CONTENTS

QUOTE 1

INFORMATION FOR AUTHORS 2

LETTERS 3

MESSAGE FROM THE CHAIR 6

EDITORIAL

PROTECTION OF THE PUBLIC, *Nancy Kerr* 8

PROFESSIONAL BOUNDARY VIOLATIONS BY PHYSICIANS, *Glen O. Gabbard, M.D., Melissa Martinez, M.D.* . . 10

THE IMPACT OF A PATIENT SAFETY PROGRAM ON MEDICAL ERROR REPORTING, *Donald R. Woolever* . . . 16

THE INTRODUCTION OF CLINICAL SKILLS ASSESSMENT INTO THE UNITED STATES MEDICAL LICENSING EXAMINATION (USMLE): A DESCRIPTION OF USMLE STEP 2 CLINICAL SKILLS (CS), *Richard E. Hawkins, M.D.* 22

FROM OUR INTERNATIONAL EXCHANGES 26

FROM OUR MEMBER BOARD EXCHANGES 34

MEDICOLEGAL DECISIONS 42

JOURNAL OF MEDICAL LICENSURE AND DISCIPLINE

Published Continuously Since 1915
Volume 91 Number 3 2005

The Journal of Medical Licensure and Discipline (ISSN 1547-48IX, publication number 189-120) is published quarterly by the Federation of State Medical Boards of the United States Inc., P.O. Box 619850, Dallas, TX 75261-9850
Telephone: (817) 868-4000
Fax: (817) 868-4098
Periodicals postage paid at Euless, Texas, and additional mailing offices.

Postmaster
Send address changes to the *Journal of Medical Licensure and Discipline*, P.O. Box 619850 Dallas, TX 75261-9850

Subscriptions and Correspondence
Subscriptions and correspondence about subscriptions should be addressed to the *Journal of Medical Licensure and Discipline*, P.O. Box 619850, Dallas, TX 75261-9850. Subscriptions for individuals are $70 per year; single copies are $18 each. Subscriptions for libraries and institutions are $140 per year; single copies are $36 each. Notification of change of address should be made at least six weeks in advance. Enclose new and old addresses, including ZIP code.

Submissions
Manuscripts, letters to the editor and other materials to be considered for publication should be addressed to:

Editor
Journal of Medical Licensure and Discipline
Federation of State Medical Boards
P.O. Box 619850, Dallas, TX 75261-9850
Submit by e-mail to: epittman@fsmb.org

"Let us not look back in anger or forward in fear, but around in awareness."

— *James Thurber*

INFORMATION FOR AUTHORS

The Editorial Committee accepts original manuscripts for consideration of publication in the *Journal of Medical Licensure and Discipline*. The *Journal* is a refereed journal, and all manuscripts are reviewed by Editorial Committee members prior to publication. (The review process can take up to eight weeks.) Manuscripts should focus on issues of medical licensure and discipline or related topics of education, examination, postgraduate training, ethics, peer review, quality assurance and public safety. Queries and manuscripts should be sent by e-mail to epittman@fsmb.org or by mail to:

Editor
Journal of Medical Licensure and Discipline
Federation of State Medical Boards
P.O. Box 619850
Dallas, TX 75261-9850

Manuscripts should be prepared according to the following guidelines:

1. An e-mail or letter should introduce the manuscript, name a corresponding author and include full address, phone, fax and e-mail information. The e-mail or letter should disclose any financial obligations or conflicts of interest related to the information to be published.
2. The title page should contain only the title of the manuscript. A separate list of all authors should include full names, degrees, titles and affiliations.
3. The manuscript's pages should be numbered, and length should be between 2,750 and 5,000 words, with references (in Associated Press style) and tables attached.
4. The manuscript should include an abstract and between 5 and 10 keywords to aid online referencing. The abstract should be 200 words or less should describe the purpose of the study, the main finding(s) and conclusions. Footnotes or references should not be included in the abstract.
5. Any table or figure from another source must be referenced. Any photos should be marked by label on the reverse side and up direction noted. Tables and figures can be supplied in EPS, TIF, Illustrator, Photoshop (300 dpi or better) or Microsoft PowerPoint formats.
6. The number of references should be appropriate to the length of the text, and references should appear as endnotes, rather than footnotes.
7. Commentary, letters to the editor and reviews are accepted for publication. Such submissions and references should be concise and conform to the format of longer submissions.
8. If sent by mail, a PC- or MacOS-compatible CD-ROM should accompany a printed copy of the manuscript. Microsoft Word format is the preferred file format.
9. Manuscripts are reviewed in confidence. Only major editorial changes will be submitted to the corresponding author for approval. The original copy and disk will be returned if the submission is not accepted for publication and a SASE is supplied with sufficient postage.

PERSPECTIVES ON PAIN MANAGEMENT

As a longtime associate and courtesy member of FSMB, lecturer at FSMB conventions and an exhibitor for the past two years on "Mini-Residency in Appropriate Prescribing" (MRAP), a DVD course on pain management and addiction) published by the University of Medicine and Dentistry of New Jersey, I am dismayed over "Guidelines For Medical Board Investigators And Medical Board Consultants Dealing With Distressed Pain Medical Practices" by David G. Greenberg, M.D., M.P.H., published in the Volume 91, Number 2, issue of the *Journal*.

While I understand articles do not necessarily reflect the policies of FSMB, I cannot figure why the editorial staff and/or peer reviewers allowed the gross misstatement of facts, the distortion, if not decimation of the wonderful work that FSMB published as *The Model Guidelines (now Policy) for the Use of Controlled Substances for the Management of Pain*. As an invited addictionologist/pain manager panelist and lecturer in 1997 in Dallas, Texas, I gave input and promise of teaching physicians how to properly prescribe analgesics, avoid under-prescribing and over-prescribing leading to injury, addiction and license sanctions. This led to your *Model Guidelines* of 1998.

Dr. Greenberg erroneously states (pages 7 and 8) that "long-acting drugs can be as much as 80 mg oxycodone taken 3-4 times a day. The 'new maximum' amount to be taken per day is 240-320 mg." This is all from "the author's experience." Where is his research or bibliography that sustains this "experience" in light of the product description of the three companies that are manufacturing and distributing long-acting or extended release oxycodone? These drugs have not had their dosage frequency changed or suggested by the Food and Drug Administration (FDA) or the Drug Enforcement Administration (DEA). Many patients need more than 80 mg every 12 hours to quell their pain. Rescue, or breakthrough, short-acting opioid analgesics are appropriate if the long-acting drug doesn't sustain analgesia for the full 12 hours. But, if the [patient] needs rescue doses more than two times throughout the day, it indicates that the long-acting strength is too weak. Then the physician needs to prescribe a higher strength long-acting strength every 12 hours to keep the real pain patient comfortable while eliminating the short acting rescue dose of an opioid. This process can be repeated if the patient develops more pain or becomes tolerant to the opioid drug.

What literature, doctrine, research statistics, FDA, DEA or manufacturers state there is any "maximum" opioid dose, or support Dr. Greenberg's statement that 240-320 mg is the "new maximum"? In fact, there is no limit on opioid doses unless intolerable side effects occur. This is one of the basic tenets of modern age pain management with opioids that was completely misunderstood until the past 15 years and understood and clarified finally by this organization's own basic concepts to physicians and their licensing boards.

If the dosing needs changing, the FDA, after careful scrutiny and scientific studies, must notify the manufacturer to change the published product description, journal advertising, etc. It is entirely within the good practice of pain management to give reasonable rescue doses up to a reasonable strength and frequency during a 24-hour period.

What message is being taught by this abstract and sent around the country by Dr. Greenberg from his pain clinic in Arizona? While everyone has a right to his opinion, I would think that FSMB should want and need to know where this doctor's substantiated medical and scientific records warrant his published report in your journal and with whom did your editorial review panel consult since this is supposed to be a refereed publication. Has there been any consensus amongst responsible certified pain management physicians regarding this type of aberration from the acceptable standard of care practiced by the responsible segment

of physicians in the United States? If so, where is this documented study by which all physicians and patients might benefit?

What message does this abstract send to the consortium of state medical and osteopathic boards that read this article and then judge physicians' prescribing patterns? Is this the adherence to the acceptable standard of care that FSMB's *Model Policy* wants the boards to adopt? Does this clarify or further confuse the analgesic prescribing problem in the U.S. for the practicing physicians or their state boards? I think the latter is more likely to occur!

Sincerely,
William Vilensky, D.O., R.Ph.
Executive Medical Director
Forensic and Educational Consultants

The author replies:

I found it most heartening and gratifying that the sole criticism of my recent article by my colleague, Dr. Vilensky, was based entirely upon his misunderstanding of a common and proper use of quotation marks in the English language. He argues that I have arbitrarily set some sort of new official upper limit as to how much of the drug oxycodone may be prescribed. Nothing could be further from the truth, as my article is simply a proposed guide for investigators and consultants. Dr. Vilensky is specifically concerned with the portion of my article's 4th paragraph which reads: 'A common current Rx for severe pain with the new "long-acting" drugs can be as much as oxycodone 80mg taken 3 to 4 times per day. The new "maximum" amount to be taken per day is 240 to 320mg.' One of the several uses of such double quotation marks in our language is to draw the readers' attention to the fact that a word or phrase is being used in a special or peculiar way meaning something other than its normal use, and is often ironic.[1,2] Armed with this basic information concerning ordinary written English, the readers of my article are instantly and forthrightly assured that in no way am I declaring any sort of official scientific maximal dose. As one can easily see, the quotation marks enclosing the words "long-acting" and "maximum" are in the correct format to warn the reader that they are indicating the words within them are being used in a special and possibly ironic sense and not in their usual orthodox literal sense. Taken in the context of my article's preceding paragraph, it is indeed even more clear that I was commenting on past and current trends of pain practitioner prescribing over time and not claiming to be setting the new national standard for medical science.

Dr. Vilensky's letter contained concerns about my experience. Briefly, my training and experience in the field of chronic pain medicine began with an anesthesiology residency program, where during 1979-1981 I was able to study chronic pain, manage complex patients in the large University of Arizona and Tucson VA pain clinics and perform multiple nerve blocks. In addition to this, I subsequently served six years as the medical director for an active interdisciplinary pain clinic serving approximately 250,000 members of the largest HMO in Arizona. I have performed thousands of pain prescribing evaluations and investigations during my 21-year history of working for medical boards and other health care entities. I have worked for the Arizona Medical Board in the capacities of consultant, investigator, chief medical investigator, assistant executive director and currently serve as a contract medical director involved in substance abuse investigations, chronic pain investigations, physician monitoring programs, investigator training and liaison work with the DEA and other agencies. Since ASAM certification in 1987, I've successfully worked in many addiction treatment and monitoring positions. My experience has revealed that chronic pain prescribing activities are all too often, unscientific and dangerous to both patients and society, while at the same time placing unethical financial burdens on our medical system. Many distressed pain practitioners' only qualifications are an active state license and a current DEA registration. In many such situations, these hapless practitioners' only source of clinical and prescribing information turns out to be that provided by their patients or the distributors of "long-acting" narcotic preparations.

In closing, unqualified, self declared, "pain specialists," who only desire to become wealthy conduits for controlled substances, threaten us all. These predatory doctors, posing as compassionate souls, are all too often in a symbiotic relationship with drug abusers and diverters. By inciting a pain backlash, they could jeopardize legitimate narcotic prescribing so necessary for helping millions of pain patients. We must effectively deal with these dangerous prescribers or risk destroying two decades of progress that presently allow for the full compassionate use of narcotic drugs to relieve suffering.

Sincerely,
David G. Greenberg, M.D., M.P.H.

REFERENCES

1. http://webster.comnet.edu/grammar/marks/quotation.htm.
2. *American Medical Association Manual of Style*, 9th ed., 1998.

EMERGING TRENDS

I read with great interest the excellent article, "Emerging Trends in the U.S. Physician Workforce's Implications for Licensure and Professional Standards," by Robert M. Galbraith, M.D., M.B.A., and Stephen G. Clyman, M.D., (published in the Volume 91, Number 1, issue of the *Journal*). The authors comment that an expansion of entering class size in Liaison Committee on Medical Education (LCME)-approved schools might simply allow more enrollments of international medical graduates is no doubt true. They thus conclude that there might be no net workforce gain if such physicians are already coming here. However, this does not take into consideration the possibility of increased applications from the many who currently do not pursue medicine as a career or who else drop it as an option in college for a number of reasons. Foremost among the latter is the difficulty of obtaining admission where the ratio of applicants to acceptances has been as high as 3:1.

The authors mention that roughly one-fourth of physicians annually entering the U.S. workforce graduate from non-LCME foreign medical schools, and appropriately refer to the reservations that have been raised about IMG education since it lies outside of the U.S. accrediting and monitoring systems. Yet the reality is that the LCME is, in point of fact, only monitoring the quality of the medical school education of 75 percent of the physicians annually entering the U.S. workforce. It is not monitoring the quality of the medical school education of the remaining 25 percent.

I would have liked to have seen the authors expand their discussion of this important issue because it raises serious questions about the adequacy of USMLE alone as providing protection for the public. Expanding the global numbers of LCME-accredited medical school graduates is an obvious solution. However, there has long been resistance to doing this because of a number of factors including cost, a sense that projecting manpower needs is an imprecise science, and a concern that increasing physician numbers will escalate medical care costs. Meanwhile, we have by default put in place an intellectually inconsistent policy. It is one in which the graduates of LCME-accredited medical schools are individually assessed through USMLE and their schools monitored through the LCME accreditation process. It is also a policy in which IMGs are individually assessed through USMLE but their medical schools never monitored nor assessed by the LCME. This is somewhat analogous to the Food and Drug Administration (FDA) assessing only 75 percent of approved drugs through its approval process and using some other mechanism to assess the 25 percent not subjected to the approval process.

Pascal James Imperato, M.D., M.P.H. and T.M.
Former Chair
New York State Board for Medicine

MESSAGE FROM THE CHAIR

TIMELY DATA-SHARING ESSENTIAL DURING TIMES OF DISASTER

Lee E. Smith, M.D., *Chair, Federation of State Medical Boards*

In times of crisis, perhaps the most important component to public safety is reliable information. A steady flow of trustworthy information can keep crucial systems running in the midst of chaos. I am proud to say the state medical board community did just that when it rallied to the aid of the Louisiana State Board of Medical Examiners in the wake of Hurricane Katrina.

As the magnitude of the devastation became apparent, many member boards sprang into action to meet the enormous health care challenge created by Katrina. Boards helped coordinate groups of volunteer physicians moving into areas affected by the disaster, while simultaneously scrambling to handle the flood of an estimated 6,000 displaced doctors who fanned out across the country. Many boards quickly developed expedited temporary licenses, enabling Gulf Coast doctors to quickly resume providing medical care again – often to the patients they had followed out of the devastated region.

On a national level, the FSMB and Administrators in Medicine collaborated in swiftly establishing an emergency round-the-clock system to verify the licensure of Louisiana physicians to state medical boards, disaster aid facilities and hospitals. This system, which operated throughout September, verified the licenses of more than 1,200 displaced doctors, enabling them to be quickly available for hurricane victims both in and outside of Louisiana. The value of the Federation Credentials Verification Service (FCVS) also shone through during the crisis. Because their core medical credentials were stored in FCVS' central repository, scores of doctors who were unable to retrieve their credentials during Katrina were able to verify their credentials simply by having medical boards contact FCVS.

You may be unaware of the wide array of services FSMB can provide to state boards during a time of emergency: This includes restoring the hard copies of any disciplinary files, electronic data or data elements such as licensure files — all items submitted by boards to the FSMB. Also, FSMB staff and resources can be provided to process license applications, coordinate the resources of the state medical board community to provide maximum support to affected boards, and assist with communications to physicians and physician assistants.

In addition to expediting verifications for emergency workers and displaced physicians, FSMB can help minimize the opportunity for credentials fraud. In conjunction with the licensure verification system, boards can receive expedited credentials verification for displaced physicians who used FCVS. FSMB also has recently completed a pilot project with the Centers for Disease Control and Prevention (CDC) to assist CDC in providing critical information to physicians in the event of a public health emergency.

The Katrina disaster dramatically illustrates the importance of comprehensive and consistent data sharing among the member boards of FSMB. Thankfully, the Louisiana State Board of Medical Examiners had sent FSMB's All Licensed Physicians database a complete file update of their licensees in late July – ensuring the verifications subsequently provided to member medical boards, clinics and hospitals in the wake of the hurricane were up-to-date and accurate.

It is imperative for the safety of the public that all boards regularly supply FSMB with their most complete, up-to-date information, preferably every 30 days. This will enable FSMB to maintain, on behalf of all 70 member boards, a complete, centralized repository of physician information that can be accessed by those who need it, if

and when disaster strikes in the future. As protectors of the public, it is our duty to be ready to respond immediately in times of crisis. The lives of the patients we have sworn to protect depend upon it.

EDITORIAL

PROTECTION OF THE PUBLIC

Nancy M. Kerr, *Executive Director, Idaho State Board of Medicine*

When asked by legislators or the members of the public regarding the function of medical boards, our reply is always protection of the public. As medical regulatory boards we are mandated to protect the public through licensure, the prevention of unlicensed practice, through regulation of licensees and the discipline of those licensed by our agencies.

The licensure process is a purely proactive process. Before we allow practice in our respective states we verify all aspects of education and training. We assure entry level competency with the passage of standard national examinations, which now includes a clinical skills assessment. We verify safe practice with our sister states by verifying the licensure and discipline status of the applicant. The process is fairly standard across the United States for graduates from domestic medical schools.

In recent years, I have been fortunate to see great strides being taken to ensure that a level of competency is being maintained throughout the span of an individual's licensure. The American Board of Medical Specialties (ABMS), in conjunction with the Federation of State Medical Boards (FSMB), has taken a giant leap in providing a level of assurance to the public that a license to practice medicine provides the public with the assurance that professional competence is evaluated and maintained throughout the span of an individual's professional career — through continued competency programs that include not only knowledge assessment through testing, but also a component to assure that clinical skills are maintained.

