Commonwealth of Massachusetts

Board of Registration In Medicine

Annual Report
~ 2005 ~

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 pleased to announce the submission and availability of a report summarizing the Agency's activities for the calendar year 2005. The Board of Registration in Medicine continues to make tremendous strides in all areas of public protection and health care quality assurance. The 2005 annual report can be found on line on the Board's web site at: www.massmedboard.org.

In 2005, annual disciplinary actions continued apace, although down from 2004's record high, and the agency made further progress in its ambitious program to expand and improve its information technology infrastructure and capabilities.

The Board and the Department of Public Health, the agency in which it resides administratively, remain close partners in the work of patient protection and support for the physicians who continue to offer the highest quality health care to the citizens of the Commonwealth. I would note again 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 in 2005 the Board continued its record of stability and deep commitment to protecting the public and serving the state's physicians. In 2006 the Board will be unwavering in its pursuit of that important mission, and dedicated to working with its many partners, including the administration and the legislature, to fulfill it.

As a final note, the work of the Board would be impossible without the tireless efforts and dedication of our talented staff. I also want to thank my fellow Board members who volunteer many long hours to improve the quality and delivery of health care in Massachusetts.

Sincerely,

Martin Crane, MD

Martin Crane, MD
Board Chair

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Mission Statement

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

2005 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.

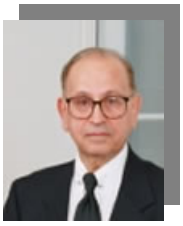
Roscoe Trimmier, Jr., J.D., Vice Chair

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. She is Chair of the Department of Family Medicine at the Cambridge Health Alliance. Dr. Wertheimer 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. She serves on the Board's Complaint Committee.

Honorable E. George Daher, Public Member

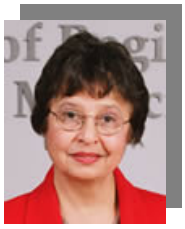


Before joining the Board in 2002, Justice Daher was Chief Justice of the Commonwealth's Housing Court Department. He is a graduate of Northeastern College of Allied Sciences (New England College of Pharmacy); Suffolk University Law School; and Boston University Graduate School of Education. Chief Justice 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 Annual, Semi-Annual and Major Incident Reports. These reports describe adverse outcomes, full medical reviews of the incidents, and the corrective action plans implemented by the institutions. The plans are part of the Committee's commitment to preventing patient harm through the strengthening of medical quality assurance programs in all institutions. The work of the PCA Committee has become a national model for the analysis of systems to enhance health care quality.

Committee on Acupuncture

The Board of Registration in Medicine also has jurisdiction over the licensing and disciplining of acupuncturists through its Committee on Acupuncture. The members of the Committee include four licensed acupuncturists, one public member and one 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 was 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, medical and other professionals who perform research and make recommendations to the members of the Board on issues of licensure, discipline and policy. In addition, the Executive Director is responsible for all management functions, budget and contract issues, and public information activities of the Agency. The Executive Director oversees senior staff members who, in turn, manage the various areas of the Agency.

Licensing Division

The Licensing Staff 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.

Public Information 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 Data Repository Unit and the Physician Health & Compliance Unit.

Patient Care Assessment Division

The Patient Care Assessment Division is responsible for receiving and evaluating reports from the Commonwealth's hospitals that detail their patient safety programs, and report Major Incidents, defined as any unexpected adverse patient outcomes. The Division works with hospitals to assure

that hospital patient safety programs are effective and comprehensive, that hospitals conduct full and competent medical reviews of patient safety incidents, and that hospitals are fully in compliance with reporting and remediation requirements regarding Major Incidents.

Information Technology Division

Over the past ten 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 2005 the Division began to upgrade Profiles by expanding the data fields so, for example, Profiles will list a physician's secondary, as well as primary, practice specialty. The improvements will go online in 2006. Similarly, a reconfiguration of internal physician data formats is in process, to aid Enforcement Division staff to better track and documents progress on physician disciplinary matters.

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 over 5,000,000 individual document pages.

EXECUTIVE DIRECTOR'S REPORT

Nancy Achin Audesse

Since 1999 the Board has worked hard to regain the credibility lost after years of poor performance. Today that credibility is restored and robust. The means that achieved this continue to be new information technology applications, revised licensing forms and processes, better records management and a conscientious disciplinary approach. In 2006 I fully expect the pace of improvement to continue, with the first priority being the start of implementation of online re-licensure.

Disciplinary Actions

The Board fairly, but energetically, investigates reports of physician misconduct, and imposes appropriate discipline when the facts of a case warrant it. In 2005 the Board disciplined 69 physicians, a drop from last year's record high of 78, but still over 80 percent higher than the number disciplined in 1999.

Technology Improvements

The Board is getting closer to its goal of retiring the last remnants of its antiquated database systems. Most of the Board's information is now stored in the Consolidated Licensing and Regulation Information System, or CLARIS. Records are more accurate and complete, better data sharing is enabled and the Board can more easily analyze its data for trends. Further improvements to CLARIS and other Board applications are planned for the coming year.

