicine
2003 Annual Report

Table Of Contents

Commonwealth of Massachusetts

Board of Registration in Medicine

Annual Report

2003

The Board of Registration in Medicine's mission is to ensure that only qualified physicians are licensed to practice in the Commonwealth of Massachusetts and that those physicians and health care institutions in which they practice provide to their patients a high standard of care, and support an environment that maximizes the high quality of health care in Massachusetts.

2003 Members
Massachusetts Board of Registration in Medicine

The Board of Registration in Medicine consists of seven members who are appointed by the Governor to three-year terms. There are two public members and five physician members. Each member also serves on one or more of the Board's committees. Board members are volunteers who give tirelessly of their time and talent to lead the work of the agency. The Board hires an Executive Director to run the agency on a day-to-day basis.

Martin Crane, M.D., Chairman

Dr. Crane, who joined the Board in 2000, is Board-certified in obstetrics and gynecology, operates a private practice in Weymouth and is affiliated with South Shore Hospital. He is a graduate of Princeton University and Harvard Medical School, training in general surgery at the University of Colorado Medical Center and did a residency in obstetrics/gynecology at Boston Hospital for Women. He also performed endocrine research at the Royal Karolinska Institute in Sweden. Dr. Crane chairs the Board's Patient Care Assessment Committee and Data Repository Committee. Dr. Crane recently retired as a member of the Board of Selectmen in the town of Hingham.

Roscoe Trimmier, Jr., J.D., Vice Chair

Mr. Trimmer, a trial lawyer and partner at Ropes & Gray, was named to the Board in 2001 as a public member. A graduate of Harvard College and Harvard Law School, Mr. Trimmier joined the esteemed law firm in 1974, shortly after graduation from law school, and became a partner in 1983. Attorney Trimmier has represented numerous health care providers in disputes concerning the operation and management of Health Maintenance Organizations. He chairs the Board's Complaint Committee.

Randy Ellen Wertheimer, M.D., Secretary

Dr. Wertheimer, who joined the Board in 2002, is a Board-certified family practitioner, on the staff of University of Massachusetts Memorial Health Care in Worcester and the University of Massachusetts School of Medicine, where she is vice-chair of the Department of Family Medicine and Community Health. She is a graduate of the Boston University School of Medicine and was named one of the "50 Most Positive Doctors in America'' in 1996 by the American Hospital Association. Dr. Wertheimer serves on the Board's Complaint Committee.

Honorable E. George Daher, Public Member

Before joining the Board in 2002, Justice Daher was Chief Justice of the Housing Court Department of Massachusetts. He is a graduate of Northeastern College of Allied Sciences (New England College of Pharmacy); Suffolk University Law School; and Boston University Graduate School of Education. Chief Justice Daher has written several books and articles concerning landlord/tenant issues and serves as a lecturer for the American Trial Lawyers Association. He is a member of the Massachusetts Bar Association and Judicial Council and is a former member of the Board of Governors for the Shriners Burns Hospital. He is also a registered pharmacist and serves on the Board's Licensing Committee.

Guy Fish, M.D., Physician Member

Dr. Fish, who was named to the Board in 2003, is a graduate of Harvard College, the Yale University School of Medicine, and the Yale School of Management. He works as a senior consultant at Fletcher Spaght Inc., Boston, with interests in health care policy, biotechnology and finance issues. Research projects completed include *The Economic Rationale for Cultural Competency in Medicine*; and *Magnitude Estimates of Fraud, Waste, and Abuse in U.S. Healthcare*. He serves on the Board's Data Repository Committee.

Asha P. Wallace, M.D., Physician Member

Dr. Wallace, who joined the Board in 2002, is a Board-certified family practitioner and graduate of the University of Adelaide Medical School. In addition to her medical practice, she served as chair of the International Medical Graduates Caucus of the American Medical Association; president of the Massachusetts Branch of the American Medical Women's Association; a member of the Board of Directors of the Tufts HMO; and president of Needham Physicians Inc., a Tufts HMO-affiliated physicians' practice at Deaconess Glover Hospital. She is also a former member of the Committee on Ethics and Discipline and the Legislative Committee for the Massachusetts Medical Society. Dr. Wallace is a past winner of the American Medical Women's Association Award for Outstanding Service to Women in Medicine. She chairs the Board's Licensing Committee and serves on the Patient Care Assessment Committee.

John B. Herman, M.D., Physician Member

Dr. Herman, who is Board-certified in psychiatry and neurology and specializes in psychiatry and clinical pharmacology at Massachusetts General Hospital, joined the Board in 2003. A graduate of the University of Wisconsin Medical School, Dr. Herman did his medical internship at Brown University Medical School and his residency in psychiatry at MGH. He has been on staff at the MGH Psychopharmacology Clinic since 1984. Dr. Herman serves as Director of Clinical Services and Director of Postgraduate Education in the Department of Psychiatry at MGH. He is also Medical Director for the Partners Health Care Employee Assistance Program. He is co-editor of the MGH Guide to Psychiatry in Primary Care and is past president of the American Association of Directors of Psychiatry Residence Training. He is a member of the Board's Licensing Committee.

STRUCTURE OF THE BOARD OF REGISTRATION IN MEDICINE

The Board of Registration in Medicine consists of seven members who are appointed by the Governor to three-year terms. There are two public members and five physician members. A member may serve only two consecutive terms. Members sometimes serve beyond the end of their terms before a replacement is appointed. Each member also serves on one or more of the Board's committees. Committees of the Board include:

Complaint Committee

The Complaint Committee reviews allegations against physicians and recommends cases for disciplinary action to the full Board. The Committee oversees the "triage" process by which complaints are prioritized, directs the Litigation staff in setting guidelines for possible consent orders, in which physicians and the Board agree on a resolution without having to go to court, and recommends to the full Board cases it determines should be prosecuted. The Complaint Committee also holds intensive remedial and investigatory conferences with physicians who are the subjects of complaints in the process of resolving cases either through consent orders or prosecution.

Data Repository Committee

Members of the Data Repository Committee review reports about physicians that are received from sources mandated by statute to file such reports. Sources of these reports include malpractice payments, hospital disciplinary reports, and reports filed by other health care providers. Although sometimes similar in content to allegations filed by patients, Data Repository reports are subject to different legal standards regarding confidentiality and disclosure than are patient complaints. The Data Repository Committee refers cases to the Enforcement Unit for further investigation as needed.

Licensing Committee

Members of the Licensing Committee review applications for medical licenses and requests for waivers from certain Board procedures. The members present candidates for licensure to the full Board. The two main categories of licensure are full licensure and limited licensure. Limited licenses are issued to all physicians in training, such as those enrolled in residency programs.

Patient Care Assessment Committee

Members of the Patient Care Assessment Committee work with hospitals and other health care institutions to improve quality assurance programs by reviewing Major Incident Reports. These reports describe adverse outcomes, full medical reviews of the incidents, and the corrective action plans implemented by the institutions. The plans are part of the Committee's commitment to preventing patient harm through the strengthening of medical quality assurance programs in all institutions. The work of the PCA Committee has become a national model for the analysis of systems to enhance health care quality.

Committee on Acupuncture

The Board of Registration in Medicine also has jurisdiction over the licensing and disciplining of acupuncturists through its Committee on Acupuncture. The members of the Committee include four licensed acupuncturists, one public member and one member designated by the chairman of the Board of Registration in Medicine.

Functions And Divisions Of The Agency

Although the policies and practices of the Board of Registration in Medicine are established by the Board and its autonomy was mandated by the legislature, historically the agency had come under the umbrella of the state's Office of Consumer Affairs and Business Regulation for administrative purposes. As of Jan. 1, 2003, a legislative change placed the agency's administrative residence under the umbrella of the Department of Public Health, but with the same level of autonomy as it had always been afforded.

The Executive Director of the Agency reports to the Board and is responsible for hiring and supervising a staff of legal and medical professionals who perform research and make recommendations to the members of the Board on issues of licensure, discipline and policy. In addition, the Executive Director is responsible for all management functions, budget and contract issues, and public information activities of the Agency. The Executive Director oversees senior staff members who, in turn, manage the various areas of the Agency.

Licensing Division

The Licensing Staff performs the initial review of all applications for medical licensure to ensure that only competent and fully trained physicians are licensed in Massachusetts. The staff also works

with applicants to provide requirements for examinations and training that must be met before a license will be issued.

Enforcement Division

The Enforcement Division is responsible for the investigation of all consumer complaints and statutory reports referred from the Data Repository Committee. The Consumer Protection Unit of the Enforcement Division coordinates the initial review of all complaints as part of its "triage'' process. Complaints with allegations of substandard care are reviewed by experienced clinical nurses from the division's Clinical Care Unit and then sent to outside expert reviewers.

