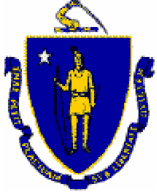
Commonwealth of Massachusetts

Board of Registration In Medicine

Annual Report
~ 2006 ~



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

Deval L. Patrick
Governor

Timothy P. Murray
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

Peter Paige, MD
Physician Member

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

Dear Governor Patrick and Members of the General Court:

On behalf of the Board of Registration in Medicine, I am pleased to announce the submission and availability of the Agency's Annual Report for calendar year 2006. The Board remains dedicated to all areas of public health protection and health care quality assurance. The 2006 Annual Report can be found on line on the Board's web site at: www.massmedboard.org.

In 2006, the Board took 79 disciplinary actions against physician licenses, up 8 percent from 2005. I hasten to point out, however, that the Board licenses over 30,000 physicians, yet disciplined only 76 of them. We must remain diligent and effective in applying discipline when necessary, but also cognizant that Massachusetts is fortunate to have so large and talented a physician community.

The Board and the Department of Public Health, in which it resides administratively, continued their close partnership to protect patients and support the physicians who offer the highest quality health care to the citizens of Massachusetts. I would note again in this annual report, as in annual reports past, that the Board, while under the DPH's umbrella, continues to operate as an autonomous agency and generates the bulk of its funding from licensing fees paid by physicians.

We are pleased and grateful that in 2006 the Legislature passed legislation allowing the Board to carry over unexpended balances in its Trust Fund. The Trust Fund receives a portion of physician licensing fees, and funds the bulk of Board operations. Unique among EOHHS agency Trust Funds, previously any balance remaining at the end of a fiscal year reverted, creating cash flow difficulties and making long-term project planning nearly impossible. With this change, the Board can finally begin to implement an ambitious agenda to enhance patient safety, improve health care delivery and upgrade services to physicians and health care facilities.

Finally, I want to acknowledge once again the Board's staff. Their professionalism and dedication to patient protection serve the citizens of the Commonwealth superbly. I also want to thank my fellow Board members for their commitment and willingness to devote many long hours to improve the quality and delivery of health care in Massachusetts.

Sincerely,

Martin Crane, MD

Martin Crane, MD
Board Chair

Board of Registration in Medicine
2006 Annual Report

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Commonwealth of Massachusetts

Board of Registration in Medicine

Annual Report

2006

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.

2006 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.

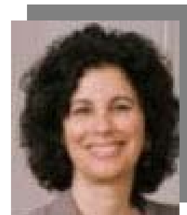
Martin Crane, M.D., Chairman

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, trained 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. He is a member of the Board of Directors of the Federation of State Medical Boards and holds the rank of Commander in the Medical Reserves of the United States Navy. Dr. Crane chairs the 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 is a Family Medicine physician, and joined the Board in 2002. She is a graduate of Swarthmore College and Boston University School of Medicine, and has been an active clinician / teacher for the past 25 years. Dr. Wertheimer is past President of the Massachusetts Academy of Family Physicians, and is known for her community advocacy to improve health care for underinsured and uninsured citizens of Massachusetts, and her passion for community oriented primary care. She was a recipient of a Robert Wood Johnson Foundation grant to develop physician driven initiatives to care for the uninsured in Central Massachusetts and currently serves on the Blue Cross Blue Shield Foundation Board. She is the Chair of the Department of Family Medicine at Cambridge Health Alliance, and on the faculty of Harvard Medical School. Dr. Wertheimer serves on the Board's Complaint Committee.

Honorable E. George Daher, Public Member

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

Guy Fish, M.D., Physician Member

Dr. Fish, who was named to the Board in 2003, is a graduate of Harvard College, the Yale University School of Medicine, and the Yale School of Management. Dr. Fish did his internship and residency at MetroHealth, a Case Western Medical School affiliated public hospital, and is ABIM certified in Internal Medicine. A former solo-practitioner and ER physician, he is a Vice President at Fletcher Spaght Inc., Boston, a specialized consultancy focused on health care technologies and innovation, with personal 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 as the Chairman of the Board's Licensing Committee.

