Commonwealth of Massachusetts

Board of Registration In Medicine

Annual Report
~ 2004 ~

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

Mitt Romney
Governor

Kerry Healey
Lieutenant Governor

Martin Crane, MD
Chairman

Roscoe Trimmier, Esq.
Vice Chairman

Randy Wertheimer, MD
Secretary

Hon. E. George Daher
Public Member

Guy, Fish, MD
Physician Member

John Herman, MD
Physician Member

Asha Wallace, MD
Physician Member

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

Dear Governor Romney
and Members of the General Court:

On behalf of the Board of Registration in Medicine, I am honored to announce the submission and availability of a report summarizing the Agency's activities for the calendar year 2004. The Board of Registration in Medicine continues to make tremendous strides in all areas of public protection and health care quality assurance.

The 2004 annual report can be found on line on the Board's web site at: www.massmedboard.org.

2004 marked another year of continuing progress since 1999, when the Board appointed a new Executive Director, reorganized its staff and began to change many of its operating procedures and policies. Over the past five years, annual disciplinary actions have more than doubled, the average time to resolve a consumer complaint has dropped sharply and the Board has made major improvements and expansions to its information technology infrastructure and capabilities.

During the past year the Board was also active on the policy front, releasing a major report on ten years of medical malpractice payments in Massachusetts, from 1994 to 2003. The Board also directed its Patient Care Assessment unit to monitor and oversee the implementation of the recommendations made in the Department of Public Health/Betsy Lehman Center report on weight loss surgery. The Board joined with the Division of Professional Licensure to alert the public about the dangers of so-called "Botox salons" where potentially dangerous medical procedures are performed by untrained individuals in inappropriate, non-medical settings.

The Board continues to enjoy a cooperative relationship with the Department of Public Health, the agency in which it resides administratively. It is a naturally collaborative partnership, given that both agencies are united in a passion for protecting the public while at the same time supporting the practices of the physicians who provide the residents of Massachusetts with the world's highest quality health care.

I would note in this annual report, as in annual reports past, that the Board of Registration in Medicine, while under the Department of Public Health's umbrella, continues to operate as an autonomous agency and generates the bulk of its funding from licensing fees paid by physicians.

I am pleased to report that the Board of Registration in Medicine is an effective and stable agency deeply committed to protecting the public and serving the state's physicians. As always, the Board looks forward to the coming year and to working with its many partners, including the administration and the legislature, to fulfill its important mission.

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

Sincerely,

Martin Crane, MD

Martin Crane, MD
Board Chair

Board Of Registration In Medicine
2004 Annual Report

Table Of Contents

Commonwealth of Massachusetts

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Annual Report

2004

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.

2004 Members
Massachusetts Board of Registration in Medicine

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

Martin Crane, M.D., Chairman

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

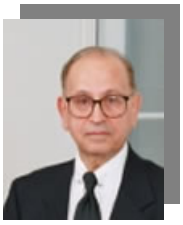
Roscoe Trimmier, Jr., J.D., Vice Chair

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

Randy Ellen Wertheimer, M.D., Secretary

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

Honorable E. George Daher, Public Member

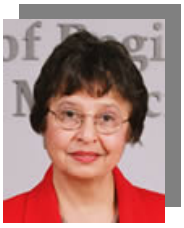


Before joining the Board in 2002, Justice Daher was Chief Justice of the Commonwealth's Housing Court Department. He is a graduate of Northeastern College of Allied Sciences (New England College of Pharmacy); Suffolk University Law School; and Boston University Graduate School of Education. Chief Justice Daher has written several books and articles on landlord/tenant issues and serves as a lecturer for the American Trial Lawyers Association. He is a member of the Massachusetts Bar Association and Judicial Council and is a former member of the Board of Governors for the Shriners Burns Hospital. In 2003 Governor Romney appointed Justice Daher chairman of the State Ethics Commission. He is a registered pharmacist and serves on the Board's Licensing Committee.

Guy Fish, M.D., Physician Member

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

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



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

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

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

STRUCTURE OF THE BOARD OF REGISTRATION IN MEDICINE

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

Data Repository Committee

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

Licensing Committee

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

Patient Care Assessment Committee

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

Committee on Acupuncture

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

FUNCTIONS AND DIVISIONS OF THE AGENCY

Although the policies and practices of the Board of Registration in Medicine are established by the Board, and its autonomy was mandated by the legislature, historically the agency had come under the umbrella of the state's Office of Consumer Affairs and Business Regulation for administrative purposes. In 2003 a statutory change placed the agency's administrative residence under the umbrella of the Department of Public Health, but with the same level of autonomy as it had always been afforded. As expected, the transition has been smooth and harmonious, given the two agencies' shared mission of protecting the public.

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

Licensing Division

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

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

Enforcement Division

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

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

Education and Outreach Division

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

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

Division of Law & Policy

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

Information Technology Division

Over the past eight years the Board has introduced many new technology applications to streamline Board administrative processes, reduce data error, and provide more and better information to consumers. The first of these was Physician Profiles. In 2004 the Division reached another major milestone when it migrated Board data from several antiquated and incompatible database systems into a new, consolidated database called CLARIS. Access to Board data is now possible from a single system, improving efficiency, expanding the potential for cogent data analysis and reducing errors. The Divisions next major project is the introduction of online physician license renewal.

Document Imaging Unit

In addition to improved data storage and retrieval capabilities, in 2001 the Board began to address the huge volume of paperwork and physical records storage generated by its activities. The agency started to scan documents into a database for easier retrieval and reduced storage needs. In response to an expansion of the types of documents being scanned, in 2004 the agency created a separate Document Imaging Unit. The Document Imaging Unit has a state-of-the-art client/server and browser based electronic imaging system. This system allows the agency to standardize and automate its processes of receiving, routing, indexing, storing, retrieving and distributing the documents for physician's records. The Unit scans all license applications and supporting material, Enforcement case files, closed complaint files and a variety of other types of records. To date the Unit has scanned approximately 4,810,000 individual document pages.

EXECUTIVE DIRECTOR'S REPORT
Nancy Achin Audesse

The story of the Massachusetts Board of Registration in Medicine is one of revitalization and success. Since 1999 the agency has been reenergized and refocused after years of poor performance that had undermined our credibility in the eyes of the legislature, health care professionals and the public. By every measure, the agency has earned a restoration of that lost credibility.

2004 continued the trend of improvement and innovation. New information technology applications, revised licensing forms and processes, better records management and the largest number of disciplined physicians in the history of the Board all contributed to make 2004 another year of success and accomplishment. Other hallmarks of 2004 included accelerated case management, enhanced working relationships with law enforcement agencies and record usage by the public of the online Physician Profiles.

Consumer Complaints

In 2000, it took an average of over 14 months to resolve a consumer complaint. Such was the extent of the case backlog. By 2002 the caseload and the time it took to resolve a complaint were each cut dramatically, as the Board's new management team made the matter its top priority. By 2003, the average time to resolve a complaint was just 10 months. In 2004, that was reduced to only six months, an astonishing reduction of 41%, and cumulative drop of 57% since 2000.