Experienced investigators research complaints by interviewing witnesses, gathering evidence, and working with local, state and federal law enforcement agencies. The division's Disciplinary Unit is staffed by prosecutors who represent the public interest in proceedings before the Board's Complaint Committee, the Board itself, and the Division of Administrative Law Appeals (DALA), which ultimately rules on disciplinary actions that are appealed by physicians.

Education and Outreach Division

Massachusetts continues to lead the nation in the quality and accessibility of information for patients and the general public. Since the launch of the Physician Profiles project in 1996, tens of thousands of Massachusetts residents have found the information they needed to make informed health care decisions for their families using this innovative program.

In addition to on-line access to the Physician Profiles, the Board of Registration in Medicine assists consumers who do not have Internet access through a fully staffed Call Center. Employees of the Call Center answer questions about Board policies, assist callers with obtaining complaint forms or other documents and provide copies of requested Profiles documents to callers.

Division of Law & Policy

The Division of Law & Policy operates under the supervision of the agency's General Counsel. The Office of the General Counsel acts as legal counsel to the Board during adjudicatory matters and advises the Board and staff on relevant statutes and regulations. Among the areas within the Division of Law & Policy, in addition to the Office of the General Counsel, are the Patient Care Assessment Unit, the Data Repository Unit, the Physician Health & Compliance Unit and the Committee on Acupuncture.

EXECUTIVE DIRECTOR'S REPORT
Nancy Achin Audesse

After several years of hard work playing catch-up, the Massachusetts Board of Registration in Medicine is exactly where it should be – stable, consistent, up-to-date and looking forward to the future. The year 2003 marked the completion of Herculean efforts on the part of the Board and its staff to get out from under a backlog of complaints and reports that had piled up over the course of many years.

Consumer complaints had stacked up to the point that it was taking an average of 14 months for one to be resolved. That problem was cleared up in 2002, when the caseload and the time it took to resolve a complaint were each cut dramatically, as the Board's new management team made the matter its top priority. In 2003, the caseload and the average time to resolve a complaint each were reduced again.

Patient Care Assessment

In 2003, the Board set its sights on what is known as the Patient Care Assessment (PCA) program, where reports of serious incidents at hospitals had gone unreviewed in some cases for years. Under the leadership of Board Chairman Dr. Martin Crane, the PCA Committee dove in to the pile of hundreds of reports head-first, not only completing the reviews of nearly 90 percent of the reports by year's end, but also uncovering what proved to be a serious patient care pattern that until then had gone unnoticed – deaths following gastric bypass surgery.

An Alert issued by the Board's PCA Committee in June advised hospitals that there had been six deaths of patients within 30 days following these weight reduction operations and caused attention to be paid for the first time to the risks of the increasingly popular surgery. The Department of Public Health also later launched its own investigation into the matter. The successful turnaround of the once-moribund PCA program is reflective of the new way the Board is doing its work. Not only was the PCA Committee able to review all of the reports that had piled up before it, but improvements in coding and tracking the data led to the panel's ability to unearth the problem with gastric bypass mortality.

Using up-to-date coding methods of data entry, employing codes that are compatible with those used by other health care organizations, has allowed the agency to make much better use of the information it has available. Using standardized diagnostic codes allows the agency to work more collaboratively with other entities, including other state agencies such as the Massachusetts Health Data Consortium, as well as hospitals and health plans, in assessing health care quality.

The Board, quite simply, no longer operates in a vacuum. It recognizes that the best way to protect the public and to improve health care quality in Massachusetts is to collaborate and cooperate with all those who have a stake in quality assessment and improvement.

Physician Profiles

The Board's first-in-the-nation Physician Profiles program, which allows consumers to access information on physicians' histories, took another great leap forward in 2003. Consumers may now search for physicians by more than just name or community. A redesign of the Profiles section of the Board's web site has expanded the search capability to allow consumers to search by specialty, hospital and insurance plans accepted. It is another example of how the Board has become more consumer-friendly.

The web site has actually been completely redesigned and includes links to other health care sites as the Board believes it has the responsibility to help consumers find whatever type of health care information they need. The web site continues to grow in popularity – attracting more than 16 million "hits" in 2003 alone.

Better Wallet Cards

A simple suggestion from a doctor in Chelmsford led to the Board's upgrading the license cards issued to physicians to carry in their wallets. Dr. Gary Cushing used a new feedback line on the Board's web site to suggest the Board get rid of its old paper wallet cards in favor of something a little sturdier and, frankly, classier. So in 2003 the Board rolled out a new plastic wallet card that won't fray or rip, can't be altered and, one day, can contain information that could prove important when it comes to responding to disasters, for example. The cards may one day include photos and magnetic strips that could include information allowing carriers access to disaster scenes, hospitals or other locations during times of emergency--all for less than 20 cents per physician. The new wallet cards are one more example of the customer-service focus of the agency.

On-Line Licensing

The year 2003 also saw great progress towards reaching another ambitious goal – On-Line Licensing. Getting to the point where physicians may renew their licenses on-line will not only make their lives easier, but will save the Board money and help in the goal of making it easier for various agencies, hospitals and health plans to share information as they seek to be more efficient in protecting the public.

To get to On-Line Licensing, the agency is working to establish a single data entry point for all information that comes into the Board. When that is completed, sometime in 2004, the Board will be ready to take the next step towards On-Line Licensing. Unfortunately, reaching that goal will take more funds than the Board has available. Rather than ask the Legislature for taxpayer money to fund this program, the Board is hopeful that it will be able to get legislative backing for a plan that would allow the agency to keep all of the money it raises from physicians' license fees.

Physicians' license fees were increased in 2002 and the agency was allowed to keep all of the additional funds the increase generated. But the agency still retains only about 75 percent of what it takes in from fees. The Board believes it would be able to institute On-Line Licensing if it were able to retain 100 percent of the fees it takes in. It is the way that nearly every other state medical Board operates. Once On-Line Licensing is a reality, the Board would use additional funds received each year from retaining all of the license fees collected to embark on new programs designed to protect the public.

Clinical Skills Assessment

One of the key areas that the Board wants to pursue in the coming years is that of Clinical Skills Assessment – a testing procedure to measure the clinical skills not only of new doctors, but of those coming into the state from elsewhere, those who have been away from practice for an extended period or those who may have had multiple medical malpractice payments or other problems. Starting this year, the National Medical Board of Examiners is requiring all new physicians to pass a clinical skills exam. But there are only five locations nationwide where such physicians may take the test. The closest one to Massachusetts is in Philadelphia, Pennsylvania. The Board is hopeful that it will be able to convince the National Medical Board of Examiners to add a sixth site – in the Boston area. Such a site could be used not only for testing of new physicians but also for those veteran physicians whose clinical skills may be in question. The Board believes that Massachusetts is the ideal site for such a program as it has a depth of medical schools, teaching hospitals and expertise unmatched in the nation.

Looking To the Future

Establishment of a clinical skills testing facility could be only the beginning for a new model for the future. Such a center could become a national model for physician retraining or skill development. Imagine a center, staffed by experts from Massachusetts and around the country, where physicians from Massachusetts and around the world could come to be brought up-to-date on the latest surgical procedures or treatment philosophies. Medicine is changing very rapidly. Genetic testing, gene therapy, new technologies, cutting-edge surgeries, targeted medications – it's a lot for an individual physician to keep up on. But how to teach established physicians how to perform these operations or diagnose conditions using the latest tests in a safe, effective environment? Now, a physician typically might be brought up-to-date at a two-day seminar held at any one of a number of locations. The course may be of high quality – or it may not be. The physician doesn't know until he or she gets there. But courses taught at the center envisioned by the Board would be of known quality. It would be the place for physicians to be updated on the latest medicine has to offer. Such a facility could be just the thing to ensure that Massachusetts retains – or some would say regains – its place as the leading health care quality center in the world.

A center like this would boost the state's biotechnology industry, the medical device industry, the local economy – and would go a long way towards improving patient safety in Massachusetts and throughout the country.

ENFORCEMENT DIVISION REPORT

Barbara A. Piselli, Director

The work of the Enforcement Division is the area within the Board of Registration in Medicine that historically has been subject to intense scrutiny by watchdog groups, the media and others who, in the past, had complained that the Board was not doing enough about disciplining bad doctors and was taking too long to investigate and adjudicate complaints.

Those days are long gone. Disciplinary actions are up, and the long waits for action are down. The trend, which began to be evidenced in 2000, continued in 2003.

