Commonwealth of Massachusetts

Board of Registration in Medicine

2000 Annual Report

Members of the Board of Registration in Medicine

Peter N. Madras, MD
Chairman

Peter Gelhaar, JD
Vice-Chairman

Rafik Attia, MD
Secretary

Arnold S. Relman, MD
Physician Member

Mary Anna Sullivan, MD
Physician Member

Martin Crane, MD
Physician Member

Dorothy Keville
Public Member

Walter Prince, JD*
Public Member

Nishan Kechejian, MD*
Physician Member

** Members whose terms expired in 2000*

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Attachments:

Note: A Special Report on Medical Malpractice Payments has been released concurrently with the 2000 Annual Report

PCA Updates

Members of the Board of Registration in Medicine

Standing (*Officers of the Board of Registration in Medicine*)
Dr. Rafik Attia, *Secretary*; Dr. Peter Madras, *Chair*; Peter Gelhaar, JD, *Vice-Chair*

Seated
Dorothy Keville, *Public Member*; Dr. Arnold Relman, *Physician Member*;
Dr. Mary Anna Sullivan, *Physician Member*; Dr. Martin Crane, *Physician Member*

His Excellency Argeo Paul Cellucci
Governor of the Commonwealth
and the Honorable Members of the
General Court of Massachusetts

Dear Governor Cellucci and
Members of the General Court:

It has been my privilege and pleasure to serve the patients of our Commonwealth as member and chairman of the Board of Registration in Medicine. On behalf of the Board members, I submit this report summarizing the Agency's activities for the first year of the new millennium.

As this year may be characterized by transition and achievement, I would like to draw your attention to some of our more visible work. We have almost entirely eliminated the backlog of old cases that severely impaired our credibility and effectiveness. During this year, the issue of medical errors burst upon the national scene through the Institute of Medicine report, *"To Err is Human"* and the leadership role of the Board in this arena was noted. The acclaimed Physician Profiles instituted by the Board in 1996, remains the dominant program of this type in the country – although other states are starting to institute programs base don our model. All these initiatives are described in this report.

The work remaining is still voluminous. The changing face of medicine requires that we empower good physicians, not only to treat their patients safely, but to advocate for them in the confusing arena occupied by so many participants: alternative health practitioners, confounding third party payers, and corporate practice plans, to name a few. Through this maze, the safety of consumers remains paramount, and the quality of our 30,000 practitioners continues to be maintained through stringent licensing requirements.

I express the Board's gratitude to our staff for their tireless effort and dedication. In addition, I am indebted to your staff for re-invigorating our agency and creating an environment in which the above work remains not only possible but highly rewarding. Finally, the Board members must be applauded for the long hours they devote to this important work.

Sincerely,

Peter N. Madras

Peter N. Madras, M.D.
Chairman,
Massachusetts Board of Registration in Medicine

Structure of the Board of Registration in Medicine

Board & Committee Work

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

Complaint Committee

Members review allegations against physicians and recommend cases for disciplinary action to the full Board. The Complaint Committee members oversee the "triage" process by which complaints are prioritized, direct the Litigation staff in setting guidelines for possible consent orders, and hold intensive remedial and internal conferences with physicians who are the subject of complaints.

Data Repository Committee

Members review reports filed about physicians from statutorily mandated reporting sources. Reports include malpractice payments, hospital discipline reports, and reports filed by other health care providers. Although sometimes similar in content to allegations filed by patients, Data Repository reports fall under different legal standards for disclosure than do patient complaints. The Data Repository Committee refers cases to the Enforcement Unit for further investigation, as needed.

Licensing Committee

Members review applications for licensure and requests for waivers from certain Board provisions. The members present candidates for licensure to the whole Board. The two primary categories of licensure include full licensure and limited licensure. Limited licensees include all physicians in training, such as those enrolled in residency programs.

Patient Care Assessment Committee

Members work with hospitals and other institutions to improve quality assurance programs through the review of Major Incident Reports. These reports describe adverse outcomes, full medical reviews of the incidents, and the corrective action plans of the facilities. 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 Committee has become a national model for health care excellence in response to the recent Institute of Medicine Report on the prevention of medical errors.

Committee on Acupuncture

The Board of Registration in Medicine also oversees the licensing and discipline of licensed acupuncturists through the Committee on Acupuncture. One member of the full Board sits on the Committee on Acupuncture, with other members appointed by the Governor.

Structure of the Board of Registration in Medicine

Functions and Divisions of the Agency

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. The Divisions of the agency include the following:

Division of Law & Policy

The Division operates under the supervision of the General Counsel. The Office 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 and Policy are the Patient Care Assessment Unit, the Data Repository Unit; and Physician Health & Compliance Unit. A full description and report of each unit can be found later in this report.

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 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 Clinical Care Unit, then sent to outside expert reviewers. Experienced Investigators investigate complaints by interviewing witnesses, gathering evidence, and working with local, state, and federal law enforcement agencies. The Disciplinary Unit is staffed by experienced prosecutors who represent the public interest before the Complaint Committee, the Board, and the Division of Administrative Law Appeals. A recap of the accomplishments of the Enforcement Division can be found later in this report.

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 clarify requirements for examinations and training that must be met before a license will be issued. A full report of the Licensing Division can be found later in this report.

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

Operations & Systems Divisions

The Massachusetts Board of Registration in Medicine continues to improve efficiency in operations and services through technological innovation. In 2000, the agency added new functionality to its web-based licensing system, brought new enhancements to the Physician Profiles system, and undertook a significant project to make the consumer web-site a better resource for consumer and physicians

Office of Consumer Affairs & Business Regulations

Although the policies and practices of the Board of Registration in Medicine are established by its Board, the agency resides administratively within the Office of Consumer Affairs and Business Regulations (OCABR). Through its close contact with the OCABR, the Board is able to keep the issues of health care consumers at the forefront of consumer rights initiatives.

Executive Director's Report

Report of the Executive Director ~ *Nancy Achin Sullivan*

One year ago, a new management team began its work at the Massachusetts Board of Registration in Medicine. There was a clear mandate from the Administration, the Legislature, and the public for meaningful change in how the agency operated. The volunteer Board of five physicians and two public members led a massive effort to restore public confidence in the agency, re-engineer key work processes, and reinvigorate the agency. The Board set as its first two goals the completion and reporting of its review of all previously dismissed patient complaints within certain parameters and the reduction of the large backlog of open, aging consumer complaints. Through the initiative of the Board members and the diligent efforts of the staff, these goals have been met.