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 occur during odd-numbered years, and in 2005 over 20,000 of the state's more than 30,000 physicians renewed their licenses to practice medicine. Redesigned application forms and instructions made the renewal process considerably easier and more efficient. The new forms came about from helpful comments from licensees themselves. The Board had three goals in mind for the redesigned application: 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 was clearly a success, as applications arrived earlier and more complete than in years past and the Board's data is now more accurate and complete.

Online Licensing

Making it possible for physicians to renew their licenses online continues to be one the Board's highest priorities. It will not only make physicians' lives easier, but will allow the Board to direct more resources toward enforcement and patient safety 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 support online licensing. The further development of CLARIS was another major step toward the goal. As a single data entry point for all information that comes into the Board, it paves the way for the introduction of online license renewal. Funding for the project is also required and, rather than ask the Legislature for additional taxpayer money, the Board is hopeful that the Legislature will approve pending language that will allow for unexpended amounts in the Board's Trust Fund to carry over to subsequent fiscal years. Currently, every year hundreds of thousand of dollars worth 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 and other important Board projects can become a reality.

Patient Care Assessment

The Board's Patient Care Assessment (PCA) Division 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 several years of report review backlog, the PCA Committee turned its focus to encouraging greater reporting compliance by hospitals, faster and more detailed review and more comprehensive data analysis.

In 2005 compliance with reporting remained virtually identical to the all-time high set in 2004. 72 percent of hospitals submitted MIRs, 100 percent submitted Semi-Annual Reports and 97% submitted Annual Reports. The Patient Care Assessment Committee of the Board also reviewed over 800 MIRs and over 205 Annual and Semi-Annual Reports. PCA continues its analysis of the incidence and circumstances of sepsis in hospitals, its comprehensive review of the adequacy of House staff (residents and interns) supervision by hospital attending physicians and a review of telemedicine.

PCA's database became much more user-friendly and accessible in 2005, allowing other types of reports to be extracted and enabling the Board to identify trends or concerns better and faster. An example would be examining the gender differences between MIRs reported among older patients. In this particular instance, Board data are reassuring, in that the differences are as expected given demographics and variations in health care utilization rates.

Clinical Skills Assessment

The Board is committed to ensuring patient safety and quality health care delivery through robust clinical skills assessment. It is critical that a means is developed to assess the clinical skills of 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. It is a vital part of the future of patient protection, and the Board intends to occupy a central place in the evolution of this new and exciting regulatory program. 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.

Patients' Rights

In 2005 the Board implemented legislation, enacted in 2004, 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 final action on that complaint. Similar to victim impact statements presented prior to sentencing in criminal proceedings, such statements may be made orally or in writing. The Board has embraced this concept, and appreciates the opportunity to expand its efforts to further patients' rights

Newsletters

In an effort to keep physicians and other partners more informed, and to open new opportunities for cooperation and assistance, the Board has begun publishing two newsletters. "*Newsbrief*," a newsletter of general interest to the Commonwealth's 30,000 physicians is a quarterly publication designed to reach out to those whom the Board regulates and inform them of the Board's activities, opportunities for volunteering, helpful advice based on the Board's experience and topics of current

interest to the physician community. "*First*" is a newsletter by the PCA Division, sent to the Commonwealth's hospitals and rehabilitation and specialty facilities, and other partners in patient care standards and assessment. It advises hospitals about their responsibility to report unexpected adverse events, how the Board uses those reports and how hospitals must respond to the circumstances of such reports. "*First*" also publicizes workshops and training offered by the PCA Division and provides other information to help health care facilities meet to proper standards of patient safety and patient care assessment and quality.

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 has under review include updating licensing provisions, addressing the issue of licensing and credentialing in times of national emergency and considering a new category of medical license: 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), problems like sepsis, which appears to be a growing problem in hospitals nationally and maternal deaths.

In 2006 the Board will issue the third in a series of reports on medical malpractice payment data, adding the years 2004 and 2005 to reports now analyzing data from 1994 through 2003. As the central repository of medical malpractice payment data, received from the courts, insurers and physicians, the Board is in the unique position of being able to provide policymakers with the accurate and complete information necessary to proper decision making on this issue so critical to the medical profession and the public.

The Board also hopes to work closely with the Division of Administrative Law Appeals (DALA) to ensure DALA has sufficient resources to devote to handling the caseload of cases referred to it by the Board. In 2005 the number of complaints sent to DALA more than doubled. Given the complex and time-consuming nature of the cases at DALA, the Board wants to focus on how to expedite their resolution.

And finally, the Board will host the 2006 national convention of the Federation of State Medical Boards (FSMB) in Boston. This will put the Board and the Massachusetts health care sector in the national spotlight, and is a testament to our leadership nationally on issues of patient safety. Board Chair Dr. Martin Crane and I both serve on the FSMB Board.

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 the physician conduct and the process by which allegations of misconduct are adjudicated.