While the actual number of doctors disciplined in 2003 was down ever so slightly from the 2002 total, the small drop actually reflects the fact that Board operations, and the work of the Enforcement Division, has stabilized. After several years of playing catch up, reducing the backlog of complaints and seeing disciplinary actions rise sharply as a result, the number of disciplinary actions taken in 2003 appears to be right on target.

The Enforcement Division's continued focus on decreasing the backlog of open cases, improving communications with consumers filing complaints against physicians, expediting the review and resolution of cases and increasing the number of disciplinary actions reflects its staff's ongoing commitment to these matters, as well as the mandate of the Board and its Executive Director. As a result, the Division functions more successfully than it ever has.

The Division, which is mandated by statute to investigate all potential disciplinary matters involving physicians and acupuncturists, strives to pursue complaints efficiently, fairly and effectively as it tries to protect the public and at the same time follow Board statutes, regulations and policies.

The Enforcement Division operates under the supervision of the Director of Enforcement and is comprised of three units: the Consumer Protection Unit, the Clinical Care Unit; and the Disciplinary Unit. Each unit plays an essential role in the Division's mission to ensure quality health care for Massachusetts consumers.

Consumer Protection Unit

The Consumer Protection Unit (CPU) is the first line of review for complaints filed with the Board by consumers and includes a "Triage Team'' to help identify cases that may be of the utmost urgency as part of its mission to protect the public. The unit placed 650 cases on its docket –

opened them for investigation -- in 2003. In addition, the unit reviewed 221 reports that were referred by the Department of Public Health's Division of Health Care Quality. Some 30 of these reports involved possible physician misconduct or hospital quality assurance concerns and were referred to the Board's Data Repository and Patient Care Assessment Units for investigation. In addition to the 650 docketed consumer complaints, the unit received 101 additional communications from consumers that were not placed on its docket because they were deemed not to fall under the jurisdiction of the Board of Registration in Medicine. These included such matters as complaints against non-physicians or matters that were more than six years old and deemed stale. The unit does help consumers to identify the appropriate agencies to assist them on such cases, however.

In screening complaints, the Unit Manager and two staff members flag serious and priority cases and bring them to the attention of the Division Director for immediate action. In most cases, the staff obtains responses from physicians as part of its initial review and "triage'" process. But some urgent matters are fast-tracked and physician responses in these cases are not done as part of the initial review.

Clinical Care Unit

The Clinical Care Unit (CCU) reviews complaints that allege substandard care. It received 83 new complaints in 2003. Just over half are currently on the disciplinary track. Another 69 complaints were closed and 125 more remain under investigation.

The CCU is staffed by the Unit Manager, two nurse reviewers -- both experienced clinicians -- and a paralegal. Staffers analyze patient records and physician responses, work with the Board's experts, help Enforcement Division attorneys in the preparation of litigation involving complex substandard care cases and prepare analyses for the Data Repository Committee and the Licensing Committee. The CCU also coordinates remedial conferences for physicians appearing before the Complaint Committee. These conferences are designed to discuss concerns about the delivery of care or the running of their practices that may not require formal disciplinary action.

Disciplinary Unit

The Disciplinary Unit is responsible for the investigation and litigation of all cases that may result in disciplinary actions being taken against licensed physicians and acupuncturists. In 2003, there

were 60 doctors disciplined by the Board, a decrease of 11 percent from 2002, but an increase of 9 percent over 2001. The 2003 number was 36 percent higher than the number for 2000 and 57 percent more than in 1999.

The unit is staffed by a Managing Attorney, six complaint counsels or prosecutors, four investigators, a paralegal and an administrative assistant. Complaints are referred to the unit by the Data Repository Committee, the Consumer Protection Unit and various other sources. Staffers interview witnesses, gather evidence, work with local, state and federal law enforcement agencies on coordinated investigations and present cases to the Complaint Committee and the full Board. The Complaint Counsels also draft pleadings, negotiate Consent Orders, identify and present cases for Summary Suspensions and prepare and litigate contested Board cases at administrative hearings at the Division of Administrative Law Appeals (DALA).

Enforcement Division Accomplishments During 2003

Disciplinary Actions and Prioritization of Cases

Just what did the Division accomplish in 2003? The Board investigated and closed out 572 of 789 docketed complaints brought before the Complaint Committee. The final tally was as follows: there were 79 docketed cases that resulted in disciplinary actions being imposed by the Board. A total of 60 different physicians were involved in 62 separate disciplinary actions.

Each investigation involves a prompt but complete review of the allegations, a review of the physician's response, and the analysis of other materials relevant to the case. Included are victim and witness interviews, document reviews and analysis of medical records that may be presented to the Complaint Committee, the Board and, in some cases, an independent Magistrate at the Division of Administrative Law Appeals (DALA). A complex case involving allegations of substandard care, for example, may involve hundreds of hours of input from expert witnesses, Board clinical reviewers, Board prosecutors and support staff.

Types of Disciplinary Actions

There are a variety of ways to resolve a case if the Board determines disciplinary action is appropriate. One way is for the matter to be resolved through what is known as a Consent Order or negotiated settlement. Such a resolution eliminates the need for protracted litigation and evidentiary hearings. In 2003, some 26 physicians entered into such Consent Orders. These actions are public and considered a disciplinary action.

If a settlement cannot be negotiated, the Board issues a statement of allegations and the matter is referred to DALA for a full evidentiary hearing on the merits. There were 20 cases pending at DALA as of Dec. 31, 2003. Once the evidentiary hearing is completed, the DALA Administrative Magistrate issues a Recommended Decision to the Board, containing facts and conclusions of law. When the Recommended Decision is received by the Board, it considers the recommendation and issues a Final Decision & Order that may include disciplinary action. Disciplinary actions may include revocation, suspension, censure, reprimand, restriction, non-renewal, denial or restriction of privileges, or resignation. The Board may also impose fines.

Disciplinary Actions, Voluntary Agreements and Related Activity

Category	2003	2002	2001	2000	1999
Doctors Disciplined	**60**	68	55	44	38
Statements of Allegations Issued	**36**	57	39	40	29
Summary Suspensions	**4**	5	7	7	5
Voluntary Agreements Not to Practice	**14**	16	4	4	3
Voluntary Agreements for Practice Restrictions	**1**	4	2	0	3

Of the 60 physicians disciplined, 12 had their cases referred to DALA. There were 36 cases in which statements of allegations were issued by the Board, and three cases where probation agreements were violated, and two where a Letter of Agreement (LOA) was violated.

Prioritization and Management of Cases

Expedited Case Review and Resolution

Cases are screened at intake to determine the nature of the alleged misconduct. The most serious cases are given the highest priority in terms of resource allocation, investigation and prosecution. Such cases are identified and prioritized sooner due to the Triage process. Cases that do not merit formal disciplinary action are resolved more quickly, most within 90 days.

Summary Suspension and Voluntary Agreements

Each complaint or case is immediately evaluated to determine if the physician appears to pose an immediate and/or serious threat to the public health, safety or welfare. If this is determined to be a

possibility, the Complaint Counsel must bring the matter to the Board's attention, recommending that the physician no longer be allowed to practice medicine until safeguards are put into place. In the most serious cases, the counsel may recommend to the Board that it summarily suspend the license of a physician. This is an interim public disciplinary action the Board may take to protect the public prior to going through the disciplinary process. Most importantly, such an action ensures that the physician cannot continue to practice medicine while the case is adjudicated by the Board. In some cases, the physician may choose to enter into a voluntary agreement not to practice medicine or to practice with certain restrictions pending resolution of the matter on its merits. These actions take place immediately and are public.

Team Approach

The team approach is used on a widespread basis, particularly on complicated or emergency cases. Paralegals, investigators, nurse-investigators and supervisors play key roles in the investigation and prosecution of such cases. Often, a second Complaint Counsel is assigned to work with the primary attorney on complex cases. These investigative teams make these cases their top priority, with the goal of acting quickly but fairly to investigate the allegations before making a recommendation to the Board.

Caseload Statistics

Docketed Complaints Opened, Closed, and Pending

COMPLAINTS	2003	2002	2001	2000	1999
Docketed	**650**	677	670	626	584
Closed	**673**	680	865	773	365
Pending as of 12/31	**328**	358	361	537	698

YEAR	Average Age of Complaint	Open Complaints at End of Year
2003	**315 days**	**328**
2002	**322 days**	358
2001	**364 days**	361
2000	**429 days**	537

Enhanced Communications With Complainants

The Consumer Protection Unit now sends the physician's response to the complainant in most cases, as opposed to in the past when it was only sent upon request of the complainant. Those who file complaints are also sent letters informing them of the resolution of their complaints, including details of the Board action taken.