The success of the agency has come during a period of tremendous change in the health care industry. During the past year, the Institute of Medicine released a landmark report "*To Err is Human*" that informed the public that thousands of patients die in American hospitals each year due to medical errors. The report brought swift and intense reaction from the general public, legislative bodies, and the medical community. Concurrent to this increased attention to the issues of patient safety, medical errors, and quality assurance were unparalleled cost pressures on doctors, hospitals, and other medical facilities.

It is within this complex environment that the Board of Registration in Medicine tries to find the appropriate balance between its unrelenting commitment to public protection and the realization that unnecessary intrusion into the practice of good physicians comes at the expense of time those physicians have with their patients. The agency has made great strides in upgrading its systems to make its work more efficient.

This improvement is evident in the commitment of funds from both the Board and the Office of Consumer Affairs and Business Regulation to an investment in improved

licensing technology.   The first phase of implementation of a web-based licensing system has been completed. During the next two years, the agency hopes to bring all licensing functions on-line in order to facilitate the application process for physicians.

In addition to the plans for on-line license applications and processing, the agency is in the process of adding on-line edit capabilities for physicians who wish to update demographic information such as business address, insurance plan affiliations, hospital affiliations, and other information. By accepting this information electronically, the Board of Registration will increase the accuracy and timeliness of its data files and provide better service to physicians. Electronic capture of the updates will also allow the agency to incorporate the changes immediately into its Physician Profiles system, resulting in improved services for patients and other consumers.

The greatest accomplishment in 2000 was the remarkable improvement in the agency's handling of its complaint backlog. As part of the FY01 budget, the Massachusetts Legislature mandated that the Board of Registration in Medicine report on specific performance benchmarks for calendar year 2000.

As the reports from individual divisions within the agency will demonstrate, the Board of Registration has met the challenge presented in 2000. Cases are being resolved expediently and appropriately, resources are being channeled to maximize effectiveness, and the public is enjoying a high level of public protection. Through its consumer protection functions, patient and professional education and outreach services, and high standards for licensure, the Massachusetts Board of Registration in Medicine has succeeded in all measures of performance in 2000.

Comparison of Mass. Board of Registration in Medicine to National Averages for Funding and Staffing

Category of Information	**1999 Mass.* Performance**	**National Average Performance**
$ Spent per Physician	**$160**	**$248**
% Spent in Licensing	15%	29%
% Spent on Discipline	78%	45%
% Spent on Administration	7%	26%
Staffing		
Licensing-(FTEs/1,000 physicians)	0.47	1.16
Discipline-(FTEs/1,000 physicians)	0.75	1.48
Investigators (FTEs/5,000 physicians)	0.47	3.67
Legal Staff (FTEs/5,000 physicians)	2.58	2.51
Cases per Investigator	35	42
Cases Investigated	1,409 **	481
% Cases with Disciplinary Action	4.5%	20.0%
Disciplinary Actions per Investigator	32.0	13.7
Disciplinary Actions per Attorney	5.8	17.9
Per Total Enforcement Staff	4.0	5.9

Mass. Board of Medicine Expenditures vs. National Average.
Source: Federation of State Medical Boards

*Based on expenditure of $3,396,117 and 21, 225 physicians practicing in Massachusetts.

** The Board undertook a closed case review project that required re-investigating approximately 300 cases in 1999.

2000 national figures for comparison will not be available until April 2001

Education & Outreach Division's Report

Public Information Overview

The first of its kind in any state in this country, the Physician Profiles Project was developed in partnership with the state legislature, Governor, and the Massachusetts Medical Society to help health care consumers gain better insight to make informed decisions as to physicians, their history in practice, training, or any disciplinary or medical malpractice concerns.

Profiles has gained national attention and as such, Nancy Achin Sullivan, the Executive Director of the Board of Registration of Medicine, was twice invited to testify before Congress in 2000 as an expert on consumer information concerning physicians. Other states have followed Massachusetts' lead in bringing this service to citizens across the country.

Since launching the Physician Profiles Project in 1996, we have increased public awareness to consumers from 25, 771 web site page requests during the first year to a whopping 7,454,321 to date. Because of this public feature, Massachusetts' residents are better able to make educated health care decisions for their families. Access to the Internet is as follows: http://www.massmedboard.org.

Any consumer without on-line capability can gain the same valuable information by contacting our fully staffed CALL CENTER at 1-800-377-0550. Call Center employees are readily available from 9:00 am to 5:00 pm – Monday through Friday – to answer questions concerning Board policies, obtain complaint forms or other documents, and provide copies of requested Profile documents to callers.

In June of 1999, BORIM effectively heightened its awareness of public information to the public by publishing a list of disciplinary actions taken against physicians on its web site. It also provides information regarding Disciplinary Action press releases and other releases, Board Meeting dates for the calendar year, and other information to further educate consumers in making enlightened decisions.

Physician Profiles Output Summary

Year	Calls Received By Call Center	Profiles Mailed/Faxed By Call Center	Physician Profiles Web Site Hits	Total # Profiles *(Web Hits + Call Center Requests Processed)*
1996	17,127	25,771	0	25,771
1997	43,698	57,619	529,250	586,869
1998	30,085	32,316	1,642,500	1,674,816
1999	22,642	22,779	2,555,000	2,577,779
2000	20,400	15,647	2,573,439	2,589,086
TOTAL	**133,952**	**154,132**	**7,300,189**	**7,454,321**

In addition, Call Center staff maintains updates on profiles (8,537).

Enforcement Division's Report

- Consumer Protection Unit
- Clinical Care Unit
- Disciplinary Unit
- Annual Disciplinary Actions
- Case Management Statistics

Report of the Director of Enforcement - Barbara A. Piselli

The Enforcement Division of the Board is mandated by statute to investigate all potential disciplinary matters involving physicians licensed to practice medicine within the Commonwealth of Massachusetts. The Division prepared to meet its mandate of public protection through changes focused on laying the foundation to meet specific goals for the new millenium. These goals include a reduction in the backlog of open cases, improved communication with consumers filing complaints against physicians, expedited review and resolution of cases and increased disciplinary actions. The implementation of these changes had a major and positive impact on the functioning of the Enforcement Division during 2000.

The Enforcement Division is supervised by 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 and important role in the Enforcement Division's mission to ensure quality health care for consumers. A brief overview of each Unit and a summary of the significant accomplishments of the Division follows.