Disciplinary Actions

After years of alleged lackadaisical enforcement, the Board today fairly, but energetically, investigates reports of physician misconduct, and imposes appropriate discipline when the facts of a case warrant it. In 2004 the Board disciplined 78 physicians, the highest number in its history, and more than double the number disciplined in 1999.

Technology Improvements

For many years the Board maintained multiple, incompatible and antiquated database systems. This made accurate record-keeping difficult, and made information sharing and the ability to fully analyze Board data for trends and insights nearly impossible. In 2004 the Board made significant strides toward a consolidated computerized records system. Several old applications were scrapped

and data migrated to the Consolidated Licensing and Regulation Information System, or CLARIS. CLARIS will ultimately be the repository of all Board data. This will reduce data entry errors, save staff time and make it possible for Board data to be utilized fully in pursuit of the Board's mission of patient safety.

Medical Malpractice Report

The Board is the repository of medical malpractice payment data. It receives reports of medical malpractice payments from the courts, medical malpractice insurance carriers and from physicians. In November 2004 the Board issued a report analyzing medical malpractice payment data from 1994 through 2003. Among many significant findings, the report shows that the number of medical malpractice payments in Massachusetts peaked in 2001 and has since declined by 17%. The size of malpractice payments, however, continues to grow. Perhaps most surprising, the report found that fully 13% of all malpractice payments made, and 13% of all dollars paid during the 1994-2003 period were attributable to just 98 physicians. Going forward, the Board intends to issue annual updates detailing the preceding year's data and noting whether recent trends, such as the drop off in the number of payments made annually, are continuing.

New License Renewal Application

A physician's license to practice medicine expires every two years on his or her birth date, and the license must be renewed for the physician to continue to practice. Most license renewals, approximately 22,000, occur during odd-numbered years. In 2004, responding to comments from licensees, the Board undertook a redesign of the renewal application forms with three goals: make the forms easier for physicians to understand and complete; capture additional information like sub-specialty; and, create forms that support the introduction of online licensing. The effort appears to be a success, as applications for the current renewal year are coming in both more complete and earlier than past years.

Online Licensing

The Board continued to make great progress toward reaching another ambitious goal – Online Licensing. The advent of physicians being able to renew their licenses online will not only make their lives easier, but will save the Board money and help in the goal of making it easier for various agencies, hospitals and health plans to share information as they seek to be more efficient in protecting the public.

As noted, the new license renewal application forms will support online licensing. CLARIS is another major step toward the goal. It provides a single data entry point for all information that comes into the Board, and paves the way for the introduction of online license renewal. Funding for the project is also required and, rather than ask the Legislature for taxpayer money, the Board is hopeful that the Legislature will approve an outside section filed in the Governor's budget that would allow for unexpended amounts in the Board's Trust Fund to carry over to the next fiscal year. Currently, every year several hundred thousand dollars of physician license fees paid to the Board are lost to reversion. In addition to carry over language, ultimately the Board hopes to be able to retain 100% of physician license fees. Right now only approximately 75% of fee revenue is available to the Board. With carry over language and full license fee retention, online licensing can become a reality.

Patient Care Assessment

The Board's Patient Care Assessment (PCA) program, receives three kinds of reports from hospitals: Major Incident Reports (MIR), detailing events resulting in death or serious impairment of a patient; and Annual and Semi-Annual Reports which detail a facility's progress with respect to its patient safety program. Having eliminated a years long backlog of report review, the PCA Committee turned its focus to encouraging greater reporting compliance by hospitals, faster and more detailed review and more comprehensive data analysis.

In 2004 compliance reached an all-time high, with 73 percent of hospitals submitting MIRs and 100 percent submitting Annual and Semi-Annual Reports. The Committee also reviewed over 900 MIRs and nearly 150 Annual and Semi-Annual Reports. PCA also began to analyze the incidence and circumstances of sepsis in hospitals, and started a comprehensive review the adequacy of House staff (residents and interns) supervision by hospital attending physicians.

Other types of reports can now be extracted from the PCA database, such as the age and gender of the patients involved in MIRs reported, or the locations where the incidents occurred. The ability to extract this type of data is important to the PCA Committee as it moves forward with efforts to identify and address quality and patient issues statewide. For example, recent database query shows that 280 Major Incident Reports list the operating room as the location where the incident occurred. Additional analysis of these statistics is needed, but it is a start towards a review of incidents that may be related to surgical technique, skill or other complications. Furthermore, only eight MIRs list the doctor's office as the location where the incident occurred. However, only recently has the staff looked for Major Incident Reports from this location.

Clinical Skills Assessment

One of the key areas the Board wants to pursue in the coming years continues to be Clinical Skills Assessment. This testing procedure would measure the clinical skills not only of new doctors, but of physicians coming into the state from elsewhere, who have been away from practice for an extended period or who may have had multiple medical malpractice payments or other problems. In 2004, the National Medical Board of Examiners began requiring all new physicians to pass a clinical skills exam. But there are only five locations nationwide where such physicians may take the test. The closest one to Massachusetts is in Philadelphia. The Board remains committed to convincing the National Medical Board of Examiners to add a sixth site – in the Boston area. Such a site could be used not only for testing new physicians but also for those veteran physicians whose clinical skills may be in question. Massachusetts is an ideal site for such a program as it has a depth of medical schools, teaching hospitals and expertise unmatched in the nation.

Looking To the Future

The Board has embarked on an effort to comprehensively update its regulations, something that has not been done in many years. Some of the areas of the Board may review include updating licensing provisions, addressing the issue of licensing and credentialing in times of national emergency and considering a category of administrative medicine.

Another major goal of the agency is the full revitalization of the Patient Care Assessment Division. With a full complement of staff, sufficient resources and excellent compliance by hospitals, PCA can finally begin to comprehensively and intensively analyze its database for possible trends and concerns with procedures like weight loss surgery (several post-surgical deaths were noted in 2003, prompting an alert) and problems like sepsis, which appears to be a growing problem in hospitals nationally.

ENFORCEMENT DIVISION REPORT

Barbara A. Piselli, Director

The Enforcement Division is mandated by statute to investigate all potential disciplinary matters involving physicians and acupuncturists. It strives to pursue complaints efficiently, fairly and effectively as it tries to protect the public and at the same time follow Board statutes, regulations and policies. The Division, not surprisingly, is the unit of the Board of Registration in Medicine that generates the most attention by the media, watchdog groups and others who have an interest in physician conduct and the process by which allegations of misconduct are adjudicated. In the past, much criticism was leveled at the Board for indifferent and inefficient case management of complaints against physicians.

Today the Enforcement Division staff have earned the reputation as a group of dedicated professionals committed to fairly and swiftly investigating complaints against physicians, and recommending that the Board impose appropriate discipline if the facts of a case support it. In 2004 the recent upward trend of annual disciplinary actions continued, with a record 78 physicians being disciplined.

The Enforcement Division continues to focus on the expeditious handling of open cases, improving communications with consumers filing complaints against physicians, and ensuring speedy review and resolution of cases. The increasing number of disciplinary actions reflects its staff's ongoing commitment to patient safety, as well as directives from the Board and the Executive Director. The Enforcement Division today is the model of a smooth, experienced and efficient investigatory and disciplinary unit, certain of its mission and dedicated to just outcomes.