Cases Alleging Substandard Care

The Board continues to use the services of the Center for Health Care Dispute Resolution/Maximus (CHDR) and sent many of these cases out to the center for expert review. CHDR is a peer-review organization based in New York that provides expert medical opinions by board-certified physicians. Outsourcing of these cases was started in 2000 to help reduce a backlog of complaints that was so large it was deemed an "emergency" by the Executive Director. The outsourcing has significantly reduced the backlog of open cases involving substandard care, resulting in much more timely review and evaluation of these mostly less serious cases and allowing the CCU staff to work more closely on more serious cases that have the potential for disciplinary action to be taken.

In 2003, the Board saw an increase in the number of extremely complex substandard care cases. These types of complaints often allege misconduct by an entire treatment team, for example, rather than by just one physician. As a result, they involve several specialized areas of medicine rather than just one, posing even greater challenges to the investigative team in terms of resources, expert review and investigation.

Number of Complaints Alleging Substandard Care

Status	2003	2002	2001	2000
Opened	**83**	101	111	177
Closed	**69**	90	168	322
Pending	**125**	110	99	156

Complaint Committee Actions

The Complaint Committee and the Enforcement Division work together quite efficiently to review all cases in a timely manner. Once an investigation is completed, staff members present the cases to the Board's Complaint Committee, a subcommittee of the Board consisting of at least two members. The Complaint Committee determines whether disciplinary action should be taken and makes recommendations to the full Board. The Complaint Committee also reviews and resolves all matters that are not serious enough to warrant disciplinary action, often taking informal actions such as issuing letters of advice, concern, or warning or asking the physicians to come in for remedial conferences.

In 2003, the Enforcement Division presented 665 cases involving 557 physicians to the Complaint Committee. Some 56 of these physicians appeared before the Committee to discuss the allegations against them and/or to take part in remedial conferences.

Complaint Committee Non Disciplinary Enforcement Actions

Category	2003	2002	2001	2000
Closed	**440**	458	500	476
Letter of Acknowledgement	**3**	4	0	1
Letter of Information	**4**	3	14	13
Letter of Advice	**63**	53	103	140
Letter of Concern	**21**	41	71	58
Letter of Warning	**1**	30	27	19

Enforcement Division Cases Presented to the Complaint Committee

Category	Docketed cases	Physicians
Appearances & Remedial Conferences	**86**	**56**
Non Appearances	**579**	**501**

Sexual Misconduct Investigations in 2003

Sexual misconduct is an area that has long been taken very seriously by the Board and the Enforcement Division continues to he proactive and aggressive in its investigation and prosecution of such cases.

The Board and the staff are committed to the protection of patients from physicians who cross boundaries, yet strive to make sure due process is afforded the physician who has been accused of such a heinous violation. To this end, special safeguards first implemented in 2000 were expanded in 2003 to further guarantee that these delicate cases are handled sensitively and fairly, balancing public protection concerns with the rights of the physicians.

All complaints that allege sexual misconduct, including inappropriate touching or remarks, are immediately docketed and given to the Director of Enforcement for assignment to an Investigator and Complaint Counsel. All such allegations are prioritized by seriousness and investigated, with alleged victims -- and the physician -- interviewed in person whenever possible. Serious cases are evaluated immediately to determine if a Summary Suspension of the physician's license is warranted. As an alternative, the Enforcement Division staff is increasingly using public disciplinary agreements for practice restrictions as public protection measures during the investigation period.

Sexual Misconduct Cases

	2003	2002	2001	2000
Resolved	22 doctors 29 complaints	20 doctors 20 complaints 1 acupuncturist 3 complaints	27 doctors 58 complaints	10 doctors 10 complaints
Pending 12/31	20 doctors 30 complaints 1 acupuncturist 1 complaint	29 doctors 38 complaints 1 acupuncturist 1 complaint	22 doctors 29 complaints	28 doctors 43 complaints

Sexual Misconduct or Boundary Violations Disciplinary Cases

In 2003, the Board disciplined six physicians for sexual misconduct. They were broken down as follows:

- Revocation for sexual relations with a patient
- Revocation for inappropriate touching and malpractice, multiple patients
- Reprimand and probation for boundary violations and billing irregularities involving a patient
- Suspension for boundary violations and sexual contact with a patient
- Revocation for inappropriate examination of three teenage patients
- Suspension for disruptive behavior, substandard care and boundary violations with a patient

Special Projects and Initiatives

Document Imaging

The Enforcement Division implemented the scanning and indexing of all cases closed during 2003 as part of the Board's effort to use document imaging as an efficient method of data storage and retrieval.

MIS Users Group

Enforcement staff participated in ongoing MIS Users Group meetings as work continued towards the agency's goal of overhauling and streamlining the Board's case tracking, reporting and information systems. Staff also assisted in the design of new, more user-friendly Board website.

Codes that Indicate the Nature of the Complaint

The Triage Team revised and streamlined the codes that specify the nature of the complaint to better identify allegations of misconduct and identify problem areas, patterns and trends.

Outreach, Training and Professional Development

The Enforcement Division continues to work in cooperation with law enforcement and other government agencies to encourage prompt reporting of physician misconduct and to facilitate cooperative investigations. The investigatory staff participates in the FBI Health Care Fraud Working Group meetings.

In the past year, Enforcement Division staffers were panelists at seminars held by the Boston and Massachusetts Bar Associations and made presentations to the New England Fraud Investigators Association as they made efforts to gain additional knowledge to help them do their jobs better and to share information with others pursuing similar goals.

Staff members also attended professional development courses in the areas of evidentiary privilege, high risk obstetrics and gynecology, regulatory and administrative proceedings.

PUBLIC INFORMATION DIVISION REPORT

Susan Carson, Director of Operations

The Board of Registration in Medicine continues to lead the nation in providing important health care information to tens of thousands of consumers, physicians and health care organizations in Massachusetts and beyond.

The Board's first-in-the-nation Physicians Profiles program, whereby consumers can find out information that can help them in choosing a physician, continues to be more successful than anyone had ever imagined. And it has been improved.

In the year 2003, the site attracted more than 16 million page hits -- a staggering number for a site that doesn't advertise. And hits are coming from Internet users from all over the world -- Europe, Latin America, Israel, even New Zealand. The average number of hits per day is estimated at 46,000 – with weekdays averaging 60,000 hits each day. The average user spent about three minutes on the site and viewed four pages.

On the site, consumers can find out such pieces of valuable information such as how long the doctor has been licensed, practice location, hospital affiliations, health plans accepted, educational and training history, specialties, Board certifications, honors or awards received, papers published, malpractice payments made, and disciplinary and/or criminal history, if any.

In 2003, the Board completely redesigned its web site, making it easier for consumers to look up information about physicians.

The new site, with the enhanced Profiles application process, was unveiled in December 2003. The new site provides more information to the public faster, easier and with a fresh new look that enhances the Board's image to the world.

The revised web site comes in conjunction with a change in the site's host. When the idea of Physician Profiles was first advanced back in 1996, the intention was to provide the information on paper, to libraries on CDs and from a consumer hotline. Widespread use of the Internet was not yet a reality. While the Board had a web site, it did not have the resources to develop and support a site able to handle the profiles. But the Administrators in Medicine (AIM), a non-profit group that supports medical licensing and regulatory authorities, offered to host the Profiles site on its own Internet site, http://www.docboard.org. It hosted the site for seven years until the change this year.

In addition to the web site, consumers also call and write for Profiles information as well as information on complaints.

In 2003, the agency received 24,562 calls for information, processed and mailed 41,273 Profiles and made 34,594 updates to Profiles.

LICENSING DIVISION REPORT

Rose M. Foss, Director

The Licensing Division is the point of entry for physicians applying for a license to practice medicine in the Commonwealth and has an important role in protecting the public as the "gatekeepers" of medical licensure. The Division conducts an in-depth investigation of a physician's credentials before forwarding a license application to the Board for issuance of a license to practice medicine to validate the applicant's education, training, experience and competency.

There are three types of licenses: full license, limited license, and temporary license. A full license allows a physician to practice medicine independently. A limited license is issued to a physician who is participating in an approved residency or fellowship program under supervision in a teaching hospital. Massachusetts's teaching hospitals have earned a reputation for having the most respected training programs in the world. The Licensing Committee and staff work closely with all Massachusetts teaching hospitals to facilitate the licensure of their trainees. The Board also issues temporary licenses to eminent physicians who previously held a faculty appointment in another country or territory, and who are granted a faculty appointment at a medical school in the Commonwealth. Temporary licenses are also granted to physicians for providing *locum tenens* services or for participating in a continuing medical education program in the Commonwealth. Full licenses are renewed every two years on the physician's birth date, and limited licenses are renewed at the end of each academic year.

