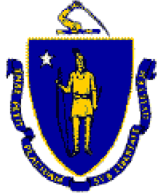
Commonwealth of Massachusetts

Board of Registration In Medicine

Annual Report ~ 2008 ~



Deval L. Patrick
Governor

Timothy P. Murray
Lieutenant Governor

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880

John B. Herman, MD
Chair

Peter Paige, MD
Vice Chair

Myechia Minter-Jordan, MD
Secretary

Francisco Trilla, MD
Physician Member

Honorable Herbert Hodos
Public Member

His Excellency Deval L. Patrick
Governor of the Commonwealth
And the Honorable Members of the General Court

Dear Governor Patrick and Members of the General Court:

On behalf of the Board of Registration in Medicine I'm honored to announce the submission and availability of a report summarizing the agency's activities for the calendar year 2008. The full report can be found on the Board's website at www.massmedboard.org.

First the data on our primary mission: we license physicians. For the record, as of January 2009, a total of 31,789 physicians held active full licenses. An additional 4,418 residents and fellows in hospital training programs held limited licenses. Last year 2,345 new full licenses were approved by the Board. That is 395 more new licenses than were granted in 2007 – a 20 % increase. And over half of the new full licensees specialize in primary care, OB/GYN, pediatrics and emergency medicine. The population of physicians in the Commonwealth is strong and growing.

2008 was historic for the Board of Registration in Medicine. In a year characterized by sea changes in our political and economic landscape, the Board has endured and advanced as it underwent its own significant changes in personnel and location. Perhaps never before has the Board been faced with such enormous challenges, a convergence of external circumstance and ambitious internal projects.

Most significant of our challenges was the change in Board leadership. In August, after 10 years of extraordinary endeavor, Executive Director Nancy Achin Audesse entered a well-deserved retirement from state service. During her decade of leading the agency the Board was transformed by her guidance, and the Massachusetts Board attained national prominence. A four-time cancer survivor, Nancy has a deep and personal commitment to patient advocacy, bolstered by skills taught by her family's tradition of public service, and honed by her term as a state senator from Lowell. While state government may have lost its most ardent champion of patient safety and health care quality, her legacy endures at the agency she inspired to adopt a commitment as sincere as her own.

In 2008 Board Chair Martin Crane, M.D., long-time and brilliant collaborator with Nancy during much of the Board's decade of change also departed the Board. A steady hand with the gavel at board meetings, Marty was an able public spokesman, and respected on

Beacon Hill and in conferences with Massachusetts health-care leaders. All the while, Marty maintained an active office practice and was a community leader at home. Marty's vision and leadership in promoting a systems-approach to safety in health care was demonstrated in his role of Chairman of the Board's Patient Care Assessment Committee, the unique "qualifier" for every hospital-based patient safety program in the Commonwealth. His expertise was quickly recognized on the national level, particularly as Massachusetts' delegate to the Federation of State Medical Boards. Marty has ascended the ranks of leadership at the FSMB, and in May of 2009 will become Chair of FSMB Board of Directors. Massachusetts should be proud to have one of our own in this important position and at this crucial time as national attention turns to debate the urgent issue of health care reform.

The Board does more than license and discipline physicians, however. It also is an active participant in policy development. In 2008 the Medical Spa Task Force, created by the Legislature and chaired by the Board's Executive Director, completed work on a final report that recommends a comprehensive licensing and regulatory structure for currently unregulated medical spas. The report included legislation which has been filed in the state Senate, and the Task Force is hopeful the legislation will receive favorable consideration by the Legislature.

The Expert Panel on Credentialing convened by the PCA Division finalized its report in 2008. The Panel created a standardized framework for credentialing hospital-affiliated practitioners. Several hospitals, large and small, acted as beta sights for testing. Some of the data from these sights has been reported back to PCA. This year will see the Panel examine the data and issue a final definitive report, which is expected to serve as a national model for practitioner credentialing by hospitals.
The structure and stability created by the collaboration of our former Executive Director and Board Chair created a solid foundation upon which we have continued to build. With their departure the Board's talented senior staff were called upon to steward the agency in the interim, and they have performed ably and well.

In the heat of the summer the Board headquarters moved, lock, stock, and barrel from our home on Boston's Harrison Avenue to a former mill building in Wakefield. Notwithstanding significant logistical complexities, including tons of office equipment, gargantuan files and complicated IT infrastructure, the move was completed over one weekend, with virtually no interruption in our usual functions. This was truly a sensational achievement.

Around this same time we welcomed the appointment of three new Board members: Judge Herbert Hodos, J.D., public member and physician members Myesha Minter-Jordan, M.D., MBA and Francisco Trilla, M.D. Our new members took to their new assignments with enthusiasm and their contributions have already made a wonderful impact on the Board and its work. Board Vice-Chair Peter Paige, M.D. has accepted Governor Patrick's appointment to a second three-year term, and we are grateful that he will continue to contribute his integrity, hard work and judgment to the Board.

I must also include a public acknowledgment for the enormous contributions made by two other Board members who have completed their service: physician members Randy Wertheimer, M.D. and Guy Fish, M.D. Each served the Board for six years and contributed extraordinary service to the Commonwealth. Their attention to the quality of the Board's business can only be described as priceless. Few individuals outside of our Board understand the effort required by its members, week-in and week-out, over the course of many years. A typical twice monthly "board day", requires many hours of preparation reviewing documents, and the meetings themselves often extend well into the evening. The work is gratifying, and the dedication is required. Their wisdom, good humor and steady judgment will be deeply missed.

As Board Chair I have enjoyed regular meetings with Commissioner John Auerbach of the Department of Public Health. His guidance and the cooperation of DPH staff has been sought often and given generously. Conversations and meetings with allied health care officials, representatives from the medical societies, academic health centers, hospitals, health plans, the defense bar, other state agencies, legislative leaders and the Governor's office have been collaborative and fruitful. We all share the same goal.

Our agenda for the coming months is aggressive. After several years of planning we will soon go "live" with online renewal of physician licenses. This project will provide a major convenience to physicians, and create a significant opportunity to electronically gather and analyze demographic and workforce data. The Board will use this data in order to inform policy makers as they work to improve patient safety and access to quality health care in the Commonwealth.

We are in the final stages of the search for a new Executive Director. With the superb help of a professional search firm, an advisory group has been meeting for several months and will soon forward to the Board an impressive group of finalists. The interest in this important position has been enthusiastic and widespread. The Board is expected to make its final decision in the early spring of 2009.

Finally, on a very personal note, I would like to acknowledge my friends, the Board's wonderful senior administrative leadership. Each of them works selflessly on behalf of the Commonwealth. My thanks to Sue Carson, Russell Aims, Barbara Piselli, Rose Foss, Stan Riley, M.D. and, especially, General Counsel Brenda Beaton who, with great energy and aptitude, has gracefully performed the role of Acting Executive Director.

Sincerely

John B. Herman

John B. Herman, M.D.
Chair

Board of Registration in Medicine
2008 Annual Report

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Commonwealth of Massachusetts

Board of Registration in Medicine

Annual Report

2008

Mission Statement

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

MEMBERS OF THE BOARD

John B. Herman, M.D., Chair of the Board, Physician Member
Dr. Herman is Director of Clinical Services in the Department of Psychiatry at MGH, and joined the Board in 2002. He is also Medical Director for Partners HealthCare Employee Assistance Program. Dr. Herman is Board-certified in psychiatry and neurology, and is a Distinguished Fellow of the American Psychiatric Association. A graduate of the University of Wisconsin Medical School, Dr. Herman served his medical internship at Brown University Medical School and his residency in psychiatry at MGH. He has been on staff at the MGH Psychopharmacology and Addiction Clinics since 1984, where he directed the department's continuing education program and was Director of Psychiatry Residency Training. He is co-editor of the MGH Guide to Psychiatry in Primary Care and MGH Psychiatry Update and Board Preparation. Dr. Herman is past president of the American Association of Directors of Psychiatry Residence Training. He serves as Chair of the Board's Patient Care Assessment and Licensing Committees.