At the state level, we are offered a tool to evaluate the licensee's level of competence and training on an ongoing basis through the specialty board certification process — a proactive measure to again provide the public a level of assurance and protection through periodic evaluation of the licensee.

The regulation aspect or discipline on the other hand is an entirely different process.

At the state level we are required to prove a pattern of substandard practice in order to then be able to protect the public by limiting or restricting a license until remediation through education or training is obtained, or in some extreme cases, revocation of a license that is beyond remediation or has failed remediation.

In this arena of regulation and discipline we at the state level are almost purely operating in a reactive mode. We are dependent on the public to bring us their concerns and complaints and help us identify any problems in the practice of one of our licensees. In short, some adverse event has usually had to occur before the board can act to protect the public from further harm.

The investigation process is typically driven by an event, usually a complaint from a patient, another regulatory agency or a hospital advising the board of an adverse event regarding a licensee. The board then begins an investigation into the event, determines its authority to act, the nature of the event, the best outcome for involved individuals, what remediation is most appropriate and then the board acts. The rights of the licensee to due process are maintained throughout the discipline process.

The process takes time, personnel and funds that historically underfunded and undermanned boards perform with remarkable efficiency in most cases.

What if there was another approach to public protection?

As a driver on a public highway system, I understand I may be stopped if driving erratically or checked randomly at a check point and subject to a number of tests to assure I was

not, in fact, driving under the influence of drugs or alcohol. While I am aware I do not drink and or use drugs, I have displayed a behavior indicating there may be a problem, a performance indicator of a potential problem. The only way to make a determination if there is an actual problem is to investigate.

In 2002, following a Performance Evaluation by the legislature, the Idaho State Board of Medicine adopted rules allowing investigation based not on a violation of the Idaho Medical Practice Act, but on performance indicators. A proactive investigation, if you will.

The performance indicators were adopted from the FSMB guidance at the time and include behaviors or characteristics that may indicate a potential problem.

The indicators include, but are not limited to:

a. Frequent changes in geographical location
b. Number of inactive licenses held
c. Number of malpractice complaints
d. Number of complaints
e. Failure to obtain specialty board certification
f. Changes in area/specialty without formal retraining
g. Health status
h. Age
i. Prescribing practices
j. Physicians without hospital privileges or medical practice affiliation who are not routinely subject to peer review
k. Physician performance and outcome data received from sources such as Professional Review Organizations
l. Disciplinary reports from managed care organizations
m. Disciplinary reports by other government agencies

It is not the intent of the rules to seek out and discipline individuals who may have a problem, but, instead, to use the performance indicators to identify potential problems and avert an adverse action for the public and the physician in as many instances as possible. The Idaho State Board of Pharmacy and the Idaho Board of Medicine have a cooperative relationship. The pharmacy board refers suspicious or concerning prescribing practices to the medical board. The medical board is then able to review the care, appropriateness of the prescribing and intervene with education and or training where possible.

The Idaho Board of Medicine also reviews malpractice complaints and is able to obtain information relating to many of the indicators on renewal information and agency reports the board receives. The board may now investigate on the basis of these performance indicators instead of a violation of the Medical Practice Act or rules. It no longer has to wait for the adverse event to occur, but may investigate a physician's practice proactively based on these performance indicators.

I would love to be able to say the board is able to review all the performance indicators for each licensee of the board and take some proactive measure before an adverse event occurs, but I cannot. Like most other boards, the Idaho State Board of Medicine lacks the investigative staff, and funds to be able to fully implement and monitor the performance indicators. But the Idaho State Board of Medicine does now have another powerful tool to use in its mission of public "protection."

PROFESSIONAL BOUNDARY VIOLATIONS BY PHYSICIANS

Glen O. Gabbard, M.D.

Melissa Martinez, M.D.

ABSTRACT

Boundary violations by non-psychiatric physicians have received relatively little attention in available literature. In this report, the authors reviewed 100 cases of professional boundary violations identified in physicians undergoing outpatient psychiatric evaluation. They included boundary violations with a patient, boundary violations with non-patients, such as family members, employees, and co-workers, and prescribing/treating irregularities. Fifty-three of the physicians had engaged in sexual boundary violations with patients. Twenty-two had engaged in sexual boundary violations with non-patients. Eighteen of the physicians had non-sexual violations involving financial matters, social relationships, confidentiality and other transgressions. Twenty-six of the 100 were involved in some type of prescribing/treating irregularity. Fifty-two percent of the physicians sampled met criteria for an Axis II personality disorder, 17 had a substance abuse diagnosis, and 13 had a paraphilia or sexual disorder. The implications of these findings are discussed in a context relevant to ethics and regulatory bodies.

INTRODUCTION

With the widespread recognition that the Hippocratic oath offers no insurance policy against professional misconduct by physicians, the problem of professional boundary violations in medical practice has received increasing attention. Although variously defined, professional boundaries may usefully be considered as "the parameters that describe the limits of a fiduciary relationship in which one person (a patient) entrusts his or her welfare to another (a physician) to whom a fee is paid for the provision of a service".[1] Although sexual misconduct with patients is perhaps the most egregious and most widely publicized example of professional boundary violations, a variety of other problematic behaviors also require attention. The Massachusetts Board of Registration in Medicine has even issued detailed guidelines on professional boundaries of both sexual and non-sexual types.[2] These guidelines apply only to physicians practicing psychotherapy and thus are less readily applicable to other specialties.

Boundary violations of non-psychiatric physicians have received less systematic elaboration. Physician behaviors may violate boundaries if they exploit the patient's dependency on the physician.[1] These behaviors include sexual relationships, business transactions, large gifts, denigrating language, mishandling of fees, misuses of the physical examination, some types of physical contact and prescribing irregularities that involve dual relationships (where prescriptions are written for employees, family members, oneself, or persons for whom there is no medical record or doctor-patient relationship). Some professional boundary violations do not exploit patients, but involve the treatment of employees, nurses or other allied health professionals in ways that are sexually harassing or otherwise disrespectful of personal space.

In a report on 375 physicians licensed by the Medical Board of California that examined records of discipline from October 1995 to April 1997, 465 separate offenses were identified.[3] The most common involved incompetence or negligence and abuse of alcohol or other drugs. However, professional boundary violations involving inappropriate prescribing practices (11 percent) and inappropriate contact with patients (10 percent), were in third and fourth place, respectively. Despite the widespread frequency of this type of professional misconduct, the varieties of professional boundary violations seen in a clinical context have not been well described. In this article we seek to characterize a large series of boundary violations by physicians in the clinical setting of outpatient and/or inpatient evaluations. Only a subgroup of these came to the attention of licensing boards and resulted in discipline.

METHOD

Since the late 1980s, the senior author has conducted outpatient or inpatient evaluations of physicians and other professionals, first at the Menninger Clinic in Topeka, Kan., and subsequently at the Baylor Psychiatry Clinic at the Baylor College of Medicine in Houston, Texas. Patients have been referred for these multi-disciplinary, three-day outpatient evaluations from many different states and from Canada.

In preparation for this report, we reviewed 159 records of these evaluations and identified professional boundary violations in 100 of the physicians. In our systematic review of these cases involving violations, we recorded basic demographic data, including date of the evaluation, referral source, age, gender, specialty, years in practice and practice setting. This latter category was divided into four categories: private practice, academic, public sector/military and training program. The physician's cultural background was also recorded. In addition, the following clinical information was also documented: type of boundary violation, presence or absence of substance abuse and Axis I and Axis II psychiatric diagnoses.

The sample was limited to those physicians with a M.D. or D.O. degree. Years of practice included all years of post-medical school, including training programs. Professional boundary violations were defined as they are in the introduction to this communication. We included prescribing irregularities where the person being treated was also a family member or employee who may or may not have paid for his service. Also, where physicians prescribe for people with whom there was no medical record or a doctor-patient relationship established, a professional boundary violation was deemed to have occurred. Finally, physicians prescribing for themselves were regarded as blurring professional boundaries as well. Substance abuse referred broadly to both alcohol and drugs, whether street drugs or prescription drugs. Sexual harassment was considered part of professional boundary violations where there was a hierarchical relationship between the physician and the target of the harassment, whether employee, student or co-worker.

Simple incompetence or negligence was not regarded as a boundary violation. Similarly, irresponsibility, characterized by failing to return calls or poor charting, was not included. Finally, physicians who exploded in anger or committed fraud in terms of billing practices did not meet criteria for inclusion in this review.

Physicians who commit boundary violations do so for a variety of reasons.[1,4,5] Some physicians who engage in sexual relations with patients have fallen madly in love with the patient and are otherwise ethical practitioners. Others are sexual predators and systematically exploit the power differential in the doctor-patient relationship. Prescribing irregularities may include corrupt physicians who function like drug dealers, benevolent overprescribers who try to please their patients by getting them the treatment they desire, and those who are addicts themselves and feed their habit by prescribing for friends and family members, only to use the drugs themselves. In any case, the underlying motive for the boundary violation is not considered in this review of records. Our goal is merely to characterize the types of boundary violations seen in the clinical setting. Some physicians in this sample came to clinical attention because of the threat of disciplinary action by a board, physicians' health organization, hospital, or lawsuit, while others were self-referred and were seeking help for problems they recognized in themselves and in their practice. Still others were referred by a psychiatrist or other mental health professional.

RESULTS

Table 1 reflects the demographic and diagnostic information relevant to this sample. Ninety-six percent of the physicians seen were male and 92 percent were Caucasian. The ages ranged from 27-74. Many specialties were represented, but psychiatry was by far the most common, with 41 percent, followed by family practice at 16 percent. Of the practice settings, 86 percent were from the private sector, with small numbers coming from training programs, academic settings and the public/military sector.

The most common referral source was a physicians' health organization, often functioning independently from a licensing board and more interested in providing some form of monitoring and rehabilitation than in disciplinary action. Twenty-three percent were referred from licensing boards. Eleven of the physicians were self-referred because of their own concerns. Other sources of referral included attorneys, ethics committees, hospitals, residency training programs and practice partners.

Psychiatric diagnoses were common in this sample. Fifty-two percent met criteria for an Axis II personality disorder. Twenty-six were diagnosed with a mood disorder. Seventeen physicians had substance abuse disorders; eight of those were in remission at the time of the evaluation. Paraphilias and sexual disorders were found in 13 of the

Table 1.

Demographic and Diagnostic Information	
Gender	
Males	96
Females	4
Age	
Range	27-74
Mean	47.83
Cultural Background/Ethnicity	
Caucasian	92
Hispanic	3
Middle Eastern	3
Asian	2
Dates of Evaluation	6/86-3/05
Specialty	
Psychiatry	41
Family Practice	16
Internal Medicine	12
General Practice	9
Surgical Subspecialties	9
Pediatrics	3
OB/Gyn	4
Emergency Medicine	2
Radiology	1
Anesthesiology	1
Physical Medicine & Rehabilitation	1
Rotating Internship	1
Practice Setting	
Private	86
Training Program	7
Academic	4
Public Sector/Military	3
Years in Practice	
Range	1-49
Average	20.28
Referral Source	
Physicians' Health Organization	41
Licensing Board	26
Self-Referred	11
Hospital	5
Treating Mental Health Professional	4
Attorney	4
Ethics Committee	4
Residency Program	3
Practice Partner	2

Psychiatric Diagnoses at End of Evaluation	
No diagnosis	27
Axis I Disorders	
Mood Disorders	26
Substance Abuse Disorder	17 (8 in remission)
Major Depression	15
Paraphilia and Sexual Disorder	13
Paraphilia	11
Male Erectile Disorder	2
Sexual Disorder NOS	2
Anxiety Disorder	7
Cognitive Disorder NOS	5
Bipolar Disorder	5
Bulimia	1
Other	6
Axis II Disorders (Personality Disorders)	52

physicians. Seven had anxiety disorders. Some of them had multiple diagnoses reflecting the fact that there was considerable co-morbidity in our sample. Twenty-seven had no psychiatric diagnosis.

In organizing the types of boundary violations committed by the physicians in our sample, we divided them into three overall categories: 1) boundary violations with a patient, 2) boundary violations with non-patients (employees, co-workers, family members) and 3) prescribing/treating irregularities. We recognize there is some degree of overlap across these categories. Boundary violations with patients are further subdivided according to whether they are sexual or nonsexual. Sexual misconduct in physicians is usefully regarded as involving one of three categories delineated by the Medical Council of New Zealand (1992).[6] Sexual impropriety refers to gestures or expressions disrespectful to the patient's privacy and sexually demeaning to the patient. Many cases of sexual harassment involving unwanted advances, sexually explicit remarks and denigrating comments would fall into this category.

The second category is sexual transgression, which involves sexualized and inappropriate touching of the patient that falls short of actual sexual relations. Such behaviors as kissing, touching of the breasts or genitals not appropriate for the physical exam, or performing a physical exam without gloves, all would be included under this grouping.

Finally, sexual violation proper is the third category, and this refers to physician-patient sexual relations. This category applies regardless of whether the patient or the physi-

Table 2.

Types of Boundary Violations	
Violations with a patient	
Sexual Violations	82
Impropriety	14
Unzipping one's fly in front of a patient	
Touching one's own genitals during group therapy	
Making derogatory or disrespectful comments to a patient	
Bringing medications to a patient's home & making overtures	
Sending patients love notes	
Mailing jokes with sexual humor to patients	
Sexually inappropriate comments to patients	
Transgression	15
Sexually molesting unconscious patients	
Masturbating in front of a patient	
Inappropriate exam/touching	
Having patients undress unnecessarily	
Hugging and kissing patients	
Violation Proper	53
Intercourse with a patient	
Marrying a patient	
Receiving fellatio from a patient	
Having sex with boys in a residential treatment center	
Having demented elderly females fondle one's genitals	
Current patient	43
Former patient	10
Nonsexual Violations	18
Financial	5
Giving money to or borrowing money from patients	
Soliciting a donation for one's own building	
Social	6
Staying in a patient's home	
Going on vacation with a patient	
Accepting rides from or giving rides to patients	
Having coffee with patients	
Taking a patient and her child to dinner	
Allowing a patient to live in one's house	
Confidentiality	
Talking about one patient with another	
Giving a patient an open bottle of medication with another patient's name on it	
Other	
Simultaneously treating & supervising psychiatric resident	
Helping a patient move	
Frequent and extensive extensions of therapy sessions	
Using drugs with a patient	
Violations with nonpatients (employee, coworker, family)	
Sexual	22
Impropriety	10
Asking a nurse out on a date	
Commenting to a nurse on the size of her breasts	
Sexual harassment of nurses	
Exposing oneself to one's employees	
Telling obscene jokes in the operating room/at work	
Transgression	2
Fondling a nurse's breasts	
Violation Proper	10
Intercourse with a supervisee	
Intercourse with a family member of a former patient	
Intercourse with an employee or coworker	
Prescribing/Treating Irregularities	26
Prescribing for self	9
Prescribing for employee	6
Prescribing for or treating family members	3
Trading sex for drugs	2
Prescribing for or treating someone without a medical record	6

* Sexual relations with an employee who is also a patient are rated as both patient and employee in this table.

cian initiates the contact and irrespective of whether the two profess love for one another. Included in this category are oral sexual relations, anal intercourse, genital intercourse and mutual masturbation.

Using these categories, sexual boundary violations proper with patients were identified as problems in 53 of the physicians in the sample, making it by far the most common boundary violation (see Table 2). Of these violations, 43 involved a current patient or patients, and 10 were related to a former patient. Fifteen of the sexual violations were transgressions. Fourteen cases of sexual impropriety occurred in the sample and ranged from a physician who unzipped his fly in front of a patient to another who walked into an examination room and told his female patient that she "smelled like a French whore."

Eighteen nonsexual violations occurred with patients in this sample of physicians. Five involved financial matters, such as soliciting a donation for one's own building or borrowing money from patients. Six were social in nature and ranged from staying in a patient's home to taking a patient and her child to dinner. Only three confidentiality boundary violations were reported. Some nonsexual violations were not

easily categorized and involved such things as helping a patient move, frequent extensions of psychotherapy sessions, using drugs with a patient and simultaneously treating and supervising a psychiatric resident.

Turning to boundary violations with non-patients, all 22 were sexual in nature (as there is very little agreement on what would constitute a non-sexual boundary violation involving non-patients). Ten involved sexual boundary violations proper, wherein a physician had sex with a supervisee, employee or co-worker beneath the physician in the hierarchy of the institution or office, or with a family member of a former patient. Two involved transgressions and 10 were cases in the sexual harassment spectrum that are classified as impropriety.

The category of prescribing/treating irregularities addresses instances where there is a blurring of boundaries about one's role. Nine cases of prescribing for oneself were reported. In some cases, prescribing narcotics for oneself was identified as a problem, while in other cases physicians prescribed drugs for a patient and then had the patient turn them over to the physician for his/her own use. Prescribing for employees occurred six times in this sample. Prescribing for and treating family members accounted for three instances. In one case, a physician performed a pelvic exam on his teenage daughter. In another case, controlled substances were prescribed for the physician's spouse. Trading sex for drugs occurred on two occasions. Another problem that was reported six different times involved prescribing for or treating someone without a medical record. These instances ranged from prescribing medications for friends and family, treating female employees at a massage parlor that a physician frequented, to treating the 13-year-old daughter of a woman a physician was dating.