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

Consumer Protection Unit

The Consumer Protection Unit (CPU) is the first line of review for complaints filed with the Board by consumers and coordinates a "Triage Team'' to help identify cases that may be of the utmost urgency as part of its mission to protect the public. The unit opened 760 cases for investigation in 2004, a 17% increase over 2003. In addition, the unit reviewed 170 reports that were referred by the

Department of Public Health's Division of Health Care Quality. Some 35 of these reports involved possible physician misconduct or hospital quality assurance concerns and were referred to the Board's Data Repository and Patient Care Assessment Units for investigation. In addition to the 760 docketed consumer complaints, the unit received 62 additional communications from consumers that were not placed on its docket because they were deemed not to fall under the jurisdiction of the Board of Registration in Medicine. These included such matters as complaints against non-physicians or matters that were more than six years old and deemed stale. The unit does help consumers to identify the appropriate agencies to assist them on such cases, however.

In screening complaints, serious and priority cases are flagged and brought them to the attention of the Division Director for immediate action. In most cases, the staff obtains responses from physicians as part of its initial review and "triage'" process. Some urgent matters, however, are fast-tracked and physician responses in these cases are not always included as part of the initial review.

Clinical Care Unit

The Clinical Care Unit (CCU) reviews complaints that allege substandard care. It received 102 new complaints in 2004. Another 61 complaints were closed and 153 more remain under investigation.

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

Disciplinary Unit

The Disciplinary Unit investigates and litigates all cases that may result in disciplinary actions being taken against licensed physicians and acupuncturists. In 2004, the Board disciplined 78 doctors. That is a 30 percent increase over 2003, and a 105 percent increase since 1999.

The unit is staffed by a Managing Attorney, complaint counsels or prosecutors, investigators and paralegal and administrative assistants. Complaints are referred to the unit by the Data Repository Committee, the Consumer Protection Unit and various other sources. Staff interview witnesses,

gather evidence, work with local, state and federal law enforcement agencies on coordinated investigations and present cases to the Complaint Committee and to the full Board. The complaint counsels also draft pleadings, negotiate consent orders, identify and present cases for summary suspensions and prepare and litigate contested Board cases at administrative hearings before the Division of Administrative Law Appeals (DALA).

Disciplinary Actions

The Board investigated 616 docketed complaints brought before the Complaint Committee. Seventy-eight different physicians were involved in 83 separate disciplinary actions.

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

Types of Disciplinary Actions

There are a variety of ways to resolve a case if the Board determines disciplinary action is appropriate. One way is for the matter to be resolved through a Consent Order or negotiated settlement. Such a resolution eliminates the need for protracted litigation and evidentiary hearings. In 2004, some 46 physicians entered into such Consent Orders. These actions are public disciplinary actions.

If a settlement cannot be negotiated, the Board issues a Statement of Allegations and the matter is referred to DALA for a full evidentiary hearing on the merits. There were 20 cases pending at DALA as of Dec. 31, 2004. Once the evidentiary hearing is completed, the DALA Administrative Magistrate issues a Recommended Decision to the Board, containing facts and conclusions of law. When the Board receives the Recommended Decision, it considers the recommendation and issues a Final Decision & Order that may include disciplinary action. Disciplinary actions may include revocation, suspension, censure, reprimand, restriction, resignation, denial or restriction of privileges or denial or restriction of the right to renew a license. The Board may also impose fines.

Disciplinary Actions, Voluntary Agreements and Related Activity

Category	2004	2003	2002	2001	2000	1999
Doctors Disciplined	**78**	60	68	55	44	38
Statements of Allegations Issued	**59**	36	57	39	40	29
Summary Suspensions	**2**	4	5	7	7	5
Voluntary Agreements Not to Practice	**10**	6	16	4	4	3
Voluntary Agreements for Practice Restriction	**4**	1	4	2	0	3

Prioritization and Management of Cases

Expedited Case Review and Resolution

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

Summary Suspension and Voluntary Agreements

Each complaint or case is immediately evaluated to determine if the physician appears to pose an immediate and/or serious threat to the public health, safety or welfare. If this is determined to be a possibility, the complaint counsel must bring the matter to the Board's attention, recommending that the physician no longer be allowed to practice medicine until safeguards are put into place. In the most serious cases, the counsel may recommend to the Board that it summarily suspend the license of a physician. This is an interim public disciplinary action the Board may take to protect the public prior to going through the disciplinary process. Most importantly, such an action ensures that the physician cannot continue to practice medicine while the Board adjudicates the case. In some cases, the physician may choose to enter into a voluntary agreement not to practice medicine or to practice with certain restrictions pending resolution of the matter on its merits. These actions take place immediately and are public.

Team Approach

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

Caseload Statistics

The 760 complaints opened in 2004 represent a 17% increase over 2003, and is the largest number opened in many years. At the end of the year, 406 complaints were awaiting final action by the Board, also a significant increase over 2003, but still in accordance with the agency's goal to keep pending complaints to under 425.

Docketed Complaints Opened, Closed, and Pending

COMPLAINTS	2004	2003	2002	2001	2000
Docketed	**760**	650	677	670	626
Closed	**682**	673	680	865	773
Pending as of 12/31	**406**	328	358	361	537

Average Age of Open Complaints at Year's End

YEAR	Average Age of Complaint	Open Complaints at End of Year
2004	**308 days**	**406**
2003	315 days	328
2002	322 days	358
2001	364 days	361
2000	429 days	537

Cases Alleging Substandard Care

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

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

Number of Complaints Alleging Substandard Care

Status	2004	2003	2002	2001	2000
Opened	**102**	83	101	111	177
Closed	**61**	69	90	168	322
Pending	**153**	125	110	99	156

Complaint Committee Actions

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

In 2004, the Enforcement Division presented 681 cases involving 569 physicians to the Complaint Committee. Fifty-four of these physicians appeared before the Committee to discuss the allegations against them and/or to take part in remedial conferences.

Complaint Committee Non Disciplinary Enforcement Actions

Category	2004	2003	2002	2001	2000
Closed	**462**	440	458	500	476
Letter of Acknowledgement	**0**	3	4	0	1
Letter of Information	**5**	4	3	14	13
Letter of Advice	**38**	63	53	103	140
Letter of Concern	**49**	21	41	71	58
Letter of Warning	**30**	41	30	27	19

Enforcement Division Cases Presented to the Complaint Committee

Category	Docketed cases	Physicians
Appearances & Remedial Conferences	**68**	**48**
Non Appearances	**548**	**577**

Sexual Misconduct and Boundary Violation Investigations in 2004

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

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

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

Sexual Misconduct or Boundary Violations Disciplinary Cases

The number of docketed complaints has been relatively static over the past several years, averaging about 17 per year, although 2004 saw the total spike to 30. Whether this is the result of the public being more willing to report incidents, the start of a trend or merely a statistical anomaly remains to be seen. It is, however, worth noting that the overall number of cases is small, and even a small variance from one year to the next can look large on a statistical basis. Figures such as these must be looked at over a period of years to identify any true trends.

That point is illustrated by looking at instances of actual Board discipline for sexual misconduct or boundary violations. From 2003 to 2004, the number of physicians disciplined by the Board dropped by 50 percent – from six cases in 2003 to three cases in 2004.