CONSUMER PROTECTION UNIT

The Consumer Protection Unit was created as a result of recommendations contained in the January 1992 Final Report of the Blue Ribbon Task Force in an effort to make the Board more accessible and responsive to the public. It is staffed by the Unit Manager and two support personnel. The Unit is responsible for the intake and screening of all consumer complaints received by the Board. During 2000, the Unit docketed 626 cases. The consumer protection staff coordinates the Triage Team, the Voluntary Mediation Program, and other patient advocacy initiatives. The Unit is also the initial and primary liaison with complainants during the intake and screening of their complaints.

CLINICAL CARE UNIT

The Clinical Care Unit was formed in April 1996 to investigate allegations of substandard care. Over the past four years, the mission of the Clinical Care Unit has become clearer and is perhaps best described in three parts:

1) the identification of substandard care;
2) the analysis of its cause; and
3) Board intervention by way of remediation, discipline or both.

The Unit is staffed by a Nurse Manager, two nurse investigators and a paralegal. The nurses review and investigate complaints alleging substandard care, presenting their findings and recommendations to the Complaint Committee. The Unit also coordinates the Board's informal remediation conference program for substandard care matters.

At its lowest level, remediation takes the form of letters of advice, concern or warning sent to a physician whose case is dismissed. At mid-level, remediation occurs during conferences between the Committee members and physicians about the problems underlying the complaint and, more importantly, whether the physician has engaged in serious thinking on how to avoid similar problems in the future. At the highest level, remediation is a formal request by the Committee that the physician engage in some type of remedial activity, the successful completion of which may result in the dismissal of the case. When the Complaint Committee recommends remediation, the remediation does not have a disciplinary component. Instead, the Committee intervenes when there are patient complaints about issues that do not rise to a level requiring disciplinary action.

The Clinical Care Unit staff members are also responsible for the preparation of reports for the Data Repository Committee and the Licensing Committee.

DISCIPLINARY UNIT

The Disciplinary Unit is responsible for the investigation, preparation and litigation of all cases that may result in enforcement action against licensed physicians and acupuncturists. The Unit is staffed by a Managing Attorney, six complaint counsel, 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. The responsibility of the Unit is to pursue complaints against individual doctors efficiently and effectively in order to ensure that the public is protected and that Board statutes, regulations and policies are enforced. All complaints referred to the Disciplinary Unit are assigned to a complaint counsel (the Board prosecutor) and to an investigator. Complaints alleging substandard medical care are also assigned to a member of the Clinical Care Unit.

These staff members all work together to gather and organize evidence, negotiate with the physicians who are the subjects of the complaints; draft Complaint Committee memoranda and other documents to be presented to the Complaint Committee, Board and DALA; and present cases before DALA. They also interface with other local state and federal law enforcement officials on coordinated investigations and referrals.

Staff Category	Average #Cases At Any Time for 2000
Complaint Counsel	**41**
Investigators	**78**
Nurse Investigators	**77**

In 1999, the national average for caseloads for investigators was 42 cases. Figures for 2000 for national comparison are not yet available, but these figures indicate significant understaffing for the investigator function at the Board of Registration in Medicine.

Significant Accomplishments During 2000

REDUCTION OF BACKLOG

The Enforcement Division has made tremendous efforts to eliminate its backlog of cases in all units within the Division. This has resulted in the significant reduction of all backlog matters. When the new management came to the Board at the beginning of the year, it faced the daunting task of reviewing, prioritizing, and investigating nearly 700 open cases, many of which were extremely old.

Developing and implementing a strategy to respond to this challenge was the top operational priority of the new management team. Through the exhaustive efforts of the Complaint Committee and the Enforcement staff, the goals set at the beginning of 2000 have been met.

COMPLAINTS	1999	2000
DOCKETED	584	626
CLOSED	365	773
OPEN AS OF 12/31	698	537

As this chart demonstrates, the agency opened more new cases than in previous years. We believe that this statistic demonstrates renewed public confidence in the Board. In addition, the agency resolved 773 cases, more than in any year in the Board's history. As will be demonstrated in a later chart, the aging of these cases is also significantly improved. Other than cases that are no longer within the purview of the Board, (i.e. those referred to the Division of Administrative Law Appeals) nearly every case still open is less than one year old. At the beginning of 2000, nearly one-third of all cases were over one year old. In addition, the cases have been resolved with a higher level of intervention than ever before. In the past, many cases were dismissed with no action for the physician. This year, the agency increased its use of informal conferences, as well as letters of advice, concern, and warning; to educate physicians about ways to improve their practices, rather than issue simple dismissals. The Board

also increased the number of remedial conferences, an intensive intervention for physicians with substandard complaints.

NON-DISCIPLINARY ACTIONS IN 2000

ACTION TAKEN	Number of Action
DISMISSED	**476**
CLOSED /LETTER OF AKNOWLEDGEMENT	1
CLOSED /LETTER OF EDUCATION	1
CLOSED /LETTER OF INFORMATION	12
CLOSED /LETTER OF ADVICE	140
CLOSED /LETTER OF CONCERN	58
CLOSED /LETTER OF WARNING	19
TOTAL	**707**

PRIORITIZATION OF CASES

Complaint Counsel, Investigators and Nurse Investigators, in consultation with the Director of Enforcement, the Managing Attorney and the Clinical Care Manager, are responsible for identifying and prioritizing serious cases such that the Board's mandate of public protection is carried out. The most serious cases are given the highest priority in terms of resource allocation, investigation and prosecution.

When a doctor appears to be a serious threat to the public health, safety, or welfare, it is the responsibility of the Complaint Counsel to bring this matter to the attention of the Board to recommend that the doctor no longer practice medicine until safeguards are in place. In the most serious cases, the Complaint Counsel and Investigator may recommend that the Board summarily suspend the license of a physician or attempt to seek a voluntary agreement not to practice medicine from the physician.

The Executive Director and the Director of Enforcement have conducted statewide proactive outreach with law enforcement agencies to familiarize these organizations with the mission of the Board and encourage prompt reporting of criminal misconduct by physicians. These efforts are resulting in cooperative and collaborative

investigative efforts by law enforcement and the Board.

The Triage Team has become more efficient as noted elsewhere in this report. Additionally, streamlined case presentations are being made to the Complaint Committee on cases that do not have disciplinary potential. These changes, coupled with the conscientious efforts of the new CPU manager, have resulted in the elimination of the consumer protection backlog as well as the more expedient intake and screening of all consumer complaints.