Peter Glenn Paige, M.D., Physician Member

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

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

Dr. Herman is Director of Clinical Services in the Department of Psychiatry at MGH, and joined the Board in 2002. He is also Medical Director for Partners HealthCare Employee Assistance Program. Dr. Herman is Board-certified in psychiatry and neurology, and is a Distinguished Fellow of the American Psychiatric Association. A graduate of the University of Wisconsin Medical School, Dr. Herman served his medical internship at Brown University Medical School and his residency in psychiatry at MGH. He has been on staff at the MGH Psychopharmacology and Addiction Clinics since 1984, where he directed the department's continuing education program and was Director of Psychiatry Residency Training. He is co-editor of the MGH Guide to Psychiatry in Primary Care and MGH Psychiatry Update and Board Preparation. Dr. Herman is past president of the American Association of Directors of Psychiatry Residence Training. He chairs the Board's Patient Care Assessment 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 went 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 and more efficient 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 6,000,000 individual document pages, and the Board no longer requires space for off-site document storage.

EXECUTIVE DIRECTOR'S REPORT

Nancy Achin Audesse

2006 marked another year of continuous improvement for the Board, which suffered from years of poor performance throughout the 1990s. Today, the Board's credibility and reputation for excellence has been restored. Much of the credit for this achievement may be given to be new information technology applications, revised licensing forms and processes, better records management and a conscientious disciplinary approach. I believe 2007 will see yet another year of continued success and excellence in ensuring patient protection in the Commonwealth.

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 2006 the Board disciplined 76 physicians. The Board also takes non-disciplinary actions, including letters of warning to physicians. These may involve any number of situations, examples of which may be poor administrative organization leading to billing issues or miscommunication with patients; rude behavior toward patients, or; tardiness in providing patients with copies of their medical records.

Improvements to Physician Profiles

Massachusetts was the first state in the nation to offer detailed information about its licensed physicians online. The "Physician Profiles" program went live in 1997, and provides consumers, health care facilities, insurers and others the opportunity to review physician information with online convenience. Today nearly every state offers some online capacity, but Massachusetts remains a leader. In 2006 *Public Citizen*, a national non-profit consumer group, ranked the Massachusetts Profiles program third in the nation for the quantity, quality and accessibility of physician information online.

In the fall of 2006 the Board upgraded Profiles, providing even more information on Massachusetts' 30,000 licensed physicians. Multiple physician specialties and subspecialties can now be listed instead of just one. Similarly, listing unlimited hospital affiliations, insurance plans accepted and translation services offered is now possible. Furthermore, with more specialties listed, medical malpractice payments are more accurately attributed to the specialty in which the payment was made. These and other improvements will ensure that the Massachusetts Physician Profiles program stays at the forefront of consumer information concerning licensed health care professionals.

Online License Renewal

First among new technology applications on the Board's agenda is online license renewal. It will not only make physicians' lives easier, but will allow the Board to direct more resources toward other patient safety initiatives 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.

It has been a long process to get to the implementation stage. New license renewal application forms introduced in 2005 support online licensing. The continuing centralization of Board data in the CLARIS database also furthers the goal. As a single data entry point for all information that comes into the Board, CLARIS is paving the way for the introduction of online license renewal. Funding was the last roadblock, and the Board is extremely grateful to the Legislature for approving a change to the Board's Trust Fund in 2006. The change allows the Board to make long-range systems development decisions beyond just a single fiscal year, and manage its cash flow more intelligently. A number of technology and operational improvements are planned; online license renewal is just the first.

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 Massachusetts. 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.

Continuity of Government

State Agencies are responsible for the safety of their employees. They also have a moral and legal obligation to their employees and to the consumers/clients and communities they serve to continue to operate in a prudent and efficient manner, even in the circumstance of an impending or existing

threat or actual emergency. In the event of a disaster, the Board has a plan in place to maximize its ability to continue operations subject to limitations on resources, including materials, equipment, and human resources. This plan outlines a comprehensive approach to enable the continuity of essential services during a disaster while ensuring the safety and well being of employees. It includes the emergency delegation of authority, the emergency acquisition of resources necessary for business resumption, and the capabilities to work at alternative work sites, both in Massachusetts and in another state, until normal operations can be resumed.