Peter Glenn Paige, M.D., Vice Chair, Physician Member
Dr. Paige was appointed to the Board in 2006. He is a Board-certified Emergency Medicine Physician, and a graduate of SUNY Health Science Center Medical School in Syracuse, NY. Dr. Paige completed his residency at the University of Massachusetts Medical Center in Worcester. He is Vice-Chair of the Department of Emergency Medicine and Clinical Associate Professor at UMass Memorial Medical Center. He is very active in the community and was named Volunteer of the Year by the American Heart Association, Northeast Affiliate, for his hard work as Chairman of the Worcester Heart Ball. Dr. Paige is also Chairman of the Children's Injury Prevention and Pediatric Trauma fundraiser. He serves as Chair of the Complaint Committee.

Myechia Minter-Jordan M.D., MBA, Physician Member
Dr. Minter-Jordan currently serves as Chief Medical Officer of the Dimock Community Health Care Center, one of the largest health care centers in the city of Boston. Prior to this, she served as Director of Medical Consultation Services at Johns Hopkins Bayview Medical Center in Baltimore, Maryland. Dr. Jordan completed her medical school education and undergraduate studies at Brown University. She completed her residency in internal medicine at the Sinai Hospital/Johns Hopkins Program in Internal Medicine. In addition, Dr Jordan has completed a Masters of Business with a focus on the Business of Medicine at Johns Hopkins Carey Business School. Dr. Jordan is board certified in internal medicine. She joined the Board in 2008.

Honorable Herbert H. Hodos, Public Member
Judge Hodos graduated from Yale University in 1960 and from Boston College Law School in 1963. He practiced law in general practice in Springfield from 1964 to 1966 with the law firm of Robinson and Dibble and from 1966 to 1993 in Greenfield as a partner of the law firm of Levy, Winer. Judge Hodos was appointed to the Massachusetts Trial Court as a judge of the Greenfield District Court in 1993, and served as its first justice from 1995 until his retirement from the bench in 2008. Judge Hodos was appointed to the Board in 2008. He was presented with the judicial excellence award for the District Court by the Massachusetts Judges Conference in 2008. He has been involved in numerous civic, charitable and professional positions locally as well as statewide throughout his career.

Francisco Trilla, M.D., Physician Member
Dr. Trilla was appointed to the Board in 2008. He is a 1980 graduate of Harvard Medical School, trained at Bellevue Hospital in New York City, and served in the National Health Service Corps. Currently he is on staff at Beth Israel Deaconess Medical Center, is Medical Director of Atreva Healthcare in Jamaica Plain, and is MinuteClinic's North East Regional Medical Director. He is an Assistant Clinical Professor at Harvard Medical School, is Board Certified in Emergency Medicine and Internal Medicine, and has published on the topic of Physician and Nurse Practitioner collaboration. In 2006, he was recognized by the Boston VNA as a "Home Healthcare Hero" in recognition of his years in community healthcare.

STRUCTURE OF THE BOARD OF REGISTRATION IN MEDICINE

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

COMMITTEES OF THE BOARD

Complaint Committee

The Complaint Committee is comprised of two Board members who meet on a monthly basis to review the evidence gathered by the Enforcement Division during investigations. Depending on the nature of the case, the Complaint Committee determines whether disciplinary action is appropriate and makes recommendations to the full Board. The Complaint Committee also closes investigations when evidence gathered is insufficient to support disciplinary action. In closing investigations, the Complaint Committee may issue letters of advice, concern, or warning and/or conduct conferences with physicians to discuss issues uncovered during the investigation.

Data Repository Committee

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

Licensing Committee

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

Patient Care Assessment Committee

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

Committee on Acupuncture

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

FUNCTIONS AND DIVISIONS OF THE AGENCY

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

Licensing Division

The Licensing Staff, under the direction of the Director of Licensing, performs the initial review of all applications for medical licensure to ensure that only competent and fully trained physicians are licensed in Massachusetts. The staff also works with applicants to explain the requirements for examinations and training that must be met before a license will be issued.

Enforcement Division

The Enforcement Division is mandated by statute to investigate complaints involving physicians and acupuncturists, and to litigate disciplinary actions. The Enforcement Division operates under the

supervision of the Director of Enforcement and is comprised of three units: the Consumer Protection Unit, the Clinical Care Unit and the Disciplinary Unit.

Division of Law & Policy

The Division of Law & Policy operates under the supervision of the Board's General Counsel. Division Board Counsel act as legal counsel to the Board during adjudicatory matters and advise the Board and staff on relevant statutes, regulations and cases. Additional counsel within the Division work with the Licensing Division, in the Data Repository Unit and in the Physician Health & Compliance Unit.

Patient Care Assessment Division

The PCA Division is responsible for receiving and evaluating reports from the Commonwealth's hospitals that detail their patient safety programs, and report Major Incidents, defined as any unexpected adverse patient outcomes. Supervised by the Director of PCA, Division works with hospitals to assure that hospital patient safety programs are effective and comprehensive, that hospitals conduct full and competent medical reviews of patient safety incidents, and that hospitals are fully in compliance with reporting and remediation requirements regarding Major Incidents.

Information Technology Division

The Board is a leader in applying information technology to its functions, and the Information Technology Division is responsible for maintaining the Board's sizeable technology infrastructure, developing and introducing new applications and keeping the Board at the cutting edge of technological innovation. The Division services the entire agency and identifies and fills individual staff needs, responds to emergencies and ensures the continuity of the Board's electronic records by securing them at offsite backup locations, both within Massachusetts and in another state. The Board's IT Division Director works with the Commonwealth's Information Technology Division to keep the Board's systems in compliance with Commonwealth standards, and to take advantage of IT opportunities in the broader state government.

Operations Division

The Operations Division is supervised by the Director of Operations, and is responsible for human resources, procurement, expenditure tracking and facilities. It also manages both the Call Center and the Document Imaging Unit. Since the launch of the Physicians Profiles project in 1996, Massachusetts residents have found the information they need to make informed health care decisions, using this first in the nation program. In addition to online access to the Physician Profiles,

the Board assists consumers who do not have Internet access through a fully staffed Call Center. Staff in the Call Center answer questions about Board policies, assist callers with obtaining complaint forms or other documents and provide copies of requested Profiles documents to callers. The Document Imaging Unit scans agency documents into an electronic database. This system has allowed the agency to standardize and automate its processes for storing and retrieving documents.

LICENSING DIVISION REPORT

Rose M. Foss, Director of Physician and Acupuncture Licensing

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

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

Physician Demographics

Total Licensed	**31,789 (100%)**
Men	**20,795 (65%)**
Women	**10,994 (35%)**
Age Groups	
<40	**8,610 (27%)**
40-49	**8,620 (27%)**
50-59	**8,001 (25%)**
60-69	**4,624 (15%)**
>69	**1,934 (6%)**
Board Certified	
Yes	**26,585 (84%)**
No	**5,204 (16%)**