Special Projects and Initiatives

Document Imaging

The Enforcement Division implemented the scanning and indexing of all non-adjudicatory cases closed during 2003 as part of the Board's effort to use document imaging as an efficient method of data storage and retrieval. In 2004, nearly 4,000 individual case file documents from closed Enforcement Division cases were scanned into the electronic database.

Taylor's Law Implementation

In 2004 the legislature passed, and the Governor signed, a bill that has become known as "Taylor's Law." The legislation for the first time grants patients, or their representatives, who have filed a complaint with the Board, to present an impact statement to the Board prior to any final disciplinary action that may arise from that complaint. Similar to victim impact statements presented at the time of sentencing in criminal proceedings, such statements may be made orally or in writing. The Board has embraced this concept, and has adjusted its procedures to accommodate patient impact statements.

Outreach, Training and Professional Development

The Enforcement Division continues to work in cooperation with law enforcement and other government agencies to encourage prompt reporting of physician misconduct and to facilitate

cooperative investigations. The investigatory staff participates in the FBI Health Care Fraud Working Group meetings.

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

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

PUBLIC INFORMATION DIVISION REPORT

Susan Carson, Director of Operations

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

The Board's first-in-the-nation Physicians Profiles program, whereby consumers can access information that can help them in choosing a physician, continues to be more successful than anyone had ever imagined. The Profiles server recorded almost 29 million hits in 2004. The site was redesigned in late 2003 to give it a fresh look, to make it easier and faster for consumers to access physician information. In 2004 the site attracted over 8 million page hits -- a staggering number for a site that doesn't advertise. And hits come from Internet users all over the world. The average number of hits per day is approximately 21,500 – with weekdays averaging about 28,000 hits each day. The average user spent about three minutes on the site and viewed four pages.

On the site, consumers can find out such 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. In 2004, the agency received 24,585 calls for information, mailed or faxed 6,407 Profiles to consumers and made 22,768 updates to Profiles based on changed physician information, such as address or hospital affiliation.

2004 Public Information Statistics

Profiles server "hits"	29,000,000
Profiles page "hits"	8,000,000
Avg. daily website "hits"	21,500
Calls for information	24,585
Faxed or mailed Profiles	6,407
Updated Profiles	22,768

LICENSING DIVISION REPORT

Rose M. Foss, Director

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

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

Physician Demographics

Total Licensed	**29,033 (100%)**
Men	19,917 (69%)
Women	9,116 (31%)
Age Groups	
<40	7,103 (24.5%)
40-49	8,695 (30.0%)
50-59	7,586 (26.2%)
60-69	3,826 (13.2%)
>69	1,757 (6.1%)
Board Certified	
Yes	75%
No	25%

Before an application for a full, limited or temporary license is forwarded to the Board for approval, the Licensing Division conducts an extensive investigation of the applicant's

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

Licensing Division Statistics

License Status Activity	2004	2003*	2002	2001*
Initial Full Licenses	1812	1628	1,709	1,705
Full Renewals *	9645	20,188	7,286	20,960
Lapsed Licenses	113	112	123	136
Initial Limited Licenses	1521	1476	1,418	1,419
Limited Renewals	2701	2611	2,513	2,663
Temporary (initial) Licenses	22	21	17	9
Temporary Renewals	6	12	16	5
Voluntary Non-renewals	390	709	427	494
Revoked by Operation of Law	869	848	611	784
Deceased	162	148	131	93
TOTAL	**17,241**	**27,753**	**14,251**	**28,268**

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

Licensing Committee Activity Report

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

As a subcommittee of the Board, the Licensing Committee is responsible for reviewing all license applications with legal, medical, malpractice and competency issues. Physicians applying for an initial limited license or renewing a limited license who had competency issues in a training program or substandard clinical performance in a training program are reviewed by the Licensing Committee. In such cases, the Licensing Committee customarily interviews the physician and the program chairperson before making a recommendation on issuance of an initial limited license or renewal of a limited license to the full Board. The Committee may recommend approval or denial of a limited license, depending on the whether the Committee is satisfied that the physician will be closely supervised by the program director and senior staff in the training program. A recommendation for issuance of the limited license in such cases is usually contingent on a performance monitoring agreement with the physician and the program chairperson to provide regular monthly, bi-monthly or quarterly performance monitoring reports to the Board. Renewal of the limited license is contingent on satisfactory performance monitoring reports over the course of the entire academic year. Performance monitoring agreements are customarily required for the duration of the training program. However, the performance monitoring may be discontinued if the physician has demonstrated a continuous track record of satisfactory clinical performance. If the Licensing Committee determines that there is a pattern of substandard clinical performance anytime during the academic year, the Committee may recommend additional action.

Licensing Committee Activity Report

Cases Reviewed by Licensing Committee	2004	2003	2002	2001
Malpractice	**28**	35	35	23
Competency Issues	**88**	81	90	78
Legal Issues	**46**	52	27	39
Medical Issues	**42**	36	32	28
6th Limited Renewals	**33**	18	26	25
Lapsed Licenses	**73**	_	_	_
Miscellaneous Issues	**127**	146	110	134
Total Cases Reviewed	**437**	368	320	327

There was a 19 percent increase in the number of cases reviewed by the Licensing Committee in 2004, as compared with the number of cases reviewed in 2003. The increase in cases reviewed may be attributed to the addition of the review of lapsed licenses with malpractice or legal issues which began in 2004.

Performance Monitoring Agreements

The Board's performance-monitoring program for limited licensees has been in effect since 1997. The number of limited licenses issued contingent upon performance monitoring agreements has fluctuated from year to year. In 2003, there was a 15% decrease in the number of performance monitoring agreements as compared with 2002 when the number of performance monitoring agreements jumped from 7 in 2001 to 13 in 2002, representing an 86% increase. Since that time, there has been no significant increase in the number of performance monitoring agreements between 2003 and 2004.

Performance Monitoring Agreements	2004	2003	2002	2001
Performance monitoring agreements	10	11	13	7
% change from previous year	- 10%	- 15%	+ 86%	- 57%

License Division Survey

As an ongoing initiative to improve customer services, the Licensing Division randomly surveys newly licensed physicians to identify opportunities for improvement and to expedite the licensing process within the scope of the Board's regulations. Survey responses are tabulated using the Likert Scale from 1–5, with 1 rated as "poor," 2–3 rated as "average" and 4-5 is in the "excellent" range. In 2003 the Licensing Division mailed approximately 600 surveys and received responses from 325 newly licensed physicians, more than triple the number received in 2002. In 2004 the number of responses grew another 37 percent. The 2004 overall average score declined by about one percent, but remained very close to the top of the "excellent" range.

License Division Survey

Survey Questions	2004 Responses (n= 445)	2003 Responses (n=325)	2002 Responses (n=97)	2001 Responses (n=80)
1. Was the Licensing staff courteous?	**4.41**	4.52	4.20	4.15
2. Was the staff knowledgeable?	**4.42**	4.35	4.28	3.93
3. Did the staff provide you with the correct information?	**4.35**	4.53	4.23	4.00
4. Did the staff direct you to the appropriate person to answer your questions?	**4.52**	4.57	4.20	4.06
Overall average score	**4.43**	4.49	4.23	4.03

2004 Licensing Division Accomplishments

Full Renewal Application

2005-2006 is a renewal year and approximately 20,000 physicians must renew their licenses to continue to practice medicine. The Board has expanded and clarified the renewal application instructions and formatted the application to make it easier to read. Also, the new application format will support the implementation of online licensing once the Board secures sufficient funding to introduce this important licensing innovation.