The Clinical Care Unit reviewed 322 consumer complaints this year, eliminating a backlog dating back to 1997. The elimination of this backlog was a priority for the new management team and was made possible by special funding from the legislature, ongoing support from the Board and the tireless efforts of the CCU staff. In the spring of 2000, the Board was able to retain the services of the Center for Health Care Dispute Resolution (CHDR) and outsource the review of these cases. CHDR is a national company based in New York that employs a wide range of medical and legal professionals who conduct case reviews for a variety of public and private health care organizations.

In July 2000, the CCU prepared and mailed 247 cases for CHDR to review. CHDR, in turn, sent each case out for expert review to a physician practicing in the same specialty as the physician cited in the complaint. Finally, a summary of the complaint, the physician's response, the pertinent medical records and the expert's findings were returned to the Board. Nurse Investigators reviewed each report, did further research as necessary and prepared a memo for presentation to the Complaint Committee.

Presentation of this many cases in such a short period of time required many additional hours of Complaint Committee meetings. The Committee members were very generous with their time and this project would have been impossible without their cooperation.

Substandard care complaints	245	77
Litigation cases	5	67
Licensing cases	55	0
TOTAL	305	144

CASES CLOSED BY CLINICAL CARE UNIT	# Cases 1999	# Cases 2000
Substandard care complaints	113	322
Litigation cases	5	N/A
Licensing cases	55	44
TOTAL	173	366

SEXUAL MISCONDUCT INVESTIGATIONS DURING 2000

Special safeguards have been put in place for sexual misconduct cases. 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/or Complaint Counsel. Sexual misconduct cases are not handled in the Consumer Protection Unit.

All such allegations are fully investigated. The alleged victim is interviewed in person whenever possible, as is the target physician. In addition, the physician is always asked to appear before the Complaint Committee, even if dismissal is recommended.

Serious cases of sexual misconduct are always evaluated immediately in order to determine if a summary suspension of the offender's license would be appropriate.

SEXUAL MISCONDUCT CASES

Docketed in 2000	17 doctors; 17 complaints

Docketed in 2000, Resolved in 2000	2 doctors; 2 complaints
Docketed pre-2000, Resolved in 2000	8 doctors; 8 complaints
Total Open 12/31/00	28 doctors (8 @ DALA) 43 complaints (22 @ DALA)

INCREASING DISCIPLINARY ACTIONS

The Board's poor record on national reports of disciplinary actions taken resulted in intense media, Board, and legislative review of the agency's disciplinary process. Whenever possible, the complaint process has been streamlined in response to these concerns. The Disciplinary Unit prioritizes those cases where the licensee is the greatest risk to the public, explores the necessity for a summary suspension or agreement not to practice medicine and proceeds with a prompt request to the Board to issue a Statement of Allegations.

Cases that should result in quick disciplinary action have been prioritized, such as cases based on out-of-state discipline. Also, cases with disciplinary potential are identified and prioritized sooner due to changes in the Triage process.

Through the CHDR review, those substandard care cases that will not result in disciplinary action are resolved, allowing Unit staff more time to work on those cases with disciplinary potential.

Complaint Counsel request prompt hearing and consecutive hearing dates at the Division of Administrative Law Appeals (DALA). The agency continues to have serious concerns about the adequacy of the staffing levels at DALA. The DALA magistrates hear cases involving many agencies other than the Board. The high caseload and relatively small staff make it impossible for DALA magistrates to schedule cases in a time frame that is of benefit to the Board and the patients it represents. Recent changes in policy coverage offered by Massachusetts Malpractice Insurers make it more likely that physicians will refuse to sign consent orders to

resolve pending Enforcement cases and instead will choose to request a full adjudicatory hearing. The increased caseload of Board of Registration cases at DALA will present a serious threat to the success of the agency unless cases can be heard more quickly.

Disciplinary Actions

In 2000, the agency issued 45 disciplinary actions and disciplined 44 physicians. This record represents a 15.8% increase in the number of physicians disciplined. This increase is significant, but is even more impressive when reviewed in the context of the significant decrease in disciplinary actions taken in 1999 when compared to 1998. From 1998 to 1999, the number of physicians disciplined decreased by over 25%. In 2000, the agency both stopped the slippage in performance from previous years and initiated a more appropriate number of actions.

Category	2000	1999
Doctors Disciplined	44	38
Statements of Allegations Issued	40	29
Summary Suspensions	7	5
Voluntary Agreements Not to Practice	5	5

DECREASE IN AMOUNT OF TIME TO RESOLVE CASES

The Complaint Committee and the Enforcement Division have worked expediently and efficiently to review all cases in a timely manner.

Cases Presented to Complaint Committee during 2000

Source of Case	# Presented
Litigation	**601**
Appearances	116
Non-Appearances	485
Clinical Care Unit	**392**
Remedial Conferences	33
Non-Appearances	359
TOTAL	**993**

Investigators handle out-of-state discipline cases until the time a Statement of Allegations issues or a Consent Order is recommended. Paralegal staff handle *"failure*

to respond" cases until the time that a Statement of Allegations is issued or a Consent Order is recommended. Complaint Committee memorandums have been streamlined in cases where dismissal is recommended and there are no allegations of sexual misconduct.

The Triage (initial review and screening) process has been streamlined. All cases (with the exception of sexual misconduct and other priority matters) are reviewed as a package once the complaint and physician's response have been received. Physicians' responses are requested immediately upon receipt of the complaint in most cases, considerably reducing turnaround time and allowing for a more expedient response to consumers.

Substandard care cases are now referred to the CCU after the Triage Team has obtained the physician's response and an initial determination of possible substandard care has been made. The manager of the CCU evaluates all substandard care referrals, determines which are a priority, assigns them to an investigator and determines if they are appropriate for outsourcing. Cases identified as having disciplinary potential are flagged for review ahead of other cases, regardless of date of receipt, and will be handled as soon as the pertinent medical records are received.

The CCU paralegal requests the medical records from physicians and hospitals, a task that was previously performed in the Consumer Protection Unit. The paralegal is aware of the priority status of cases and will use that information to expedite the retrieval of the medical records whenever possible

Recent changes in the Triage and Complaint Committee processes have decreased the resolution time on cases without disciplinary potential.