As of January 2009

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

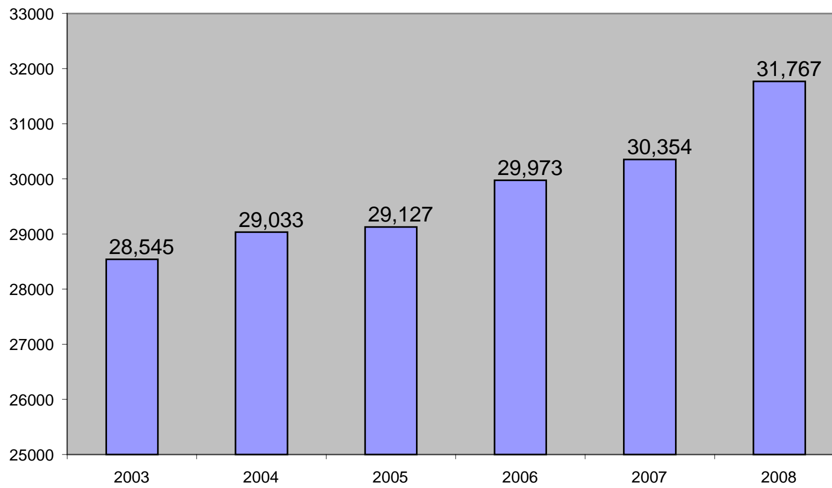
Licensing Division Statistics

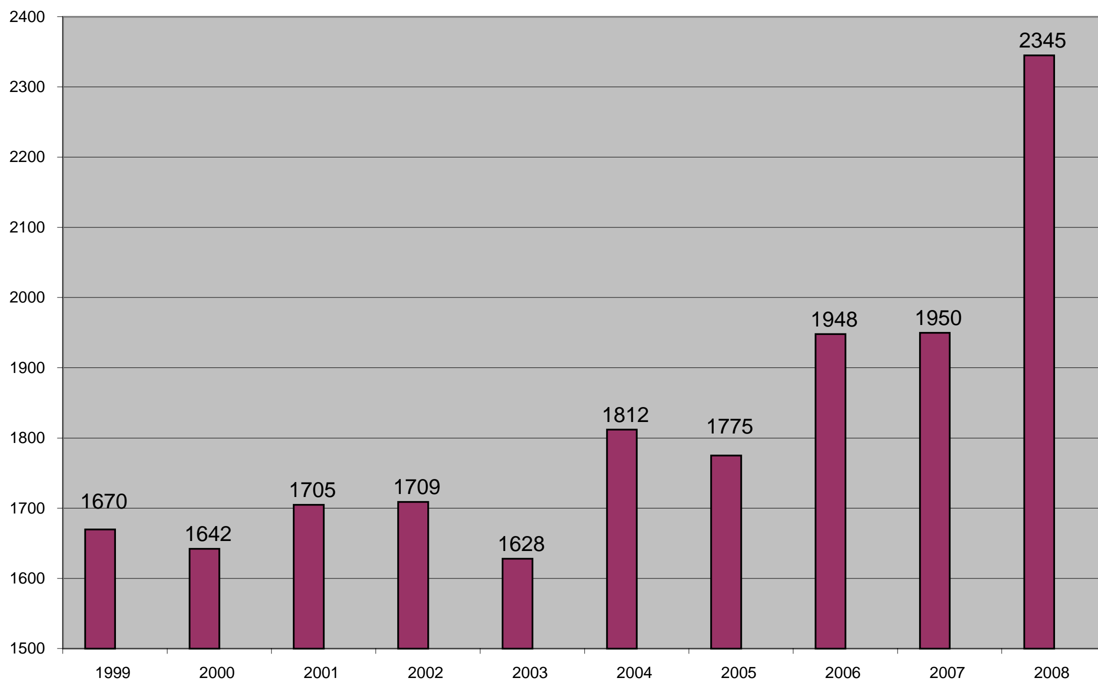
License Status Activity	2008	2007*	2006	2005*	2004
Initial Full Licenses	**2,345**	1,950	1948	1,775	1,812
Full Renewals *	**10,801**	20,676	9,371	19,648	9,645
Lapsed Licenses Revived	**221**	204	206	192	113
Initial Limited Licenses	**1,612**	1,629	1,587	1,549	1,521
Limited Renewals	**2,869**	2,841	2,811	2,751	2,701
Temporary (initial) Licenses	**21**	10	13	21	22
Temporary Renewals	**15**	13	11	17	6
Voluntary Non-renewals	**260**	517	320	561	390
Revoked by Operation of law	**770**	1,090	874	1,084	869
Deceased	**56**	203	155	265	162
TOTAL	**18,970**	29,133	17,296	27,863	17,241

**The majority of full licenses are renewed in odd-numbered years*

In 2008, 395 more new full licenses were issued than in 2007, an increase of approximately 20%. The majority of full licenses are renewed in odd-numbered years, and this can be observed in the table above, as licensing activity varies from odd- to even-numbered years. There was little change in the number of limited licenses issued or renewed in 2008, as the number is based on the number of available training positions in healthcare facilities. These statistics indicate a strong and growing physician population in the Commonwealth. Over half of the new full licensees specialize in primary care, OB/GYN, pediatrics and emergency medicine.

The Board plans to conduct further research on the physician population, in cooperation with the Department of Public Health, to determine where and to what extent physicians are practicing in the Commonwealth. Anecdotal evidence suggests persistent geographic disparities in the ability of citizens to access physician care, as well as an uneven distribution of certain specialties, availability of translation services and other demographic characteristics.





Licensing Committee

The primary role of the Licensing Committee is to ensure that every physician applying for licensure is qualified and competent to practice medicine in the Commonwealth. As a subcommittee of the Board, the Licensing Committee is responsible for reviewing all license applications presenting possible legal, medical, malpractice and competency issues that could be barriers to licensure.

Physicians applying for an initial limited license or renewing a limited license who had competency issues or substandard clinical performance in a training program are reviewed by the Licensing Committee. In such cases, the Licensing Committee customarily interviews the physician and may invite the training program chairperson to attend before making a recommendation on issuance of a limited license to the full Board. The Committee may recommend approval or denial of a limited license, depending on whether the Committee is satisfied that the physician will be closely supervised by the program director and senior staff in the training program. A recommendation for issuance of a limited license in such cases is usually contingent on a performance monitoring agreement with the physician and the program chairperson to provide regular monthly, bi-monthly or quarterly performance monitoring reports to the Board. Renewal of the limited license is contingent on satisfactory performance monitoring reports over the course of the entire academic year. Performance monitoring agreements are customarily required for the duration of the training program.

Licensing Committee Activity Report

Cases Reviewed by Licensing Committee	2008	2007	2006	2005	2004
Malpractice Issues	**47**	30	29	39	28
Competency Issues	**56**	63	56	78	88
Legal Issues	**51**	43	57	53	46
Medical Issues	**25**	31	22	39	42
6th Limited Renewals	**34**	28	31	23	33
Lapsed Licenses	**89**	81	59	70	73
Miscellaneous Issues	**36**	97	92	181	127
Total Cases Reviewed	**338**	373	346	483	437

Performance Monitoring Agreements

The Board's performance-monitoring program for limited licensees began in 1997 to monitor the clinical performance of a limited licensee who may have had performance issues. A performance monitoring agreement is not a disciplinary action; it is an agreement between the licensee and

training program director to provide the Board with periodic evaluations of the licensee's clinical performance. Performance monitoring agreements are discontinued when the licensee's performance is consistently satisfactory. The number of limited licenses issued contingent upon performance monitoring agreements has been relatively stable for the past several years, with the exception of 2007, in which there was a significant decrease. In 2008, the number returned to its historical level.

Performance Monitoring Agreements	2008	2007	2006	2005	2004
Performance monitoring agreements	**11**	5	9	10	10
% Change from previous year	+ **51%**	- 44%	-1.0%	0%	- 10%

Renewals Triage Committee

The Renewals Triage Committee is comprised of a multi-disciplinary team of Board staff with representation from the Licensing, Legal and Enforcement divisions. The primary role of the Committee is to review full renewal applications with "yes" answers on legal, malpractice or medical questions. Renewal applications with affirmative answers are reviewed by the Committee to insure that supporting documentation is complete. Additionally, the Committee reviews criminal, legal and malpractice issues and may recommend follow-up, additional investigation or referral to supportive services, such as the Massachusetts Medical Society's Physician Health Services.