DISCUSSION

This sample of physicians is by no means representative of all physicians who are referred for clinical evaluations by licensing boards, physicians' health organizations and other agencies. The sample is skewed in the direction of psychiatry and boundary violations because of the senior author's extensive writings on boundary violations among mental health professionals.[7-10] Nonetheless, the 100 physicians seen in evaluation in a clinical setting provide useful information about the types of boundary violations seen and the psychopathology of the physicians. Of note in this regard is that 52 percent of the physician sample met criteria for an Axis II personality disorder. By far the most common personality disorder was "Mixed, or personality disorder not otherwise specified," meaning that criteria were not met for a pure personality disorder in most cases, but a mixture of personality characteristics of different personality disorders was present. In a recent presentation at the Annual Conference of the Academy of Organizational and Occupational Psychiatry, Schouten presented data from his experience with 82 cases of physicians who had been referred for evaluation because of disruptive behavior.[11] He too found that personality disorder not otherwise specified was the most common diagnosis.

A substance abuse disorder was diagnosed in 17 of the cases, and at least 13 had some type of paraphilia or sexual disorder. As noted above, comorbidity was quite common in the sample, so that one diagnosis could rarely be regarded as the explanation. Twenty-seven of the physicians had no psychiatric diagnosis at all, indicating that boundary violations are not simply the outgrowth of psychopathology.

In reviewing the varying types of boundary violations, it is clear that multiple violations are common. The well-known "slippery slope" phenomenon is often at work, in which a nonsexual boundary violation leads to increasingly egregious violations and finally results in sexual relations between doctor and patient.[8] Sexual boundary violations are by far the most common in this sample, likely because of the senior author's writings. Forty-three of the sexual violations proper occurred with current patients and 10 with former patients. While the American Psychiatric Association Ethics Code states unequivocally that sex with former patients is unethical, the AMA Council on Ethical and Judicial Affairs (1991) regards sexual relationships between former patients and physicians as potentially unethical if exploitation of a still emotionally dependent patient is involved.[12] Whether the doctor and patient are "in love" or married is not relevant to whether exploitation has occurred. The inherent power differential between doctor and patient makes it difficult for a patient to give fully informed consent to a sexual relationship.

Some of the nonsexual boundary violations, such as having coffee with patients, may seem trivial, but in some of these instances, the patient misconstrued having a ride with the physician or going for coffee as a sexual overture. This misunderstanding reflects the fundamental principle that the physician's *intent* may be different from the *impact* on the patient. Physicians may cross boundaries with a perfectly reasonable and benevolent intent, but patients can easily experience the departure from normal professional role as violating, particularly if the patient has a history of sexual abuse.

Most of the boundary violations occurring with non-patients, such as employees, co-workers, and family, involve variations on sexual harassment. Power differentials exist between doctor and employee, and they also exist in a hospital hierarchy even when there is not a specific contract of employment between a physician and another employee of the hospital who might be a nurse, an X-ray technician, a medical student or a secretary.

The last major category, prescribing/treating irregularities (see Table 2) addresses a pervasive problem in the medical profession. Many physicians do not place themselves under the care of a colleague, and they often use samples to treat themselves. Many also prescribe for employees, family members and others with whom there is no doctor-patient relationship. The American Medical Association's Principle of Medical Ethics has long advised against the practice of treating oneself or one's family members because of a lack of professional objectivity. Nevertheless, in our sample, nine physicians prescribed drugs for themselves, including controlled substances. Six prescribed for employees. Moreover, some of these transgressions involved treating family members that went beyond prescribing. One physician performed a pelvic examination on his teenage daughter, for example, and another physician traded sex for drugs. Treating or prescribing for people without a medical record or a doctor-patient relationship was also common. In one case, a physician treated the 13-year-old daughter of a woman he was dating. In another case, a physician routinely prescribed informally for friends who had complaints.

Space considerations do not allow for detailed discussion of prevention or treatment. Suffice it to say that education on professionalism in medical school is crucial. Moreover, identification of medical students with problematic professional behaviors and remediation for those students are badly needed.[13] Many physicians who commit boundary violations are amenable to rehabilitation, but a careful evaluation is needed to rule out those with antisocial or severe narcissistic personality disorders who are unlikely to respond to a rehabilitation program.[9]

REFERENCES

1. Gabbard GO, Nadelson C. Professional Boundaries in the Physician-Patient Relationship. *JAMA* 1995;273:1445-1449.
2. Massachusetts Board of Registration in Medicine. *General Guidelines Related to the Maintenance of Boundaries in the Practice of Psychotherapy by Physicians (Adult Patients)*, 1994; Board of Registration in Medicine, Boston, Massachusetts.
3. Morrison J, Wickersham P. Physicians disciplined by a state medical board. *JAMA* 1998;279:1889-93.
4. Epstein RS. *Keeping the Boundaries*. 1994; Washington, DC, APPI.
5. Bloom J, Nadelson C, Notman M (eds). *Physician Sexual Misconduct*. 1999; Washington, D.C., APPI.
6. Medical Council of New Zealand. Sexual Abuse in the Doctor-Patient Relationship: Discussion Document for the Professions. *Newsletter of the Medical Council of New Zealand* 1992;6:4-5.
7. Gabbard GO, Lester E. *Boundaries and Boundary Violations in Psychoanalysis*. 2003; Washington, D.C., APPI.
8. Gutheil TG, Gabbard GO. Misuses and misunderstandings of boundary theory in clinical and regulatory settings. *American Journal of Psychiatry* 1998;155:409-414.
9. Gabbard GO. Sexual misconduct. *Review of Psychiatry, Volume 13*, 1994; Ed. by Oldham JM and Riba MB. Washington, D.C., American Psychiatric Press, 433-456.
10. Gabbard GO. Boundary violations. *Psychiatric Ethics, Third Edition*, 1999; Ed. by Bloch S, Chodoff P, Green SA. Oxford & New York, Oxford University Press, 141-160.
11. Splete H. Anger common in disruptive physicians. *Clinical Psychiatry News* 2005; 33(3):1.
12. Council on Ethical and Judicial Affairs, American Medical Association. Sexual misconduct in the practice of medicine. *JAMA* 1991; 266:2741-2745.
13. Papadakis M. Unprofessional behavior in medical school is associated with subsequent disciplinary disciplinary action by a state medical board. *Academic Medicine* 2004;79:244-249.

THE IMPACT OF A PATIENT SAFETY PROGRAM ON MEDICAL ERROR REPORTING

Donald R. Woolever

ABSTRACT

Background: **In response to the occurrence of a sentinel event—a medical error with serious consequences—Eglin U.S. Air Force (USAF) Regional Hospital developed and implemented a patient safety program called Medical Team Management (MTM) that was modeled on the aviation industry's Crew Resource Management program and focused on communication, teamwork, and reporting.** ***Objective:*** **To determine the impact of a patient safety program on patterns of medical error reporting.** ***Methods:*** **This study was a retrospective review of 1,102 incident reports filed at Eglin USAF Regional Hospital in Florida between 1997 and 2001. Collected data from the comparison periods (1998 and 2001) was statistically analyzed using the chi-square test.** ***Results:*** **The number of reports submitted increased significantly from 200 for 4,671 hospital admissions in 1998 to 276 for 4,003 admissions in 2001 (chi-squared = 28.38, P < 0.0001). Evaluation of incident severity showed 172 (86 percent) near misses (no impact on patient) in 1998 and 251 (91 percent) in 2001. In 1998, there were 28 (14 percent) adverse events (patient minimally effected) and 25 (9 percent) in 2001 (chi-squared = 3.302, P = 0.069). Analysis by rank of person filing the report revealed 39 reports submitted by junior nurses and 11 submitted by junior enlisted personnel in 1998, while in 2001 those numbers increased to 75 and 24 reports, respectively (chi-squared = 6.554, P = 0.161).** ***Conclusion:*** **This study indicates that, since the implementation of MTM, there has been a statistically significant increase in the number of reports filed at Eglin USAF Regional Hospital. Similarly, the severity of incidents shows an overall decline approaching statistical significance. Although there was an increase in reporting from junior team members, this was not statistically significant. These findings suggest that there have been changes in the patterns of error reporting since the implementation of MTM.**

INTRODUCTION

The Hippocratic Oath, a foundation of medical practice, urges practitioners to "first, do no harm." However, the 1999 Institute of Medicine (IOM) report, *To Err Is Human: Building a Safer Health System*[1] revealed that much harm is being done. This often-cited report compiled statistics suggesting as many as 98,000 people may be dying each year as a result of medical errors. Medical facilities have long had systems in place to monitor errors. These systems, however, mostly consisted of the filing of incident reports once an error was discovered.[2,3] This was, by design, a retrospective approach that often assigned blame to individuals and did little to analyze systems, identify trends, or make recommendations for overall improvements. With increasing media attention and public awareness of medical errors, it became clear this system of monitoring was inadequate.

Patient safety has become a central focus for most medical institutions and many new programs to monitor safety and prevent medical mistakes have emerged as a result. The use of new technologies, the employment of automated systems, the introduction of system redundancies, the use of event simulation, and the implementation of new staff training are all strategies that have been put in place in an attempt to reduce the rate of errors.[4-7]

Like most hospitals, Eglin U.S. Air Force (USAF) Regional Hospital in Florida had been practicing reactive error monitoring. However, as the result of a sentinel event (a medical error resulting in an unanticipated death or injury) that coincided with the release of the IOM report, Eglin USAF Regional Hospital decided to reconsider this system. A working group was formed and tasked with developing a new strategy to identify and reduce medical errors. What resulted is a patient safety program known as Medical Team Management (MTM).

While changes to staff training have been a common response to the new focus on patient safety,[8,9] MTM is unique in several respects. First, as an Air Force hospital closely associated with aviation, this program draws heavily from the lessons learned about human error and flight mishaps.[10] The aviation industry developed a safety program known as Crew Resource Management that teaches fliers the principles of teamwork, communication, stress management, and other human factor principles to prevent aviation mishaps. Crew Resource Management also emphasizes the need for anonymous reporting of near misses and the removal of blame as a deterrent to the collection of accurate information.[10,11] In addition to incorporating these principles, MTM is directed at all members of the medical team — physicians, nurses, medical technicians, and other hospital workers. As miscommunication has been identified as the leading cause of preventable medical errors,[12-14] MTM focuses primarily on facilitating clearer communication within and between these groups to create a safer patient care environment.[15]

While course evaluations of MTM have been overwhelmingly positive,[15] a quantitative look at this training's impact on communication, reporting or severity of medical errors had not been undertaken. Because the chain of events that results in a bad patient outcome is so complex, it is difficult to analyze medical errors.[1,5] However, one method of measuring the initial impact of MTM is to examine patterns of error reporting. As a routine component of continuous quality improvement (CQI), most medical facilities track errors and incidents. Of all practice locations, the inpatient, non-intensive care unit setting is a high-volume area with rapid turnover of patients and minimal staffing where the risk for serious medical errors is high.[16]

This study hypothesizes that, by focusing on improved communication and the removal of blame from reporting mistakes, the initiation of MTM training will result in an increase in error reporting. As a result of a larger volume and improved information made available by increased reporting, it is subsequently believed the severity of incidents will decline and bad patient outcomes will be averted. It is the aim of this paper to evaluate the success of MTM by comparing rates of error reporting and types of errors reported prior to and since the program's implementation. It will also examine which members of the health care team are filing reports, hypothesizing that a curriculum emphasizing communication and empowerment of even the most junior team members might result in an increase in reporting from lower-ranking nurses and medical technicians. Finally, by comparing the rates of reporting at Eglin USAF Regional Hospital to that of other military medical facilities not exposed to MTM training, the impact of this program will be demonstrated.

Although a direct cause-and-effect relationship may be impossible to establish, finding significant differences in reporting rates will strongly suggest that MTM was at least one important factor in changing Eglin USAF Regional Hospital's approach to patient safety.

METHODS

This study is a retrospective review of routinely filed incident reports. As per hospital operating instruction, staff members are required to file an incident report on SGQ Form 1 to record any deviations from the expected plan of care. At Eglin Regional USAF Regional Hospital, these error-tracking reports are processed by the Quality Office (formerly known as the Risk Management Office), and each is categorized as a *near miss*, an *adverse event*, or a *sentinel event*. A near miss is a mistake that is caught and corrected before it ever reaches the patient. An adverse event has minimal effect on the involved patient and does not result in any significant or permanent disability. A sentinel event, however, is a major occurrence resulting in an unexpected death or permanent disability. Most sentinel events are reportable and require further investigation via a formal root cause analysis. The total number of reports received is also used as a surrogate for rate of errors per hospital admission. The Quality Office at Eglin USAF Regional Hospital is staffed primarily by civilian contract employees and had little turnover during the period of time covered by this study. All incident reports included in this study were reviewed in an aggregate form with no associated patient identifying information.

For this study, 1,102 incident reports filed by the Multi-Service Inpatient Unit between 1997 and 2001 were reviewed. The Multi-Service Inpatient Unit provides care for all medical, surgical, and pediatric inpatients. It is staffed by a combination of active duty Air Force and civilian contract nurses and medical technicians. It has an average daily census of 26 patients and an average length of stay of 48 hours.

A historical review for confounding factors revealed that a computer system upgrade, occurring in 1997, changed the way report data was processed. MTM training commenced in 1999. Initially, all personnel assigned to the medical group received the training in scheduled, large group ses-

sions. Subsequently, the training was directed at all new hospital and clinic employees as an ongoing effort with sessions offered every other month. By the end of 2001, more than 750 medical group employees, approximately 91 percent of all assigned personnel, had been trained.[15] Given this, it was determined to compare data from incident reports filed in 1998 to that collected in 2001. As a point of comparison, 2001 data on number and severity of reports filed from all medical facilities in the U.S. Air Force Materiel Command (AFMC) was obtained. These medical facilities are grouped together solely by the primary mission of the U.S. Air Force base where they are located. Data from the AFMC was only made available in an aggregate form calculated per 100 hospital admissions. Although useful comparison information, its significance is diluted because Eglin USAF Regional Hospital is a part of the AFMC and its statistics are also included within this dataset.

Data pertaining to the total number of reports, the assigned incident category and severity, and the military rank/job title of the person filing the report was entered for statistical analysis. SPSS software (SPSS, Inc., Chicago, IL) was used to analyze the data and the Pearson chi-square test was used to compare different datasets.[17]

RESULTS

Using data collected from routinely filed incident reports from the Multi-Service Inpatient Unit, the total number of reports filed, the severity of incidents reported, and the military rank/job title of the person submitting the report in 1998 were compared to the same parameters from 2001. The total number of reports submitted increased significantly from 200 for 4,671 hospital admissions in 1998 to 276 for 4,003 hospital admissions in 2001 ($P < 0.0001$). That is a rate of 6.89 reports per 100 hospital admissions in 2001 compared to 4.28 per 100 hospital admissions in 1998 (Figure 1).

Evaluation of the severity of incidents reported showed 172 near misses (no impact on patient) among 200 total reports filed in 1998, compared to 251 among 276 in 2001. In 1998, there were 28 adverse events (patient minimally effected) among 200 reports, and 25 among 276 in 2001 ($P = 0.069$; Figure 2). Standardized per 100 reports filed, that gives a rate of 90.94 near misses and 9.06 adverse events in 2001, compared with a rate of 86.00 near misses and 14.00 adverse events in 1998 (Table 1).

Analysis by military rank/job title of the person filing the incident report revealed 39 of 200 reports were filed by lieutenants (junior nurses) and another 11 of the 200 were filed by junior enlisted personnel (junior medical technicians) in 1998, while in 2001 those numbers increased to 75 of 276 and 24 of 276, respectively ($P = 0.161$; Figure 3). Although absolute reporting increased for team members of all military ranks/job titles from 1998 to 2001, as a percentage of all reports filed, only lieutenants (junior nurses) and junior enlisted members (junior medical technicians) showed an increase.

Figure 2: Total number of incident reports and number categorized as "near miss,""adverse event," or "sentinel event" in 1998 and 2001; $P = 0.069$

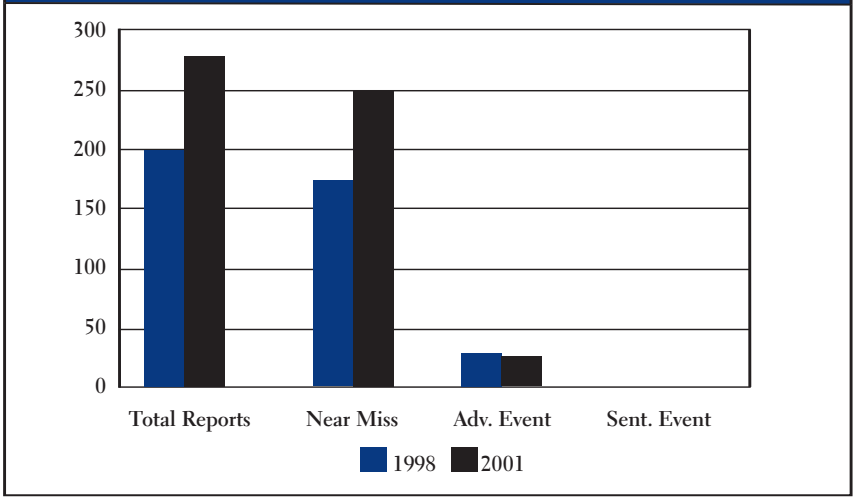


Figure 1: Rate of incident reports filed per 100 hospital admissions in 1998 and 2001

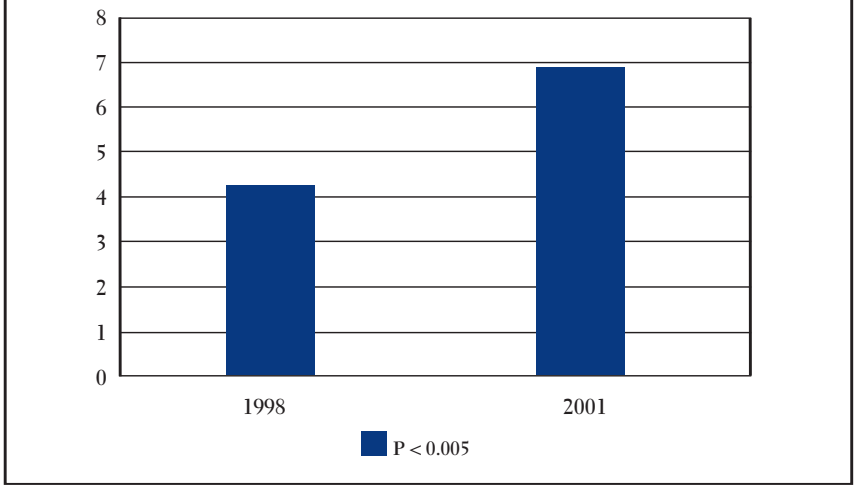


Table 1. Rate of near misses and adverse events per 100 incident reports filed in 1998 and 2001; *P* = 0.061

Incident type	1998	2001
Near misses	86.00	90.94
Adverse events	14.00	9.06

Reports filed by lieutenants increased from 19.5 percent to 27.2 percent of all reports filed, and from 5.5 percent to 8.7 percent for junior enlisted members, although these increases were not statistically significant.