The Enforcement Division staff are recognized 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 2005, the Board disciplined 69 physicians after investigation by the Enforcement Division. This number is somewhat less than 2004's 78 disciplinary actions, but still far higher than the agency's past history, solidifying the reputation of the Enforcement Division staff as expert, thorough and meticulous.

In 2005 the Enforcement Division was challenged by a significant staff vacancy rate. This made swift case management more difficult than in the past several years. Nevertheless, staff continues to focus on the expeditious handling of open cases and improving communications with consumers filing complaints against physicians.

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 661 cases for investigation in 2005, a 15% drop from 2004's record high, but quite close to the number of cases opened in other recent years. In addition, the unit reviewed 177 reports that were referred by the Department of Public Health's Division of Health Care Quality. Some 96 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 review. In addition to the 661 docketed

consumer complaints, the unit received 181 additional communications from consumers that were not placed on the Board's 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 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. But some urgent matters are fast-tracked and physician responses in these cases are not done as part of the initial review.

Clinical Care Unit

The Clinical Care Unit (CCU) investigates complaints that allege substandard care. It received 91 new complaints in 2005. Another 69 complaints were closed and 177 more remain under investigation.

The CCU is staffed by the Unit Attorney/Manager, three nurse reviewers -- all experienced clinicians -- and a paralegal. Staffers analyze patient records and physician responses, work with medical experts, help Enforcement Division attorneys in the preparation of litigation involving complex substandard care cases and prepare analyses for Licensing Committee. The CCU also coordinates conferences for physicians appearing before the Complaint Committee. These conferences are designed to discuss concerns about a physician's delivery of care or the running of his or her practice 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 2005, the Board disciplined 69 physicians. That is an 11 percent decrease from the record high of 78 in 2004, but still over an 80 percent increase since 1999.

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

Sixty-nine different physicians were involved in 73 separate disciplinary actions. Each investigation by the Board 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, witness and physician 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, investigators 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 2005, 30 physicians entered into such Consent Orders. These actions are public and disciplinary, and reportable to the National Practitioner Data Bank.

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 27 cases pending at DALA as of Dec. 31, 2005. 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	2005	2004	2003	2002	2001	2000	1999
Doctors Disciplined	**69**	78	60	68	55	44	38
Statements of Allegations Issued	**58**	60	36	57	39	40	29
Summary Suspensions	**5**	2	4	5	7	7	5
Voluntary Agreements Not to Practice	**25**	10	14	16	4	4	3
Voluntary Agreements for Practice Restriction	**8**	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.

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 during the pendency of cases 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 661 complaints opened in 2005 represent a 13% decrease over 2004, although 2004 saw a surge in opened complaints over 2003; this year the number has returned to a more historical level. At the end of the year, 507 complaints were awaiting final action by the Board -- a significant increase over 2004, and not in accordance with the agency's goal to keep pending complaints to below 425. The large number of pending cases at the end of 2005 can be attributed in part to a 120 percent increase in the number of cases referred to DALA. Cases at DALA require much greater staff time, taking away from cases of more recent vintage. The aftereffects of 2004's heavy caseload persist, and several staff vacancies during the year also contributed.

Docketed Complaints Opened, Closed, and Pending

COMPLAINTS	2005	2004	2003	2002	2001	2000
Docketed	**661**	760	650	677	670	626
Closed	**562**	682	673	680	865	773
Pending as of 12/31	**507**	406	328	358	361	537

Growth in the number of complaints pending at year's end might raise concerns about a returning case backlog. Another figure the Board will watch carefully throughout 2006 is the length of time to close cases. Like pending cases at year's end, this trended upward in 2005. Again, case complexity and a significant vacancy rate among the Enforcement Division staff during 2005 is the cause of much of this increase. Nevertheless, Board staff will monitor these two measures closely, determined to drive them down before the end of 2006.

Complaint Aging and Number at Year's End

YEAR	Average Age of Complaint	Open Complaints at End of Year
2005	**370 days**	**507**
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 intensively on more serious cases that have the potential for disciplinary action to be taken.

Number of Complaints Alleging Substandard Care

Status	2005	2004	2003	2002	2001	2000
Opened	**91**	98	83	101	111	177
Closed	**69**	62	69	90	168	322
Pending	**177**	158	125	110	99	156

In recent years, the Board has seen a significant increase in the number of cases of misprescribing by physicians. Cases involving prescription drug practices by physicians are extremely complex and time consuming because they require obtaining and analyzing mountains of prescribing records, typically from multiple pharmacies. Such cases often involve more than one patient,

sometimes many more, presenting even greater challenges to the investigative teams in terms of resources, time to interviews all the parties and, in many cases, cooperation with local, state and federal law enforcement agencies. All of this is affecting the Enforcement Division's timetables and resource allocation plans.

Complaint Committee Actions

The Complaint Committee works 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 Committee also hears from physicians and/or their attorneys. After hearing from the parties the 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.