2008 Renewals Triage Committee Statistics

Renewal Applications Reviewed	Total Renewal Issues	Disposition of Cases Reviewed
315	472	• Cases--no further follow-up 255 • License status changes from inactive to active 38 • Enforcement referrals 4 • Physician Health Committee referrals 10 • Data Repository Committee referrals 2

Licensing Division Survey

As an ongoing initiative to improve customer services, the Licensing Division surveys newly licensed physicians to identify opportunities for improvement and to expedite the licensing process within the scope of the Board's regulations. Survey responses are tabulated using the Likert Scale from 1–5, with 1 rated as "poor," 2–3 rated as "average" and 4-5 rated in the "excellent" range. In 2008, the Licensing Division mailed approximately 2,345 surveys and received responses from 816 newly licensed physicians. In 2008, there was a 37% increase in survey responses, and the overall average score of the responses was 4.20%.

Licensing Division Survey Results

Survey Questions	2008 Responses (n=816)	2007 Responses (n=594)	2006 Responses (n=467)	2005 Responses (n= 350)
1. Was the Licensing staff courteous?	**4.25**	4.18	4.33	4.40
2. Was the staff knowledgeable?	**4.40**	4.18	4.11	4.28
3. Did the staff provide you with the correct information?	**4.28**	4.12	4.17	3.92
4. Did the staff direct you to the appropriate person to answer your questions?	**3.87**	4.14	4.17	4.29
Overall average score	**4.20**	4.16	4.20	4.22

Limited License Workshops

In 2008, the Licensing Division conducted 5 regional Limited License Workshops for residency program coordinators and administrative staff who serve as the liaisons between the Board and limited licensees. Workshops were held at the Board, and at Children's Hospital Medical Center, UMass Memorial Medical Center and Lahey Clinic. Residency program coordinators in teaching facilities are responsible for ensuring that residents and fellows who staff the Commonwealth's training programs complete the limited license requirements in accordance with Board regulations, and by the July start date for hospital training programs.

GOING FORWARD IN 2009

Continuing Medical Education (CME) Auditing

As a condition for renewal of a full license, the Board requires that a licensee complete 100 hours of CME credits within the immediate preceding two years, of which 10 hours must be in the area of risk management. The majority of the CME's must relate to the physician's primary area of practice. The Board will begin random auditing of physician renewals in 2009 to confirm that the CME's are in compliance with the Board's regulations. Physicians who are not in compliance with the Board's CME credit requirements may be subject to disciplinary action.

License Portability

The Board has been participating in the New England Regional License Portability project. The goal of the project is to help physicians licensed in one state obtain licensure in other states by using information already obtained by a state medical board. The increasing demand for telemedicine services and the compelling need for specialized physician services in states where there is a shortage of physicians, or states that have underserved areas, highlight the need for license portability. The License Portability project was initiated by the Federation of State Medical Boards (FSMB) to develop a centralized data repository for storing biographical, educational, licensure and disciplinary information on each physician. The master database will facilitate license portability by allowing states to access and share information when a physician applies for licensure in another state and thus simplify and expedite the licensing process. One of the most significant obstacles identified in the sharing of licensing information is that all documents must be digitally scanned for electronic storage in order to be stored in a central data repository. In 2000, the Board began scanning all license applications and other licensing information and it is now stored electronically and readily available to share with other states as soon as guidelines are established and any potential legal issues are addressed. One feature of the License Portability project is the development of a Uniform License Application which will allow physicians to complete and submit license applications online. The Uniform License Application will reside in the FSMB database and will permit physicians to update their information, and will be available if they apply for licensure in another state. The Board will be able to download the application information in an XML format that will automatically populate the data fields in the licensing database. Processing physician applications using the Uniform License Application will be considerably more efficient and cost-effective and reduce both data entry time and errors.

COMMITTEE ON ACUPUNCTURE

Rose M. Foss, Director of Physician and Acupuncture Licensing

The Board's Committee on Acupuncture is responsible for the licensure and discipline of acupuncturists. Acupuncture originated in China 2000 years ago and is unique in that it is one of the oldest and most commonly used practices in the world. In order to ensure that only qualified and competent acupuncturists are approved for licensure, the Board established the Committee on Acupuncture in June of 1987.

In the fall of 2005, acupuncture licensing was integrated into the mainstream licensing of physicians. It is now a component of the Licensing Division under the direction of the Director of Licensing. As a result of this integration, the acupuncture process has benefited by utilizing the processes, procedures and information technology already in use within the Licensing Division. Since that time, significant progress has been made in streamlining and modernizing the acupuncture licensing process.

Acupuncture Committee Members

Weidong Lu, Lic.Ac.
Chairman

Nancy E. Lipman, Lic.Ac.
Vice Chairman

Joseph F. Audette, M.D.
Secretary

Kristen E. Porter, Lic.Ac.
Member

Francisco Trilla, M.D.
Board Representative

Amy Soisson, J.D.
Public Member

Committee on Acupuncture

The Committee on Acupuncture consists of seven members: a licensed physician member of the Board; a licensed physician who is actively involved in the practice of acupuncture; a public member; and four acupuncture practitioners. The role of the Committee on Acupuncture is to work collaboratively with the Board of Registration in Medicine to regulate the practice of acupuncture. The Committee on Acupuncture establishes the standards for acupuncture licensure and scope of practice, including approval of acupuncture schools, training programs and continuing acupuncture education activities.

The Committee's primary function is to protect the safety of the public by ensuring that applicants applying for licensure to practice acupuncture independently are qualified, competent and possess the education, examination and training requirements established by the Committee. The Committee is also responsible for interpreting the existing laws (M.G.L. c. 112 §§148-162) and regulations (243 CMR 4.00-5.00) relating to the practice of acupuncture and disciplinary process for acupuncturists

who engage in misconduct. Meetings of the Committee on Acupuncture are held every three months at the Board of Registration in Medicine and are open to the public for non-adjudicatory matters.

Committee on Acupuncture License Activity Report

License Type	2008	2007	2006	2005
Initial Licenses	**75**	50	65	84
Renewals	**504**	374	482	348
Full Inactive Licenses	**92**	63	78	57
Lapsed Licenses	**1**	1	55	51
Temporary (initial) Licenses	**0**	2	1	2
Voluntary Non-renewals	**6**	1	5	2
Expired	**1**	0	1	0
TOTAL	**679**	491	687	544

Acupuncture licensing and administrative functions are managed as a separate entity under the supervision of the Licensing Division. In addition to providing administrative support to the members of the Committee on Acupuncture, the Licensing Division responds to acupuncture issues raised by the licensees and the public. Legal issues are referred to the Legal Division and disciplinary issues are referred to the Enforcement Division of the Board. The 2008 annual acupuncture legal activity report is listed below.

Acupuncture Disciplinary Actions

Legal Issues	2008	2007	2006	2005
Denial of License	**0**	1	0	1
Disciplinary Actions	**1**	1	0	0
Letter of Advice	**1**	1	1	0
Letter of Concern	**0**	2	0	0
Letter of Warning	**1**	0	1	0
Closed/No Action	**2**	2	0	0
Total Complaints	**5**	5	3	1

COMMITTEE ON ACUPUNCTURE ACCOMPLISHMENTS

Committee on Acupuncture Regulations

For the first time since their original promulgation in 1988, the acupuncture regulations, 243 CMR 4.00 and 5.00, underwent a major revision. In 2008, the Committee on Acupuncture (COA) reviewed the current acupuncture regulations and proposed a number of important revisions, especially in the area of acupuncture education. The highlights of the proposed acupuncture regulations include: raising the education requirements to conform with the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) and the number of education hours from 1350 to 1905; requiring all new applicants to be NCCAOM-certified in either Acupuncture, Oriental Medicine or Chinese Herbology, and; increasing the continuing education requirements for acupuncturists who use herbs in their practice. Additionally, the COA instituted a Temporary License category for acupuncturists attending education courses in Massachusetts under the supervision of a licensed acupuncturist. The new regulations were promulgated and became effective on January 1, 2009.