Investigators and Complaint Counsel have regular case review meetings with the Director of Enforcement and the Managing Attorney. This process assists in the identification of priority cases, problem areas and the need for additional resources as the implementation of appropriate timelines on a case by case basis.

The team approach is being utilized on a more widespread basis, especially on complicated or emergency cases. Paralegals, investigators, nurses and supervisors play a more integral role in the investigation and prosecution of each case. Another Complaint Counsel is assigned to second seat the primary attorney on complex adjudicatory cases.

IMPROVEMENT OF COMPLAINT AND TRACKING PROCESSES

All complaints are now date stamped and input into database so that they can be tracked for statistical and case management purposes. More importantly, this tracking system enables the staff to be more responsive to inquiries from complainants about the status of their cases. Prior to May 2000, these cases were never date stamped or tracked in any manner. If the cases were never docketed, there would be no record of receipt or review other than the file itself.

Representatives from the Enforcement Division have been active participants in the newly formed MIS Users Group.

As noted elsewhere in this report, changes in the Triage process have significantly improved the complaint process.

IMPROVED COMMUNICATIONS WITH COMPLAINANTS

Specific calling hours have been eliminated and the Call Center now handles a wider range of inquiries from consumers. This allows the public to obtain information more quickly and efficiently. It also allows the CPU staff to have more time to speak with consumers with more substantive questions about the complaint process or their specific complaint. The revisions of the Triage process have been very instrumental in improving communication with consumers as the Board continues to rebuild public confidence.

PROFESSIONAL DEVELOPMENT

Staff members are encouraged to take practice-related courses to enhance their skills and keep abreast of recent legal, medical and investigative techniques and developments. During the past year, staff members attended a number of seminars in areas such as expert witnesses, legal writing skills, case development, Legal advocacy skills, understanding medical records, drug diversion, management skills, Power Point, etc.

WORKING GROUPS

In an effort to meet the Agency goals set by the Executive Director, the Division has convened working groups in the areas of Regulations Revision, Case File Standardization, Investigative Reports, Timelines, the Triage process and MIS Issues.

REGULATIONS REVISION PROJECT

The revision of Board regulations and policies, as well as the enactment of new legislation is vital to the progress of the Board in the new millenium. The Enforcement Division has convened a working group to focus on this very important goals. Staff meets weekly to research, discuss and draft revisions that will better serve the mission of the agency.

Division of Law & Policy's Report

- Office of the General Counsel
- Data Repository Unit
- Patient Care Assessment Unit
- Physician Health & Compliance Unit
- Committee on Acupuncture

Report of the General Counsel – Pamela Wood

During 2000, the Division of Law and Policy began a large-scale review of the regulations and underlying statutes that provide the framework for the operation of the Board of Registration in Medicine. The agency plans to have proposed revisions available for public comment during Spring 2001. Along with this important project, the staff members continue to offer legal guidance to the Board on issues of licensure, disciplinary actions, and other key functions. The Division of Law and Policy also performs legal and policy research for the Board and the Executive Director.

In addition to the Office of the General Counsel, the Division of Law and Policy encompasses the Data Repository Unit, the Physician Health and Compliance Unit, the Patient Care Assessment Unit and the Committee on Acupuncture. Each unit plays an important role in meeting the agency's mission of public protection through the regulation of physicians and acupuncturists.

The Data Repository Unit collects, analyzes and recommends action on mandated reports of malpractice payments, hospital disciplinary actions, and other adverse information about physicians. The Physician Health and Compliance (PHC) unit assists physicians who are successfully battling substance abuse problems or physical or mental impairments. In conjunction with outside resources, the PHC staff recommend monitoring agreements and report on a physician's readiness to resume practice. The PHC staff also monitors physician compliance with Board-ordered probation agreements. The Patient Care Assessment (PCA) Unit is a nationally recognized program that assists hospitals and other facilities in their efforts to promote patient safety and enhance health care quality. The Committee on Acupuncture regulates all aspects of the practice of acupuncture in Massachusetts, including setting standards for practice and licensure.

DATA REPOSITORY UNIT

The Data Repository counsel receives and processes statutory reports concerning physicians licensed in the Commonwealth. Data Repository staff work with the Board's Data Repository Committee to review mandated reports to determine which should be referred to the Board's Enforcement Division, and to develop policies relating to statutory reporting. In 2000, the Data Repository Committee reviewed 243 cases, including 154 physicians reviewed based on their malpractice history. The Data Repository Unit also disseminates information regarding Board disciplinary actions to national data collection systems and via the Board's Website, and ensures that appropriate statutory report information is accurately posted on Physician Profiles.

Report	# Received in 2000
Medical Malpractice Reports	1,525
Health Care Facility Discipline Reports	124
5D & 5F Reports (5D & 5F are mandatory Peer Reports)	46

Patient Care Assessment Unit

The Board's Patient Care Assessment (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, known collectively as PCA programs. Over 800 health care facilities in the state are affected by the PCA requirements, including hospitals, clinics, HMOs, and nursing homes. Currently, the PCA Committee consists of five physicians, three of whom are members of the full Board and two of whom serve as consultants. Medical specialties represented by the Committee include: internal medicine, surgery, nephrology, anesthesia and psychiatry. The PCA Unit consists of 3.6 staff members with backgrounds in nursing, law and public health. In 2000, a new position was approved for the Unit, resulting in its current 3.6 staff complement.

The Legislature placed responsibility for institutional systems of quality assurance at the Board in 1986. It is a function unique among the nation's medical licensing boards; its presence at the Board of Medicine recognizes the principle that without physician leadership and participation, institutional quality assurance programs cannot and will not be successful. An approved PCA program is a condition of hospital licensure; moreover, no licensed physician in Massachusetts may work at a health care facility that does not have an approved PCA program. The Legislature also mandated, by statute, that information submitted to the Board as required by the PCA regulations is confidential and not subject to subpoena, discovery or introduction into evidence.

The Board ensures that health care facilities have PCA programs in place by reviewing and approving their PCA plans. The PCA plan must describe how the facility carries out the requirements found in the PCA regulations. To monitor the

on-going operations of a facility’s PCA program, the Board requires three types of reports, two of which are, in essence, quality assurance “progress” reports and must be submitted to the Board on a routine basis.

The third type of report, called the “major incident” report, is the principal method by which the Board ensures that institutional quality assurance systems are functioning effectively and appropriately. Major incidents are serious, unexpected patient outcomes; they are defined as: maternal deaths related to delivery; deaths in the course of, or resulting from, elective ambulatory procedures; invasive diagnostic procedures or surgical interventions performed on the wrong organ, extremity or body part; and deaths or major or permanent impairments of bodily functions that are not ordinarily expected as a result of the patient’s condition on presentation.