Complaint Committee Non Disciplinary Enforcement Actions

Category	2005	2004	2003	2002	2001	2000
Closed	**384**	462	440	458	500	476
Letter of Acknowledgement	**0**	0	3	4	0	1
Letter of Information	**0**	5	4	3	14	13
Letter of Advice	**48**	37	63	53	103	140
Letter of Concern	**27**	45	21	41	71	58
Letter of Warning	**29**	24	1	30	27	19

Special Projects and Initiatives

Regulations Revision Project

The Enforcement Division has been an integral part of the Board's regulations revision project. Staff has met regularly to propose and review potential changes and determine the impact on Enforcement investigations and capabilities.

Expert Witnesses

In 2005 the Clinical Care Unit began developing an expert witness bank, a group of highly trained and skilled physicians in a variety of specialties who can advise the Enforcement Division on complex medical issues. This effort is being aided by the Board's newsletter, *Newsbrief*, the inaugural issue of which encouraged physicians to volunteer their services in this way. Nearly two dozen have responded to this call so far.

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 staff participate in various working groups and task forces.

In the past year staff attended a variety of National Association of Drug Diversion Investigators programs and trainings, an Essex County program on heroin and prescription drug abuse and the Federation of State Medical Boards program on the Oversight of Pain Care. Other staff participated in the New England Conference on Health Care Fraud sponsored by the Office of the Attorney General, and several Bar Association programs and courses for investigators on interviewing and interrogation. Nurses on staff also attended a number of courses to for continuing education units (CEUs).

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, remains a spectacular success story beyond the wildest dreams of its creators. The Profiles server recorded almost 29 million hits in 2005. 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 again attracted over 8 million page hits -- a staggering number considering the site is unadvertised. 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. A further redesign of the website is planned for 2006.

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.

2005 Public Information Statistics

Profiles server "hits"	29,000,000
Profiles page "hits"	8,000,000
Avg. daily website "hits"	21,500
Calls for information	20,914
Faxed or mailed Profiles	2,112
Updated Profiles	30,849

In addition to the web site, consumers also call and write for Profiles information as well as information on complaints. In 2005, the agency received 20,914 calls for information, mailed or faxed 2,112 Profiles to consumers and made 30,849 updates to Profiles based on changed physician information, such as address or hospital affiliation. The numbers vary significantly over 2004, most dramatically in a two-thirds drop in faxed or mailed Profiles and one-third more updated Profiles. It is safe to assume that more Profiles were updated because in 2005 over 20,000 physicians renewed their licenses, and were likely more focused on making sure their Profiles had the most current information. Why so many fewer physical requests for Profiles were made is unclear, but increasing use of the Internet by the public is not an unreasonable assumption.

LICENSING DIVISION REPORT

Rose M. Foss, Director of Physician and Acupuncture Licensing

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

Physician Demographics

Total Licensed	**29,127 (100%)**
Men	19,687 (68%)
Women	9,440 (32%)
Age Groups	
<40	7,885 (27%)
40-49	8,565 (29%)
50-59	7,469 (26%)
60-69	3,667 (13%)
>69	1,541 (5%)
Board Certified	
Yes	84%
No	16%

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. 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	2005*	2004	2003*	2002
Initial Full Licenses	**1,775**	1,812	1,628	1,709
Full Renewals *	**19,648**	9,645	20,188	7,286
Lapsed Licenses	**192**	113	112	123
Initial Limited Licenses	**1,549**	1,521	1,476	1,418
Limited Renewals	**2,751**	2,701	2,611	2,513
Temporary (initial) Licenses	**21**	22	21	17
Temporary Renewals	**17**	6	12	16
Voluntary Non-renewals	**561**	390	709	427
Revoked by Operation of Law	**1,084**	869	848	611
Deceased	**265**	162	148	131
TOTAL	**27,863**	17,241	27,753	14,251

** The majority of full licenses are renewed in odd-numbered years, 2003 and 2005.*

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 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	2005	2004	2003	2002
Malpractice	**39**	28	35	35
Competency Issues	**78**	88	81	90
Legal Issues	**53**	46	52	27
Medical Issues	**39**	42	36	32
6th Limited Renewals	**23**	33	18	26
Lapsed Licenses	**70**	73	_	_
Miscellaneous Issues	**181**	127	146	110
Total Cases Reviewed	**483**	437	368	320

There was a 9 percent increase in the number of cases reviewed by the Licensing Committee in 2005, as compared with the number of cases reviewed in 2004. The most significant increase, 54 cases, were miscellaneous issues, the majority of which were substantial equivalency of medical school training issues and extension of training dates for limited licensees.

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 increased from 7 in 2001 to 13 in 2002, representing an 86% increase. In 2005, there were 10 new Performance Monitoring Agreements.