ENFORCEMENT DIVISION REPORT

Barbara A. Piselli, Director

The Enforcement Division is mandated by statute to investigate complaints and litigate disciplinary actions involving physicians and acupuncturists. It strives to pursue complaints efficiently and fairly as it assists the Board in executing its public protection mandate. The Enforcement Division staff is a group of dedicated professionals who are very knowledgeable about administrative law and practice and are committed to fairly investigating complaints and recommending appropriate disciplinary action when the evidence and the law support it. In 2008, the Board disciplined 53 physicians after investigation by the Enforcement Division.

In addition to its investigative and litigation functions, Enforcement staff members also work cooperatively with other Board staff throughout the agency, participate in the Board's initiatives and are committed to the Board's goals aimed at improving the quality and delivery of health care in the Commonwealth.

The Enforcement Division operates under the supervision of the Director of Enforcement and is comprised of three units: the Consumer Protection Unit, the Clinical Care Unit and the Disciplinary Unit.

Consumer Protection Unit

The Consumer Protection Unit (CPU) provides the first line of review for complaints filed with the Board. The Unit is staffed by a manager, a consumer protection coordinator and an administrative assistant.

The Unit docketed 557 cases for investigation in 2008. In addition to those docketed consumer complaints, the unit received 298 additional communications regarding licensed physicians that were not docketed, as the allegations did not involve conduct within the Board's jurisdiction. These communications, however, were sent to the named physicians for informational purposes. The Board closed 678 complaints during 2008.

Clinical Care Unit

The Clinical Care Unit (CCU) investigates complaints that allege substandard care. The CCU is staffed by a Nurse Manager who is an attorney, three experienced nurse reviewers and a paralegal. CCU staff members assist in the investigation of cases by obtaining necessary documents, reviewing patient records and physician responses, and interviewing witnesses. They work with Enforcement

Division attorneys in the preparation of litigation involving complex substandard care cases. The nurses participate in Data Repository Committee meetings and prepare analyses of physicians' medical malpractice histories for the Licensing Committee. The CCU staff members are also responsible for recruiting and working with medical experts. These experts review medical records and other relevant evidence in order to provide an opinion regarding quality of care concerns. Physicians who have served as Board experts believe their service contributes to making the practice of medicine safer.

Disciplinary Unit

The Disciplinary Unit investigates and litigates cases that may result in disciplinary actions being taken against the licenses of physicians and acupuncturists. The Unit is staffed by attorneys (identified as complaint counsel by statute), a Managing Attorney, investigators, a paralegal and an administrative assistant. Complaints are referred to the Unit by the Data Repository Committee, the Consumer Protection Unit and various other sources. Staff travels throughout the Commonwealth to interview witnesses, gather evidence, and work with local, state and federal law enforcement and other agencies on coordinated investigations.

At the conclusion of each investigation, complaint counsel advises the Complaint Committee with regard to the need for disciplinary action based on the evidence gathered, the relevant professional standards identified, the law and Board precedent. The Complaint Committee then determines whether disciplinary action is appropriate, and makes recommendations to the full Board. The Complaint Committee also resolves matters that are not serious enough to warrant discipline, often issuing letters of advice, concern or warning, and/or conducting conferences with physicians. During 2008, the Complaint Committee closed 597 complaints.

Complaint counsels are also responsible for all litigation, such as drafting pleadings, negotiating consent orders and presenting cases for summary suspension, as well as all legal advocacy at administrative hearings before the Division of Administrative Law Appeals (DALA). DALA hearings often involve complex issues of law and fact, the testimony of numerous witnesses and multiple hearing dates. Later in the adjudicatory process, if appropriate, the team coordinates with victims of physician misconduct to facilitate their submissions of victim impact statements.

In addition, the Director of Enforcement is a Special Assistant Attorney General, which enables the Enforcement Division to initiate actions in the Superior Court to enforce the Board's investigative

subpoenas, and subpoenas issued to compel the appearance of witnesses at hearings. The Division has successfully utilized this tool for compliance in the past and will continue to do so when faced with challenges to the Board's subpoena power.

Disciplinary Actions

In order to impose discipline upon a physician, the Board must issue a Statement of Allegations pursuant to G.L. c. 30A, § 10 to commence an adjudicatory proceeding. The purpose of the adjudicatory proceeding is to provide the physician with due process, and an element of the proceeding is a hearing before the Division of Administrative Law Appeals (DALA). In 2008, 24 Statements of Allegations were referred to DALA. These Statements usually involve multiple allegations of physician misconduct and may encompass more than one complaint. Once the evidentiary hearing is completed, the DALA Administrative Magistrate issues a Recommended Decision to the Board, containing findings of fact and conclusions of law only. When the Board receives the Recommended Decision, it considers the recommendation and issues a Final Decision & Order that may impose discipline. The Board, not the DALA Administrative Magistrate, determines the type of disciplinary action to impose. In 2008, DALA issued 14 Recommended Decisions. As of December 31, 2008, 40 adjudicatory proceedings were pending at DALA.

In lieu of a hearing, the Board may be able resolve the adjudicatory proceeding by entering into a Consent Order with the physician, wherein the physician agrees with the discipline to be imposed. In 2008, 31 physicians entered into such Consent Orders.

Discipline may be in the form of license revocation, license suspension, censure, reprimand, admonishment, practice restriction(s), or denial or restriction of the right to renew a license. The Board may also impose fines or, pursuant to the imposition of a disciplinary action, require that a physician be subject to probation for a certain period of time as a condition of licensure. If a physician tenders the resignation of his or her license and the Board accepts it, the resignation is also a reportable disciplinary action. All disciplinary actions are public, and reportable to the Federation of State Medical Boards' Federation Physician Data Center, the National Practitioners Data Bank and the Healthcare Integrity and Protection Data Bank. Board regulations also permit the Board to resolve minor violations of the Board's regulations with an Assurance of Discontinuance, unless there is an allegation of patient harm and/or allegations of drug or alcohol impairment. These Assurances are reportable to most of the databanks.

DIVISION OF LAW AND POLICY REPORT

Brenda A. Beaton, General Counsel

The Division of Law and Policy is the agency's legal department, and oversees compliance with the broad spectrum of the Board's legal obligations, ranging from statutory reporting to adherence to the Commonwealth's laws and regulations and to physicians' compliance with agreements with the Board. The Division also coordinates the disciplinary work of the Board including Statements of Allegations, Consent Orders, Final Decisions and Orders, and Appeals.

The Division consists of a managing attorney, a manager of the Physician Health & Compliance Unit, counsels, paralegals and administrative personnel. Staff provide advice and support to the Board and its committees. For example, Board counsel advise the Board on a variety of issues such as the disposition of adjudicatory matters, ethics considerations, interpretation of laws and regulations, and formulation of policy. Other counsel review and render advice on specific legal issues affecting the agency, while others review and draft regulations, policies and legislation.

Coordination of Adjudicatory Matters

The Division of Law and Policy maintains the Board's adjudicatory case files, schedules cases to be heard by the Board, prepares its Final Decisions and Orders, and tracks its disciplinary numbers. In 2008, the Board took 53 disciplinary actions against 53 physicians. The Board issued 14 Final Decisions and Orders and entered into 31 Consent Orders. 47 Statements of Allegations were issued, and 24 of those were referred to the Division of Administrative Law Appeals (DALA).