The 2001 data on numbers and severity of incident reports collected at Eglin USAF Regional Hospital was compared to the same data collected from all of the medical facilities in the AFMC. Per 100 hospital admissions, there were 6.89 incident reports filed with 6.27 near misses and 0.62 adverse events at Eglin USAF Regional Hospital, compared to 5.07 reports, 4.43 near misses, and 0.65 adverse events for all of AFMC (*P* = 0.067; Table 2).

Table 2. Comparison of reporting rates and incident severity per 100 hospital admissions at Eglin U.S. Air Force Regional Hospital and all medical facilities in AFMC; *P* = 0.068

	Eglin	All AFMC
Total Reports	6.89	5.07
Near Misses	6.27	4.43
Adverse Events	0.62	0.69

DISCUSSION

Aviation's Crew Resource Management is one of industry's safety gold standards. Its focus on attitude and leadership, team training, skill enhancement with simulation, and reporting changed the culture of aviation.[7,10,11] Given that aviation and health care share many common characteristics, including high stakes, complex environments, a team setting, and personnel with similar personality traits,[10,11] the concepts of Crew Resource Management are well suited to application in the health care setting. Medical Team Management has incorporated many of the lessons learned from Crew Resource Management. The MTM curriculum emphasizes seven Critical Success Elements:[15]

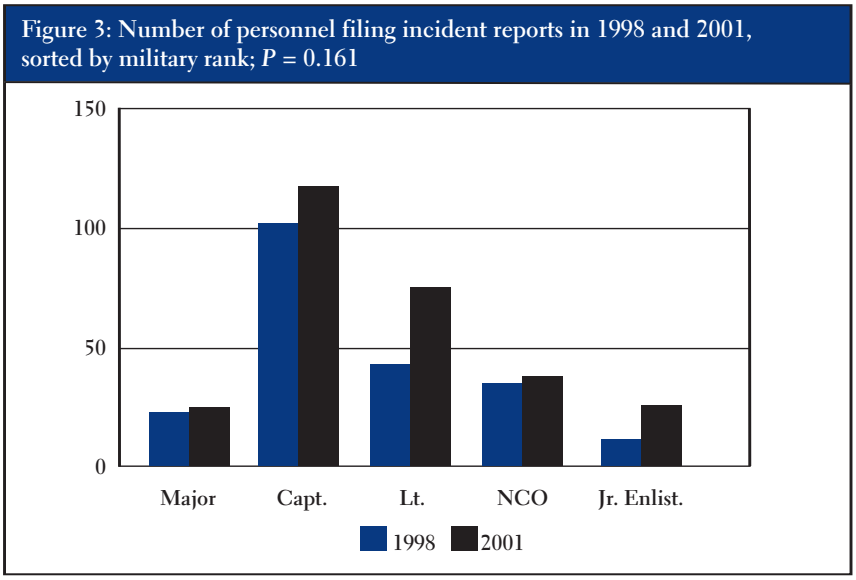
- Daily Operating Strategy,
- Situational Awareness,
- Workload Performance,
- Available Resources,
- Policies and Regulations,
- Command Authority, and
- Medical Team Communication.

These concepts are taught during a four-hour session of lecture, role-playing, interactive situational analysis, and video presentations. In addition, MTM is unique in its focus on the entire medical team. Training has been mandated for all personnel and is included as part of required orientation for all new arrivals to the medical group — housekeeper to medical records administrator, nurse manager to senior physician.

As the breakdown in communication has been implicated as the single leading factor in medical mistakes,[12-14] MTM's primary focus is on improving team interactions and clarity of communication. Given the multiple hierarchies that impact the medical team, particularly in the military setting, empowering team members to speak up and, sometimes, question the plan of care has involved a culture change. Teamwork training has not, traditionally, been a part of medical education, and as a result, there are many barriers to clear communication between the various contributors to the care of a patient.[18,19] MTM teaches communication by discussing verbal and nonverbal cues and listening skills.[15] These concepts are implemented through several exercises and role-playing activities that encourage increased involvement from more junior members of the team.

In addition to ongoing training for all med-

Figure 3: Number of personnel filing incident reports in 1998 and 2001, sorted by military rank; *P* = 0.161



ical group personnel, MTM has evolved to further facilitate communication between members of specific care teams. This new component of the training has been directed at the high-risk areas of obstetrics, surgery, emergency medicine and the intensive care unit. It involves eight small-group sessions with assigned teams or shifts. The sessions focus on identification of intra-team conflicts and team-building, as well as on mutually agreed-upon problem areas and solution proposals. This phase of the training had not yet been initiated at the time this study was completed.

Like Crew Resource Management, MTM also emphasizes the importance of incident reporting. Although this is not a new concept, its evolution into a nonpunitive tool is a dramatic change.[20,21] In the past, acknowledging mistakes has often meant taking blame. However, Crew Resource Management, as well as recommendations from the IOM, the Department of Defense, and the U.S. government's Quality Interagency Coordination Task Force, have all advocated the establishment of improved reporting systems as a way to learn from errors.[1,20] There are mandatory and voluntary reporting systems, each of which offers strengths at collecting certain types of data.[20] Mandatory reporting allows for the collection of standardized data and the identification of errors that could and should be prevented.[1,20] It also facilitates the dissemination of important information to the public and holds health care organizations accountable for the safety of the care they provide. Voluntary reporting programs are usually anonymous and, as such, can often provide more candid information that ultimately leads to improved safety in processes and systems.[20-22] A number of large medical and nonmedical organizations have employed voluntary reporting systems to obtain improvements in their respective safety parameters.[20] Both mandatory and voluntary reporting systems have a role in the overall improvement in patient safety. The key to any reporting system however, is in the analysis and feedback of the information gathered in the reports.[20] The report analysis often includes a thorough probe of the root causes and contributing factors associated with the identified problem, and the feedback must present leaders empowered to make change with clear recommendations for the implementation of action-oriented outcomes.[1,20]

CONCLUSIONS

Medical mistakes are a serious problem for health care systems and the patients they treat.[1,16,23] While medical facilities and health care providers at all levels strive to provide competent, compassionate, and safe care, they are not currently achieving this goal. Many approaches to improving safety have been initiated and many have focused on improved training. MTM is a U.S. Air Force patient safety program unique in its origins from aviation's Crew Resource Management and in its emphasis on communication, teamwork, and reporting. The program has been presented to all employees, whether involved in direct patient care or not, at Eglin USAF Regional Hospital, where the program originated. MTM has since been expanded to include other Air Force and Department of Defense medical facilities and has evolved into a phase of teamspecific training in high-risk areas. This study suggests changes have occurred in the patterns of medical error reporting at Eglin USAF Regional Hospital since MTM was initiated.

Medicine is practiced in a very complex environment.[1,10,16,23] The multidimensional process by which a medical mistake occurs is even more complex.[1,23] This complexity makes the analysis of errors and patterns of mistakes particularly difficult to analyze. The causes of mistakes are always multifactorial and therefore, by necessity, so are the remedies. In addition to specific interventions, the media, general public awareness, and personal experiences all impact on changes in behavior. Because of this, a direct causal relationship between patient safety programs and changes in specific safety measures are difficult to establish.

This study, however, did demonstrate a statistically significant increase in medical error reporting after the implementation of the MTM training program. An increase in reporting is the first step and the key to gathering more information for analysis, the identification of trends, and, ultimately, recommendations for changes in the way health care is practiced. Similarly, this study also demonstrated a trend approaching statistical significance of an overall decline in the severity of the incidents reported. Support for the reality of this trend and changes in reporting that were independent of external influences is suggested by comparing the total number of filed incident reports and the severity of those reports at Eglin USAF Regional Hospital to other military health care facilities. Finally, while the study did show a percentage increase in the number of reports being filed by the most junior members of the health care team, this finding was not statistically significant.

Although these changes in the patterns of medical error reporting at Eglin USAF Regional Hospital are undoubtedly the result of many influences, the implementation of the Medical Team Management training program appears to be one significant factor.

ACKNOWLEDGMENTS

I would like to acknowledge the 96th Medical Operations Squadron, 96th Medical Group, Eglin Air Force Base, Fla., for providing funding for the completion of a Faculty Development Fellowship in Family Medicine at the University of North Carolina at Chapel Hill, during which this research was completed. I would also like to acknowledge mentors and colleagues at the University of North Carolina and at the Quality Office at the 96th Medical Group who facilitated the completion of this project.

AUTHOR AFFILIATIONS

U.S. Air Force

Reprinted with permission from pages 307-316 of Volume One of the four-volume *Advances in Patient Safety: From Research to Implementation*, published in February 2005 by the Agency for Healthcare Research and Quality.

REFERENCES

1. Kohn LT, Corrigan JM, Donaldson MS, editors. *To err is human: building a safer health system. A report of the Committee on Quality of Health Care in America, Institute of Medicine*. Washington, D.C.: National Academy Press; 2000.
2. Bates D, O'Neil AC, Boyle D. Potential identifiability and preventability of adverse events using information systems. *JAMIA* 1994;1:404–11.
3. Cullen D, Bates DW. The incident reporting system does not detect adverse drug events: a problem for quality improvement. *Jt Comm J Qual Improv* 1995;21:541–8.
4. Berwick D. Continuous improvement as an ideal in health care. *N Engl J Med* 1989;320:53–6.
5. Moray S. Error reduction as a system problem. Bogner MS, editor. In *Human error in medicine*. Hillsdale, NJ: Lawrence Erlbaum Associates; 1994; pp.67–91.
6. Jha A. Identifying adverse drug events: development of a computer-based monitor and comparison with chart review and simulated voluntary report. *JAMIA* 1998;5:305–14.
7. Barach P. Patient safety curriculum. *Acad Med* 2000;75(5):551–2.
8. Jay G, Risser DT. Formal teamwork training improved teamwork and reduced emergency department errors. *Acad Emerg Med* 1999;6:408.
9. Ioannidis JP, Lau J. Evidence on interventions to reduce medical errors: an overview and recommendations for future research. *J Gen Intern Med* 2001;16(5):325–34.
10. Helmreich R, Merritt A. *Culture at work in aviation and medicine: national, organizational and professional influences*. Brookfield, VT: Ashgate Publishing Limited; 1998.
11. Trollip S, Jensen RS. *Human factors for general aviation*. Englewood, CO: Jeppesen Sanderson, Inc.; 1991.
12. Bogner MS, editor. *Human error in medicine*. Hillsdale, NJ: Lawrence Erlbaum Associates; 1994.
13. Coiera E, Tombs V. Communication behaviors in a hospital setting: an observational study. *BMJ* 1998;316:673–76.
14. Donchin Y. A look into the nature and causes of human errors in the intensive care unit. *Crit Care Med* 1995;23:294–300.
15. Stone F. Medical Team Management: using teamwork to prevent medical errors. *Legal Medicine* 2001;26–30.
16. Brennan TA, Leape LL, Laird NM, et al. Incidence of adverse events and negligence in hospitalized patients: results of the Harvard Medical Practice Study. *N Eng J Med* 1991;324:370–76.
17. SPSS Software, Inc. Chicago, IL.; 2001.
18. Clinical Systems Group. *Improving clinical communications*. Sheffield, England: Centre for Health Information Management Research; 1998.
19. Risser DT, Rice MM, Salisbury ML, et al. The potential for improved teamwork to reduce medical errors in the emergency department. *Ann Emer Med*. 1999;343:373–83.
20. Tackett S, Birk CC. The patient safety mandate—rebuilding the trust and creating a reporting system. *Legal Medicine* 2001;7–16.
21. Pietro D, Shyavitz LJ, Smith RA, et al. Detecting and reporting medical errors: why the dilemma? *BMJ* 2000;320:794–6.
22. Voelker R. Treat systems, not errors, experts say. *JAMA* 1996;276:1537–8.
23. Weingart SN, Wilson RM, Gibberd RW, et al. Epidemiology of medical error. *BMJ* 2000;320:774–85.

THE INTRODUCTION OF CLINICAL SKILLS ASSESSMENT INTO THE UNITED STATES MEDICAL LICENSING EXAMINATION (USMLE): A DESCRIPTION OF USMLE STEP 2 CLINICAL SKILLS (CS)

Richard E. Hawkins, M.D., *Deputy Vice President, Assessment Programs, National Board of Medical Examiners*

Clinical Skills Evaluation Collaboration (CSEC)

ABSTRACT

In June 2004, Step 2 Clinical Skills (CS) was introduced into the United States Medical Licensing Examination (USMLE). The purpose of USMLE Step 2 CS is to ensure successful candidates for licensure in the United States possess the clinical skills that are essential for safe and effective patient care. Ensuring high quality in such a large-scale, performance-based test requires meticulous attention to detail at multiple levels in preparing for implementation. These levels include: case and test development, standardized patient training, quality assurance, scoring and standard setting. The authors describe the efforts undertaken to ensure the examination provides for a fair assessment of individual examinee performance with regard to those fundamental patient-centered skills.

In June 2004, an examination component designed to assess clinical skills was introduced into the United States Medical Licensing Examination (USMLE). USMLE Step 2 Clinical Skills (CS) consists of a multiple-station, standardized patient-based examination developed and administered through the collaborative efforts of the National Board of Medical Examiners (NBME) and the Educational Commission for Foreign Medical Graduates (ECFMG); and with the cooperation of the Federation of State Medical Boards, co-sponsor with the NBME of the USMLE. The purpose of Step 2 CS is to ensure successful candidates for licensure in the United States possess the fundamental clinical skills essential for safe and effective patient care. These clinical skills include taking a medical history, performing a physical examination, communicating effectively with patients, clearly and accurately documenting the findings and diagnostic impressions from the clinical encounter, and identifying appropriate initial diagnostic studies.

The examination typically consists of 12 encounters with standardized patients (SPs) who portray common and important medical problems. SPs are individuals trained to portray a patient problem or condition in representing a realistic clinical situation. More than four decades of research supports the reliability of scores using SP-based assessments of clinical skills. Similarly, extensive research shows that scores from SP-based examinations yield valid interpretations of examinee performance. For USMLE Step 2 CS, examinee data gathering performance is documented by SPs using checklists constructed to represent the appropriate history and physical examination components for a specific patient presentation. Communication, interpersonal skills and spoken English proficiency are evaluated by SPs using rating scales that are based on the communication, interpersonal and spoken language skills that should be exercised in all patient encounters. The patient note, recorded by an examinee after the encounter, is rated by a physician. In formulating a score for each note, patient note raters are extensively trained to consider the extent to which important information is recorded for the specific case, as well as the quality of the written documentation. Examinees are scored on three examination components: the Integrated Clinical Encounter (ICE), which reflects the examinee's skill in data gathering and in completing the patient note; Communication and Interpersonal Skills (CIS); and Spoken English Proficiency (SEP). Examinees must pass all three components on the same attempt to pass Step 2 CS.

USMLE Step 2 CS is administered at five regional centers located across the United States. These centers operate year round, administering exams up to seven days per week, with as many as three testing sessions per day, depending upon examinee volume. It is estimated that approximately 30,000 examinees, comprising students and graduates of both U.S. and international medical schools, will take Step 2 CS annually. This delivery model was chosen because it repre-

sented an achievable balance of quality control, cost-efficiency and examinee convenience, while still permitting attainment of the high psychometric standard needed for a licensing examination.

As expected, significant operational challenges were encountered in developing the infrastructure for this delivery model, including test center construction, recruitment, hiring and training of personnel, and configuration of the audiovisual and information technology backbone necessary to support simultaneous, multiple-site administrations. Interwoven with these logistic challenges, yet extending well beyond them in terms of their complexity, were the potential impediments to attaining the psychometric standard required for high-stakes examinations.

Ensuring fairness and consistency in examination delivery and scoring across multiple sites and administrations requires meticulous attention to detail and appropriate planning at several levels, including identification of the ideal scoring approach, case and test development, blueprint design and construction of equivalent test forms, standardized patient (and standardized patient trainer) training, quality assurance, equating and standard setting.

In developing the scoring instruments and planning the rating process for each of the examination components, the intent was to assure the reliability of scores and the validity of the interpretations that would be based upon those scores. However, feasibility and credibility were also important qualities in terms of acceptability to the medical profession and other stakeholders. Through the application of checklists and global ratings provided by SPs and ratings of the patient note by physician raters, these criteria are met. For Step 2 CS, dichotomous checklists completed by SPs are a reliable and efficient means for determining whether examinees obtain the essential history and physical examination data for a given clinical encounter. Checklist scores (a process measure) are complemented by patient note ratings (a clinical outcome measure) in appraising data-gathering proficiency. Physician ratings of the patient note provide credibility; examinees are evaluated by medical "experts". In addition, the note rating process is cost-effective since rater training and scoring can be centralized. Global rating scales provide an ideal measure of interpersonal and communication skills and spoken English proficiency. These generic rating scales are constructed to represent a patient's perspective within the context of a clinical encounter, thus identifying the patient (SP) as the expert rater of examinee performance within these domains. Here, the USMLE engages members of the public (SPs) as participants in scoring the examination, providing them with the training and instruments to assess skills critical to patient satisfaction and provision of high quality care.