Performance Monitoring Agreements	2005	2004	2003	2002
Performance monitoring agreements	**10**	10	11	13
% Change from previous year	**0%**	- 10%	- 15%	+ 86%

Licensing Division Survey

As an ongoing initiative to improve customer services, the Licensing Division randomly surveys newly licensed physicians to identify opportunities for improvement and expedite the licensing process within the scope of the Board's regulations. Survey responses are tabulated using the Likert Scale from 1–5, with 1 rated as "poor," 2–3 rated as "average" and 4-5 rated in the "excellent" range. In 2005 the Licensing Division mailed approximately 1,200 surveys and received responses from 350 newly licensed physicians. There was a 21% decrease in survey responses in 2005 and the 2005 overall average score of 4.22% was slightly lower than the 2004 score of 4.43%. This is not particularly troubling, as the Division was in contact with so many more physicians renewing their licenses in 2005. The process was made easier in the past year, but it can still remain the source of frustration for some.

Licensing Division Survey Results

Survey Questions	2005 Responses (n= 350)	2004 Responses (n= 445)	2003 Responses (n=325)	2002 Responses (n=97)
1.Was the Licensing staff courteous?	**4.40%**	4.41%	4.52%	4.20%
2. Was the staff knowledgeable?	**4.28%**	4.42%	4.35%	4.28%
3. Did the staff provide you with the correct information?	**3.92%**	4.35%	4.53%	4.23%
4. Did the staff direct you to the appropriate person to answer your questions?	**4.29%**	4.52%	4.57%	4.20%
Overall average score	**4.22%**	4.43%	4.49%	4.23%

2005 LICENSING DIVISION ACCOMPLISHMENTS

National Practitioner Identifier (NPI)

The Health Insurance Portability and Accountability Act (HIPAA) mandates the use of the NPI, which is a National Practitioner Identifier number and a unique identifier for health care providers. All health care providers who choose to transmit any health information in electronic form will be required to obtain and use an NPI number by May of 2007. This includes physicians with an active license and other health care practitioners.

As a service to physicians, the Board of Registration in Medicine assumed the leadership role as the designated repository for the NPI number. The "designated repository" status means that the Board can process a request for an NPI number on behalf of any Massachusetts physician. Physicians were given the following choices: (1) obtain his/her own NPI number, (2) have a hospital or health plan secure the number on his/her behalf, or (3) take advantage of this free service from the Massachusetts Board of Registration in Medicine by completing the NPI application included with the regular license initial or renewal application form. The NPI number will be made available to healthcare facilities and authorized agencies. It will also be imprinted on the wallet card.

New Wallet Cards

The Board replaced the traditional paper wallet card with a heavy-duty laminated wallet card that is more durable, more professional and protects the licensing information from of being altered. Additionally, after the license renewal process is completed and the wallet card is printed the physician is sent an e-mail to confirm that his/her license has been renewed. The Board is 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. The addition of a physician's photograph on the physician's wallet cards will fulfill the JCAHO requirement, save time and effort for both hospitals and physicians and create a universal form of licensed physician identification that may be utilized for identification during times of serious emergency.

Common License Application

The Director of Licensing participated in a Federation of State Medical Boards (FSMB) workgroup to develop a Common License Application (CLA) for physicians who apply for state licensure. A CLA will eliminate duplicative information collection by different states and expedite the licensing process by providing a single, online license application that a physician can complete once. The information will be stored electronically and updated as often as necessary. The CLA and supporting documentation will 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 will be eliminated for both physicians and the state medical boards. The demand for telemedicine services has significantly 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 2005, the Licensing Division conducted 5 regional Limited License Workshops hosted by Beth Israel Deaconess Medical Center, Brigham and Women's Hospital, Children's Hospital Medical Center, St. Vincent's Hospital and the Lahey Clinic for training program coordinators and administrative staff who serve as the liaisons 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.

2006 LICENSING DIVISION GOALS

Online Renewals

The initiative for the online renewal project was not accomplished in 2005 due to insufficient funding. The Board is hopeful the Legislature will approve retention of fees, in order for 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 technology will significantly improve the Board's ability to protect the public by obtaining more timely information on physicians currently reported biannually when a physician renews his or her medical license.

CORI Checks

Another of the Licensing Division goals is to obtain CORI (criminal background) checks 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.

Regulations Revisions for Licensing

The Licensing Division proposed new regulations to reflect current licensing practices and to streamline the licensing process. The Board will review and approve the proposed regulations in 2006. The proposed revisions include the following: 1) extending limited licenses for intervals for the duration of the training program with a Board approved quality improvement program; 2) increasing the postgraduate requirements for a full license for U.S. graduates from one to two years and for international graduates from two to three years; and, 3) adding a new license category for volunteer physicians who wish to provide uncompensated medical care in underserved areas.

COMMITTEE ON ACUPUNCTURE

Rose M. Foss, Director of Licensing Division and Acupuncture

The Board of Registration in Medicine licenses Acupuncturists on the recommendation of the Committee on Acupuncture. Acupuncture originated in China 2000 years ago and is unique in that it is known as one of the oldest and most commonly used practices in the world. In order to ensure that only qualified and competent acupuncturists are approved for licensure, the Board established the Committee on Acupuncture in June of 1987.