Before an application for a full, limited or temporary license is forwarded to the Board for approval, the Licensing Division conducts an extensive investigation of the applicant's credentials. The Licensing Division collects documentation from primary sources that include verification of medical school training, licensing examination scores, postgraduate training, evidence of professional experience and profiles from the Federation of State Medical Boards, National Practitioner Databank, and the American Medical Association. In addition to processing license applications, the Licensing Division also provides information and verification of the status of a physician's license for state licensing boards, credentialing for privileges at healthcare facilities, managed care plans and consumers.

Licensing Division Statistics

License Status Activity	2003	2002	2001*	2000
Initial Full Licenses	1,628	1,709	1,705	1,642
Full Renewals *	20,188	7,286	20,960	6,331
Lapsed Licenses	112	123	136	137
Initial Limited Licenses	1476	1,418	1,419	1,384
Limited Renewals	2611	2,513	2,663	2,591
Temporary (initial) Licenses	21	17	9	6
Temporary Renewals	12	16	5	7
Voluntary Non-renewals	709	427	494	320
Revoked by Operation of Law	848	611	784	474
Deceased	148	131	93	7
TOTAL	**27,753**	**14,251**	**28,268**	**12,899**

** The majority of full licenses are renewed in odd-numbered years, 1999, 2001,2003, etc.*

Licensing Committee Activity Report

The Licensing Committee is a sub-committee of the Board comprised of two Board members. The primary role of the Licensing Committee is to ensure that every physician applying for licensure in the Commonwealth is qualified and competent in compliance with the Board's regulations.

As a subcommittee of the Board, the Licensing Committee is responsible for reviewing all license applications with legal, medical, and malpractice or competency issues. Physicians applying for an initial limited license or renewing a limited license who had competency issues in a training program or substandard clinical performance in a training program are reviewed by the Licensing Committee.

In such cases, the Licensing Committee customarily interviews the physician and the program chairperson before making a recommendation on issuance of an initial limited license or renewal

of a limited to the full Board. The Committee may recommend approval or denial of a limited license, depending on the whether the Committee is satisfied that the physician will be closely supervised by the program director and senior staff in the training program.

A recommendation for issuance of the limited license in such cases is usually contingent on a performance monitoring agreement with the physician and the program chairperson to provide regular monthly, bi-monthly or quarterly performance monitoring reports to the Board. Renewal of the limited license is contingent on satisfactory performance monitoring reports over the course of the entire academic year.

Performance monitoring agreements are customarily required for the duration of the training program. However, the performance monitoring may be discontinued if the physician has demonstrated a continuous track record of satisfactory clinical performance. If the Licensing Committee determines that there is a pattern of substandard clinical performance anytime during the academic year, the Committee may recommend additional action.

Performance Monitoring Agreements

Since implementation of the performance-monitoring program in 1997, the number of limited licenses issued with performance monitoring agreements fluctuated from year to year. In 2003, there was a 15% decrease in the number of performance monitoring agreements as compared with 2002 when the number of performance monitoring agreements jumped from 7 in 2001 to 13 in 2002, representing an 86% increase. It remains to be seen if this increase is a statistical oddity or the beginning of a trend of larger numbers of licensure applicant with problematic histories.

Performance Monitoring Agreements	2003	2002	2001	2000
Performance monitoring agreements	**11**	**13**	7	11
% change from previous year	**- 15%**	**+ 86%**	- 57%	-

Licensing Committee Activity Report

Cases Reviewed by Licensing Committee	2003	2002	2001	2000
Malpractice	**35**	35	23	29
Competency Issues	**81**	90	78	93
Legal Issues	**52**	27	39	24
Medical Issues	**36**	32	28	28
6th Limited Renewals	**18**	26	25	24
Miscellaneous Issues	**146**	110	134	88
Total Cases Reviewed	**368**	**320**	**327**	**286**

License Division Survey

As an ongoing initiative to improve customer services, the Licensing Division randomly surveys newly licensed physicians to identify opportunities for improvement and to expedite the licensing process within the scope of the Board's regulations. Survey responses are tabulated using the Likert Scale from 1–5, with 1 rated as "poor," 2–3 rated as "average" and 4-5 is in the "excellent" range. In 2003 the Licensing Division mailed approximately 600 surveys and received responses from 325 newly licensed physicians. From 2002 to 2003, the number of responses tripled. The total average performance score for customer service in 2003 was 4.49 %, which represents a 16.2 % increase in the overall rating from 2002.

Survey Questions	2003 Responses (n=325)	2002 Responses (n=97)	2001 Responses (n=80)
1. Was the Licensing staff courteous?	4.52	4.20	4.15
2. Was the staff knowledgeable?	4.35	4.28	3.93
3. Did the staff provide you with the correct information?	4.53	4.23	4.00
4. Did the staff direct you to the appropriate person to answer your questions?	4.57	4.20	4.06
Overall average score	**4.49**	**4.23**	**4.03**
% of increase from prior year	**+ 16.2 %**	**+ 20 %**	**N/A**

2003 Licensing Division Accomplishments

Scanning License Applications

In 2003 the Licensing Division completed its goal to scan and electronically store over 2 million licensing documents. Scanning has significantly decreased the number of lost or misfiled licensing documents and expedited the method of retrieving licensing documents. It only takes a click of the mouse and within seconds a physician's entire license file is available on the computer screen without having to retrieve the paper file. If the physician requests a copy of an initial license application or the most recent renewal application, as required by all healthcare facilities for credentialing and provider enrollment, the application can be retrieved and printed within minutes. In the past, retrieving licensing documents was a time consuming and labor intensive process. First, the licensing file had to be retrieved from the file room, (sometimes it was misfiled), the documents had to be copied and then the license file was returned to the file room for storage. The average turn around time for retrieving, copying and mailing license documents has been significantly decreased from an average of two weeks to five minutes. Overall, scanning technology has significantly improved the Licensing Division's efficiencies and improved the security of historical documents. Moreover, the instantaneous retrieval of current and archived license applications and documents is vital to the Board's Enforcement and Legal investigation process.

Uniform Application for Credentialing

The Director of Licensing participated in a task force comprised of representatives from hospitals, health insurance plans, health systems and group practices to standardize, streamline and reduce the redundancy, inefficiencies and economic impact of the credentialing process and expedite health plan provider enrollment. Under the current system, a physician must complete the credentialing process by the healthcare facility and then undergo a reduplication of the credentialing process by the health plans before acceptance as a health plan provider. The impact on physicians awaiting plan approval as a health care provider also significantly impacts a patient's access to health care. The primary function of the task force was to develop a uniform application for credentialing and recredentialing physicians in compliance with the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the National Committee on Quality Assurance (NCQA), the Utilization Review Committee Accreditation Commission

(URAC) and the Centers for Medicare and Medicaid Services (CMS). The task force first identified the core demographic information required by both the health care facilities and health plan providers and then designed a uniform application that could be used by both hospital credentialing and health plan providers for physician enrollment. The task force established the target date of April 1, 2004 for phasing in the uniform application and specific timeframes for health plans to complete the credentialing and physician enrollment process as health care providers for health plan subscribers. The secondary function of the task force was to evaluate the feasibility of establishing a centralized data repository for storage of a physician's education, training and experience that could be accessed by health care facilities and health plan providers for expediting the credentialing and provider enrollment process.

Common License Application

When a physician applies for an initial state license, each state requires basic core information, i.e. medical school training, examination scores, postgraduate training and other specific documentation required by the state licensing regulations. The Director of Licensing participated in a workgroup with the Federation of State Medical Boards (FSMB) to develop a Common License Application (CLA) for physicians applying for state licensure to reduce the duplication of collecting the same information and to expedite the licensing process. The CLA would be the only license application that a physician would be required to complete, on-line that could be stored electronically and updated as often as necessary. The CLA and supporting documentation would be available to all state Boards when a physician is applying for a license to practice medicine in that state. The CLA will significantly reduce the redundancy of providing the same information over and over again which is time consuming and expensive for both physicians and state Boards. Telemedicine has expanded the scope of the practice of medicine by enabling a physician to provide health services to a patient located in another state via the Internet. The CLA will expedite the licensing process since all states require a physician to hold some type of licensure in that state in order to practice medicine.