ADJUDICATORY STATISTICS

Type of Action	2008	2007	2006	2005	2004
Consent Order	**31**	31	41	30	46
Final Decision & Order (FD&O)	**14**	12	12	17	10
Summary Suspension	**2**	4	1	5	2
FD&O on Summaries	**0**	3	0	1	2
Resignation	**5**	14	10	8	9
Voluntary Agreement Not To Practice	**2**	10	13	15	14
Assurance of Discontinuance	**1**	1	2	1	1
TOTAL	**53**	72	79	73	82

ADJUDICATORY STATISTICS

Discipline by Type of Sanction	2008	2007	2006	2005	2004
Admonishment	**1**	1	2	2	4
Continuing Med. Educ. Requirement	**2**	2	4	3	5
Community Service	**0**	0	0	2	0
Costs	**0**	0	0	1	0
Educational Service	**0**	0	0	1	0
Fine	**3**	8	15	12	13
Monitoring	**0**	0	0	4	0
Practice Restrictions	**1**	0	3	16	15
Probation	**11**	9	17	10	6
Reprimand	**3**	15	24	14	18
Resignation	**5**	14	10	8	9
Revocation	**10**	12	9	10	10
Summary Suspension	**2**	4	1	5	2
Suspension	**18**	15	31	12	17
Stayed Suspension	**10**	10	16	5	7
TOTAL PHYSICIANS DISCIPLINED	**53**	67	76	69	77

	2008	2007	2006	2005	2004
Cases Referred to DALA	**24**	28	16	29	13
Cases Pending at DALA on 12/31	**40**	31	39	27	20
Cases Dismissed	**4**	3	0	3	1
Statements of Allegations Issued	**54**	59	57	58	60
Probation Violations/Other Violations	**2**	1	3	0	1

Data Repository Unit

The Data Repository Unit (DRU) receives and processes statutory reports concerning physicians licensed in Massachusetts. Mandated reporters include physicians, other health care providers, health care facilities, malpractice insurers, professional medical associations, government agencies involved in the provision or oversight of health care and civil and criminal courts.

DRU staff members work with the Board's Data Repository Committee (DRC) to review mandated reports and to determine appropriate resolution, which can include referral to the Board's Enforcement Division for formal investigation. The DRU also provides information regarding Board disciplinary actions to national data collection systems, and it also ensures that appropriate hospital discipline information is accurately posted on Physician Profiles.

In 2008, the DRU received 4,652 statutory reports. 184 of these reports were forwarded to the Enforcement Division for further investigation, and 11 statutory reports relating to potential impairment issues were forwarded to the Physician Health and Compliance Unit.

The number of reports received annually since 2002 has increased substantially in nearly every category of report. The Board attributes this to the various reporting sources taking seriously the responsibility to inform the Board when they take disciplinary actions against physicians. Even though mandated by law, compliance over the years was inconsistent. More recent figures suggest a slower, but steady, increase in statutory reporting. The remarkably improved reporting gives the Board confidence in DRU's continuing aggressive outreach campaign to educate health care facilities about their reporting requirements, and the strong relationships the Board has made with health care facilities and physicians. Such increased compliance can only help to improve the quality of health care delivered in the Commonwealth.

Statutorily Mandated Reports Received

TYPE OF REPORT	2008	2007	2006	2005	2004	2003
Renewal "yes" answers – malpractice	**1,499**	3,143	919	3,173	1,146	3,401
Court Reports – malpractice	**871**	818	727	962	995	912
Court Reports – criminal	**0**	4	0	1	0	1
Closed Claim Reports	**904**	867	977	854	981	988
Initial Disciplinary Action Reports	**95**	137	155	138	170	141
Subsequent Disciplinary Action Reports	**75**	82	115	172	198	148
Annual Disciplinary Action Reports	**904**	1,002	678	602	632	580
Professional Society Disciplinary Actions	**3**	3	5	0	3	5
5d (government agency) Reports	**238**	245	116	139	99	57
5f (peer) Reports	**40**	31	57	68	58	32
ProMutual Remedial Action Reports	**0**	1	4	3	8	5
Self Reports (not renewal)	**23**	5	4	8	12	10
TOTAL	**4,652**	6,338	3,757	6,120	4,302	6,280

Note: Physicians file renewal applications bi-annually. 2003, 2005 and 2007 were major renewal years.

Data Repository Unit Highlights

1,499 Physician License Renewal Applications were reviewed by the DRC pursuant to M.G.L. c. 112 §2.

95 Health Care Facility Initial Disciplinary Action Initial Reports (HCFD-1) were submitted by health care facilities pursuant to M.G. L. c. 111 §53B. These reports are required by law and are submitted in response to disciplinary actions taken against physicians, as defined by 243 CMR 3.02. Seventy-five Health Care Facility Disciplinary Action Subsequent Reports (HDFD-2) were submitted by health care facilities. These reports follow up on Initial Reports, when the discipline is of an ongoing nature, such as physician practice monitoring.

904 Annual Disciplinary Action Summary Reports (HCFD-3) were received from hospitals, clinics and nursing homes. These reports are collected by the DRU pursuant to M.G.L. c. 111 § 53B and §203, and summarize the disciplinary actions taken by the facility during the past year.

238 reports of alleged physician violations of M.G.L. c. 112 §5 or Board regulations were filed by other government agencies pursuant to M.G.L. c.112 §5D in 2008. The Department of Public Health files the majority of these reports, which involve the investigation of major adverse events that occurred at health care facilities.

40 Peer Reports of physician violations were submitted by mandated health care providers in 2008, pursuant to M.G.L. c. 112 §5F. In 2002, the DRU began focusing on educating health care providers about their "5F'' or peer reporting obligations. As a result, there has been a marked increase in the number of reports filed in subsequent years.

23 physicians filed self-reports in 2008, compared to 2001 when no such reports were filed. These were self-reports that were not made in the context of license renewal. In 2008, 3 reports of disciplinary actions taken by professional medical associations pursuant to M.G.L. c. 112 §5B, were filed.

Medical malpractice insurers submitted 904 Closed Claim Reports in 2008 pursuant to M.G.L. c. 112 §5C.

The courts filed 871 reports. Note that this tends to be a dynamic figure, rising and falling in various years, as the chart on page 22 indicates.

Direct Referrals of Statutory Reports

The Data Repository counsel, in accordance with the DRC policy, review statutory reports and determine whether certain reports should be referred to other Board units. In 2008, The DRU referred 174 reports directly to the Enforcement Division for investigation, based on DRC procedure. Direct referrals include, but are not limited to, reports of physicians who already have an open complaint pending with the Enforcement Division, reports of physicians who had been disciplined by a licensing

Board in another state and reports that contain such serious allegations that a summary suspension may be needed. In addition, the DRU forwarded 3 reports to the Physician Health and Compliance Unit and 238 reports to the Patient Care Assessment Unit.

Reporting Board Actions

In 2008, the DRU made a total of 278 reports of formal Board actions to the Federation of State Medical Boards (FSMB), the National Practitioners Data Bank (NPDB), and the Healthcare Integrity and Protection Data Bank (HIPDB). All formal Board actions are reported to the FSMB, and all but probation modifications are reported to the other two organizations. The DRU reported 111 actions to the FSMB, 87 actions to the HIPDB and 78 actions to the NPDB. The DRU also resolved 8 physician disputes of the Board's NPDB and HIPDB reports.

Physician Profiles

During the year, the DRU assures the accuracy of the malpractice payment, hospital discipline, and criminal conviction information published on Physician Profiles. The DRU reviewed and resolved 24 Physician Profiles disputes in 2008. The vast majority of these complaints involve physician misunderstandings of the requirements of the Profiles law. While these inquiries do not result in changes to individual Profiles, they provide an opportunity for agency staff to educate physicians about Profiles.

Education and Outreach

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

Physician Health and Compliance Unit

PHC Case Presentations

The Physician Health & Compliance (PHC) Unit prepares and presents cases to the Board, serving as the agency's primary resource related to physician health. In 2008, the PHC Unit presented 78 matters to the Board.

PHC staff also works closely with the Licensing Committee and reviews the licensing files of applicants who disclose problems that might affect the ability to practice, including mental health, chemical dependency, physical disability, or behavioral issues. In 2008, the PHC Unit presented 66 matters to the Licensing Committee. In addition, the PHC Unit reviewed 20 renewal applications on behalf of the Licensing Division.

The PHC Unit also presents cases to the Board's Complaint Committee, which must approve all confidential monitoring agreements, as well as any amendment or termination of these agreements. In 2008, the PHC Unit presented 29 cases to the Complaint Committee.