Online Renewals

The initiative for the online renewal project was not accomplished in 2004 due to insufficient funding. Governor Romney's FY2006 budget submission, however, includes a provision to allow unexpended sums in the Board's Trust Fund to carry over to the next fiscal year. The Board is hopeful the Legislature will approve this provision, which make additional funds available to the Board, and help the agency move forward on the development of the online renewals project. The ability to renew a license electronically online will be a major benefit for physicians by significantly reducing the license renewal time and eliminating last minute renewals. Online

renewals and demographic information updates will further streamline the license renewal process for both full and limited licenses. They will be more convenience for physicians practicing medicine in the Commonwealth and especially for physicians from out of state or from other countries who wish to maintain a license in Massachusetts and who have to rely on traditional mail services. Online renewals will be cost effective by reducing reproduction costs, mailing costs, the data entry process and the current manual process of reviewing every renewal application for completeness. Electronic access for online renewals will improve data quality and reduce data entry errors. And the online renewal technology will enable the Board to collect malpractice, legal and criminal information more frequently and increase the Board's ability to protect the public by receiving and acting on adverse information in a more timely manner.

New Wallet Cards

In 2004, the Board replaced the traditional paper wallet card with a heavy-duty laminated wallet card that is that is more durable, more professional and protects the licensing information from of being altered. The Board is also exploring various technologies to include a physician's photograph on the wallet card for additional security and purpose of positive identification of the cardholder. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires all hospitals to issue photo identification cards to their credentialed physicians. Adding photographs to the physician wallet cards will allow them to be used to satisfy the JCAHO requirement, saving time and effort for both hospitals and physicians, and creating a universal form of licensed physician identification that may have applications during times of serious emergency.

Scanning License Applications

Since 2002, the Massachusetts Board of Registration in Medicine has been a leader among state medical boards in scanning licensing documents. Since scanning began, 55,696 full initial license applications have been scanned into the database, and 90,043 full renewal applications have been scanned. Approximately 2,000,000 individual license application pages are now available electronically.

Scanning has significantly decreased the number of lost or misfiled licensing documents and expedited the retrieval of licensing information. Instead of searching for an archived paper record, it only takes a click of the mouse to display a physician's entire license file on a computer screen.

If a physician requests a copy of an initial license application or the most recent renewal application, as required by all healthcare facilities for credentialing and provider enrollment, the application can be retrieved and printed within minutes. The average turn around time for retrieving, copying and mailing license documents has been cut from an average of two weeks to five minutes. Overall, scanning technology has significantly improved the Licensing Division's efficiencies and improved the security of historical documents. Moreover, instantaneous retrieval of current and archived license applications and documents is vital to the Board's responsibility to provide accurate and timely information on licensed physicians to health care providers and the physicians themselves.

Common License Application

The Director of Licensing participated in a workgroup with the Federation of State Medical Boards (FSMB) to develop a Common License Application (CLA) for physicians who apply for state licensure. A CLA would eliminate duplicative information collection by different states and expedite the licensing process. It would be a single online license application that a physician would be required to complete, and that could be stored electronically and updated as often as necessary. The CLA and supporting documentation would be available to any state medical board when a physician applies for a license to practice medicine in that state. The time consuming and expensive redundancy of providing the same information to each state will be eliminated for both physicians and the state medical boards. The increased demand for telemedicine services has expanded the scope of the practice of medicine by enabling physicians to provide health services across state lines via the Internet. The CLA will expedite the licensing process since all states require a physician to hold some type of licensure in that state in order to practice medicine across state lines.

Limited License Workshops

In 2004, the Licensing Division conducted three regional Limited License Workshops hosted by Beth Israel Deaconess Medical Center, St. Vincent's Hospital and the Lahey Clinic for training program coordinators and administrative staff who are the liaison between the Board and limited licensees. A more intensive workshop was held at the Board for new program coordinators to provide an in-depth review of the limited license requirements. The training program coordinators in teaching facilities are responsible for ensuring that residents and fellows who staff the Commonwealth's training programs complete the limited license application in accordance with Board regulations. The annual Limited License Workshops are crucial in providing information on changes in the limited license process, new forms and new procedures. The

workshops also provide an opportunity for the exchange of information between Board staff and the training program coordinators to identify opportunities for improving the limited license process. In addition to the workshops, Board staff and the Coalition of Teaching Hospitals (COBETH), exchange information and work collaboratively to improve the limited license process and ensure that training programs will be staffed by the beginning of the academic year on July 1, without interrupting the continuity of patient care in the Commonwealth.

2005 Licensing Goals

CORI Checks. One of the Licensing Division goals is to obtain a CORI (criminal background check) on all initial full and initial limited licensees, and licensees applying for license renewal. The addition of criminal background checks will further expand the Board's continuing initiatives to protect the safety of the public.

National Provider Identification (NPI) Repository: The Licensing Division is developing the framework for the collection and storage of physician NPI numbers which is a requirement of HIPPA for all healthcare provider reimbursement. NPI numbers will be available to all third party payers on the Board's license verification site.

DIVISION OF LAW AND POLICY REPORT

Peter J. Morin, General Counsel

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

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

In 2004 the Division of Law and Policy saw another sharp increase in the number of reports received concerning physicians who had been disciplined by hospitals, paid malpractice claims, or found themselves in trouble with the law. These results further extend the trend, begun in 2000, of continuous improvement in compliance on the part of those institutions and agencies that are mandated by law to file such reports. The improving compliance rates indicate that the educational campaign on the part of the Division's Data Repository Unit is paying off.

At the same time, disciplinary actions taken against physicians by the Board swung upward again, after declining slightly in 2003, following several years of steady increases.

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

Office of the General Counsel

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

Oversight of Adjudicatory Matters

The Legal Division maintains the Board's active adjudicatory case files, prepares its Final Decisions and Orders, and tracks its disciplinary numbers. In 2004, the Board took 83 disciplinary actions against 78 physicians. The Board issued 10 Final Decisions and Orders and entered into 46 Consent Orders. 59 Statements of Allegations were issued, and 13 cases were referred to the Division of Administrative Law Appeals (DALA).