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

The Committee on Acupuncture

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

The Committee's primary function is to protect the safety of the public by ensuring that applicants applying for licensure to practice acupuncture independently are qualified, competent and possess the education, examination and training requirements established by the Committee. The Committee is also

Committee Members

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 Medicine Member

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

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

responsible for interpreting the existing laws (M.G.L. 112) and regulations relating to the practice of acupuncture and disciplinary process for acupuncturists who engage in misconduct. Meetings of the Committee on Acupuncture are held every three months at the Board of Registration in Medicine and are open to the public.

Acupuncture License Activity Report

License Type	2005	2004
Initial Licenses	**84**	89
Renewals	**348**	414
Lapsed Licenses	**6**	4
Temporary (initial) Licenses	**2**	0
Voluntary Non-renewals	**2**	1
Revoked by Operation of Law	**0**	2
Deceased	**0**	1
TOTAL	**442**	511

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

Acupuncture Disciplinary Actions

Legal Issues	2005	2004
Acupuncture Complaints	**2**	4
Letter of Warning	**0**	3
Letter of advice	**0**	1
Disciplinary Actions	**0**	0

COMMITTEE ON ACUPUNCTURE GOALS FOR 2006

Plastic Wallet Cards

Acupuncture paper wallet cards will soon be replaced with heavy-duty laminated wallet cards that are currently issued to physicians. The acupuncture wallet card will be more durable and more professional than the paper wallet card currently in use and will protect the licensing information from being altered. The Board is also exploring technologies to include an acupuncturist's photograph on the wallet card for additional security and purpose of positive identification of the cardholder.

Revised Acupuncture License Applications

Full Acupuncture License Application: A more streamlined initial full license acupuncture application, which mirrors the physician application form, will replace the current acupuncture application. This format is easier to read and will capture more pertinent demographic, education and training information.

Acupuncture Renewal Form: Additionally, the new acupuncture renewal application is easier to read and has more detailed instructions to assist the licensee in completing the renewal process.

National Practitioner Identifier (NPI): The Board is the designated repository for the NPI, which is required by the Health Insurance Portability and Accountability Act (HIPAA) for all healthcare provider reimbursement. Acupuncturists will be required to select one of the options for providing the NPI on the acupuncture initial and renewal applications.

DIVISION OF LAW AND POLICY REPORT

Charlene A. Deloach, J.D., CISR
Acting 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 the Commonwealth's 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.

2005 saw another sharp increase in the number of reports received concerning physicians who had been disciplined by hospitals, paid malpractice claims or found themselves facing criminal charges. This continues 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 declined from the 2004 high, after 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 remains convinced 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 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 2005, the Board took 73 disciplinary actions against 69 physicians. The Board issued 17 Final Decisions and Orders and entered into 30 Consent Orders. 58 Statements of Allegations were issued, and 27 cases were referred to the Division of Administrative Law Appeals (DALA).

ADJUDICATORY FIGURES	2005	2004	2003	2002
1. **Total Number of Disciplinary Actions Taken:**	**73**	**83**	**62**	**73**
a. Consent Orders:	30	46	26	37
b. Final Decision and Orders:	17[1]	10	8	12
c. Summary Suspensions:	5	2	4	5
d. Final Decision and Orders On Summary Suspensions:	1[2]	2	1	0
e. Resignations:	8	9	14	8
f. Voluntary Agreements:	15[3]	14	7	10
g. Assurances of Discontinuance:	1	1	2	0
h. Suspensions pursuant to violation of Letters Of Agreement	0	1	1	1
2. **Discipline by Type of Sanction:**				
Admonishment:	2	4	1	0
Censure:	0	0	2	2
Continuing Medical Education Requirement:	3	5	4	8
Community Service:	2	0	0	1
Costs:	1	0	0	0
Educational Service:	1	0	0	0
Fines:	12	13	6	13
Monitoring:	4	0	1	0
Practice Restrictions:	16	15	7	10
Probation:	10	6	9	13
Reprimand:	14	18	6	16
Resignation – part a:	5	4	5	3
Resignation – part b:	3	5	9	5
Revocation:	10	10	5	7
Summary Suspension – part a:	5	2	4	4
Summary Suspension – part b:	0	0	0	1
Suspension:	12	18	13	12
Stayed Suspension:	5	7	7	11
Total Number of Physicians Disciplined:	**69[4]**	78	60	68

[1] This includes 3 Final Decision and Orders that resulted in Dismissals, which are not counted in the total number of disciplinary actions.
[2] This is not included in the total number of disciplinary actions.
[3] This number includes both Agreements Not to Practice and Agreements for Practice Restrictions.
[4] Several physicians were disciplined more than once: Upton (3 times: voluntary agreement practice restrictions (2) and probation); Arndt (2 times: revocation); Monafo (2 times: voluntary agreement and resignation). There were 69 physicians disciplined and 73 disciplinary actions.