The examination blueprint for Step 2 CS is designed to reflect the broad distribution of patients new residents are likely to encounter in different settings and contexts for graduate training programs in the United States. These include common and important clinical problems of varying acuity. In the aggregate, the exam also includes a broadly representative sample of patients of different ages, genders and ethnicities. To ensure delivery of content equivalent examinations at the five sites, rules for creating individual test forms have been defined, and software programs have been developed to select SP-case combinations at each site, and for each exam administration, that yield content-representative test forms.

Committees of content experts, representing various aspects of the medical profession (clinicians, academic faculty, state medical board members) participate in decision-making regarding test design and in the development of individual cases. This provides a level of assurance that examination content and difficulty are appropriate for the intended purpose of the examination. The case development process is iterative in nature, with individual test development committee members leading discussion on specific cases. Practice encounters with SPs and other committee members unfamiliar with the particular case inform case refinement and checklist development. Once the initial case development is complete, SPs are identified to portray the case in un-scored stations during live Step 2 CS examinations at one or more test sites. After completing a number of encounters in un-scored stations, interdisciplinary review committees consider both examinee and SP performance data in making decisions regarding continued use of the case and the need for specific refinements in SP training and/or checklist structure. Such a process will also occur periodically during ongoing live administrations of each case.

During the case development process, committees identify specific patient characteristics that are used to recruit SPs for each case. Blueprint category requirements, as well as case-relevant clinical criteria, guide selection of the age distribution, gender and race/ethnicity for SP-case combination. Additionally, for specific cases, patient Body Mass Index and other physical features, such as the presence of various physical findings or scars, may represent

characteristics that the committees believe are inappropriate for the proper presentation of the case; these characteristics are used for excluding some potential SPs. Once all relevant characteristics are defined, it is important that SP recruitment and selection be consistent within and across testing sites.

Despite the application of specific rules for creating test forms, developing cases and selecting SPs, an important threat to examination equivalence is the potential variability in performance and scoring of SPs both within and between testing sites and over time. To ensure consistency strict procedures and standards have been adopted for both SP and SP trainer performance. Additionally, staff undertook two projects critically important to maintaining consistency in SP training procedures, case portrayal and scoring across multiple sites:

1. The use of identical, multimedia-based training materials and methods administered electronically (via a process called "E-case") at all sites guarantees consistency in delivery of SP training materials and instructions. Periodic modifications and updates of test and case materials are transmitted simultaneously to all sites, automatically replacing existing versions. This electronic system allows for SPs and SP trainers to access current training and case materials between and during administrations of the examination as necessary. This system also supports the periodic delivery of quizzes to gauge SP readiness for entry into un-scored stations and then into live examinations, and to monitor accuracy on an ongoing basis. The use of electronic methods also provides an additional level of security by minimizing the availability of paper materials and controlling exposure of case materials and scoring instruments.

2. The SP Trainer Training Academy is conducted at NBME headquarters in Philadelphia. Faculty members include external consultants (expert SP trainers) and test development and SP training staff. At these sessions, all trainers receive identical, intensive instruction in SP training methods, including the use of the E-case for on-site SP training. Additionally, central "Academy" staff periodically travel to each site to co-facilitate various training sessions as an additional measure to ensure consistency in training and performance.

While the above innovations enhance consistency in SP performance within and across sites by requiring strict adherence to training procedures and successful completion of periodic assessments, stringent quality assurance approaches are necessary to maintain optimal performance. Quality assurance begins with a sign-off process designed to ensure SP readiness to participate in live examinations. SPs are required to complete a minimum number of portrayals in un-scored stations and must demonstrate consistency and accuracy in recording and scoring examinee actions. Once an adequate level of portrayal and scoring is established, the SP can be used as part of the live examination. However, quality assurance continues with strict monitoring of compliance with guidelines for portrayal consistency and scoring accuracy. This is accomplished via random review of live and recorded SP performances, both by local site trainers and central test development staff. Lastly, a series of ongoing score-based analyses provide continuous statistical monitoring and feedback on SP performances over time for each score component.

Despite rigorous training methods and stringent approaches to quality assurance, it is unavoidable that residual systematic differences in case difficulty and SP stringency will remain within and across testing sites. For this reason, equating procedures have been developed to adjust for differences in the difficulty of test forms between and within sites, and over time. Separate video-based ratings of checklist and CIS/SEP performance by SPs from across multiple sites provide a basis for placing scores across centers on a common scale. These ratings are also used to monitor consistency in portrayal and accuracy in scoring across sites and SPs. For patient note ratings specifically, since these are performed at a single location, ratings only need to be adjusted for differences in stringency among individual raters.

The standard setting process for Step 2 CS is similar to that used for the other USMLE Steps, involving the medical education and practice communities. Individuals from these groups define expectations for examinee performance through an extensive review of data from live administrations of the examination. Surveys completed by medical school administrators, undergraduate and graduate medical educators, clinicians, state medical board members and examinees themselves provide an important perspective on the prevalence of substandard clinical skills. In addition, panels of faculty and clinicians review samples of examinee/SP encounters and provide their opinion on a minimal standard for performance in each of the areas tested. The USMLE Step 2 Committee, comprising leaders in medical education and licensing, review these data and other

related information in identifying minimally acceptable performance levels for all of the Step 2 CS components.

In conclusion, the addition of clinical skills assessment into the USMLE provides the public with another level of assurance regarding the clinical skills of individuals granted a license to practice medicine in the United States. The inclusion of such a large scale, performance-based examination has posed unique logistical and psychometric challenges. We have described the efforts undertaken to ensure that the examination provides for fair assessment of individual examinee performance with respect to those fundamental patient-centered skills necessary for safe and effective health care.

CONTRIBUTING AUTHORS

The following individuals from the National Board of Medical Examiners and the Educational Commission for Foreign Medical Graduates were responsible for developing and implementing the programs and processes described in this article. All participated in the writing or critical review of this article.

National Board of Medical Examiners

Richard E. Hawkins, M.D., Deputy Vice President, Assessment Programs

David B. Swanson, Ph.D., Deputy Vice President, Professional Services

Gerard F. Dillon, Ph.D., Associate Vice President, USMLE

Brian E. Clauser, Ed.D., Associate Vice President, Measurement Consulting Services

Ann M. King, Manager, SP Test Material Development

Peter V. Scoles, M.D., Senior Vice President, Assessment Programs

Educational Commission for Foreign Medical Graduates

Gerald P. Whelan, M.D., Vice President, Assessment Services

William P. Burdick, M.D., M.S. Ed., Assistant Vice President, Assessment Services

John R. Boulet, Ph.D., Assistant Vice President, Research and Evaluation

Ann G. Homan, Director, Center Operations, Assessment Services

ALBERTA, CANADA
VERBAL PRESCRIPTION FORGERIES

The Alberta College of Pharmacists has reported a significant increase in verbal forgeries throughout the province. Individuals will call pharmacies with prescription orders, claiming to be a physician. They will often be able to provide the physician's College of Physicians and Surgeons of Alberta (College) license number, office address, and telephone number. Prevention of forgeries and fraud should be a concern for all physicians prescribing narcotics and other controlled drugs. The following are suggestions to prevent verbal forgeries of prescriptions:

- Limit the use of verbal prescriptions to exceptional cases.
- Do not use verbal prescriptions for medications prone to misuse or abuse such as benzodiazepines or acetaminophen with codeine compounds.
- Fax prescriptions to the patient's choice of pharmacy.
- Limit the quantities of prescriptions, where possible, for medications prone to abuse.
- Be accessible to pharmacists who require verification and authentication of prescriptions. It is not recommended that office staff verify prescriptions for narcotics and controlled substances.
- Protect your College registration number and only provide it when necessary for legitimate purposes.

Verbal prescription forgeries may be the most difficult forgery to detect and prevent. Using these general approaches to prescribing will assist the pharmacist in identifying a potential forgery when it is not the physician's customary practice to provide verbal prescriptions.

PHYSICIAN RESOURCE PLANNING ACTIVITIES

The Physician Resource Planning Committee (PRPC), which includes College representatives, is again working to update Alberta's physician resource plan by Dec. 31, 2005. PRPC's primary task will be to identify Alberta's optimal number, mix, skill level and distribution of physicians (working in collaboration with other health providers) to deliver appropriate care that meets the province's health care needs. The workplan will include consultation with AMA Sections, RHAs and other stakeholders with a significant interest in physician resource issues. In the long-term, PRPC will:

- provide advice about strategies and mechanisms to meet the requirements of a physician resource plan;
- develop and recommend strategies to the appropriate stakeholders to integrate physician resource planning with planning for other health human resources provincially and within regional health authorities; and
- identify and inform Regional Health Authorities and other stakeholders on opportunities to better coordinate and/or integrate medical services to create an integrated health system.

In addition to the College, PRPC members include Alberta Health and Wellness, the Alberta Medical Association, Regional Health Authorities, both Faculties of Medicine, the Professional Association of Residents of Alberta and the Medical Students' Associations. PRPC also has ex officio representatives from the Post- Graduate Medical Education Advisory Group, Alberta Physician Resource Database Working Group, Rural Physician Action Plan Coordinating Committee, and Alberta International Medical Graduate Program. PRPC provides a forum to coordinate advice and proposed initiatives including those of the member entities. In future communications, the PRPC will provide an update of progress to create a provincial physician resource plan and provide additional information about physician resource issues and upcoming activates for the committee.

THE ETHICS OF PATIENT SELECTION

The College recently received the following complaints:

One

A woman contacted a general practitioner's office to inquire whether the physician was taking new patients. The receptionist advised the physician was taking new patients but the patient was first required to answer some

questions before being granted an appointment. The receptionist inquired as to the woman's age, and upon learning that she was in her eighties, the receptionist informed the woman that the physician was not taking new patients over 65.

The physician responded he felt he was justified in refusing to see elderly patients because they require more time and he did not have the time to devote to additional members of this patient population given the current demands of his practice.

Two

A patient attended an appointment to meet a family physician taking new patients. She informed the physician her diagnoses included depression, borderline personality disorder and anxiety disorder. The physician responded that she must seek another physician. When she asked why, the patient was told that his practice was full.

The physician responded that prior to seeing the patient, he had recently made the decision to stop seeing new patients, and his staff were not fully aware of this decision. He wrote, had the patient required immediate care, he would have provided it, but because her issues were not emergent, he felt justified in refusing her care.

Three

An elderly woman made an appointment for a complete physical with a physician who advertised in the local paper that she was accepting new patients. Upon arrival for the physical, she was informed by the receptionist she would not be given a physical, instead the physician wanted to meet her first. The patient was interviewed by the physician with respect to her medical problems. At the termination of the appointment, the physician advised the patient that she would not accept her into the practice.

The physician responded that during the interview, she learned that the patient had a physician but was looking for a new physician closer to her new home in another part of the city. As such, the physician felt justified in refusing to take the patient on. All three complainants believed that they were victims of discrimination. The Canadian Medical Association (CMA) Code of Ethics states:

> "In providing medical service, do not discriminate against any patient on such grounds as age, gender, marital status, medical condition, national or ethic origin, physical or mental disability, political affiliation, race, religion, sexual orientation, or socioeconomic status. This does not abrogate the physician's right to refuse to accept a patient for legitimate reasons."

The College appreciates that the demands of practice are great. However, the practice of screening patients based on age, medical condition and other grounds of discrimination is not acceptable, despite the fact that some groups of patients in general need more time and attention. Having said that, it is reasonable to decline to take on a patient whose needs cannot be met. For example, while it is not acceptable to screen out all patients over 65, it is acceptable to decline services to an elderly patient who attends with complex medical problems for which she has seen multiple practitioners and is not satisfied with the advice and treatment given to date, when that advice and treatment meets the standard of care. The College would not be critical of a physician who determined, after careful evaluation of the patient's history, that they had nothing to offer this patient that had not been previously offered by other providers. Physicians also have a right to limit their practices. Examples include:

- No new patients.
- Limiting new patients to family members of existing patients or referred patients only.
- Limitation of types or range of services provided. None of the three physicians listed in the above complaints intended to be discriminatory, yet their actions were clearly perceived by the prospective patients as such.

To help avoid complaints of discrimination:

- Be aware of your ethical obligations.
- A "meet and greet" appointment should not be used as a tool by physicians to screen potential patients.
- When screening potential patients on the telephone, office staff should ensure they clearly explain the physician's limitations. Appointments to meet the doctor should not be given if the patient falls outside the limitations of that physician's practice.
- When declining a new patient, the patient should be provided with the reason they were not accepted into the practice.

METHADONE MAINTENANCE STANDARDS FOR TREATMENT IN ALBERTA

In September 2004, the CPSA established an expert group

of physicians to develop consensus standards and guidelines for methadone maintenance treatment in Alberta. Their work has resulted in the development of a draft document titled *The Standards and Guidelines for Methadone Maintenance Treatment in Alberta*.

This resource will guide physicians in how best to prescribe methadone for opioid dependent patients. During the next several months, physicians will be asked to review the draft document and provide recommendations for improvement. Look for details on how you can be involved in future issues of *The Messenger*.

Other stakeholders such as pharmacists and other Colleges across Canada will also be given the opportunity to provide feedback on the draft document. Once the guidelines and standards are finalized, the document will be sent to physicians throughout Alberta to raise awareness of opioid dependency and to encourage physicians to address this issue in general practice. Although other therapies for opioid dependency have been used in locations around the globe, this document will focus on the use of methadone in addressing the issue.

Support for this project has been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

Reprinted from issues 117 and 118 of *The Messenger*, published by the College of Physicians and Surgeons of Alberta.

BRITISH COLUMBIA, CANADA
PATIENTS ARE ENTITLED ACCESS TO MEDICAL RECORDS

A written or stamped message on a consultation report, stating "not to be released to third party," has no authority or impact if the request for medical records comes from the patient or a patient's agent, such as the patient's lawyer. This is in compliance with a ruling of the Supreme Court of Canada (*McInerney v. MacDonald*, (1992) 93 DLR (4th) 415), which states:

> "In the absence of regulatory legislation, the patient is entitled, upon request, to inspect and copy all information in the patient's medical file which the physician considered in administering advice or treatment."

These provisions are added:

> "unless there is a significant likelihood of a substantial adverse effect on the physical, mental or emotional health of the patient or harm to (an innocent) third party" and "provided the patient pays a legitimate fee for the preparation and reproduction of information."

MEDICAL MARIJUANA UPDATE

Pursuant to the Medical Marijuana Access Regulations, SOR/2001-227 ("the Regulations"), marijuana may be prescribed to patients fulfilling the criteria set out in the Regulations. The medical benefits of marijuana have been subject to much debate. To assist members in considering patient requests for medical marijuana and in making an informed decision, the College of Physicians and Surgeons of British Columbia (College) has conducted a review of the current research literature on the risks and benefits of medical marijuana. The results of this review are available to members for review in person at the College's Library or online through the College website at www.cpsbc.ca. Members may review the table of contents online and e-mail the library to request a copy of any referenced article.

Reprinted from Issue 48 and 49 of *College Quarterly*, published by the College of Physicians and Surgeons of British Columbia.

ONTARIO, CANADA
ELECTRONIC, DIGITIZED SIGNATURES NOT APPROPRIATE FOR PRESCRIPTIONS

The Physician Advisory Service of the College of Physicians and Surgeons of Ontario (College) receives frequent calls from physicians asking whether it is appropriate for them to sign prescriptions using electronic signatures. While the trend of implementing electronic medical records is advancing rapidly, neither Health Canada nor the Ontario College of Pharmacists currently recognizes electronic signatures as acceptable for signing prescriptions. The College endorses electronic record-keeping and the use of technology to assist in the practice of medicine, however, physicians should not use electronic or digitized signatures for prescriptions at this time. Recently, after inspecting 11 pharmacies that practiced distance dispensing, Health Canada issued a letter to all pharmacists reminding them of their obligations under the Food and Drug Act. The following is an excerpt from Health Canada's letter dated Nov. 16, 2004:

"During the inspections it was observed that sale of drugs was occurring pursuant to prescriptions signed using rubber stamps or electronic prescriptions signed with electronic signatures and not supported at the time of sale by a written prescription transmitted by mail or electronic means. The use of a rubber-stamp or other means of signature which is not distinct for each transaction as the basis for a prescription order is not a valid signature and does not fulfill federal requirements. The sale of Schedule F drugs in this manner is a violation of section C.01.041(1.1)(a) of the Food and Drug Regulations.

C.01.041(1.1) Subject to C.01.043 and C.01.046, no person shall sell a substance containing a Schedule F drug unless (a) the sale is made pursuant to a verbal or written prescription received by the seller;

A prescription signed by a Canadian practitioner, *then* transmitted electronically to a pharmacist by faxing or scanning, is not a violation of the *Food and Drug Regulations*."

The Ontario College of Pharmacists has instructed its members to verify all prescriptions that contain rubber stamped, electronic, or digitized signatures. This verification must occur either verbally or by a faxed request for authorization to the prescriber. The College's expectation is physicians will respond to these requests for verification professionally and courteously. Patients cannot be charged a fee for this type of verification, nor is it acceptable to encourage patients to attend pharmacies that inappropriately accept electronic signatures without subsequent verification.

The College is also aware some private software vendors have indicated to physicians their product has been endorsed or approved by this College. The College does not endorse specific products or services, so please exercise caution when presented with this type of information.

For this, and all other practice-related questions, please contact our Physician Advisory Service at (416) 967-2606 or (800) 268-7096, extension 606.