Certain major incidents involve medical errors that could have been prevented, while others represent unexpected, unpreventable patient outcomes. When reporting major incidents to the Board, the facility must provide a thorough medical description of the event, the results of its internal investigation, and, if applicable, all corrective measures taken to prevent a recurrence. Major incident reports are reviewed and analyzed by the members of the PCA Committee and by staff. Following their reviews and analyses, the Committee and staff must be reassured that each reporting facility responded thoroughly and appropriately to all serious, unexpected outcomes. Moreover, if the event was the result of an error or errors (involving either individual practitioners or systemic processes), the Board must be confident that the facility has taken all necessary corrective action to prevent a recurrence.

In terms of volume, the Board has received 296 major incident reports thus far about events that occurred in 2000 (facilities have three months following an incident to submit a report). Table 1 provides summary data on the number of major incident reports received over the past four years. During 2000, 378 major incident reports

underwent review by the PCA Committee and staff. Of those, 82 reports needed no further investigation or follow-up. The remaining 296 cases required additional information and investigation. A total of 115 cases were closed in 2000.

Table 1. Major Incident Reports: 1997 through 2000

Year	Number of Reports
1997	150
1998	228
1999	414
2000	296*

[Note: Data are based on date of incident and exclude fetal death reports.

**Statistics for 2000 are incomplete due to reporting deadlines. Fourth quarter reports for calendar year 2000 are due by 04/01.]*

As part of its review of major incidents, the PCA Committee and staff work closely with the reporting facility. If the PCA Committee is not satisfied with the facility's response to an event, it often recommends that the facility take a number of actions. These recommendations have included: changes in internal policies or procedures; additional staff training or monitoring; an entire re-review of an incident; cessation of specific surgical or diagnostic procedures; and the hiring of additional staff, such as a hospitalist or an outside QA consultant.

If the PCA Committee remains dissatisfied, it calls for a meeting with the facility's chair of the board of trustees, the chief executive officer (CEO), the medical director, the director of quality assurance and the chiefs of the major clinical departments. The purpose of the meeting is to educate those present about the Board's PCA function, convey the Committee's concerns about the operations of the facility's PCA program, and recommend changes and improvements. The meetings require a great deal of preparation; feedback from facility representatives

who have met with the Committee indicates that while the experience was not always pleasant, it was educational and helpful. In 2000, the PCA Committee and staff held nine such meetings.

An important issue addressed by the PCA Committee and staff in 2000 was the low volume of reports submitted by the state's teaching hospitals. In April, 2000, a letter from Arnold Relman, M.D., Chairman of the PCA Committee, was sent to the CEO and the PCA Coordinator of the state's major teaching hospitals. The letter discussed the PCA function at the Board, pointed out each hospital's reporting history for the past three years, and asked for both reassurance that the hospital was meeting its regulatory obligations and an explanation for the low volume of reports. Over the ensuing summer and fall, all of the hospitals responded to the Committee's concerns, both by letter and by an increased number of reported major incidents. In addition, several members of the PCA Committee met with administrative and medical personnel from individual teaching hospitals to discuss specific issues and concerns.

By their reviews of major incident reports, the PCA Committee and staff are in a unique position to identify quality assurance problems in health care that require broad, state-wide attention. When such problems are identified, advisories, known as PCA Updates, are distributed to all hospitals in the state, alerting facilities about the issue, describing the problem and, often with the aid of advice from experts, offering possible solutions. In 2000, the PCA Committee and staff distributed two such advisories: "Radiology Coverage in Emergency Rooms" (June, 2000) and "Unread Electrocardiograms" (September, 2000). A listing of all PCA Updates can be found in Table 2.

Table 2. List of PCA Updates

- Oncology Drug Administration (2/93)
- Intravenous Potassium Chloride (1/97)
- Pediatric Neurosurgical Procedures (1/98)
- Adrenocortical Insufficiency Secondary to Previous Treatment with Adrenal Corticosteroids (10/98)
- Laparoscopic Injuries (5/99)
- Radiology Coverage in Emergency Rooms (6/00)
- Unread Electrocardiograms (8/00)

The PCA Update on radiology coverage in emergency rooms was a product of much time and effort on the part of the PCA Committee and staff. Major incident reports indicated a growing trend of serious outcomes, including deaths, of patients whose x-rays were misinterpreted by emergency room physicians. These occurrences generally took place in community hospitals during "off-hours," that is, on evenings, nights, and weekends, when no radiologist was on site. The PCA Committee and staff worked closely with the Massachusetts Radiological Society (MRS) to learn more about the problem and to identify possible solutions. In the Update distributed in June, 2000, the Committee presented its ideal goal, namely, that all radiologic studies taken on ER patients be promptly interpreted by radiologists, who are available either on site on a twenty-four hours per day/seven days per week basis, or by teleradiologic technology. Recognizing limited resources, the Committee recommended that hospitals move toward this goal as soon as possible with the assistance and support offered by the MRS.

The problem of unread electrocardiograms (EKGs) was of equally troubling concern to the PCA Committee and staff. Again, the review of major incident reports identified an increasing number of patient deaths associated with unread

EKGs, often taken before a patient's diagnostic or surgical procedure or in the emergency room. Invariably, these EKGs indicated serious cardiac problems (ischemia, myocardial infarction, arrhythmia) but, unfortunately, they were read after the patient's death. Had the EKGs been interpreted prior to the scheduled procedure or before the patient was discharged from the emergency room, the resultant deaths might have been prevented. The Update, distributed in September, 2000, alerted hospitals to this growing problem and recommended that relevant procedures be reviewed and, if necessary, reinforced or revised.

During 2000, the Committee and staff worked on a project involving the review and assessment of the PCA regulations as they relate to the Board's enforcement authority over health care facilities whose PCA programs are not functioning adequately. Committee members and staff, with input from the state's Attorney General's Office, continue to work on drafting and promulgating regulations that will clarify the steps to be taken when a facility's PCA program is found to be seriously lacking.