	ADJUDICATORY FIGURES	2004	2003	2002
1.	**Total Number of Disciplinary Actions Taken:**	**83**	**62**	**73**
	a. Consent Orders:	46	26	37
	b. Final Decision and Orders:	10	8	12
	c. Summary Suspensions:	2	4	5
	d. Final Decision and Orders On Summary Suspensions:	2[1]	1	0
	e. Resignations:	9	14	8
	f. Voluntary Agreements:	14[2]	7	10
	g. Assurances of Discontinuance:	1	2	0
	h. Suspensions pursuant to violation of Letter Of Agreement	1	1	1
2.	**Discipline by Type of Sanction:**			
	Admonishment:	4	1	0
	Censure:	0	2	2
	Continuing Medical Education Requirement:	5	4	8
	Community Service:	0	0	1
	Costs:	0	0	0
	Educational Service:	0	0	0
	Fines:	13	6	13
	Monitoring:	0	1	0
	Practice Restrictions:	15	7	10
	Probation:	6	9	13
	Reprimand:	18	6	16
	Resignation – part a:	4	5	3
	Resignation – part b:	5	9	5
	Revocation:	10	5	7
	Summary Suspension – part a:	2	4	4
	Summary Suspension – part b:	0	0	1
	Suspension:	18	13	12
	Stayed Suspension:	7	7	11
	Total Number of Physicians Disciplined:	**78**[3]	**60**	**68**

[1] This is not included in the total number of disciplinary actions.
[2] This number includes both Agreements Not to Practice and Agreements for Practice Restrictions.
[3] Several physicians were disciplined more than once: Rojcewicz (2 times: voluntary agreement and CO); Caulkins (2 times: voluntary agreement and CO); Kim (2 times: voluntary agreement and CO); Zappala (2 times: 2 COs); and Murphy (2 times: Violation of LOA and CO) There were 78 physicians disciplined and 83 disciplinary actions.

ADJUDICATORY FIGURES CONT'D		2004	2003	2002
3.	**Total Number of Cases referred to DALA:**	**13**	12	20
4.	**Total Number of Cases Dismissed:**	**1**	1	
5.	**Total Statement of Allegations:**	**59**	36	57
6.	**Total Probation Violations/violations of LOAs:**	**8**	3	

Data Repository Unit

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

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

In 2004, the DRU received 4,302 statutory reports. Some 236 reports were forwarded to the Enforcement Division for further investigation, and 196 statutory reports relating to potential impairment issues were forwarded to the Physician Health and Compliance Unit.

The number of reports received over the past three years is up substantially in nearly every category of report. It indicates that the various reporting sources are doing a much better job of informing the Board of when they take disciplinary actions against physicians. Even though mandated by law, compliance over the years has been spotty. But since 2002 the number of disciplinary actions taken by health care facilities is up by nearly 60 percent, and the number of physician violations filed by other government agencies has tripled. The number of reports filed by physicians themselves has also skyrocketed. The extraordinarily improved reporting may be the result of 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. Only with increased compliance can health care quality continue to be improved.

Statutorily Mandated Reports Received

STATUTORY REPORTS RECEIVED	2004	2003	2002	2001	2000
Renewal "yes" answers – malpractice	**1,146**	3,401	866	3,818	815
Court Reports – malpractice	**995**	912	780	654	758
Court Reports – criminal	**0**	1	5	0	0
Closed Claim Reports	**981**	988	811	1,096	1,021
Initial Disciplinary Action Reports	**170**	141	106	114	124
Subsequent Disciplinary Action Reports	**198**	148	117	124	103
Annual Disciplinary Action Reports	**632**	580			
Professional Society Disciplinary Actions	**3**	5	1	0	0
5D (government agency) Reports	**99**	57	38	21	26
5F (peer) Reports	**58**	32	37	8	18
ProMutual Remedial Action Reports	**8**	5	3	3	0
Self Reports (not renewal)	**12**	10	1	0	3
TOTALS	**4,302**	6,280	2,765	5,838	2,868

Note: Physicians renew bi-annually. 2001 and 2003 were renewal years.

Data Repository Unit Highlights

1,146 Physician License Renewal Applications were reviewed by the DRC pursuant to M.G.L. c. 112 §2. The Licensing Division refers renewal applications to the DRU whenever applicants inform the Board of medical malpractice claims or payments, lawsuits related to competency to practice medicine, criminal charges, disciplinary actions, and certain other matters. Physicians renew their licenses every two years. 2004 was not a renewal year for most physicians.

170 Initial Disciplinary Action Reports (HCFD-1) were submitted by health care facilities pursuant to M.G. L. c. 111 §53B. This represents a 21 percent increase in reporting by health care facilities over 2003, and more than a 60 percent increase since 2002.

198 Subsequent Disciplinary Action Reports (HDFD-2) were submitted by health care facilities, representing a 34 percent increase over the 148 received in 2003, and a 70 percent increase over 2002.

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

99 reports of physician violations of M.G.L. c. 112 §5 or Board regulations were filed by other government agencies pursuant to M.G.L. c.112 §5D in 2004. This marks a 75 percent increase over the number filed in 2003, and nearly triple that filed in 2002. The majority of these reports were filed by the Department of Public Health and involved the investigation of major adverse events that occurred at health care facilities.

58 Peer Reports of physician violations were submitted in 2004 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. In 2004 these so-called "peer reports" are up by over 80 percent from 2003.

- 12 physicians filed self-reports in 2004, compared to 2002 when only one such report was filed. These were self-reports that were not made in the context of license renewal.
- 2 reports of disciplinary actions taken by professional societies were filed, pursuant to M.G.L. c. 112 §5B.

Medical malpractice insurers submitted 981 Closed Claim Reports in 2004 pursuant to M.G.L. c. 112 §5C. This represents a steady level of reports, after an increase of 22 percent in 2003.

The courts filed 995 reports, an increase of nine percent over the prior year.

Direct Referrals of Statutory Reports

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

In 2004, some 185 reports were referred directly to the Enforcement Division for investigation, based on DRC policy. These were reports of physicians who had an open complaint pending with the Enforcement Division, or physicians who had been disciplined by a licensing Board in another state. When the allegations in a report are so serious that a summary suspension may be needed, the report is referred directly to the Enforcement Division. The DRU referred 90 reports directly to the Physician Health and Compliance Unit.

Reporting Board Actions

In 2004, DRU reported formal Board actions to the Federation of State Medical Boards, the National Practitioners Data Bank (NPDB), and the Healthcare Integrity and Protection Data Bank (HIPDB). All formal Board actions are reported to the FSMB, and all but probation modifications are reported to the other two organizations.

Physician Profiles

During the year, the DRU was responsible for assuring the accuracy of the malpractice payment, hospital discipline, and criminal conviction information published on the Physician Profiles. The unit reviewed and resolved 21 complaints by physicians about the accuracy of information published on their profiles. The vast majority of these complaints involve physician misunderstandings of the requirements of the Profiles law and, while they 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, and civil and criminal courts. The DRU also assists those who report with the technical aspects of filing statutory reports and explains and interprets the "Profiles Law" to physicians, health care facilities, and other non-consumer interested parties.

Physician Health and Compliance Unit

Disruptive behavior by physicians -- doctors who yell at nurses or are rude to patients -- is a growing focus of the Physician Health and Compliance Unit (PHC), which generally advises the Board on issues related to drug or alcohol abuse, or mental or physical impairment that may affect a physician's ability to practice medicine safely and competently. The focus on disruptive behavior is a somewhat controversial area, as some doctors believe that as long as they are good clinicians, their treatment of co-workers should not be an issue. The Board has directed

Physician Health & Compliance Statistics 2004

Total Physicians Monitored	**92**
Behavioral Health	38
Mental Health	23
Chemical Dependency	18
Behavioral & Mental Health	5
Other	8
License Applications Reviewed	70
Renewal Applications Reviewed	58
Cases Presented to Board	78

the PHC Unit to respond to the issue of disruptive physician behavior, which can have a harmful effect on health care, and has decided to be aggressive in this area, particularly when red flags show up during the application process for new licensees. The Board believes that disrespect shown to colleagues and co-workers can have a negative impact on patient care in that it can have a chilling effect on a nurse, for example, by discouraging him or her from calling a physician at an odd hour to report a problem with a patient.