COMMITMENT TO COMPETENCE: COUNCIL SUPPORTS PRINCIPLES OF REVALIDATION

At a recent meeting, the Council demonstrated its commitment to the principles of revalidation by moving forward with a consultation of stakeholders on all aspects of the program. The proposed system of revalidation includes educational requirements and practice assessments — components that, in combination, will promote continuous improvement in practice for the benefit of patients. It will be integrated with the national educational systems and is based on the best available evidence about practice assessments and education.

"We want a process that ensures extensive feedback from the profession and other key stakeholders in the development of the methods of revalidation," said Dr. Gerry Rowland, College president.

The College foresees revalidation as a system to enhance lifelong learning opportunities for all members of the profession.

"It will be an extension of our existing peer assessment program. It is our hope that the final product will give the physician a practical and user-friendly method of evaluating his or her own continuing competence, in an integrated framework of quality improvement," said Dr. Rowland.

The system is based on the premise that all physicians will participate in effective education and are prepared to demonstrate their competence to their peers and the public at various points throughout their career.

Once the College has gathered input from the profession, the public and other stakeholders, it will then embark on a period of testing of the tools selected.

"We are working toward building a fully operational and integrated revalidation system, but we realize the profession needs to have time to understand the changes and to help us make the tools as useful as possible," Dr. Rowland said.

The proposal is that eventually all physicians registered with the College will participate in a regular cycle of revalidation, likely at the rate of every five years.

"One of the keys to the success of this program is to recognize that physicians are busy, and this program needs to be manageable for a busy physician, as well as relevant to each physician's particular practice. It also needs to be robust enough so that the public can be reassured that a system is in place to validate their trust in doctors' continuing competence,"said Dr. Rowland.

The proposed system and draft tools have been developed over the past year through a task force of representatives from the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, the Medical Council of Canada, and the Ontario Medical Association.

It is proposed the profession will engage with the process of revalidation in three stages: commitment to competence, demonstration of competence and proof of competence. The latter two components should be familiar to all doctors, in that the tools used — the peer assessment program (demonstration of competence) and the PREP and SAP programs (proof of competence) — have been part of the CPSO quality assurance process for 25 years.

The Commitment to Competence stage is proposed as the first stage of revalidation — indeed, it may be the only stage of revalidation in which most physicians will be expected to participate. This level of revalidation is a purely educational component designed to help all doctors develop a practice-specific educational program.

The proposed components in this stage include:

- Demonstrating completion of a self-assessment process using questionnaires designed to help individuals understand the dimensions of their practices;
- Obtaining multisource feedback from colleagues, co-workers and patients designed to help doctors target their education in these important relationships and to make changes when necessary; and
- Demonstrating completion of a recognized system of continuing professional development from the RCPSC, the CFPC or the equivalent.

Why revalidation in a regulatory framework in Ontario?

- Doctors have a position of respect and responsibility in society based on the explicit expectations of their patients and the community-at-large.
- The public's trust in the profession is related to the leadership shown by doctors for their collective performance.
- Professional accountability is in the domain of the regulatory body.
- An individual's medical school and postgraduate training (entry to practice) does not guarantee competency and performance throughout a 25–30 year career.
- While many doctors already participate in a variety of educational and performance enhancing activities, participation is not universal, nor is there the consistency of a formal and integrated system.
- Some jurisdictions have been forced to develop systems of performance evaluation after tragic circumstances in their medical systems (e.g., UK's Bristol Inquiry related to pediatric cardiac deaths); the College prefers to lead during a time of stability, and to work proactively with the profession to identify workable solutions.
- The College's register needs to stand for more than just the name and address of a doctor; it must assure the public that each physician whose name appears in the College's register has had their competence and performance revalidated on a regular basis. Revalidation will add value to the certificate to practice medicine in Ontario.
- Ontario has been a leader in physician assessment and continues to collaborate with colleges across the country in implementing assessment and educational tools for physicians.

Principles of Revalidation

The system of revalidation will meet the following core principles:

- The component parts of revalidation must be educational, based on each physician's actual practice, and be adaptable to changing circumstances.
- Performance evaluation and education will be evidence-based and will first and foremost work towards continuous improvement of doctors' practices.
- The system of revalidation will be equitable for all physicians and a successful system will require collaboration and partnership with other organizations representing medical interests.
- In meeting these criteria, we will have a system that is accountable to the public and affordable for the profession.

From the quality improvement perspective, Component 1 represents an opportunity for physicians to assure themselves their practice achieves the objectives that are explicit in the peer assessment (Component 2). The College will maintain a random selection process for peer assessment as an important component of quality assurance and improvement.

Throughout all stages, revalidation is designed to validate performance and to help physicians to identify and implement improvement opportunities.

"The maintenance of competence is an ethical obligation of the profession," said Dr. Sandy Shulman, chair of the College's Quality Assurance Committee."It forms the basis of trust between professionals and patients, and underpins, in large part, the protected status of the profession. It is a subject that should unite doctors in assuring patients that they can continue to count on exemplary care."

ACUPUNCTURE SHOULD BE A CONTROLLED ACT

Acupuncture should no longer be exempted from the controlled act provisions of the *Regulated Health Professions Act* (RHPA) and should become a controlled act authorized to those who have the appropriate knowledge, skill and judgment to perform acupuncture, says the College Council.

In a submission to government, the Council explained the College supports the practice of acupuncture as a treatment modality for symptom control, especially for pain, practiced by health professionals trained in acupuncture techniques. However, for an act to become a controlled act under the RHPA it must be inherently dangerous if not performed by a competent health professional. And Council says there is enough risk associated with acupuncture to merit its inclusion as a controlled act.

"Although the incidents of injuries and adverse reactions associated with acupuncture may be low, the safety of acupuncture is dependent on having well trained practitioners and stringent infection control procedures. As more and more people are choosing to receive acupuncture treatments, there is an increased risk to the public," stated the submission.

Physicians are currently entitled to "perform a procedure on tissue below the dermis" and as such, acupuncture is clearly within the practice of medicine. The College recommends the government regulate persons who perform acupuncture by having the regulatory colleges whose members are legally able to perform acupuncture within their scope of practice cooperate to set standards of practice for their respective members. The CPSO, as the self-regulatory college for physicians, is the appropriate entity to set standards of practice for physicians who provide acupuncture treatments. In addition, for those regulated health professions whose members currently perform acupuncture, but would not be authorized to do so once the acupuncture exemption is removed (e.g., physiotherapists and chiropractors), they should apply to the minister for an expansion of their scope of practice, said the submission.

The submission also states that given that an increasing number of people are choosing non-traditional medicine and that there are risks inherent in Traditional Chinese Medicine (TCM), the CPSO Council believes it is in the public interest it be regulated.

"The health care interventions and treatments that comprise TCM are not insignificant health care interventions. In order to ensure that patients, as consumers, know who they are seeing, it is necessary that there be adequate standards in place for practitioners and the care offered, an accountability structure and the regulation of substances being administered. In addition, patients may be receiving TCM and traditional health care simultaneously and therefore there should be some assurance of interdisciplinary communication," stated the submission.

Recently, the College submitted responses to an Health Professions Regulatory Advisory Council questionnaire regarding the regulation of psychotherapy. The responses reflected the opinions of a consultation group comprised of physicians and CPSO staff with expertise in this area. The document was presented as a reflection of the opinions of these qualified individuals, and is not to be considered the official position of the CPSO.

The consultation group stated psychotherapy should be regulated to restrict the risk of harm to patients/clients. Currently, psychotherapy is not regulated. There are no standards for entry to practice, no standards of practice and no accountability, except for those governed by other colleges, such as the CPSO or the College of Psychologists of Ontario. The merits to having psychotherapy regulated as a controlled act under the RHPA, include enabling the development of entrance criteria and the ability to create ongoing quality assurance. However, admission to the profession should not be limited to currently recognized regulated health professionals, as this would unduly limit public access to well-qualified practitioners with other backgrounds.

The consultation group stated counseling, spiritual counseling, and crisis intervention should not be controlled acts. These services are readily distinguishable from psychotherapy in their purpose, their approach, and by those who provide these services. Counseling, spiritual counseling, and crisis intervention are important services, and the

consultation group stated that unduly restricting the scope of individuals able to provide these services would be a disservice to the Ontario public.

The consultation group made the following additional recommendations regarding the regulation of psychotherapy:

- "Psychotherapist" should be a restricted title.
- A new and separate college for psychotherapy should be created to govern those practitioners who do not have the background or training required for membership in any existing professional regulatory college (e.g., the College of Social Workers and Social Service Workers, and the colleges under the RHPA).
- Members of existing professional colleges should not be required to have concurrent membership in the new college for psychotherapists.
- Mechanisms should be established to ensure minimum standards of care are consistent among all colleges regulating psychotherapy.
- Practicing psychotherapists who do not satisfy admission criteria for either the existing professional colleges or the new regulatory college may be grandfathered into membership in the new college where competency can be established based on equivalent education, practice experience in psychotherapy, or both.

The CPSO will have an opportunity to provide its official position as consultation in this matter progresses further. The CPSO will also participate in a workshop facilitated by HPRAC.

Reprinted from June/July 2005 and August/September 2005 issues of *Members' Dialogue*, published by the College of Physicians and Surgeons of Ontario.

LONDON, ENGLAND

GMC CHANGES COMPLAINTS HANDLING PROCESS

On Oct. 17, 2005, the General Medical Council (GMC) implemented a change in the way complaints are handled. It was agreed by Council in July 2005 that the GMC should refer cases directly to local procedures for consideration where the allegations as presented, if proven, would not call into question a doctor's fitness to practice.

Since July, the GMC has been developing appropriate systems to ensure that cases referred to local procedures are returned to the GMC where there is further information calling into question a doctor's fitness to practice and that written confirmation is received that there is no such evidence where the case has been concluded locally. These systems are now in place.

The GMC is mainly limited to taking action on serious concerns which call into question the doctor's fitness to practice and suitability to retain unrestricted registration. However, most of the complaints that are received do not fall into that category; as, even if the allegations were proven, they would not be sufficiently serious to warrant action on registration. The majority would be best dealt with locally, at least initially. Since May 2004, the GMC has retained ownership of some complaints while it sought further information from the employer in relation to the doctor concerned. These were complaints that, on the information supplied (although not best practice), were not particularly serious. In the vast majority of these cases the further information received has not changed the nature of the concern and, as such, it would now seem appropriate that these are dealt with locally.

This change has been introduced as there was concern previous procedures did not ensure issues about a doctor's performance or conduct would necessarily be followed up, as the onus was placed on the complainant to pursue the matter locally. There was a danger concerns raised by the complainant would not be investigated either by the GMC or by local procedures and that any pattern of poor performance would simply not be tracked and identified.

The change will enable the GMC to continue to focus on investigating those cases where the concerns raised about a doctor's fitness to practice, by patients or employers, are sufficiently serious to require restrictions on the doctor's registration or removal from the register.

According to Paul Philip, director of Fitness to Practice: "This change will allow us to focus our resources in a much more targeted way, enabling us to deal with appropriate complaints in a timely way. This will be beneficial to both patients and doctors."

THE GMC IMPROVES INFORMATION ACCESS WITH AN ONLINE DOCTOR SEARCH

On Oct. 20, 2005, the GMC launched an enhanced web-based facility which enables patients, pharmacists and

employers to gain instant access to a doctor's registration status. The Online Doctor Search requires simply the name of the doctor in order to display whether that doctor has any restrictions on his or her registration, following either a fitness to practice hearing or an undertaking made to the GMC.

This information has been available publicly but involved either a complicated web search or a telephone call direct to the GMC contact center. Improving accessibility is part of the GMC's stated commitment to increasing the transparency of its activities in order to develop its services to the public and patients.

When there are restrictions on a doctor's registration following a fitness to practice hearing, the facility will offer a direct link to minutes of that panel hearing. This facility will be developed further next year when tiered access for employers and pharmacists will enable the GMC to give them relevant information online such as photographs or a date of birth.

President of the GMC, Professor Sir Graeme Catto, said: "The enhanced Online Doctor Search is an important step forward in terms of increasing the GMC's transparency. It will provide patients with easier access to information they are entitled to, so they can approach their discussions over treatment and referrals fully informed. Although this has been available before, it required people to have a prior understanding of the system in order to gain access to it. In the interests of patient safety, employers also need ready knowledge of any restrictions that affect a doctor's registration."

Harry Cayton, National Director for Patients and the Public, said: "I welcome the GMC's intentions to make it easier for people to find important information about doctors through their website. The additional facility to link a doctor's details to other information concerning their registration will be of particular value to the public."

The search facility will form part of the newly revamped GMC website. It has been updated to make it easier to use and more accessible to all groups, including those with disabilities. The homepage reflects the interests of doctors, pharmacists, the media and the general public, with the relevant sections clearly marked. The search facility was tested along with the new website by members of the Patient and Public Reference group, who offer the GMC an external point of view.

"It is a refreshing change that a big organization like the GMC actually welcomed patient and public involvement for their new website," said Kim Longlands, of EASE Project Manager to Endometriosis SHE Trust (UK), and a member of the PPRG. "They invested time and resources to consult with the general public and seriously took on board all comments made. I am delighted to have been involved in their project."

Reprinted from the General Medical Council website.

LET US HEAR FROM YOU

Would you like for information from your board to be considered for publication in the *Journal*? If so, e-mail articles and news releases to Edward Pittman at epittman@fsmb.org or send via fax to (817) 868-4098.

ARIZONA

MEDICAL BOARD MOVES FORWARD WITH PHYSICIAN HEALTH PROGRAM

The Arizona Medical Board approved the framework presented by board staff to implement the Physician Health Program (PHP) at its annual planning meeting on Sept. 23, 2005. The PHP evaluates, treats and monitors physicians and physician assistants with medical, psychiatric, psychological, behavioral health disorders and substance abuse that impacts a licensee's ability to safely practice medicine or perform health care tasks.

The PHP is the umbrella program including the Monitored Aftercare Program (MAP), which currently monitors licensees with substance abuse and chemical dependency problems. The PHP helps address their health issues and safe return to medical practice by ensuring appropriate education, intervention, therapeutic treatment and post-treatment monitoring and support are obtained.

The board hopes the confidential nature of the program encourages physicians with these disorders to seek assistance voluntarily, rather than continuing to practice and potentially endangering the public.

This program fulfills the board's responsibility to rehabilitate physicians and protect the public. If the physician does not voluntarily disclose a disorder, does not sufficiently self-limit or returns to practice before he or she is able, the board may issue a non-disciplinary public order limiting the physician's practice. In all cases, the board must ensure public safety is preserved.

SIX PHYSICIANS ARE NOW ARIZONA MEDICAL BOARD CONSULTANTS

The role of the medical consultant is crucial when the Arizona Medical Board investigates complaints against physicians involving quality of care issues. In the past, much of the caseload went to outside medical consultants. However, Chief Medical Consultant Mark Nanney, M.D., now says he believes the work can be better done in-house.

Shortly after joining the board as the full-time chief medical consultant in May, Dr. Nanney went to work assembling a team of in-house consultants. With the recent addition of three more board certified physicians, the board now has six medical consultants on staff. And he may add another, depending on how well the present team keeps up with the caseload.

The new medical consultants are Kelly Sems, M.D., board certified in both internal medicine and rheumatology, who has joined full-time; and two new part-time medical consultants, Gerald Moczynski, M.D., board certified in orthopedic surgery; and Ingrid Haas, M.D., board certified in obstetrics and gynecology. Until this past July, Dr. Haas was a member of the board, and now will share her expertise in investigating complaints.

The board receives a great deal of complaints regarding pain management, orthopedic surgeons, obstetricians and gynecologists. With the new medical consultants, the board can now review these cases internally. Additionally, as a former board member, Dr. Haas brings valuable insight in how to best prepare cases for presentation to the board members. Already handling cases part-time were Roderic Huber, M.D., board certified in internal medicine, and William Wolf, M.D., board certified in general surgery. By dealing with more cases internally, the board can maintain a standardized system that will result in timely and better case reviews.

"We want to bring to the board a uniform analysis," Dr. Nanney said.

The increase in and diversity of in-house consultants is expected to speed up the investigation process. The board has hundreds of physicians in private practice willing to review cases. However, it has had difficulty finding outside medical consultants in some specialties who were willing or able to review cases on a consistent basis. With the wide range of experience now possessed by the in-house consultants, Dr. Nanney says she believes "we've solved big issues in that regard."

Reprinted from the Arizona Medical Board website.

CALIFORNIA

CITATION AND FINE: AN ALTERNATIVE TO AN ACCUSATION

The Medical Board of California receives a variety of complaints of physician conduct ranging from dangerous practices to more technical violations of the law. Pursuing administrative action is very time-consuming and extremely costly, with the cost of filing an accusation averaging $10,000. Prior to 1994, the board only had the option of pursuing administrative action or criminal action for all types of violations. By not taking action for the more minor violations, the board was unable to deter physicians from certain violations such as misleading advertising, failure to sign a death certificate in a timely manner or failure to provide medical records to patients. The board believed there should be some middle ground to respond to these kinds of violations, thereby providing some measure of public protection, while also achieving a quick, less expensive resolution.

In 1994, pursuant to Business and Professions Code section 125.9, the board established a system for the issuance of a citation and fine. The process is further described by regulations under Title 16, section 1364.10. Section 1364.11 lists a table of citable offenses for which the board may issue a citation, with or without a fine.

When the board receives a complaint alleging a minor, technical violation, board staff contacts the reporting party to verify the information provided in the complaint and obtains any evidence that would establish a violation. If there is sufficient evidence, staff will contact the physician to obtain his or her written response to the complaint and ask the physician to provide any explanation or mitigation that may impact the issuance of a citation. When all the information is received, board staff, including a deputy attorney general, will review the material to determine if there is a preponderance of evidence to support a determination that a violation has occurred. At this juncture, a citation may be issued. The citation is in writing and will describe the nature of the violation including specific references to the section of law that has been violated. As appropriate, the citation may contain an order of abatement (correcting the violation), fixing a reasonable time to allow for abatement of the violation. Fines imposed may range from $100 to $2,500.