Limited License Workshops

In 2003, the Licensing Division conducted three regional Limited License Workshops hosted by Beth Israel Deaconess Medical Center, St. Vincent's Hospital and Lahey Clinic for training program coordinators and administrative staff who are the liaison with the Board. The program

coordinators and administrative staff are responsible for ensuring that residents and fellows who staff the Commonwealth's training programs complete the limited license application in accordance with the Board's regulations. The annual Limited License Workshops are crucial in providing information on changes in the limited license process, new forms and new procedures. The workshops also provide an opportunity for the exchange of information between Board staff and the training program coordinators to identify opportunities for improving the limited license process. In addition to the Limited License Workshops, Board staff and the Coalition of Teaching Hospitals (COBETH), which is comprised of representatives from the major teaching institutions exchange information and work collaboratively to improve the limited license process and ensure that the training programs will be staffed by the beginning of the academic year on July 1, without interrupting the continuity of patient care in the Commonwealth.

On-line Renewals

The initiative for the on-line renewal project was not accomplished in 2003 due to lack of funding and budgetary deficiencies. However, the Board is requesting appropriation of funding in the fiscal 2005 budget to develop the on-line renewals project. The ability to renew a license electronically on line will be a major benefit for physicians and significantly reduce the license renewal time and eliminate last minute renewals. The ability to renew license or update demographic information on-line will streamline the license renewal process. On-line renewals will be convenient for physicians practicing medicine in the Commonwealth and especially for out of state physicians who have to rely on traditional mail services. On-line renewals will be cost effective for the agency by significantly reducing reproduction costs, mailing costs, the data entry process and the current manual process of reviewing every renewal application for completeness, etc. Electronic access for on-line renewals will improve data quality and manual data entry errors will significantly be reduced. Additionally, the on-line renewal technology will enable the Board to collect malpractice, legal and criminal information more frequently and increase the Board's ability to protect the public by receiving and acting on adverse information in a more timely manner.

DIVISION OF LAW AND POLICY REPORT

This report was prepared by Michael Kelly, General Counsel of the Board of Registration in Medicine. Mr. Kelly died after a courageous battle with cancer before the publication of the annual report. The staff and Board of the agency are honored and grateful for the opportunity to work with Michael Kelly. He was an exceptional person, a brilliant attorney, and an outstanding public servant.

The **Division of Law and Policy** is the agency's legal department, responsible for overseeing compliance with the broad array of the Board of Registration in Medicine's legal obligations, ranging from statutory reporting to adherence to Commonwealth laws and regulations. The Division also manages the Board's disciplinary matters, from statements of allegations to consent orders, final decisions and orders, and appeals.

The Division is made up of three units: the **Office of the General Counse**l, the **Data Repository Unit**, and the **Physician Health and Compliance Unit**. The Board's **Committee on Acupuncture** is also housed in the Division.

The Division of Law and Policy in 2003 saw a sharp increase in the number of reports received concerning physicians who had been disciplined by hospitals, paid malpractice claims, or found themselves in trouble with the law, indicating much better compliance on the part of those institutions and agencies who are mandated by law to file such reports. The improved compliance indicates that an educational campaign on the part of the Division's Data Repository Unit is paying off.

At the same time, disciplinary actions taken against physicians by the Board stabilized in 2003, after several years in a row where the numbers had increased sharply as a result of efforts to reduce a backlog of old complaints.

In its Physicians Health and Compliance Unit, the Division began paying special attention to physicians who engage in disruptive behavior, in addition to those who may be having problems with substance abuse or mental illness. The Board believes that physicians who engage in such behavior, including rudeness to staff or patients, pose as much of a threat to patient care as physicians impaired by substance abuse or mental illness.

Office of the General Counsel

The Office of the General Counsel (OCG) advises the Board on a full range of issues such as the disposition of adjudicatory matters, ethics considerations, interpretation of laws and regulations, and formulation of policy. The office also reviews and drafts regulations and proposed legislation and is responsible for reviewing and advising on all legal issues affecting the agency.

Oversight of Adjudicatory Matters

The Legal Division maintains the Board's active adjudicatory case files, prepares its Final Decisions and Orders, and tracks its disciplinary numbers. In 2003, the Board took 62 disciplinary actions against 60 physicians. The Board issued 8 Final Decisions and Orders and entered into 26 Consent Orders. A total of 36 Statements of Allegations were issued, and 12 cases were referred to the Division of Administrative Law Appeals (DALA).

ADJUDICATORY FIGURES, 2003

Total Number of Disciplinary Actions Taken:	**62**
a. Consent Orders:	26
b. Final Decision and Orders:	8
c. Summary Suspensions:	4
d. Final Decision and Orders On Summary Suspensions:	1[1]
e. Resignations:	14
f. Voluntary Agreements:	7[2]
g. Assurances of Discontinuance:	2
h. Suspensions pursuant to violation of Letter Of Agreement	1

2.	**Discipline by Type of Sanction:**	
	Admonishment:	1
	Censure:	2
	Continuing Medical Education Requirement:	4
	Community Service:	0
	Costs:	0
	Educational Service:	0
	Fines:	6
	Monitoring:	1

[1] This is not included in the total number of disciplinary actions.
[2] This number includes both Agreements Not to Practice and Agreements for Practice Restrictions.

	Practice Restrictions:	7
	Probation:	9
	Reprimand:	6
	Resignation – part a:	5
	Resignation – part b:	9
	Revocation:	5
	Summary Suspension – part a:	4
	Summary Suspension – part b:	0
	Suspension:	13
	Stayed Suspension:	7
	Total Number of Physicians Disciplined:	**60**[3]
3.	**Total Number of Cases referred to DALA:**	**12**
4.	**Total Number of Cases Dismissed:**	**1**
5.	**Total Statement of Allegations:**	**36**
6.	**Total Number of Probation Violations/violations of LOAs:**	**3/2**[4]

Data Repository Unit

The Data Repository Unit (DRU) receives and processes statutory reports concerning physicians licensed in Massachusetts. DRU staff members work with the Board's Data Repository Committee (DRC) to review mandated reports to determine which cases or matters should be referred to the Board's Enforcement Division. Mandated reporters include physicians, health care providers, health care facilities, malpractice insurers, and civil and criminal courts.

The DRU also provides information regarding Board disciplinary actions to national data collection systems and on the Board's web site. It also ensures that appropriate report information is accurately posted on the Physician Profiles.

In 2003, the DRU received 6,280 statutory reports. Some 236 reports were forwarded to the Enforcement Division for further investigation, and 196 statutory reports relating to potential impairment issues were forwarded to the Physician Health and Compliance Unit.

3 Several physicians were disciplined more than once: Yu (2 times: Voluntary Agreement and Consent Order) and Browning (2 times: Voluntary Agreement and Consent Order). There were 60 physicians disciplined and 62 disciplinary actions.

4 One of these violations of a Letter of Agreement, Ruane, counts as a separate disciplinary action because the doctor was suspended pursuant to the violation. The other violations do not count as separate discipline.

The increased number of reports received over the past two years indicates that the various reporting sources are doing a much better job of informing the Board of when they take disciplinary actions against physicians. Even though mandated by law, compliance over the years has been spotty. But in 2003, the number of disciplinary actions taken by health care facilities was up by nearly one third, while the number of physician violations filed by other government agencies shot up by half. The number of reports filed by physicians themselves was also up. The improved reporting may be the result of a campaign, begun in 2002, by the DRU to educate health care facilities about their reporting requirements. Only with increased compliance can health care quality continue to be improved.

Statutorily Mandated Reports Received

STATUTORY REPORTS RECEIVED	2003	2002	2001	2000
Renewal "yes" answers – malpractice	**3401**	866	3818	815
Court Reports – malpractice	**912**	780	654	758
Court Reports – criminal	**1**	5	0	0
Closed Claim Reports	**988**	811	1096	1021
Initial Disciplinary Action Reports	**141**	106	114	124
Subsequent Disciplinary Action Reports	**148**	117	124	103
Annual Disciplinary Action Reports	**580**			
Professional Society Disciplinary Action Reports	**5**	1	0	0
5D (government agency) Reports	**57**	38	21	26
5F (peer) Reports	**32**	37	8	18
ProMutual Remedial Action Reports	**5**	3	3	0
Self Reports (not renewal)	**10**	1	0	3
TOTALS	**6280**	2765	5838	2868

Note: Physicians renew bi-annually. 2003 was a renewal year.

Data Repository Unit Highlights

3,401 Physician License Renewal Applications were reviewed by the DRC pursuant to M.G.L. c. 112 §2. The Licensing Division refers renewal applications to the DRU whenever applicants inform the Board of medical malpractice claims or payments, lawsuits related to competency to practice medicine, criminal charges, disciplinary actions, and certain other matters. Physicians renew their licenses every two years. The year 2003 was a renewal year for most physicians.