Outreach

In an effort to keep physicians and other partners more informed, and to open new opportunities for cooperation and assistance, the Board continues to publish 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

In 2007 the Board expects to promulgate a comprehensive update of its regulations, the first such modernization of the Board's regulatory framework in 20 years. The new regulations will update licensing provisions, address the issue of licensing and credentialing in times of national emergency and consider a new category of medical license: administrative medicine.

Another major goal of the agency is better use of the data compiled by the Patient Care Assessment Division. With a full complement of staff, sufficient resources and excellent compliance by hospitals, PCA will begin a second year of comprehensive and intensive analysis of its database for possible trends and concerns. In 2007 PCA expects to report on over sedation related to confusion over dosages of morphine and hydromorphone; delayed recognition of epidural abscesses following epidural anesthesia; and complications associated with conversion from laparoscopic to open surgical procedures. PCA is also working to improve health care facility peer review and

credentialing processes so as to assure that credentialed health care providers are practicing competently and safely.

Improvements to the Board's website are also expected in 2007. The Board plans to modernize the website, www.massmedboard.org, to make it easier to navigate and better organized for both consumers and physicians. Changes will also include updating the "look and feel" and presenting information in a cleaner format.

In 2007 the Board will issue the third in a series of reports on medical malpractice payment data, adding the years 2004 through 2006 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 will also continue 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 2006 the number of complaints sent to DALA declined from 29 to 16, reflecting greater success by the Enforcement staff in obtaining Consent Orders from physicians, rather than physician appeals to DALA. Given the complex and time-consuming nature of DALA proceedings, the Board is pleased that more matters were settled by agreement in 2006.

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.

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.

Physician Demographics

Total Licensed		**29,973 (100%)**
	Men	20,093 (67%)
	Women	9,880 (33%)
Age Groups		
<40		8,169 (27%)
40-49		8,489 (28%)
50-59		7,689 (26%)
60-69		3,954 (13%)
>69		1,672 (6%)
Board Certified		
	Yes	84%
	No	16%

As of December 2006

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	2006	2005*	2004	2003*	2002
Initial Full Licenses	**1,948**	1,775	1,812	1,628	1,709
Full Renewals	**9,371**	19,648	9,645	20,188	7,286
Lapsed Licenses	**206**	192	113	112	123
Initial Limited Licenses	**1,587**	1,549	1,521	1,476	1,418
Limited Renewals	**2,811**	2,751	2,701	2,611	2,513
Temporary (initial) Licenses	**13**	21	22	21	17
Temporary Renewals	**11**	17	6	12	16
Voluntary Non-renewals	**320**	561	390	709	427
Revoked by Operation of Law	**874**	1,084	869	848	611
Deceased	**155**	265	162	148	131
TOTAL	**17,296**	27,863	17,241	27,753	14,251

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

In 2006, the number of initial full licenses was 1,948, nearly 10 percent higher than 2005, and almost 20 percent higher than 2003. It would seem that anecdotal accounts of new physicians being discouraged from practicing in Massachusetts are refuted by the actual facts. Further, initial limited licenses were up by 2.45 percent, and limited license renewals increased by 2.18 percent. In 2007 approximately 22,000 full licensees will apply for renewal.

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 may invite the program chairperson to attend 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	2006	2005	2004	2003	2002
Malpractice	**29**	39	28	35	35
Competency Issues	**56**	78	88	81	90
Legal Issues	**57**	53	46	52	27
Medical Issues	**22**	39	42	36	32
6th Limited Renewals	**31**	23	33	18	26
Lapsed Licenses	**59**	70	73	_	_
Miscellaneous Issues	**92**	181	127	146	110
Total Cases Reviewed	**346**	483	437	368	320

There was a 28 percent decrease in the number of cases reviewed by the Licensing Committee in 2006, as compared with the number of cases reviewed in 2005. The most significant decrease was in the number of miscellaneous issues. This may be attributed to the Board's recent acceptance of

medical school graduates from St. George's University Medical School and Ross University School of Medicine as having substantial equivalency in medical training, and no longer requiring a waiver. Committee reviews for reasons of competence fell by 28%, although those cases were significantly more complicated and involved multiple, complex medical issues.