Citations are posted on the board website upon issuance and will remain there for five years from the date of resolution. A citation is not considered discipline and is not reported to the Federation of State Medical Boards or the National Practitioner Data Bank. There is an appeals process allowed under Business and Professions Code section 125.9 that allows the physician another opportunity to provide additional input to board representatives in a face-to-face forum called an informal conference. At this meeting, the citation can be withdrawn, the fine can be reduced or the citation and fine can be upheld. Another option provided to the physician is that he or she may request a hearing on the matter before an administrative law judge. This remedy is in addition to the informal conference.

At the February 2005 board meeting, a public regulatory hearing was held to discuss changes to the cite and fine program. Specifically, new sections of law will be added to the citable offense table, and the maximum fine will be raised from $2,500 to $5,000 for certain categories of violation. The ceiling was raised pursuant to SB 362 (Figueroa, Chapter 788, Statutes of 2003); however, the maximum fine would only be imposed when: 1) the cited person has received one or more citations for the same or similar violation; or 2) the citation involves multiple violations that demonstrate a willful disregard for the law. Another change to the cite and fine program would allow for a citation to be issued to a licensee for a violation of a term or condition contained in a decision that placed the licensee on probation.

The citation and fine program, as described above, was created to allow for a less onerous resolution to less serious complaints which otherwise would result in the filing of an accusation. Physicians are encouraged to respond to any correspondence from board staff, as such response may eliminate the need for a citation and fine. Typically, the board is responsible for educating physicians on various laws relating to the practice of medicine, and compliance will often negate the need for a citation. The board website (www.caldocinfo.ca.gov) "Laws & Regulations" contains the regulations governing the citation and fine process and lists the violations that are citable.

REGARDING INFORMED CONSENT: WHAT PHYSICIANS NEED TO KNOW

The October 2003 issue of the *Action Report* contained a reminder to physicians that, prior to the performance of a hysterectomy, physicians must obtain informed consent. This reminder concerns the general doctrine of obtaining and documenting informed consent prior to beginning any

medical treatment. Informed consent is a two-step process consisting of discussion with the patient and documenting that discussion. This is especially important if there is a reasonable chance a planned medical procedure may lead to additional intervention.

Physicians are reminded that, in addition to the specific laws governing informed consent for hysterectomies, numerous other California laws address informed consent. These laws place specific requirements on physicians to obtain informed consent for a variety of treatments and procedures. Failure to obtain informed consent may lead to an allegation of unprofessional conduct.

For years, the doctrine of informed consent has been a matter addressed by the courts. In 1972, the California Supreme Court set a legal standard in an opinion that there is a requirement for divulgence by the physician to the patient of all information relevant to a meaningful decisional process. Further, the court found that, "there is a duty of reasonable disclosure of the available choices with respect to proposed therapy and of the dangers inherently and potentially involved in each."[1] This doctrine of obtaining informed consent applies to many medical treatments where incisions or surgical instruments are used, or during a diagnostic procedure, or in the course of experimentation (clinical trials).[2] Informed consent implies patient participation in medical decision-making. It is a process of communication between patient and physician resulting in the patient's authorization to undergo a specific medical procedure.[3] It includes the patient being informed that the physician having the discussion may not be the physician attending to the patient during the procedure.[4] It is the physician performing the treatment who is ultimately responsible for the disclosure and obtaining informed consent. This is not to say a physician is required to obtain a patient's informed consent for every procedure that is performed.

A physician is not required to obtain informed consent for simple and common procedures, e.g., taking a common blood sample.

According to the CMA's *California Physician's Legal Handbook*, physicians have a duty to obtain the informed consent of patients prior to performing certain medical procedures. The minimum information that must be provided includes:

- the nature of the procedure and/or recommended treatment;
- the risks, complications and expected benefits; and
- the availability of alternative treatment to the treatment that is recommended (including no treatment) and the associated risks and benefits.

In addition, *Cobbs v. Grant* and the *California Physician's Legal Handbook* note it would behoove the prudent physician to inform the patient of all relevant information about a proposed treatment prior to obtaining the consent of the patient. This information would include:

- working or presumed diagnosis and differential diagnoses;
- the name of the procedure;
- a description of the procedure in layman's terms;
- purpose and risks of any planned tests;
- prognosis;
- an estimate of the current level of severity of the patient's condition; and
- all information necessary for the patient to make an informed decision.

Potential problems for physicians arise when they perform complex procedures such as a cardiac catheterization; then during the course of the cardiac catheterization, additional procedures are performed such as renal angiograms, carotid angiograms and peripheral angiograms without the required discussion and informed consent prior to the procedure. Physicians are therefore reminded that, prior to beginning procedures, they should discuss with their patients all aspects of the recommended treatment — especially any potential for additional procedures, and obtain the appropriate informed consent for each.

In addition to the general doctrine of informed consent, there are a variety of specific medical treatments, conditions and procedures for which California law addresses the issue of informed consent. These laws place specific requirements on physicians. Some of these include the following, with the respective statute for reference:

Medical condition/procedure	Statute[5]
Blood transfusions	H&S Code 1645
Blood test for HIV/AIDS	H&S Code 120990
Cancer/Breast	H&S Code 109275, 109277 B&P Code 2257
Cancer/Prostate	H&S Code 109280, 109282
Gynecological treatment	H&S Code 109278

Hysterectomy	H&S Code 1690, 1691
Silicone Implants	B&P Code 2259
Collagen Injections	B&P Code 2259.5
Sperm and Ova removal	B&P Code 2260

In addition, the board published the *Guidelines for the Treatment of Pain*,[6] which discusses the issue of informed consent: "The physician and surgeon should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian. Annotation: A written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent. Patient, guardian, and caregiver attitudes about medicines may influence the patient's use of medications for relief from pain."

When there is any potential for additional procedures after the initial procedure has begun, the physician should discuss this potential with the patient and document the discussion. California physicians also should consult the applicable statutes when treating patients for any of the above conditions, because California law may require that additional information be disclosed, such as with hysterectomies.

REFERENCES

1. *Cobbs v. Grant* (1972) 8 Cal.3d 229, 104 Cal. Rptr. 505
2. National Cancer Institute
3. American Medical Association
4. There have been instances where the physician having the discussion and obtaining the requisite informed consent failed to advise the patient that another physician would perform the actual procedure.
5. H&S = Health and Safety Code. B&P = Business and Professions Code
6. *Action Report*, last printing October 2003 website: http://www.caldocinfo.ca.gov.

PRESIDENT'S REPORT: MEANINGFUL PEER REVIEW

The word "discipline" has a negative connotation to the practicing physician. It strikes at the heart of a physician's self esteem and perhaps even worse, can have major economic ramifications. Yet, the board's mission of public protection centers on this issue. The highest priority of the Division of Medical Quality (the board's enforcement arm) is public protection through a disciplinary system of checks and balances. Fortunately, discipline affects less than one percent of the physicians in California each year. Most physicians practice in an exemplary manner.

Medicine, like life, is a bell-shaped curve, and so is the disciplinary group whose acts range from mistakes in judgment, to sexual offenses, to felonious acts and impairments that may affect practices. The board has a difficult job in the investigation of those varied complaints and meting out appropriate discipline. While some see the board as too harsh, others say we are too lenient.

Most do not realize the board as currently constituted was a result of the MICRA legislation which required a strong medical board as a tradeoff for economic caps on pain and suffering in malpractice awards. This 21-member board is balanced in its approach, with 13 physicians who make decisions on behalf of the medical profession they are asked to regulate.

This brings us to the basic problem facing this board and its 119,000 physicians who practice in and outside of the state's borders: how can the board partner with the physician community to do a better job of regulating the profession? The board does not micromanage the quality of medicine in California. It reacts to the problems with which it is confronted when it receives complaints, 805 (hospital peer review) reports, and malpractice reports. What is our responsibility as physicians? We all must be active in peer review, which is the cornerstone of good medical care. Peer review is not necessarily punitive, but hopefully is corrective to improve the quality of medical care. Unfortunately, the quality of peer review in this state is unknown. A law was passed in 2002 to study the quality of peer review, but due to the board's current fiscal situation, it has not been funded.

As board president, I am hopeful that peer review is conducted in hospital and office-based practices. The American Society of Plastic Surgeons has a model program in place to deal with complications in the offices for its members. Peer review is a big issue with complex problems and solutions, but is necessary for the delivery of good patient care. As physicians we must police ourselves or abdicate that right to others. This represents the challenge of the future in maintaining and improving the quality of care for all patients in California. Meaningful peer review at every practice level is essential for both patient safety and for the integrity of the medical profession.

MAJOR MILESTONE FOR THE MEDICAL BOARD OF CALIFORNIA

What is the next major milestone for the Medical Board of California? Senate Bill 231 (Figueroa) has passed through the Legislature and was signed by the Governor on Oct. 9. What is the significance of this new law?

SB 1950 (Figueroa, Chapter 1085, Statutes of 2002) created an enforcement monitor to evaluate the effectiveness of the board's Enforcement and Diversion programs and to provide two extensive, written reports to the Legislature. The initial 300-page monitor's report is the basis of SB 231, and is strongly supported by the board. Many changes already have been implemented by board staff; however, certain improvements cannot be made without the statutory changes included in this law.

What controversial issues are raised? Certainly the fee increase, which affects all California physicians, is a primary concern. The current fee was established in 1994, and there have been no fee increases since that time. However, expenses have risen significantly, including salary and benefits for employees and the cost of services from the Attorney General's office, which acts as the board's representative in legal proceedings.

Costs have outstripped revenue. The increase is $95/year. Without the increase the board would have had to make drastic cuts in all programs. Remember, a strong board was the concession the Legislature gave for MICRA protections. An insolvent medical board puts a large nail in MICRA's coffin.

The California Medical Association opposed the board's continuing ability to impose the costs of investigation and prosecution of cases on physicians who are charged with and found to have violated the Medical Practice Act (commonly known as cost recovery). Historically, those physicians who have been charged and successfully prosecuted have paid some or all of the costs of that prosecution, when that prosecution is successful.

Language in the new law eliminates the board's ability to recover such costs from individual physicians. CMA supported this change in the bill. The board will be permitted, by regulation, to raise the fee beyond the $790 biennial base to offset this lost revenue.

The new law requires the board to continue to improve the Diversion Program. While the enforcement monitor had many concerns, some of the more significant concerns already have been addressed. The law requires the program to undergo a performance audit in 2006 to ensure that it is adequately protecting the public while rehabilitating physicians with substance abuse problems. If the audit determines that the program is not meeting its mission, the program will be terminated July 1, 2008. The Diversion Program has been and is a priority of this board. We have every confidence that with the changes that have been implemented and with further improvements this valuable program will continue to serve its dual purpose well.

Finally, the new law "declares that the Medical Board of California, by ensuring the quality and safety of medical care, performs one of the most critical functions of state government." It further finds that using a "vertical prosecution" model for its investigations "is in the best interests of the people of California." This will involve the joint assignment of cases to board investigators and deputy attorneys general, rather than the current "hand-off" method, where evidence is collected by board investigators and then turned over to the Office of the Attorney General for review and consideration of the disposition of a case. Vertical prosecution, which is used by many other law enforcement agencies, is widely regarded as being a much more efficient way of handling the investigation and prosecution of complaints. As such, it was a key recommendation of the enforcement monitor, and the board is committed to making this new model of investigation work to the benefit of the public and physicians alike.

Reprinted from Volumes 93-95 of the *Action Report*, published by the Medical Board of California.

COLORADO

LIMITATIONS ON PRESCRIBING FOR FAMILY AND FRIENDS

While he likely was not the first to say it, Sir William Osler is perhaps the most famous physician credited with the phrase, "A physician who treats himself has a fool for a patient." This statement could also be applied to the treatment of family members and others with whom the physician has significant emotional relationships.

Both the American Medical Association (AMA) and the American College of Physicians (ACP) have position statements against such care provision. The AMA position

states, "Physicians generally should not treat themselves or members of their immediate families," and the ACP statement reads, "Physicians should avoid treating themselves, close friends, or members of their immediate families. Physicians should also be very cautious about assuming the care of closely associated employees."

Both groups raise similar concerns about loss of objectively in medical decision-making, inadequate history taking, physical examination and possible discomfort on the part of either or both the physician and patient in sharing sensitive information or undergoing intimate exams. The AMA also raises concerns about treating conditions beyond the physician's expertise or training, loss of patient autonomy and informed consent, and impact on personal relationships that could accompany negative medical outcomes.

Finally, both groups recognize there may be emergency or isolated settings where is no other qualified physician available, but state firmly that care should be transferred to another physician as soon as practical. While there may be situations where routine care for short-term, minor problems is acceptable, physicians should not serve as a primary or regular care provider for immediate family members and should resolve requests for care from employees, family members, or friends by assisting them in obtaining appropriate care.

Despite these strong position statements, studies have found 50 to 80 percent of physicians report self-treatment, and nearly 100 percent report treatment of non-patients.

The Colorado Board of Medical Examiners has a keen interest in these issues of treatment for self, friends and family. First, prescribing Schedule II substances, except in the case of an emergency, for one's self or a family member represents grounds for disciplinary action by the board under state statute. The board also discourages self-treatment or treatment of family or others with whom significant emotional relationships exist for all controlled substances. Finally, the board feels that these practice limitations should apply to all medical and surgical care unless in the setting of minor illnesses or emergencies.

We review several cases each year where a physician has had difficulties arise due to self-treatment or treatment of family, friends or employees. Some involve controlled substances, some inappropriate or substandard care and some represent boundary violations. Probably none of the cases we review involved emergency situations where no other physician was available to provide care, and most cases involve ongoing treatment. There are even some very concerning cases involving surgical treatment. Often care is provided as a matter of convenience, but note that convenient care is not always quality care.

If care is provided to one's self, family or others with whom the physician has a significant emotional relationship, the board recommends a proper, complete written medical record documenting the care, including medications prescribed and indications, be prepared for each interaction, just as for any other patient. It is substandard to not appropriately document medical care, and too often record keeping is neglected or ignored in managing such cases.

The board believes in most cases, physicians should defer the care of themselves, their family and their friends to other qualified physicians. The board is considering adopting a policy statement regarding this issue, in order to provide licensees with specific guidance. We welcome comments and suggestions.

REGARDING MEDICAL DEVICES AND AESTHETIC PRACTICES

The Colorado Board of Medical Examiners (board) and the Office of Barbering and Cosmetology (OBC) received several inquiries about what type of medical devices are appropriate for aesthetic services and who can use such devices. The board and OBC have set some basic parameters regarding the use of medical devices for esthetic services. Medical spas and advanced aesthetic services are becoming more popular and commonplace in cosmetology salons and medical offices. There are several machines being used to improve the aesthetic appearance and health of one's skin. The most common machines are microdermabrasion, electrolysis, pulse light therapy, LED light, extreme superluminous LEDs and laser. However, depending on the machine's Food and Drug Administration (FDA) classification, all of these devices have different restrictions on who can use such device and under what circumstances.

The FDA's Center for Devices and Radiological Health (CDRH) is responsible for regulating firms who manufacture, repackage, re-label and/or import medical devices sold in the United States. In addition, CDRH regulates radiation emitting electronic products (medical and non-medical) such as lasers, X-ray systems, ultrasound equipment, microwave ovens and color televisions. Medical devices are classified into Class I, II and III. Regulatory control

increases from Class I to Class III. The device classification regulation defines the regulatory requirements for a general device type. A description of device classification and a link to the Product Classification Database can be found on the FDA's website.

The device classification is important to know in order to determine who can use the machine. In Colorado, the board and OBC deem it appropriate for licensed physicians, cosmetologists and aestheticians to use any Class I device such as electrolysis, LED and microdermabrasion. However, a Class II device can only be used under the supervision of a licensed physician in accordance with the board's delegation rule (Rule 800).

Class II devices such as pulse light and laser are more invasive than Class I, and as a result, the risk of injury is greater. Medical knowledge is needed in order to appropriately use the machine. The board and OBC have determined that Class II devices are beyond the scope of licensed cosmetologists and aestheticians and cannot be independently used unless they are using the machine under the direction and supervision of a licensed physician in accordance with Board Rule 800.

All medical device manufacturers have a FDA manufacturer number and product number. These numbers are required by federal law to be printed on all machines. Once you find either the manufacturer number or product number, you can visit the following website to determine its classification: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm

Reprinted from the Volume 13, Number 2, issue of the *Examiner*, published by the Colorado Board of Medical Examiners.

NEW MEXICO LEGISLATIVE UPDATE

There were a number of bills related to the practice of medicine introduced and considered during the recent session of the New Mexico State Legislature. Of particular interest, of course, were the changes made to the Medical Practice Act.

Graduates of Unapproved Medical Schools
New language allows a graduate of an international medical school that may or may not be "approved" to be licensed in New Mexico if they have also completed at least two years of an approved postgraduate training program at or affiliated with an institution located in New Mexico prior to Dec. 30, 2007. This change will allow the current students who were accepted into a New Mexico residency program to be licensed and hopefully practice in rural areas of the state.

Resident Licenses
To avoid similar problems in the future, new language will allow the board to establish by rule specific education or examination requirements for postgraduate training (otherwise known as "resident") licenses. Through the rule-making process, the board will be able to obtain public input and discussion before developing these specific requirements for a resident license.

Exam Timeframes
Existing licensing requirements prescribe a period of seven years for an applicant to complete the examination series (10 years for certain applicants). New language will allow the board to develop a rule establishing exceptions to this requirement. In the past few years, several qualified applicants were not able to be licensed in New Mexico because of the existing provision and many other states have dropped or revised their time frames for examinations given that there appears to be no direct correlation between time in which the examination series was completed and future competence of the physician.