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

PHC Case Presentations

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

In 2004, the PHC Unit presented 78 cases to the Board, which was consistent with its presentation of approximately 42 percent of the matters considered by the Board in 2003. The PHC Unit also presented 42 cases to the Complaint Committee for its review.

PHC staff also worked closely with the Licensing Unit and reviews the licensing files of applicants who disclose problems with substance abuse, mental health, criminal matters, or disruptive behavior. The PHC Unit brought 70 license applications before the Licensing Committee for full review in 2004.

The Unit also reviewed 58 renewal applications received in 2004, including 46 for medical conditions that might impair competency, 6 for mental health reasons, 1 for chemical dependency, and 5 for Operating Under the Influence or other criminal charges.

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

Physician Oversight

A total of 92 physicians were being monitored by PHC in 2004, either confidentially or under a public Probation Agreement with the Board. Of the total, 23 were monitored for mental health reasons, 18 for chemical dependency and 38 for behavioral health issues, including boundary violations. There were eight physicians monitored for dual diagnoses of mental health and chemical dependency issues. Five physicians were monitored for both mental health and behavioral health issues.

Committee on Acupuncture

Weidong Lu, Lic.Ac.
Chairman

Nancy Lipman, Lic.Ac.
Vice Chairman

Wen Juan Chen, Lic.Ac.
Secretary

Amy Soisson, Esq.
Public Member

John B. Herman, M.D.
Board of Registration in Medicine Member

Jonathan Kapsten, M.D., Lic.Ac
Member

Joseph F. Audette, M.A., M.D.
Member

Committee On Acupuncture

The Committee on Acupuncture works in cooperation with the Board of Registration in Medicine to regulate the practice of acupuncture and the approximately 950 licensed acupuncturists in Massachusetts. The Committee's functions include setting standards for acupuncture licensure and practice, approving acupuncture schools and training programs, reviewing applications for licensure, disciplining acupuncturists who engage in misconduct, and interpreting the laws and regulations relating to acupuncture practice. Committee meetings are held every three months at the Board of Registration in Medicine and are open to the public.

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

In 2004, the Committee granted 89 full acupuncture licenses and took action on four complaints. For comparison, in 2003 the Committee granted 87 full licenses and took action on nine complaints, including one revocation.

Committee on Acupuncture Actions on Complaints

Revoked	0
Closed with Letter of Warning	3
Closed with Letter of Advice	1

PATIENT CARE ASSESSMENT

Charlene A. DeLoach, J.D., CISR
Director

The mission of the Patient Care Assessment (PCA) Committee is to ensure that physicians, and the health care settings in which they practice, provide patients with a high standard of care and support an environment that maximizes high quality health care in Massachusetts. The PCA Division is a central repository of many statutorily mandated public safety reports, and therefore is the most comprehensive storehouse of health quality data in the Commonwealth. PCA has the ability to scientifically identify medical safety trends, to engage physician participation in health care quality improvements and to identify patterns early and the onsite intellectual capital to communicate best practices. All of this makes PCA a key player in the patient safety arena.

Selected PCA Alerts 1994-2004

- Oncology Drug Administration
- Intravenous Potassium Chloride
- Pediatric Neurosurgical Procedures
- Laparoscopic Injuries
- Unread Electrocardiograms
- Unexpected Deaths of Patients Receiving Patient-Controlled Analgesia
- Deep Vein Thrombosis and Embolism with Knee Surgery
- Deaths After Gastric Bypass Surgery

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

An approved PCA program is a condition of hospital licensure -- no licensed physician may work at a hospital that does not have an approved PCA program -- and the Legislature, in 1986, determined the Board would be responsible for oversight. This is a function unique among the nation's medical licensing Boards. Establishing PCA oversight at the Board recognizes the principle that without physician leadership and participation, institutional quality assurance programs cannot and will not be successful. Another Legislative mandate says that information submitted to the Board under PCA requirements is confidential and not subject to subpoena, discovery or introduction into evidence.

In 2004 the PCA Committee established several priorities, including enhanced health care facility compliance, timely and detailed review of reports, improved communication, better collaboration and comprehensive analysis.

Health Care Facility Compliance

Reporting compliance by hospitals has improved since July 2003, when efforts were begun to obtain better cooperation with the law. Data for the year shows a 31.5 percent increase in the number of hospitals that submitted Major Incident Reports, which describe serious, unexpected patient outcomes stemming either from medical error or from unanticipated, unpreventable events. 606 Major Incident Reports were submitted to the Board in 2004, a significant improvement in reporting over 2003. Specifically, 71 of 96 hospitals in the Commonwealth submitted Major Incident Reports, a compliance rate of 74%. Compliance for submitting the Semi-Annual and Annual Reports both reached 100% in 2004. The improvement is the result of education and outreach efforts to familiarize hospitals with the PCA Program. In addition to staff contacts, the PCA Committee Chairman regularly visits or speaks with facilities.

PCA MANDATORY REPORTING COMPLIANCE*

HOSPITALS	AS OF DECEMBER 31, 2003	%	AS OF DECEMBER 31, 2004	%
HOSPITALS THAT SUBMITTED MAJOR INCIDENT REPORTS	54	56%	71	74%
HOSPITALS THAT SUBMITTED SEMI-ANNUAL REPORTS	96	100%	96	100%
HOSPITALS THAT SUBMITTED ANNUAL REPORTS	73	76%	96	100%

* Data from new PCA database only. Percent based on denominator of 96 hospitals. Data differs from 12/03 data in Annual Report due to the recent revision of the Board's list of hospitals, which had not accounted for mergers or other hospital reconfigurations that occurred in prior years. Data for 2003 was redone using 96 hospitals as a denominator. This chart does not include data for "non-hospitals," e.g., licensed clinics, HMOs, nursing homes and "episodic walk-in centers."

The chart on the following page shows the number of Major Incident Reports received by the PCA Unit from 1999 through 2004. The growth in the number of events reported since 2002 reflects the efforts the PCA unit has made to improve compliance.

Major Incident Reports
1999-2004*

Year	Maternal Death (Type One)	Ambulatory Surgical Death (Type Two)	Diagnostic/ Surgical Intervention on Wrong Part (Type 3)	Serious/ Unexpected Patient Outcome (Type Four)	Total
1999	2	10	9	405	426
2000	5	12	10	482	509
2001	1	16	12	441	470
2002	0	13	9	410	432
2003	3	9	22	443	477
2004	6	14	24	587	631

For CY 1999 through 2001, the data was tracked by date of incident. For CY 2002 through 2004, the data was tracked by date the Major Incident Report was received. Numbers include Major Incident Reports submitted by hospitals and other health care facilities, i.e. clinics, HMOs, and other health care facilities required to report Major Incidents under the PCA regulations.