Lastly, the Board's PCA function received both local and national attention during 2000. Much of this attention was initiated by a report entitled, "To Err is Human: Building a Safer Health System," released in November, 1999 by the National Academy of Sciences' Institute of Medicine (IOM). This report, covered widely in the press, discussed issues of patient safety and presented national estimates of deaths due to medical errors. Massachusetts was credited as being one of the states in the forefront of the issue; Lucien Leape, M.D., one of the authors of the IOM report, was quoted as citing the Board's PCA function as a possible national model for patient safety programs.

Three days following the release of the IOM report, the Boston Globe published an "op-ed" piece, entitled "Improving the Fitness of Massachusetts Hospitals,"

written by two members of the PCA Committee, Dr. Mary Anna Sullivan, then chair of the Board, and Dr. Arnold Relman, chairman of the Committee. The piece discussed how quality in U.S. hospitals was currently being monitored and certified and talked about the approach developed by the PCA function. As stated in the piece, *"The advantage of the Board of Medicine's PCA program in Massachusetts is that it puts the responsibility for quality of medical care squarely where it belongs, in the hands of the professional staff of each hospital, but uses the legal authority of the Board…to ensure that hospitals do their job."*

In early 2000, Dr. Relman and staff received a number of calls from Senator Edward Kennedy's staff seeking information about the PCA function. In February, Senator Kennedy asked Dr. Relman to testify before the U.S. Senate's Health, Education, Labor and Pensions Committee and its Committee on Appropriations in Washington, D.C. In his testimony, Dr. Relman discussed patient safety, medical errors, and the PCA experience in Massachusetts.

Copies of recently released PCA updates and guidelines are included as an attachment to the 2000 Annual Report.

Physician Health and Compliance Unit

The Physician Health and Compliance Unit (PHC) was established in 1993 to address the issue of physicians with chemical dependency problems. Since that time, the PHC Unit's role has expanded to include a review of physicians with mental illness, physical illness and behavioral problems. Since an estimated one third of the Board's disciplinary cases involve physicians dealing with impairment issues, procedures have been established that reduce the risk of patient harm. Toward this end, the PHC Unit reviews physician self-reports and statutory reports of mental or physical conditions that may impact the physician's ability to practice medicine.

The Board has established both disciplinary and non-disciplinary procedures, which may permit a physician who is participating in on-going recovery to return to the practice of medicine under a structured monitoring agreement which contains sufficient safeguards such as clinical and sobriety monitoring to protect the public. The PHC Unit assists with the negotiation of agreements, and addresses probationary issues such as modification, termination or violation of probation. In addition, the PHC Unit monitors compliance with the terms of non-disciplinary and disciplinary agreements that can include provisions for treatment programs as well as requirements for continuing education programs or community outreach programs. The PHC Unit also advises the Board on policy issues and works with agency staff on questions involving impairment and probationary matters.

Category	Number of Physicians
Monitoring/Probation Agreements	108
Self-Report Evaluations License Renewal Applications	41
New License Applications	23
Noncompliance Reports from PHS/UMMC	30

Report of the Committee on Acupuncture

The Committee on Acupuncture (COA) works in cooperation with the Board of Registration in Medicine to regulate the practice of acupuncture. The COA's functions include setting standards for acupuncture licensure and practice through 243 CMR 4.00 and 243 CMR 5.00 (the acupuncture regulations), approving acupuncture schools and training programs, reviewing applications for licensure, setting standards for safe practice, disciplining acupuncturists who engage in misconduct and interpretation of the regulations and/or discussion on any relevant issues. The COA meetings, which are open to the public, are held every 3 months at the Board of Registration in Medicine. The Acupuncture Unit aids the COA in its work; in addition to providing assistance to the COA, the Unit handles issues relating to acupuncture raised by the public and licensees, and works with the Legal and Disciplinary Units within the Board on matters involving acupuncture.

The COA worked on revising and updating the *Guidebook to the Practice of Acupuncture in Massachusetts*, which is a book designed to inform licensees of the laws and regulations governing the practice of acupuncture. The COA did a mass mailing to all licensees consisting of three letters; 1) Advertising as an M.D. in China; 2) Advertising Herbal Education; and 3) Safe Office Procedures.

The Chairman of the Committee on Acupuncture, John G. Myerson, Ph.D., Lic.Ac., traveled to San Francisco, California in May 2000 and to Washington, DC in November 2000 to attend the Federation of Acupuncture and Oriental Medicine Regulatory Agencies (FAOMRA) meetings. This organization provides a resource through which state boards and state regulatory agencies can communicate and share information amongst themselves, the acupuncture profession and the public at large.

Licensing and Disciplinary Statistics for the Committee on Acupuncture - 2000

Total Number of Licensees	Licenses Issued in 2000	Total Number of Disciplinary Actions in 2000
848 *	82	6 **

*** Total number of licensees (July 7, 1988 to December 7, 2000)**
**** One Summary Suspension and 5 dismissed complaints**

Licensing Division's Report

Report of the Licensing Director - *Rose Foss*

The Licensing Division has an important role in protecting the public as the "gatekeepers" of medical licensure. This is accomplished by conducting an in-depth investigation of a physician's credentials before forwarding the application to the Board for issuance of a license to practice medicine independently in the Commonwealth of Massachusetts. Applicants are required to have completed medical school training and received an M.D. or D.O. degree. U.S. and Canadian graduates are required to have completed at least 4 years of medical school training. International medical graduates are required to have completed at least 6 years of medical school training. In addition to medical school training, a physician must also pass qualifying examinations and complete a specific number of years of postgraduate training in an accredited training program. An attestation of good moral character from another licensed physician who has known the applicant for at least two years is also required.

Information provided by the physician and other sources, is entered in the Consolidated Licensing And Regulation Information System (CLARIS). The licensing staff conducts a careful analysis of all documents and cross-references information with other agencies such as the Federation of State Medical Boards for disciplinary actions in other states, the National Practitioner Data Bank for malpractice and healthcare disciplinary actions, as well as the Health Care Integrity and Protection Data Bank (HIPDB) for information on fraud and abuse in health care insurance and health care delivery. The American Medical Association's AMA Profile is also utilized as a secondary source for verifying medical school training, postgraduate training, board certification status and other states where a physician has ever held a medical license. Following completion of the documentation and verification process, the full

license application is forwarded to the Board for approval and a wallet card is issued.

The licensing procedure is similar for a limited license applicant. A limited license is issued to a physician who is participating in a residency program in the Commonwealth under the supervision of the director of a training program. Because the physician will not be practicing medicine independently, the documentation requirements for a limited license are less intensive.