ADJUDICATORY FIGURES CONT'D		2005	2004	2003	2002
3.	**Total Number of Cases referred to DALA:**	**29**	13	12	20
4.	**Total Number of Cases Dismissed:**	**3**	1	1	0
5.	**Total Statement of Allegations:**	**58**	60	36	57
6.	**Total Probation Violations/violations of LOAs:**	**0**	1	3	0

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 2005, the DRU received 6,120 statutory reports. Some 104 reports were forwarded to the Enforcement Division for further investigation, and 78 statutory reports relating to potential impairment issues were forwarded to the Physician Health and Compliance Unit.

The number of reports received over the past four years continues has increased substantially in nearly every category of report. This indicates that the various reporting sources are taking seriously the responsibility to inform the Board when they take disciplinary actions against physicians. Even though mandated by law, compliance over the years was inconsistent. Since 2002, however, the number of reports received by the Board has more than doubled. The number of reports of physician violations filed by government agencies has more than tripled, and even the number of reports filed by physicians themselves is up. The remarkably improved reporting gives the Board confidence in DRU's continuing aggressive outreach campaign to educate health care facilities about their reporting requirements, and the strong relationships the Board has made with health care facilities and physicians. Such increased compliance can only help to improve the quality of health care delivered in the Commonwealth.

Statutorily Mandated Reports Received

TYPE OF REPORT	2005	2004	2003	2002	2001	2000
Renewal "yes" answers – malpractice	**3,173**	1,146	3,401	866	3,818	815
Court Reports – malpractice	**962**	995	912	780	654	758
Court Reports – criminal	**1**	0	1	5	0	0
Closed Claim Reports	**854**	981	988	811	1,096	1,021
Initial Disciplinary Action Reports	**138**	170	141	106	114	124
Subsequent Disciplinary Action Reports	**172**	198	148	117	124	103
Annual Disciplinary Action Reports	**602**	632	580	N/A	N/A	N/A
Professional Society Disciplinary Actions	**0**	3	5	1	0	0
5d (government agency) Reports	**139**	99	57	38	21	26
5f (peer) Reports	**68**	58	32	37	8	18
ProMutual Remedial Action Reports	**3**	8	5	3	3	0
Self Reports (not renewal)	**8**	12	10	1	0	3
TOTAL	**6,120**	4,302	6,280	2,765	5,838	2,868

Note: Physicians file renewal applications bi-annually. 2001, 2003 and 2005 were renewal years.

Data Repository Unit Highlights

3,173 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. 2005 was a renewal year for most physicians.

138 Initial Disciplinary Action Reports (HCFD-1) were submitted by health care facilities pursuant to M.G. L. c. 111 §53B.

172 Subsequent Disciplinary Action Reports (HDFD-2) were submitted by health care facilities.

602 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.

139 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 the fourth straight year of significant increases, and is more than six times the number of 5D reports filed in 2001. The majority of these reports are filed by the Department of Public Health and involved the investigation of major adverse events that occurred at health care facilities.

68 Peer Reports of physician violations were submitted in 2005 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. Since 2002 these so-called "peer reports" have nearly doubled.

- 8 physicians filed self-reports in 2005, compared to 2002 when only one such report was filed. These were self-reports that were not made in the context of license renewal.
- In 2005 no reports of disciplinary actions taken by professional societies, pursuant to M.G.L. c. 112 §5B, were filed.

Medical malpractice insurers submitted 854 Closed Claim Reports in 2005 pursuant to M.G.L. c. 112 §5C. This is a 13 percent drop after a period of relative stability in 2003 and 2004.

The courts filed 963 reports, a slight decline from 2004.

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 2005, 78 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 all 78 reports directly to the Physician Health and Compliance Unit.

Reporting Board Actions

As in previous years, 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 23 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 nursing staff or are rude to patients, for example -- is a growing component of the Physician Health and Compliance Unit's (PHC) caseload, which generally advises the Board on issues related to substance abuse, or any other medical condition that may interfere with 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 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, discouraging him or her from calling a physician at an odd hour to report a problem with a patient.

Physician Health & Compliance Statistics 2005

Total Physicians Monitored	**119**
Behavioral Health	17
Mental Health	26
Chemical Dependency	32
Clinical Competence	17
Boundary Violations	12
Behavioral & Mental Health	6
Substance Use/Mental Health	4
Other	5
License Applications Reviewed	78
Renewal Applications Reviewed	58
Cases Presented to Board	76

2005 saw some new focal points for PHC's efforts. Monitoring of physicians who have left surgical suites prior to completing procedures – which cases have received significant media attention – is one; another is a growing number of physicians accused of sexual misconduct who are required to have chaperones until the resolution of criminal, civil or Board litigation.

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 to the Board as well as to the Complaint and Licensing Committees, serving as the agency's primary resource related to physician health. In 2005, the PHC Unit presented 76 cases to the Board, consistent with its presentation of 78 cases in 2004.