Physician Health & Compliance Statistics 2008

Total Physicians Monitored	**116**
Behavioral Health	**11**
Mental Health	**13**
Chemical Dependency	**29**
Clinical Competence	**13**
Boundary Violations	**16**
Behavioral & Mental Health	**6**
Substance Use/Mental Health	**11**
Other	**17**
Cases Presented to the Board	**78**
Cases Presented to Licensing Committee	**66**

Physicians who may be experiencing difficulties with these matters are brought to the PHC Unit's attention in a number of ways, from self-reporting to non-compliance reports by the Massachusetts Medical Society's Physician Health Services (PHS), or by disclosures on license applications that result in review of a physician's history. PHC Unit staff will follow up on any report of impairment by requesting additional documentation.

For many years, Board Counsel for the PHC Unit have also worked closely with PHS to provide oversight of physicians in health related monitoring programs, to ensure compliance of physicians in PHS contracts, and to receive and respond to reports of non-compliance with contracts. The PHC Unit received a total of 52 reports in 2008. The PHC Unit meets monthly with staff at PHS to discuss individual cases, and also meets quarterly to discuss policy initiatives. In addition, the PHC Unit engages in educational outreach efforts by having staff speak at hospitals throughout the state.

Physician Oversight

While the PHC Unit came into existence to monitor physicians who were being treated for chemical dependency, the unit now monitors physicians for a variety of health reasons, as well as for clinical competency. PHC Unit staff actively monitors physician compliance with all Board agreements by ensuring that all required reports are filed in a timely fashion. In addition, reports of violations of Board agreements are acted upon immediately. While the Board believes that remediation of any

medical condition or impairment is possible, patient safety is paramount. If physicians do not abide by their agreements, the Board will act accordingly.

A total of 116 physicians were being monitored by the PHC Unit in 2008, either confidentially or under a public Probation Agreement with the Board. Of the total, 13 were monitored for mental health reasons, 29 for chemical dependency, 11 for behavioral health issues and 16 for boundary violations. Another 13 physicians were monitored for clinical competency. There were 11 physicians monitored for dual diagnoses of mental health and chemical dependency issues, and 6 physicians were monitored for both mental health and behavioral health issues. In addition, another 17 physicians were monitored for issues involving professionalism.

PATIENT CARE ASSESSMENT DIVISION

Stancel M. Riley, M.D., Director

The Patient Care Assessment (PCA) Division's mission is to help ensure that patients receive safe, effective and efficient care by encouraging physician and health care facility efforts to establish cultures of safety. Understanding the background of PCA is crucial to the entire process it employs. The PCA Division was created in 1986 by the legislature, in an attempt to address rising medical malpractice rates. Since then, the face of patient safety and health care quality has undergone a sea change. With the Institute of Medicine's reports of 1999 and 2001, *To Err is Human* and *Crossing the Quality Chasm,* there has been unprecedented interest in identifying and devising strategies for quality improvement practices. The PCA Division has evolved as well. With increased focus over the last several years, the Division has carefully considered how it can effectively and efficiently serve health care facilities' needs to make a difference in patient care.

Overview

For over twenty years, the Board has required both physicians and health care facilities to engage in quality improvement and patient safety programs as a condition of licensure. Known as the PCA Program, hospitals are required to have a formal plan for collecting, reviewing and reporting quality measures to the PCA Division. Safety and Quality Review (SQR) reports are submitted quarterly for all unexpected deaths, major disabilities or complications which occur to patients undergoing treatment in the facility. Semi-annual and annual reports from hospitals keep the PCA Division apprised of quality measures. These include trend and pattern recognition of events identified through their collection of incident reports, occurrence screens, focused screens when appropriate and an analysis of these data. The PCA Committee reviews these reports and communicates its findings back to facilities. Confidentiality is the bedrock of reports to PCA; names of physicians, patients and others involved in the event are not included, and the reports are not shared with other Board Divisions. Reports to PCA are confidential and protected by Massachusetts law from public disclosure in the same way records of health care facilities' peer review committees are protected. The rationale for these confidentiality protections is that limitations on public disclosure foster honest and open discussion of cases by those involved at the facility and promote better and more candid reporting to the PCA Division. Regardless of the confidentiality protections applicable to the PCA Program, however, health care providers and facilities are responsible for fully informing patients and their families when a medical error or other unanticipated complication occurs.

The Board's PCA program is intended specifically for health care facilities. There are other reporting systems in the Commonwealth designed for the public. Private citizens can file complaints with the Department of Public Health if they have concerns about the medical care they received at a DPH licensed health care facility and if they have specific concerns about a physician they can file a complaint with the Board's Consumer Protection Unit.

Accomplishments

The PCA Division has continued to emphasize establishing relationships with health care facilities. During 2008, PCA Division staff and Committee members visited individual hospitals to either present programs, or meet one-on-one with hospital leadership to support and explain reporting activities. The Director of the PCA Division was actively engaged in healthcare quality initiatives that are taking place at the state level. He represents the Board before the Health Care Quality Council, and participates in statewide quality initiatives run by the Massachusetts Coalition for Prevention of Medical Errors, the Massachusetts Medical Society, Health Care for All and other organizations active in the quality and patient safety arena. The PCA Division also revised its facility report forms again, adding race and ethnicity, and clarification about serious reportable event reporting. They are visually easier to review and graphics have been added to facilitate the interpretation of data.

In October, the membership of the PCA Committee was expanded to include experts in hospital quality improvement, physicians in varied medical specialties and a patient representative. The new members bring valued experience in clinical practice, quality and patient safety.

In February and June, the PCA Division reported its progress on collaboration with DPH to the Massachusetts Society for Healthcare Risk Management. PCA is participating with DPH in developing an online reporting system for serious reportable events. In addition, PCA is a member of the Expert Panel on Hospital Standardized Mortality Ratios convened by the Division of Health Care Finance and Policy. The Panel's aim is to validate a single measure of hospital mortality rate, which could be made available to the public. PCA also participated in the Betsy Lehman Center's Obstetrics Expert Panel. This Panel is working to lower the morbidity and mortality to mothers and infants in the period of labor.

PCA continues its work to improve health care facility peer review and credentialing processes to ensure that credentialed health care providers are practicing competently and safely. The Board's Credentialing Expert Panel developed recommendations for a standardized framework for credentialing, using the set of six domains of competency endorsed by ACGME, the Joint

Commission and the Federation of State Medical Boards (FSMB). These are Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and Systems-Based Practice. The Panel's recommendations were presented at the FSMB Annual Meeting in May of 2008 and are available online at the Board's website. A distribution of hospitals, large and small, academic and community, are in the process of using the criteria and will report back to the Panel about the effectiveness of the criteria and any barriers they encountered.

The results of research conducted on PCA reports appeared in a peer-reviewed scientific paper entitled "Holding Hospitals Accountable for Improved Patient Safety: Confidential Reporting of Major Incidents." The paper was published in the *Journal of Medical Licensure and Discipline in the May, 2008* issue. In 2008, PCA published three newsletters. PCA also issued an alert on safety concerns associated with the use of glacial acidic acid in gynecologic operations. These are available on the Board's website, www.massmedboard.org.

Trends

In 2008, the PCA Division received 828 new Safety and Quality Review (SQR) reports from hospitals, showing consistency with the numbers reported for 2007.