141 Initial Disciplinary Action Reports (HCFD-1) were submitted by health care facilities pursuant to M.G. L. c. 111 §53B. This represents a 33 percent increase in reporting by health care facilities

over 2002, when DRU received 106 HCFD-1 reports. This marks a substantial increase in the number of health care facilities complying with their statutory obligations to inform the Board when they take a disciplinary action against a physician and may be due in part to the DRU's efforts to educate health care facilities about reporting laws and regulations.

148 Subsequent Disciplinary Action Reports (HDFD-2) were submitted by health care facilities, representing a 27 percent increase over the 117 received in 2002.

580 Annual Disciplinary Action Summary Reports (HCFD -3) were received from hospitals, clinics, HMOs, and nursing homes. These reports are collected by the DRU pursuant to M.G.L. c. 111 § 53B and 203.

57 reports of physician violations of M.G.L. c. 112 §5 or Board regulations were filed by other government agencies pursuant to M.G.L. c.112 §5D in 2003. This marks a 50 percent increase over the number filed in 2002. The majority of these reports were filed by the Department of Public Health and involved the investigation of major adverse events that occurred at health care facilities.

32 Peer Reports of physician violations were submitted in 2003, pursuant to M.G.L. c. 112 §5F. In 2002, the DRU had focused on educating health care providers about their "5F'' or peer reporting obligations. As a result, there was a marked increase in the number of reports filed in 2002. That number was sustained in 2003, indicating that these educational efforts are having an effect on the health care community.

- 10 physicians filed self-reports in 2003, compared to 2002 when only one such report was filed. These were self-reports that were not made in the context of license renewal.
- 5 reports of disciplinary actions taken by professional societies were filed, pursuant to M.G.L. c. 112 §5B, also a significant increase over the one report filed the year before.

988 Closed Claim Reports were submitted by medical malpractice insurers in 2003, pursuant to M.G.L. c. 112 §5C. This represents a healthy 22 percent increase over 2002.

913 reports were filed by the courts, an increase of 16 percent over the prior year.

Direct Referrals of Statutory Reports

Data Repository Counsel, in accordance with the DRC policy, reviews statutory reports and determines whether certain ones should be referred to the Board's Enforcement Division or the Physician Health and Compliance Unit.

In 2003, some 195 reports were referred directly to the Enforcement Division for investigation, based on DRC policy. These were reports of physicians who had an open complaint pending with

the Enforcement Division, or physicians who had been disciplined by a licensing Board in another state. When the allegations in a report are so serious that a summary suspension may be needed, the report is referred directly to the Enforcement Division.

Reporting Board Actions

In 2003, DRU reported formal Board actions to the Federation of State Medical Boards, the National Practitioners Data Bank (NPDB), and the Healthcare Integrity and Protection Data Bank (HIPDB). All formal Board actions are reported to the FSMB, and all but probation modifications are reported to the other two organizations.

Physician Profiles

During the year, the DRU was responsible for assuring the accuracy of the malpractice payment, hospital discipline, and criminal conviction information published on the Physician Profiles. The unit reviewed and resolved five complaints by physicians about the accuracy of information published on their profiles.

Education and Outreach

The DRU interprets and enforces the reporting statutes for Board members, staff members, and mandated reporters, such as physicians and other health care providers, health care facilities, medical malpractice insurers, and civil and criminal courts. The DRU also assists those who report with the technical aspects of filing statutory reports and explains and interprets the “Profiles Law” to physicians, health care facilities, and other non-consumer interested parties.

Physician Health and Compliance Unit

Disruptive behavior by physicians -- doctors who yell at nurses or are rude to patients -- is a growing focus of the Physician Health and Compliance Unit (PHC), which generally advises the Board on issues related to drug or alcohol abuse, or mental or physical impairment that may affect a physician's ability to practice medicine safely and competently. The focus on disruptive behavior is a somewhat controversial area, as some doctors believe that as long as they are good clinicians, their treatment of co-workers should not be an issue. The PHC Unit, responding to national recognition that disruptive physician behavior can have a harmful effect on health care, has decided to be aggressive in this area, particularly when red flags show up during the application process for new licensees. The Board believes that disrespect shown to colleagues and co-workers can have a negative impact on patient care in that it can have a chilling effect on a nurse, for example, by discouraging him or her from calling a physician at an odd hour to report a problem with a patient.

Historically, Board Counsel for the PHC Unit has worked closely with the Massachusetts Medical Society's Physician Health Services (PHS) to provide oversight of impaired physicians, to ensure compliance of physicians in PHS contracts, and to receive and respond to reports of non-compliance with contracts. In addition, the PHC Unit assists by participating in educational outreach programs throughout the state. The PHC Unit consists of counsel and two staff members.

PHC Case Presentations

The PHC Unit prepares and presents cases before the Board, the Complaint Committee, and the Licensing Committee, serving as the agency's primary resource on matters relating to physician health.

In 2003, the PHC Unit presented 66 cases to the Board, which was consistent with its presentation of approximately 40 percent of the matters considered by the Board in 2002. The 66 cases made up 42 percent of the cases the Board heard during the year. The PHC Unit also presented 31 cases to the Complaint Committee for its review.

PHC staff also worked closely with the Licensing Unit and reviews the licensing files of applicants who disclose problems with substance abuse, mental health, criminal matters, or disruptive behavior. The PHC Unit brought 60 license applications before the Licensing Committee for full review in 2003.

The Unit also reviewed 206 renewal applications received in 2003, including 149 for medical conditions that might impair competency, 29 for mental health reasons, 16 for chemical dependency, and 9 for Operating Under the Influence charges.

Physicians who may be having problems in these areas are brought to the PHC Unit's attention in a number of ways, from self-reporting to non-compliance reports by PHS, or by disclosures on license applications that raise red flags about a physician's history.

Physician Oversight

A total of 102 physicians were being monitored by PHC in 2003, either confidentially or under a public Probation Agreement with the Board. Of the total, 28 were monitored for mental health reasons, 24 for chemical dependency and 9 for boundary violations, which can involve questionable behavior with staff members or patients.

Committee on Acupuncture

John G. Myerson, Ph.D. (Psychology), Lic.Ac.
Chairman

Weidong Lu, Lic.Ac.
Vice Chairman

Wen Juan Chen, Lic.Ac.
Secretary

Nancy Lipman, Lic.Ac.
Member

Amy Soisson, Esq.
Public Member

Asha Wallace M.D.
Board of Registration in Medicine Member

Committee On Acupuncture

The Committee on Acupuncture works in cooperation with the Board of Registration in Medicine to regulate the practice of acupuncture in Massachusetts. The Committee's functions include setting standards for acupuncture licensure and practice, approving acupuncture schools and training programs, reviewing applications for licensure, disciplining acupuncturists who engage in misconduct, and interpreting the laws and regulations relating to acupuncture practice. Committee meetings are held every three months at the Board of Registration in Medicine and are open to the public.

The Acupuncture Unit aids the Committee in its work. In addition to providing assistance to the Committee members, the Unit handles issues relating to acupuncture that are raised by both the public, as well as by licensees. The Unit also works with the Legal and Disciplinary Units of the Board to resolve matters relating to acupuncture.

John G. Myerson, Ph.D. (Psychology), Lic. Ac., has been the Chairman of the Committee since its inception in 1987. Mr. Myerson has decided not to seek reappointment when his term expires in June of 2004. During his tenure, he has been a driving force in the effort to ensure the safe practice of acupuncture in Massachusetts. The Committee is grateful for his service.

In 2003, the Committee granted eighty-seven full licenses and took action on nine complaints, including one disciplinary action.

Committee on Acupuncture Actions on Complaints

Revocation	1
Dismissal with Letter of Warning	5
Dismissal with Letter of Advice	3

PATIENT CARE ASSESSMENT

The Board's Patient Care Assessment (PCA) Committee made major strides in 2003, as it has worked toward clearing a multi-year backlog of reports of unexpected deaths and serious injuries at hospitals.

Cutting through the backlog of reports to be reviewed and creating a new database resulted in the Committee's being ahead of the curve on what turned out to be a major issue during the year -- the safety of gastric bypass operations.

The PCA Committee, made aware of problems with the surgery as a result of what it had learned by reviewing incident reports and spotting a trend, issued an alert in June saying it had tracked six patients who had died within 30 days of having weight reduction surgery and asked hospitals to report any similar deaths. Several such deaths later made headlines and the state Department of Public Health convened a panel to investigate the safety of the popular operation.

But the Committee's alert was the first inkling that there might be a problem with weight reduction surgery.

The changing of the guard at the PCA Committee included Dr. Martin Crane's assuming the chair and expanding the Committee to include other health professionals besides doctors, such as a nurse and a pharmacist.