Timely Review

Another PCA Committee goal was to review reports in a timelier manner. In addition to the Major Incident Reports, the PCA Division and the PCA Committee now review Annual and Semi-Annual Reports on an ongoing basis. In the past, the PCA Division had only reviewed these reports. Even with this additional level of review, the PCA Division and Committee have reviewed over nine hundred Major Incident Reports, forty-six Annual Reports and ninety-two Semi-Annual Reports in 2004 alone.

Detailed Review

In addition to the goal of timely reviewing, a PCA Committee's goal was to provide health care facilities with more detailed feedback on the Committee's review of the various reports, and to clarify the PCA Committee's expectations for compliance under the PCA regulations. Now the PCA Committee identifies areas of concern, makes recommendations for improvement and requires additional follow-up by the health care facility of any concerns identified. As of January 1, 2005, the PCA Committee has reviewed and issued a comprehensive report to fifty-four out of the ninety-

seven hospitals in the Commonwealth. The PCA Committee has also reviewed one clinic. As a result of Committee review of the health care facilities' reports, the Committee also met with officials from four hospitals to discuss concerns about their PCA Programs or their failure to issue thorough reports

Improved Communication

To achieve another goal, the PCA Committee looked at the manner in which the PCA Program had been functioning during prior years and identified areas where there was need for improvement. The PCA Committee found that communication with health care facilities, by prior PCA Committees, on important issues was not always ideal.

The PCA Committee now recognizes the importance of "follow-up" when it identifies a concern and issues an advisory, warning or other communication to hospitals. For example, the PCA Committee noticed a trend in patient deaths related to weight loss surgery and issued an advisory in June 2003. Because of that advisory, the Department of Public Health directed the Betsy Lehman Center for Patient Safety and Medical Error Reduction to convene a panel of experts, who, in August 2004, published best practice guidelines for weight loss surgery. The PCA Committee recently followed up with hospital officials to see if they have implemented any of the guidelines and continues to monitor hospital weight loss surgery programs.

To meet its statutory mission to assure a high level of quality medical care, the PCA Committee has also engaged a stronger presence in the health care arena. In the past, health care facilities had reservations about the role of the PCA Committee, which resulted in strained communications. Others did not know of the work of the Committee itself. Most often the Committee related these problems to the health care facilities' lack of understanding of the PCA Committee's expectations for compliance and the lack of outreach by the Committee. The PCA Committee has now increased its efforts to facilitate better relationships with the facilities to assure compliance and amplified its outreach efforts with a variety of entities in the Commonwealth and across the nation.

Better Collaboration

Another goal of the PCA Committee is the commitment to improve collaboration with patient safety organizations and other governmental agencies with health quality directives. The Department of Public Health is another state agency that has oversight of patient safety and quality in its licensed facilities. While the PCA Committee cannot share specific health care facility data

with the Department of Public Health, it can share its experiences and its findings from analysis of patterns or trends identified through the review of Major Incident and other PCA reports. Therefore, the Chair of the PCA Committee and PCA Division staff participate in initiatives undertaken by the Betsy Lehman Center for Patient Safety and Medical Error Reduction within the Department of Public Health, and are members of the Coalition for the Prevention of Medical Errors and other patient safety focused organizations.

Broadened Oversight

Next, the PCA Committee is striving to fulfill its broader mandate, by expanding its oversight and monitoring activities to other areas where physicians practice. For example, physicians who perform surgery in their offices are now required, when they renew their medical license, to inform the Medical Board whether or not they are meeting the guidelines for Office Based Procedures published by the Massachusetts Medical Society and endorsed by the Medical Board. Under the PCA regulations, the PCA Committee has the authority to collect this information as part of its quality assurance oversight responsibilities over physician office practice.

The Medical Board's mandate to oversee physician office practice through the PCA Program is the key to assuring that patients will be safe, not only when they are treated in hospitals, but when they are seen and treated in individual physician's offices. No other agency or entity has the authority to assure patient safety and quality care in physician offices. As the health care environment changes and more procedures are performed in physician offices, the Medical Board will be on the frontline to assure patients have the same safeguards in physician offices that are in place in hospitals. While office based surgery is a great trend for health care costs, the PCA Committee wants to makes sure there is no great cost to patient safety.

Public Focus

A major goal of the PCA Committee is the commitment to the public. The PCA Committee is committed to assuring the public that it is working to improve the quality of care in health care facilities in the Commonwealth. While operating within the confines of the confidentiality protections of the PCA Program, the Committee plans to increase public awareness of the PCA Program through education and outreach. As part of this effort, the PCA Committee also plans to add a "consumer" member to the PCA Committee.

Comprehensive Analysis

Lastly, the PCA Committee is committed to improving the collection, analysis and dissemination of information that it obtains from the PCA reports submitted by health care facilities. Aware of the PCA Program's ability to recognize quality concerns early on through the identification of patterns or trends seen in Major Incident Reports, as it did with oncology drug errors in 1993 and weight loss surgery concerns in 2003, the PCA Committee wants to improve its ability to collect and analyze data from Major Incident Reports. The Major Incident Reports are now being entered into a new and improved database that allows for enhanced ability to identify patterns, trends or concerns that might require a PCA Update or other communication to health care facilities and physicians.

Conclusion

The PCA Committee's PCA Program demonstrates how a confidential reporting system is effective in assuring patient safety, preventing medical errors and improving the quality of patient care in Massachusetts. To date, fifty-four hospitals have benefited from a comprehensive review of the PCA reports that have been submitted to the Medical Board over the past few years, with more to come.

All of these hospitals have received feedback and are making improvements to their PCA Programs, which in turn will result in improvement in the quality of health care provided to patients, ultimately improving patient safety and reducing medical errors. This feedback is what makes the PCA Committee, and the Medical Board, an important part of the health care system. Many other reporting systems are flawed in that those reporting systems embrace the concept that reporting alone is sufficient evidence that safety is improving. The Board of Medicine's PCA Program is like no other reporting system for it goes a step further in being a part of the solution.

Therefore, one of the PCA Committee's primary goals is to complete its review of *all* Massachusetts hospitals so that it can have baseline data for each hospital and also begin to identify those hospitals whose PCA Programs need the most attention. In addition, through the comprehensive reviews of the fifty-four hospitals thus far, the PCA Committee is able to see what issues need further attention statewide.

The PCA Committee's authority to oversee a health care facility's peer review and credentialing process in a confidential manner, and to oversee physician participation in these activities, allows the PCA Committee to address these concerns and assure that qualified and competent physicians

are caring for patients in the Commonwealth. Similarly, the Medical Board's broad authority to oversee these physician activities enables the PCA Committee to effectively address issues and concerns related to the oversight of physicians in training.

Creating a culture that assures the highest quality care to patients in the Commonwealth requires collaboration and teamwork. Physicians must be "team leaders" in these efforts. The Medical Board, through the PCA Program, guarantees physician participation and leadership. As a result, physicians are now leading hospitals to realize that if they are to improve patient safety, hospitals must evaluate and respond to patient safety concerns in a multidisciplinary approach. This work and the work of the PCA Committee and the PCA Division this past year shows that the Medical Board's PCA Program makes Massachusetts a leader in patient safety, medical error prevention and quality improvement nationwide.