PHC staff also works closely with the Licensing Unit and reviews the licensing files of applicants who disclose problems that might impair competency, including mental health, chemical dependency, Operating Under the Influence, other criminal charges or behavioral issues. In 2005 the PHC Unit brought 78 license applications before the Licensing Committee for full review. The Unit also reviewed 58 license renewal applications in 2005 for similar reasons. 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 119 physicians were being monitored by PHC in 2005, either confidentially or under a public Probation Agreement with the Board. Of the total, 26 were monitored for mental health reasons, 32 for chemical dependency and 29 for behavioral health issues, including boundary violations. Another 17 physicians were monitored for clinical competency. There were four physicians monitored for dual diagnoses of mental health and chemical dependency issues. Six physicians were monitored for both mental health and behavioral health issues.

PATIENT CARE ASSESSMENT

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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, to identify patterns early, and has the onsite intellectual capital to communicate best practices. All of this makes PCA a key player in the patient safety arena.

Selected PCA Alerts 1994-2005

- 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 this 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 states that information submitted to the Board

under PCA requirements is confidential and not subject to subpoena, discovery or introduction into evidence. It is the opinion of PCA that this encourages greater reporting.

In 2005 the PCA Committee met several priorities it established in the prior year. Some of these priorities included 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 continued to improve. Data for 2005 shows a 19 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. Health care facilities submitted 805 Major Incident Reports to the Board in 2005, a significant improvement in reporting over prior years. Specifically, 66 hospitals in the Commonwealth submitted Major Incident Reports, a compliance rate of 92 percent. Compliance for submitting the Semi-Annual Reports was 100 percent and Annual Reports 97 percent in 2005. 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.

Acute Care Hospitals

Type of Report	As of 12/31/05*	Percent Compliant
Major Incident Reports	66	92%
Semi-Annual Reports	72	100%
Annual Reports	70	97%

*Percentages based on a denominator of 72 acute care facilities.

The table on the following page shows the number of Major Incident Reports received by the PCA Division from 1999 through 2005. The growth in the number of events reported since 2002 reflects the efforts the PCA Division has made to improve compliance.

Major Incident Reports

1999-2005*

Year	Maternal Death (Type 1)	Ambulatory Surgical Death (Type 2)	Diagnostic/Surgical Intervention on Wrong Part (Type 3)	Serious/Unexpected Patient Outcome (Type 4)	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
2005	**10**	**21**	**31**	**740**	**805****

**For CY1999 through CY 2001, the data was tracked by date of incident. For CY2002 through CY2005, 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 required to report Major Incidents under PCA regulations.*

***Three MIRs were of unknown category, and are not included in the total.*

Improved Communication

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, and the Committee follow-up, 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 is now offering workshops, a newsletter and training sessions for health care facilities to help improve relationships with the facilities to assure compliance, and the Committee has also amplified its outreach efforts with a variety of entities in the Commonwealth and across the nation.

Better Collaboration

The PCA Committee strengthened its 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. 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, the Department of Public Health, 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 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 plans to have a "consumer" member on the PCA Committee by the summer of 2006, and in 2005 began to issue quarterly newsletters on the Board's website.

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 Board'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, 72 acute health care facilities and 33 rehabilitation and specialty health care facilities have benefited from a comprehensive review of the PCA reports that have been submitted to the Board over the past few years, with more to come.

All of these health care facilities 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 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's PCA Program is like no other reporting system for it goes a step further in being a part of the solution – and often before the adverse event occurs.

It has been noted that the reporting environment has changed at the Patient Care Assessment Division. The major event that triggered that change, and that changed the entire patient safety environment in Massachusetts, was the publication of "To Err is Human" by the Institute of Medicine. Many agencies, facilities and organizations have undergone a redesign since the release of the report. New and improved information fosters growth and learning about medical error reporting and patient safety needs and improvements. The PCA Division is no different and thus has strongly encouraged compliance with reporting and analyses, as well as performance improvement initiatives by health care facilities in their patient care assessment programs. This reporting, however, enables facilities to improve patient care and enables the entire system to advance the quality of health care across the state.

One of the PCA Committee's primary goals in the upcoming year 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. 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. The credentialing process is an integral part for ensuring competency to practice medicine. If a hospital overlooks the use of performance data during its credentialing processes, it misses this opportunity to ensure that qualified, competent physicians are practicing at its facility. What data or information is used, how it is used and to what extent it is used, should be determined by the individual facility, but the PCA Committee provides oversight and is a resource for health care facility systems for credentialing and peer review. Similarly, the 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 as well.

Creating a culture that assures the highest quality care to patients in the Commonwealth requires collaboration and teamwork among all of us. Most importantly, in this collaboration, physicians must be "team leaders" in these efforts. The Board, through the PCA Program, guarantees physician participation and leadership. As a result, physicians are now leading various health care facilities to realize that if they are to improve patient safety, the hospitals and other health care

facilities 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 Board's PCA Program makes Massachusetts a leader in patient safety, medical error prevention and quality improvement nationwide. We look forward to continuing the work, and the vision, in the years ahead.