By establishing a "tickler'' system by which the Committee is alerted automatically to gaps in reporting by hospitals, it can be more proactive in its investigations. And all data entries are coded in a consistent manner so that trends can more easily be spotted.

The PCA Committee and Unit are responsible for implementing regulations that require most health care facilities in the state to establish and maintain institutional systems of quality assurance, risk management, peer review and credentialing. These are known collectively as PCA programs.

An approved PCA program is a condition of hospital licensure -- no licensed physician may work at a hospital that does not have an approved PCA program -- and the Legislature, in 1986, determined the Board would be responsible for oversight. This is a function unique among the nation's medical licensing Boards. Establishing PCA oversight at the Board recognizes the principle that without physician leadership and participation, institutional quality assurance programs cannot and will not be successful.

Another Legislative mandate says that information submitted to the Board under PCA requirements is confidential and not subject to subpoena, discovery or introduction into evidence.

PCA Plans and Reports/Reporting Compliance

Reporting compliance by hospitals has improved since July, 2003, when efforts were begun in a bid to obtain better cooperation with the law. Data for the year shows a 22.7 percent increase in the number of hospitals that submitted Major Incident Reports, which describe serious, unexpected patient outcomes stemming either from medical error or from unanticipated, unpreventable events. And compliance for submitting the Semi-Annual and Annual Reports increased by 11 percent and 6.8 percent, respectively. The improvement is the result of the PCA Committee's review of reporting compliance, the identification of hospitals that were deficient, and the start of educational and informational efforts to boost compliance. The effort's purpose was both to retrospectively identify Major Incidents that had not been reported and to assist facilities in efforts to improve their procedures for identifying reportable events. The Committee is also conducting ongoing reviews of mortality and occurrence screening data from certain hospitals identified as being deficient in reporting.

PCA MANDATORY REPORTING COMPLIANCE*

	JULY 2003	DECEMBER 2003	% INCREASE
HOSPITALS THAT SUBMITTED MAJOR INCIDENT REPORTS	44	54	22.7
HOSPITALS THAT SUBMITTED SEMI-ANNUAL REPORTS	91	101	11
HOSPITALS THAT SUBMITTED ANNUAL REPORTS	88	94	6.8

*** Based on data for 105 hospitals**

.

The following chart shows the number of Major Incident Reports received by the PCA Unit in 2003, as compared to the years 1999 through 2002. While there has been a slight increase in the

number of events reported in 2003, over 2002, the numbers do not yet reflect the efforts made to improve compliance. An increase is expected to be seen in 2004.

Major Incident Reports: 1999-2003*

YEAR	Type 1	Type 2	Type 3	Type 4	Total
2003	3	9	22	429	**463**
2002	0	13	9	410	**432**
2001	1	16	12	441	**470**
2000	5	12	10	482	**509**

KEY:

Type 1: Maternal Death

Type 2: Ambulatory Surgical Death

Type 3: Diagnostic or Surgical Intervention on Wrong Body Part

Type 4: Serious, Unexpected Patient Outcomes

**For CY 2000 through 2001, the data was tracked by date of incident. For CY 2002 and 2003, the data was tracked by date the Major Incident Report was received.*

Health Care Facility Quality Improvement Review

In 2003, the PCA Committee developed a new approach to reviewing and monitoring quality improvement activities at health care facilities, looking at more data than ever before.

In the past, the Committee had focused its review only on Major Incident Reports submitted by the facilities. In 2003, the Committee broadened its review scope to include an assessment of the facilities' Annual and Semi-Annual Reports as well. The Committee also now reviews Department of Public Health reports of investigations of adverse events that have occurred at facilities. The change in approach has allowed the PCA Committee to more fully evaluate a facility's entire quality improvement program, including its ongoing measures to prevent adverse occurrences and assure patient safety. The new approach has also enabled the PCA Committee to more clearly identify patterns, trends or concerns that need further attention or corrective action.

The Committee reviewed 23 health care facilities in 2003, looking at a total of 108 Major Incident Reports submitted by them. All 23 institutions received written reports from the Committee providing advice or recommendations concerning their quality improvement programs.

In two instances, the Committee met with hospital officials, including representatives from the hospitals' governing Boards, to discuss specific concerns about quality improvement programs, including the issue of compliance with Board reporting requirements. The Committee continues to work with the two facilities on these matters.

Reduction of Major Incident Reporting Backlog

In May, 2003, the PCA Committee and staff identified a backlog of 584 Major Incident Reports that had not yet been reviewed by either the Committee or staff. A plan was developed to review them -- and the effort is nearly completed. As of December 31, 2003, 512 of the 584 reports had been reviewed and the findings have been incorporated into the overall health facility reviews that are performed by the Committee on an ongoing basis.

PCA Update/Advisories

As a result of reviewing PCA reports and other data, the PCA Committee and staff are in a unique position of being able to spot trends in quality assurance that may require statewide action. When such a trend or pattern is spotted, the Committee issues an advisory, known as a PCA Update, which is distributed to all hospitals in the state. The Updates are also posted on the Board's website. The Updates alert facilities about the problem that has been spotted, describe it and sometimes, with the advice of experts, offer possible solutions.

In June, 2003, the PCA Committee distributed an advisory concerning gastric bypass surgery. The Update, "Advisory on Major Incident Reports Involving Gastric Bypass Surgery,'' came in response to the noting of six reports of patients who had died within 30 days of having this operation. It was the first inkling that there might be a potential safety problem with this increasingly popular operation.

Later in the year, several more deaths following gastric bypass surgery made headlines and prompted an investigation by the state Department of Public Health.

But the advisory had already alerted hospitals to the risks associated with the operation and advised institutions of the need for specific policies in the areas of patient screening, informed consent, credentialing, peri-operative and post-operative care and staffing, and quality monitoring. The Advisory reminded hospitals that any deaths following gastric bypass surgery must be reported to the Board as a Major Incident.

The PCA Committee continues to study Major Incident Reports and other data related to bariatric surgery -- which includes gastric bypass. The PCA Committee is in the process of analyzing other concerning trends or patterns that have been identified through the review of Major Incident Reports. These issues may be subjects for future Updates. One issue now under review has to do with attending physicians' accountability for the supervision of residents. Other topics that have been identified for further analysis include the need for early recognition and treatment of sepsis; and communication and conflict resolution amongst health care providers.

New PCA Data Base and Data Tracking System

In 2003, the Board's MIS Department developed a new PCA database that now has the ability to research Major Incident Report data by health care facility, diagnosis code (ICD-9), date and type of incident. The database also allows for text entry that will facilitate research on issues, patterns or trends relevant to all health care facilities in the Commonwealth. PCA Unit staff has entered data from 715 Major Incident Reports into this new database.

The PCA Unit staff has reorganized more than 500 PCA Unit files and has developed new procedures for tracking, processing and filing PCA documents. This new system allows for more efficient access to data from Major Incident Reports, Annual and Semi-Annual Reports and other documents submitted by health care facilities.

Systems Improvements Reported by Health Care Facilities

The Board's PCA Program is unique in that it requires health care facilities to report on their ongoing quality improvement activities, as well as any quality improvements made following the investigation of a Major Incident. In 2003, health care facilities informed the Board of the following systems improvements. These are not the only systems improvements reported, but represent a sampling of what the PCA Committee typically sees when reviewing Major Incident Reports and other PCA data. The PCA Committee and staff plan to look at ways in which hospitals

might be encouraged to share amongst themselves well-drafted and thoughtful policies and procedures, and other systems improvements.

Reported Systems Improvements

Hospitals informed PCAS of the following improvements based on their PCA programs:

- A new policy and procedure to improve early recognition and treatment of intravenous infiltrates and phlebitis.
- Expansion of a "Risk of Fall" Assessment Guideline to include a comprehensive "Post-Fall" Assessment Guideline.
- A new policy and procedure to ensure standardization of anticoagulant monitoring.
- Revision of Naso-Gastric tube protocols following an in-depth analysis of Naso-Gastric tube complications.
- Improved monitoring guidelines for Pediatric Sedation and Analgesia procedures.
- A new policy and procedure for treatment of substance abuse in the acute-care patient.
- The establishment of nursing annual competencies in fetal heart monitoring.
- Expansion of site verification policies to include all clinical areas where invasive procedures are performed

Conclusion

The year 2003 has been one of transition for the PCA Program at the Board. The PCA Committee and staff have developed new procedures for processing and reviewing Major Incident Reports, Annual and Semi-Annual Reports and other data submitted by health care facilities to the Board. The Committee expects that these new procedures will result in more meaningful and efficient feedback to the reporting health care facilities, and ultimately improvement in the quality of care provided to patients in the Commonwealth.