The Board continues its surveillance of a licensee by requiring biennial license renewal. On completing the license renewal application, a physician must answer questions relevant to malpractice, legal issues, loss of licensure or disciplinary actions and health and impairment issues. If issues are uncovered, the information is forwarded to the Board's Data Repository Counsel for follow-up.

2000 Accomplishments

CLARIS ENHANCEMENTS

With the implementation of the CLARIS system, we have revolutionized our ability to assimilate, correlate and report on data vital to the licensing process. CLARIS provides the source data that fuels the highly regarded and widely used Physician Profiles system and provides reporting capabilities that have simplified and streamlined the licensing process. Structured data fields provide us the ability to perform data mining and analysis that was once impossible without manual data analysis. CLARIS has the potential for opening new frontiers in licensing and is the vehicle that will allow broader access to data for physicians, healthcare facilities and consumers online. The Board approved funding in FY 2000 to customize CLARIS with some vital enhancements to meet the Licensing Division's needs. However, additional funding is necessary to continue developing CLARIS into a state of the art licensing system and expand its capability for capturing pertinent information.

WEBSITE ACCESS FOR LICENSING

Various license forms and renewal information are available on the Board's web site to meet the needs of our consumers. Physicians may download these items from the web site, including a waiver form for state license verification, forms for status changes from inactive to active status, a form for requesting a CME waiver, instructions for license renewal and continuing medical education requirements, as well as resources for obtaining category 1 and category 2 credit hours.

Licensing Division Goals for 2001

In conjunction with the Office of Consumer Affairs & Business Regulations, the Licensing Division will play a lead role in designing a process whereby physicians can update changes in addresses, hospital affiliations and other pertinent demographic information using the Board's website. This information will update CLARIS – which supplies data to generate a Physician Profile. Implementation of on-line access for demographic changes will significantly reduce the thousands of paper requests for demographic changes that are currently processed manually.

The Licensing Unit also plans to provide Internet access for completing on-line license applications. This will enable a physician applying for a full or limited license to enter all demographic information on-line. The information will then be electronically transferred to CLARIS and thus will eliminate the handling of paper and reduce the labor-intensive data entry process. The success of this project relies on the appropriation of funding by the Board.

Finally, the Licensing Unit plans to revise the Board's licensing regulations, 243 C.M.R. 2.00 to improve and streamline the licensing process. One of the most important regulation revisions that will have the greatest impact on the licensing process is to extend the time limits for expiration of an initial limited license from one year to three years. At the present time, a limited license expires at the end of the

academic year and must be renewed every year while the physician is continuing in the same training program. Extending the duration of a limited license for three years will significantly reduce redundancy and the workload of the Licensing Division and training programs who must process between four and five thousand limited renewals between March and June every year. It is vital to our consumers to ensure that the residency and fellowship programs in the Commonwealth are adequately staffed by the beginning of the academic year on July first. The Massachusetts General Laws for temporary licensure and license requirements for Canadian graduates will also be included in the revision process.

2000 Licensing Statistics

Category	2000 Statistics	1999 Statistics
Initial Full licenses	1, 642	1, 670
Full Renewals *	6,331	21,141
In process 12/31/2000	340	321
Initial Limited Licenses	1,384	1,509
Limited renewals	2,591	3,246
Limited applications in process	31	36
Temporary (initial) Licenses	6	10
Temporary renewals	7	7
Licenses Verifications Processed	5,074	6,420
Copies of renewal applications	805	867

** Physicians renew bi-annually.*

Attachments

PCA Updates Released in 2000

PCA UPDATE

UNREAD ELECTROCARDIOGRAMS

September, 2000

The Patient Care Assessment (PCA) Committee of the Massachusetts Board of Registration in Medicine has seen a number of major incidents involving undiagnosed cardiac disorders because of a delay in reading electrocardiograms (EKGs). In these incidents, the EKGs were not read or seen by the treating physicians until after the patient died. Reported cases include pre-operative EKGs indicative of ischemia not read until after the patient's post-operative death, emergency room EKGs not read until after the patient's discharge and death, and routine admission EKGs taken on a general floor but not read until after the patient's death.

These incidents are of two general types: (1) the abnormal EKG was in the medical record but no physician read it, or (2) the abnormal EKG was not in the record or reported to the responsible physician.

The PCA Committee is not prescribing how this problem should be prevented; that is the responsibility of each health care facility's medical staff. The purpose of this Update is simply to alert facilities that this problem is prevalent, and to recommend that you review your relevant procedures and revise them if necessary.

Members of the PCA Committee

Arnold S. Relman, M.D., Chairman
Rafik Attia, M.D.
Mary Anna Sullivan, M.D.
Hart Achenbach, M.D., Volunteer Consultant

PCA UPDATE

RADIOLOGY COVERAGE IN EMERGENCY ROOMS

June, 2000

The Patient Care Assessment (PCA) Committee of the Board of Registration in Medicine is concerned about problems that have resulted from the misreadings of plain films taken on patients being seen after hours in the emergency rooms (ERs) of hospitals, when contemporaneous interpretations by qualified radiologists are not routinely available. Serious clinical outcomes from such misreadings unfortunately have occurred.

The Committee believes that ideally all radiologic studies taken on ER patients should be promptly interpreted by radiologists. This could be achieved by appropriate radiology staff coverage in-house on a twenty-four hours per day/seven days per week ("24/7") basis, or by the use of teleradiologic technology to supplement standard hours of coverage. We recognize, however, that current limitations of resources may make this an unrealistic immediate goal.

We recommend that all hospitals with emergency services give this matter careful consideration and move towards the desired goal as quickly as resources permit. In any case, all hospitals should be continuously monitoring the interpretations of X-rays by ER physicians, and comparing them with the later official readings by radiologists. Discrepancies should be promptly identified, discussed and corrected. We also recommend that current radiology staff coverage in all hospitals include 24/7 availability on a thirty-minute on-call basis whenever ER physicians request special diagnostic procedures or need help with interpretations of plain films. We remind all hospitals that they have a continuing responsibility to report any serious, unexpected adverse events related to the misreading of X-rays.

The PCA Committee appreciates the assistance of the Massachusetts Radiological Society (MRS) in developing this PCA Update. The MRS supports the goal of prompt interpretation of ER imaging studies by qualified radiologists and is ready to serve as a resource to Massachusetts hospitals and physicians in understanding and implementing methods to achieve that goal.

Members of the PCA Committee

Arnold S. Relman, M.D., Chairman
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