Year	Maternal Death (Type I)	Ambulatory Procedure Death (Type 2)	Wrong-site Procedure (Type 3)	Unexpected Death/Disability (Type 4)	Total
2003	3	9	22	443	477
2004	6	14	24	590	634
2005	10	21	31	744	806
2006	5	17	27	733	782
2007	8	14	40	764	826
2008	5	17	35	771	828

Table 1

Since the initial publication in 2002 of the National Quality Forum (NQF) endorsed list of *Serious Reportable Events in Healthcare* a number of states and government entities have been using this list to shape their incident reporting systems.[1] Cognizant of this national movement toward

[1] The NQF is a not-for-profit public-private partnership organization created to develop and implement a national strategy for health care quality measurement and reporting. www.qualityforum.org. The list, initially published in 2002, was updated in 2006. See *Serious Reportable Events in Healthcare 2006 Update: A Consensus Report*. Washington, DC. 2007.

standardization of incident reporting systems, and appreciating that Massachusetts health care facilities need unambiguous reporting requirements, the PCA Division has been carefully comparing its SQR reports to the NQF reporting criteria. The Division has determined that 220 (27 %) of the 828 SQR reports submitted by hospitals to PCA in 2008 describe events that are on the NQF endorsed list. This is consistent with the 2007 numbers which showed that 26% of the SQRs received were categorized as NQF *Serious Reportable Events in Healthcare* (*"SREs"*).

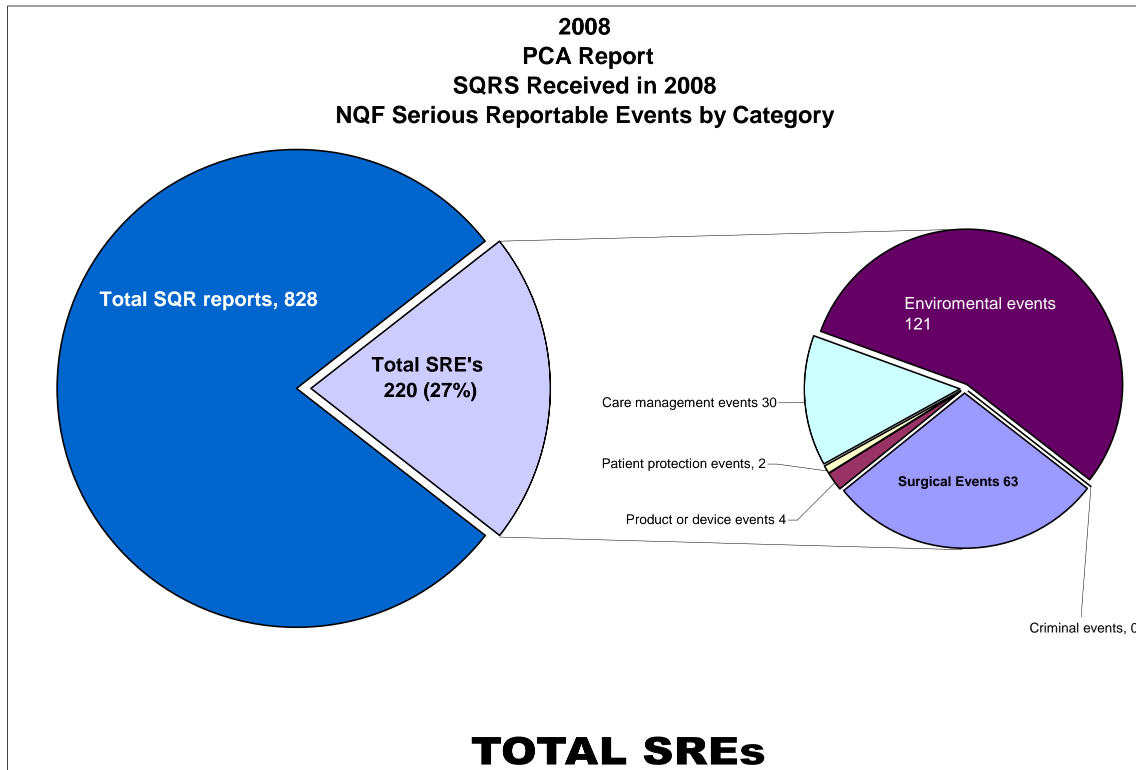


Figure 3

Through better collection of data from SQRs, the PCA Division is now able to analyze and compare its reports to other sources and use its data to identify trends and share lessons learned. Reports are now being evaluated in different ways. For example, PCA staff recently identified 215 reports since 2003 which described the patient as being found "unresponsive" at the time of the reported event. These reports are being analyzed for trends. During 2008 PCA staff reviewed over 800 SQRs and categorized them based on the description of the event and the health care facility's review findings. While these cases could be categorized in a number of different ways, this general breakdown gives the health care facilities a general understanding of the types of cases that are reported as SQRs. It also allows PCA analysts to identify possible trends in the reports received. *(Table 2)* These findings are published in the PCA newsletters.

SQRs Reviewed by PCA January 1- December 31, 2008	%
Perioperative or Post-procedure MI or Stroke	5
Wrong site or procedure	6
Retained foreign body	3
Surgical laceration or perforation	10
Wound dehiscence/anastomotic leak or disruption	2
Post surgical medical management	3
Post-surgical Infection	3
Surgical complications (other)	3
Embolism (pulmonary or air)	3
Anticoagulation management	3
Sepsis management	1
Anesthesia complications (other)	1
Endoscopy complications	5
Catheter placement issues (IJ, Epidural, NJ, IV)	3
Radiological procedure related complications (including Interventional Radiology)	3
Medical Management	5
Obstetrical management	4
Medication error	5
Equipment failures/problems	1
Chemotherapy related	1
Missed or delayed diagnosis	6
Falls with serious injuries or death	15
Psych Related (suicide /suicide attempt/psych elopement)	1
Rehab/LTAC (transfer related or falls)	3
Found Unresponsive	1
Other	1
Total	828 reports

*this category was for 4th quarter only

Table 2

Goals for 2009

The PCA Division plans to publish more Alerts and Advisories. It will continue the quarterly newsletter *First* and showcase best practices which health care facilities have found to be effective. The newsletter will continue to highlight the types of events reported in the previous quarter.

The PCA Division will work with the newly expanded and enriched PCA Committee to better define its mission. As part of this process, PCA Division staff and Committee members will look closely at the regulatory reporting requirements for health care facilities and PCA processes for review of those reports.

The Credentialing Expert Panel will focus on collecting data from the testing sites and reviewing the guidelines to ensure that they can be effectively integrated into hospital credentialing practices. The Subcommittee of the Credentialing Panel will continue to meet to address the issue of how best to ensure the competence of physicians in office based practice.

The Medical Training and Education Task Force will reconvene in 2009 under the leadership of the Chair of the Board and PCA Committee, Dr. John Herman.

During 2009 the PCA Division will work to consolidate its database of events so it is easily searchable to allow for better identification of lessons learned from aggregate facilities' experiences.

Finally, the PCA Division, on behalf of the Board, will continue to collaborate with the Massachusetts Health Care Cost and Quality Council, the DPH and other government agencies to establish goals for improving the quality of medical care provided to the citizens of the Commonwealth.

PUBLIC INFORMATION DIVISION REPORT

Susan Carson, Director of Operations

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

The Board's Physicians Profiles program, whereby consumers can access information that can help them in choosing a physician, remains a critical source of information for the Commonwealth's health care consumers. The popularity of Profiles is strong and continues to grow: the Profiles server recorded nearly 49 million hits in 2008, over 15% more than 2007; and the average number of hits per day in 2008 was over 134,000 – 40% higher than 2007. The average user spent about three minutes on the site and viewed four pages, and during the course of the year, users accessed over 4.6 million Profiles

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

In addition to the web site, consumers also call and write for Profiles information, as well as information on complaints, and physicians call to update their Profiles. In 2008, the agency received 18,097 calls for information, mailed or faxed 2,274 Profiles to consumers and made 6,001 updates to Profiles based on changed physician information, such as address or hospital affiliation.

2007 Public Information Statistics	
Profiles server "hits"	48,912,038
Profiles page "hits"	16,473,389
Number of Profiles Accessed	4,672,529
Avg. daily website "hits"	134,009
Calls for information	18,097
Faxed or mailed Profiles	2,274
Updated Profiles	6,001