Sexual Misconduct
Old language, that defined sexual misconduct between a physician and patient (or patient's guardian) as inappropriate only when the physician represents or infers that the sexual contact is part of the patient's treatment, was removed. This was an artificial and outdated limitation, and its removal will enhance the board's ability to carry out its statutory mandate to protect the New Mexico public. For a complete copy of the Medical Practice Act, go to the board website: www.nmmb.state.nm.us. Or, call the office to have a copy sent to you. It is the responsibility of all licensees to be familiar with the current law.

Other Bills of Interest

Pain Management
For the third year in a row, Rep. Danice Picraux introduced legislation dealing with pain management, and this year the bill finally made it into law. The bill mandates all boards licensing health professionals with prescriptive authority adopt rules establishing standards and procedures for the

application of the Pain Relief Act — approved by the board in 2003. Each board is also required to encourage those providers who have prescriptive authority and who treat patients for pain to obtain continuing education in pain management. The bill creates the Pain Management Advisory Council, which will review current pain management practices in New Mexico and nationally and provide pain management education for both consumers and health care professionals.

Domestic Abuse

A new section has been added to the Family Violence Protection Act requiring all health care providers to document cases of domestic abuse among their patients, and to provide those patients with information and referral to services for victims of abuse. The AMA Code of Medical Ethics requirements for reporting domestic and child abuse are actually more stringent than the new law, and these changes present no additional burden for physicians while at the same time serving to encourage more attention to this challenging social issue by all health care providers.

Telehealth Commission

A new law creates the Telehealth Commission, whose purpose is to coordinated a statewide effort to develop a telehealth system in New Mexico.

These and other bills can be viewed at the New Mexico State Legislature's website: www.legis.state.nm.us.

Reprinted from Volume 10, Issue 1, of *Information & Report*, published by the New Mexico Medical Board.

MASSACHUSETTS
STATE BOARD OF REGISTRATION IN MEDICINE TO LEAD ON NATIONAL PRACTITIONER IDENTIFIER PLAN

In a manner unique to Massachusetts, the health care community is collaborating to implement a new Federal requirement that "covered providers" in the state obtain a National Provider Identifier (NPI). The Massachusetts Board of Registration in Medicine, which licenses approximately 30,000 physicians, is taking the lead by helping Massachusetts physicians secure their NPI as part of the relicensure process. The board also will give physicians the option of authorizing the agency to get the NPI on their behalf. This process is called "bulk enumeration." We expect bulk enumeration will be a convenient way for physicians and other health care providers to obtain their NPIs.

"We recognize the critical importance of the NPI and felt we could play an important role in the process," said board Executive Director Nancy Achin Audesse. "We want to make compliance as easy as possible for state physicians."

The Health Insurance Portability and Accountability Act of 1996, commonly known as HIPAA, required the secretary of Health and Human Services (HHS) to adopt a standard unique health identifier for health care providers. The NPI Final Rule adopted the NPI as this identifier. What is an NPI? It is a 10-position, numeric identifier designed to be used in HIPAA standard transactions. With few exceptions, it is assigned for life.

The HHS secretary delegated to the Centers for Medicare & Medicaid Services (CMS) the authority to develop the NPI enumeration process and the requirements concerning NPIs. Beginning May 23, 2005, covered providers could begin to apply for NPIs. By May 23, 2007, all HIPAA covered entities except small health plans must begin using NPIs in HIPAA standard transactions, such as claims, remittance advices and eligibility inquiries.

"Massachusetts is taking a leadership role in implementing the NPI mandate," said Audesse. "The lessons learned from these efforts should have value to other states around the country.

Reprinted from the Massachusetts Board of Registration in Medicine website.

LET US HEAR FROM YOU

Would you like for information from your board to be considered for publication in the *Journal*? If so, e-mail articles and news releases to Edward Pittman at epittman@fsmb.org or send via fax to (817) 868-4098.

DISCOVERY

Godoy v. Kojian,
No. B174695 (Cal. Ct. App. July 5, 2005) – DEx 99132

The California Court of Appeal, Second District, ruled a trial court did not err in granting summary judgment in favor of a dentist and doctor in a patient's medical malpractice action.

In so ruling, the court rejected the patient's argument that the trial court improperly denied her requests for continuances to permit further discovery prior to ruling on the summary judgment motions.

The court of appeal also found the patient had waived her argument that a dentist's declaration was insufficient to support the summary judgment motion in favor of the defendant dentist. The patient did not object to the declaration on the ground asserted on appeal. However, the court noted, even if it were to address the patient's argument, it would conclude it was meritless.

White v. Lenox Hill Hosp.,
No. 02-5749 (S.D.N.Y. June 20, 2005) – DEx 98898

The U.S. District Court for the Southern District of New York ruled a magistrate judge correctly entered a discovery order denying a plaintiff's request for production of consent forms, progress notes and contact information for black recipients of non-emergency transfusions at a hospital over a five-year period.

The magistrate judge denied Laura Dodd's request because she failed to satisfy her burden of showing justification for the hospital records, especially because production of the records would violate the privacy rights of the hospital patients that are non-parties to the litigation.

The judge found Dodd's expert witness had already formed his opinion and did not need the hospital records. The district court found the judge's decision was not "clearly erroneous." (For other decisions in this case, see 14 *HLawWk* 308, May 27, 2005; and 13 *HLawWk* 732, Nov. 19, 2004.)

EXPERT TESTIMONY

Torres v. Sullivan,
No. 2D03-5227 (Fla. Dist. Ct. App. June 29, 2005) – DEx 98938

The Florida Second District Court of Appeal ruled a trial court erred in granting partial summary judgment in favor of a doctor in a parent's medical malpractice action. A trier of fact must resolve whether the parent's expert's testimony accurately reflected the standard of care.

Maria Torres, as parent and natural guardian of Luis Torres, brought a medical malpractice suit against Dr. John Sullivan Jr.; John E. Sullivan Jr., M.D., P.A.; and SMH Physician Services Inc., d/b/a First Physicians Group (collectively, Sullivan), alleging he was negligent in failing to deliver Luis by Cesarean section.

The trial court granted partial summary judgment in Sullivan's favor that dismissed Torres' malpractice claim. In entering summary judgment, the court rejected testimony from Torres' expert witness regarding what the standard of care required of Sullivan. Torres appealed.

The district court of appeal reversed the trial court's grant of partial summary judgment. Cases from other jurisdictions have concluded that whether an expert's testimony accurately reflects the standard of care applicable to the circumstances of the case is a question of fact to be resolved by the trier of fact. Similarly, the issue of whether Sullivan's actions met the appropriate standard of care involved a disputed issue of fact that could not be resolved by the trial court in a motion for summary judgment.

LICENSES

Lee v. Board of Chiropractic Exam'rs,
No. B175285 (Cal. Ct. App. June 27, 2005) – DEx 99131

The California Court of Appeal, Second District, ruled the Board of Chiropractic Examiners improperly decided to revoke a chiropractor's license as a penalty. Following an

administrative hearing, the board rejected the hearing officer's recommendation to suspend the license of Sujin Lee D.C., deciding instead that revocation was called for. Lee brought a petition for writ of mandate in the trial court to challenge the board's decision.

The trial court issued the writ directing the board to impose a penalty that was "less than revocation." The board appealed, contending the penalty imposed was not an abuse of its discretion.

The court of appeal affirmed the trial court's judgment. The court of appeal found the board abused its discretion in imposing the penalty because it failed to apply its own disciplinary guidelines.

MALPRACTICE

Bentley v. Loma Linda Univ. Med. Ctr.,
No. E035540 (Cal. Ct. App. June 13, 2005) – DEx 98511

The California Court of Appeal, Fourth Appellate District, reversed a trial court's decision in favor of a hospital and doctors in a malpractice case because the evidence did not support the verdict.

Boyd Bentley was anesthetized for colon surgery and woke up with an injury to his arm. Bentley was placed on the operating table on his back, with his feet up and in stirrups. His arms were wrapped in towels, taped to arm boards, and extended out from his body. After anesthesia was administered to Bentley, an anesthesiologist positioned Bentley's arms.

Halfway through the surgery, the operating table was tilted, placing Bentley's head downward for two hours. When Bentley was in this position, his weight was exerted toward his upper body. Normally, a patient in this position is held by stirrups, leg straps and a safety belt. However, Bentley was not positioned in this manner.

Bentley sued the hospital and anesthesiologists for negligence. The anesthesiologists, Bentley's expert and the hospital's expert all agreed that it is the standard of care to position a patient's arms appropriately prior to putting him to sleep.

Nonetheless, the jury found in the hospital's favor, and Bentley appealed. The appellate court reversed, ruling the evidence did not support the verdict because both expert witnesses, along with the anesthesiologists testified that the standard of care is to position the arms prior to administering anesthesia. The court found the evidence also indicated that Bentley's arms were not positioned until after he had fallen asleep, in violation of the standard of care.

NEGLIGENCE

Cox v. Paul,
No. 71S03-0409-CV-417 (Ind. June 14, 2005) – DEx 98521

The Indiana Supreme Court ruled an oral surgeon is not strictly liable for failure to warn a patient of a recall of Vitek dental implants but is liable for failure to make reasonable efforts to warn the patient. The court ruled that it is the burden of the healthcare provider to establish that reasonable steps to warn the patient were taken, but the surgeon failed to meet the burden.

Dr. William Paul operated on Suzan Cox to correct problems with her temporomandibular joints, which connect the jaw to the skull. Paul surgically replaced Cox' right and left temporomandibular joints with Vitek dental implants.

Seven years later, the U.S. Food and Drug Administration (FDA) recalled the Vitek implants and sent Paul a letter advising him to notify all his former and current patients that the implants were potentially defective. The FDA requested that the doctors respond to a questionnaire asking for information about each patient who received the implants.

Four months after receiving the FDA letter, Paul instructed his staff to search patient charts, but the staff did not uncover Cox' chart. Two years after the initial search, Paul's staff searched the charts again, but did not find Cox' chart. Finally, five years after the FDA letter, Paul's office finally discovered Cox' chart and notified her of the recall. By that time, Cox had already suffered from the side effects of the implants. Cox sued Paul for malpractice, alleging his failure to warn her of the side effects was a breach of duty to warn. The trial court denied Cox' motion to rule that Paul breached his duty to warn as a matter of law. The appellate court reversed (see 13 *HLawWk* 316, May 14, 2004).

The Indiana Supreme Court vacated the trial court's decision, granting Cox' motion for partial summary judgment

on whether Paul could be found negligent as a matter of law or res ipsa loquitor. The court found that the evidence showed Paul did not warn Cox of the dangerous side effects for five years after he received the FDA letter and failed to carry his burden of proving that there is a non-negligent explanation for failing to warn Cox.

Phelps v. Physicians Ins. Co. of Wisconsin Inc.,
No. 03-0580 (Wis. June 22, 2005) – DEx 98910

The Wisconsin Supreme Court ruled an unlicensed first-year medical resident is not subject to the same standard of care as a general practitioner, but is held to the standard of care of a first-year medical resident in the same or similar circumstances. Further, the court held the defendant hospital and resident waived their right to a jury trial by paying the jury fee late and failing to timely request an expansion of the payment deadline. The court ruled a letter written by the resident's superior is not protected under the state peer review statute.

Marlene Phelps was pregnant with twins. Dr. Matthew Linderman, M.D., an unlicensed first-year medical resident, cared for Phelps at the hospital when she was experiencing bleeding associated with her pregnancy and required a Cesarean section. Dr. Linderman monitored Phelps to assess her condition and report it to an upper level senior resident or to an attending obstetrician; Dr. Linderman had no authority to provide primary obstetrical care for Phelps.

Dr. Linderman monitored Phelps over the course of one night, until 7 a.m., when she felt the toes of one of her babies extending from her. Phelps' son, Adam, was delivered, and resuscitation efforts began, but he died. Kyle was delivered successfully.

Phelps and her husband sued the hospital and Dr. Linderman for negligence. Dr. Linderman's insurance company filed an answer, requesting a trial by jury. However, the defendants failed to pay the jury fee by the payment deadline. Thus, the trial court ruled that Dr. Linderman waived his trial by jury and conducted the trial. The court ruled that Dr. Linderman was held to the standard of care of an unlicensed first-year medical resident and found that he was negligent.

Further, the trial court apportioned 80 percent of the negligence to Dr. Linderman and 20 percent to the hospital, awarding the Phelps $901,015 in damages. Each of the Phelps' children were awarded $45,000. The appellate court reversed the decision of the trial court.

The Wisconsin Supreme Court reversed, agreeing with the trial court as to Dr. Linderman's standard of care and ruling the trial court did not abuse its discretion in holding Dr. Linderman to the standard of care of an unlicensed first-year medical resident. The court explained a first-year resident is limited in his ability to treat patients, as restricted by the hospital.

Further, the court ruled the jury trial was waived because the defendants failed to pay the jury fee in a timely manner and allowed almost one year to lapse before requesting an extension of the deadline. Finally, the court did not protect a letter that was written by one of Dr. Linderman's superiors in order to address his concerns about Dr. Linderman's treatment of patients because the letter was not part of a peer review proceeding.

PHYSICIAN LICENSING

Richter v. State Med. Bd. of Ohio,
No. 04AP-680 (Ohio Ct. App. June 16, 2005) – DEx 98523

The Ohio Court of Appeals ruled a trial court erred when it refused to render a declaratory judgment that the state medical board send and consider a physician's application for a new license to practice medicine.

The trial court denied the physician's request because the board had previously permanently revoked his license to practice medicine. The appellate court found the physician was entitled to declaratory judgment.

The appellate court found the conflict was justiciable in nature and appropriate for judicial resolution. The physician would suffer hardship if judicial relief were denied. The court also found the board did not have the authority to refuse to process an application for reinstatement by an applicant whose license was "permanently" revoked.

WRONGFUL DEATH

Gilmore v. O'Connor,
No. B178454 (Cal. Ct. App. June 29, 2005) – DEx 99104

The California Court of Appeal, Second District, ruled a

trial court erred in granting summary judgment in favor of a rheumatologist in a wrongful death action brought by the heirs of a patient who died from coronary failure. Conflicting expert testimony raised triable issues of fact. Brian O'Connor, M.D., a rheumatologist, treated Olivia Gilmore for various degenerative joint problems from 1988 until her death in 2002. Gilmore's medical records indicated a significant family history of coronary disease. In addition, Gilmore was being treated for hypertension and high cholesterol.

Gilmore died from coronary failure. Thereafter, Gilmore's surviving husband and adult children filed a complaint for damages, alleging wrongful death against Dr. O'Connor.

Dr. O'Connor moved for summary judgment on the grounds that he did not breach the relevant standard of care in treating Gilmore, nor was his treatment a proximate cause of her death. In support of the motion, the respondent submitted the declarations of Rodney Bluestone, M.D., a rheumatologist, and Daniel Wohlgelernter, M.D., a cardiologist.

In opposition to the motion for summary judgment, the plaintiffs submitted the declaration of Phillip Frankel, M.D., who, like Dr. Wohlgelernter, was board-certified in internal medicine and cardiology. The trial court found Frankel's declaration was not competent to refute the declarations of Bluestone and Dr. Wohlgelernter and granted summary judgment for Dr. O'Connor. The plaintiffs appealed.

The court of appeal reversed the trial court's judgment. Dr. Frankel's curriculum vitae established he was board-certified in internal medicine, with subspecialties in cardiovascular diseases and interventional cardiology. Thus, Dr. Frankel was competent to testify to the standard of care in recognizing the symptomology of cardiac disease, as well as the need to refer a patient to a cardiologist or order a cardiac evaluation.

In rejecting Dr. Frankel's declaration, the court of appeal found the trial court improperly weighed conflicting evidence. Triable issues of material fact existed as to whether Dr. O'Connor breached the standard of care and thereby proximately caused Gilmore's death by failing to refer Gilmore to a cardiologist or otherwise rule out a cardiac origin for her symptoms.

Reprinted with permission from *Health Law Week*.

Federation Physician Data Center

Disciplinary Alert Service

We've been collecting disciplinary data since 1912. Our history speaks volumes about our commitment to protecting the public and the quality and reliability of our data. The FSMB's Disciplinary Alert Service will notify you when any of your physicians or physician assistants has a reported disciplinary action from all of the following sources:

- All U.S. state medical boards (including U.S. territories)
- U.S. Department of Health and Human Services (Medicare/Medicaid)
- U.S. Department of Defense
- International medical regulatory authorities including Canada, England, Australia and New Zealand.

Federation of STATE MEDICAL BOARDS

FSMB is recognized by JCAHO, NCQA, URAC and AAAHC as primary source equivalent for disciplinary history and monitoring of sanctions.

Send us an e-mail at badb@fsmb.org to request more information, or visit us online at www.fsmb.org/badbfacts.htm. You also may contact us at (817) 868-4000 to speak to one of our highly trained representatives.

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

There's one way to make sure you know what you need to know before you hire or privilege a Physician or Physician Assistant (PA).

FCVS uses State Medical Boards Credentialing Best Practices that exceed JCAHO, NCQA, URAC, and AAAHC standards. FSMB is recognized as primary source equivalent for disciplinary data by JCAHO. FCVS exceeds the 10 principles outlined in JCAHO's MS.4.10.

Send us an e-mail at fcvs@fsmb.org to request more information, or visit us online at www.fsmb.org/fcvs_program/cvrhome.htm. You also may contact us at (888) ASK-FCVS to speak to one of our highly trained representatives.

FCVS obtains primary source verification of an M.D., D.O. or PAs:

- Identity
- Education
- Training
- Examination history
- ECFMG certification
- PA-C certification
- Disciplinary history