**Proposed Changes to Board of Registration in Medicine Regulations - 2017**

[**243 CMR 1.00 Disciplinary Proceedings for Physicians**](http://www.mass.gov/eohhs/docs/borim/proposed-regs/243-cmr-1.docx)

[**243 CMR 3.00 Patient Care Assessment Programs**](http://www.mass.gov/eohhs/docs/borim/proposed-regs/243-cmr-3.docx)

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| **243 CMR 1.00 DISCIPLINARY PROCEEDINGS FOR PHYSICIANS** | | |
| **Section** | **Description** | **Comments** |
| 1.01 (2) Definitions | * Complaint expanded to include info from “from any source” and expands the definition from “misconduct” * Disciplinary Action - expanded to include remediation, probation and academic probation | *Any allegations or comments about a provider would be permitted into record w/o facts or source.*  *Remediation added w/o guidance on type.*  *Hospital Bylaws allow for fair hearing- expanded reporting requirement will increase hosp hearings.*  *Academic probation should be limited to med school-too broad as written* |
| 1.03(5) Grounds for Complaint | * Gross and repeated negligence replaced with negligence * New grounds for discipline added "conduct which is in violation of the ethical standards of the profession” | * *Too broad: “Any person, organization, or member may make a complaint to the Board”. Need to leave in “which charges a licensee with misconduct”.* |
| 1.05 Final Decision and Order and Miscellaneous Provisions | * Require the physician entering into a Probation Agreement as a condition of the stay of an indefinite suspension; and that failure to comply with the Probation Agreement may result in an immediate suspension. |  |
| **243 CMR 3.00 PATIENT CARE ASSESSMENT PROGRAMS** | | |
| **Section** | **Description** | **Comments** |
| 3.01Scope and Purpose | * Removes applicability to office settings * Removes reference to PCA regulations' role in assisting Board with its disciplinary function |  |
| 3.02 Definitions | * New Definitions   + Adverse Event any incident or variation in processes that causes or could potentially cause serious injury or an undesirable patient outcome.   + Close Call any adverse event that did not affect a patient’s outcome but for which a recurrence carries a significant chance of causing serious injury to a patient.   + Serious Reportable Event - those events required to be reported to DPH under [105 CMR 130.332](http://www.mass.gov/eohhs/docs/dph/regs/105cmr130.pdf). * Allows a Medical Peer Review Committee to be a nonprofit established by a professional society whose primary purpose is evaluation of and assistance to impaired providers. * Changes definition of “Patient Care Assessment Coordinator” to require the it to be a person in leadership (had previously allowed a Committee to fulfill the role) | * *Very broad use of the word adverse event; should reference natl’ std such as NQF* * *Close Call as defined too broad and undefined > unnecessary reporting.* |
| 3.03 Establishment and Participating in Patient Care Assessment Programs | * Relates to nursing homes |  |
| 3.05 Patient Care Assessment Program - Credentialing | * Requires physicians to include application for privileges all disciplinary proceedings and all criminal convictions (misdemeanor or felony and all medical malpractice claims in all jurisdictions at any time * Removes 10 year malpractice look back to now be unlimited * removes 10 year look back to other healthcare facilities where the applicant had privileges * Adds telemedicine credentialing provision, allowing facility to follow the requirement of [42 CFR 482.12](https://www.law.cornell.edu/cfr/text/42/482.12) and [482.22](https://www.law.cornell.edu/cfr/text/42/482.22) | * *Extending beyond the 10 yr reporting period>admin burden. Slow credentialing process>delay pt care* |
| 3.06 Patient Care Assessment Program – Structure | * Eliminates option of having a committee fulfill the duties of the Patient Care Assessment Coordinator |  |
| 3.07 Patient Care Assessment Program - Internal Audits and Internal Incident Reporting | * QPSD of the Board may require facility to add additional incidents to its list of adverse events which must be reported * Internal incident reporting system must allow for the reporting of close calls and other adverse events not on the facility's list of reportable events * Extends retention time of incident reports, summary reports and recommendations to and from Patient Care Assessment Coordinator from 3 years to 10 years | * *Similar to comments about “adverse events” and “close calls”. Allows broad discretion to the Board w/o ability of provider to appeal or question the need to report. . No uniform definition or criteria* |
| 3.08 Patient Care Assessment Program- Reporting to the QPSD | * Adverse events that have not been reported to DPH as Serious Reportable Events have to be reported to QPSD of the Board: * “serious injuries” that were unanticipated, including   + physical or mental impairment substantially limiting one or more major life activities in the short term, which may become a disability if extended long term; substantial change in the patient’s long term risk status   + loss of a body part   + major intervention for correction, such as surgery or transfer to a higher level of care. * Name of patient and licensee is not required to be reported unless required by the Board * Facility may report close calls and other events | * *Fact that pts may be sent to a higher level of care despite highest level of care and safety provided. No Natl’ evidence based stds to support proposed requirement; when is it inappropriate to transfer to a higher level of care?* |
| 3.10 Patient Care Assessment Program – Informed Consent and Patient Rights | Extensive new requirements regarding informed consent   * informed consent must be in writing and must be obtained before all diagnostic, therapeutic or invasive procedures, medical interventions or treatments * Requires attending physician or primary operator to discuss the risks and obtain the written informed consent. Other facility personnel may assist in the completion of the written informed consent documentation. * Requires attending physician/primary operator to inform the patient of who will be participating in the procedure, intervention, treatment including the names of all involved in the procedure/surgery * Requires patient record to include documentation of the attending physician’s presence or absence during the procedure, intervention or treatment - including time of absence and who was supervising during the absence | * *Entire section needs to be rewritten. Will lead to legal confusion and increased admin time* * *Each provider to perform informed consent if pt receiving multiple procedures w/in the same facility* |
| 3.13 Medical Care Quality – Reporting to the Board – Nursing Homes | * Relates to nursing homes |  |
| 3.14 Qualified Patient Care Assessment Program – Clinics | * Deletes PCA requirements related to clinics |  |