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 2006 the Licensing Division mailed approximately 1,800 surveys and received responses from 467 newly licensed physicians. There was a 25% increase in survey responses and the overall average score was 4.20% was slightly lower than the 2005 score of 4.22%. In 2006, the licensing process was made easier, but it can still remain the source of frustration for some physicians who have legal, criminal, malpractice or medical issues which may require additional information and subsequently extend the licensing process.

Licensing Division Survey Results

Survey Questions	2006 Responses (n=467)	2005 Responses (n= 350)	2004 Responses (n= 445)	2003 Responses (n=325)	2002 Responses (n=97)
1. Was the Licensing staff courteous?	**4.33**	4.40%	4.41%	4.52%	4.20%
2. Was the staff knowledgeable?	**4.11**	4.28%	4.42%	4.35%	4.28%
3. Did the staff provide you with the correct information?	**4.17**	3.92%	4.35%	4.53%	4.23%
4. Did the staff direct you to the appropriate person to answer your questions?	**4.17**	4.29%	4.52%	4.57%	4.20%
Overall average score	**4.20**	4.22%	4.43%	4.49%	4.23%

2006 LICENSING DIVISION ACCOMPLISHMENTS

Regulations Revisions

The Board's proposed revised licensing regulations will reflect current licensing practices and streamline the overall licensing process. The proposed regulations include the following: 1) extending limited license intervals for the duration of the training program with a Board approved quality improvement program. This endeavor will reward training programs that are in compliance with the Board's Patient Care Assessment requirements for oversight and ongoing supervision of residency training programs to ensure the safe practice of medicine. The postgraduate training requirements for physician's applying for a full license will be increased to two (2) years for U.S. graduates and three (3) years for international medical graduates. Two new categories of full licenses have been added, one category is for volunteer physicians who wish to provide uncompensated medical care in underserved areas and the other category is for administrative physicians who do not participate in direct patient care activities.

National Practitioner Identifier (NPI)

The Board of Registration in Medicine assumed the leadership role in assisting physicians in applying for the National Provider Identifier Number (NPI). The Health Insurance Portability and Accountability Act (HIPAA) mandated the use of the NPI, which is 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 23, 2007. This includes physicians with an active license and other health care practitioners.

The Centers for Medicare Services designated the Board of Registration in Medicine as a 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. The Board of Registration in Medicine has received recognition from other state Boards since it is the only Board in the U.S. to assist physicians in obtaining an NPI number. 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 via a designated password. By the end of December 2006, the Board had collected approximately 45% of the physician NPI numbers. The remaining NPI numbers will be collected by May 23, 2007. The Board's initiatives with

respect to this new mandate from the federal government have lessened the administrative burden on hospitals, health care facilities and physicians, and will help ensure a smooth transition to the new requirement.

PHYSICIAN NPI STATISTICS	TOTAL
Authorized Board to apply for NPI Number	**6,961**
Personally Applied for NPI Number	**1,710**
Applied for NPI Number Using a Third Party	**1,340**
GRAND TOTAL	**10,011**

Limited License Workshops

In 2006, the Licensing Division conducted 4 regional Limited License Workshops for training program coordinators and administrative staff who serve as the liaisons between the Board and limited licensees. Representatives from the Educational Commission for Foreign Medical Graduates (ECFMG) were guest speakers at the first January 2006 Limited License workshop hosted by Boston Medical Center. The ECFMG staff presented an update on the changes in visa requirements for international medical graduates and ECFMG sponsorship for eligible candidates. Additional workshops were held at Children's Hospital Medical Center, St. Vincent's Hospital and the Lahey Clinic. An 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.

Renewals Triage Committee

In 2006, a Renewals Triage Committee (Committee) was established, comprised of an interdisciplinary team of Board staff with representation from the Licensing, Legal, Enforcement, Physician Health and the Data Repository divisions. The primary role of the Committee is to review full renewal applications with "yes" answers on legal, malpractice or medical questions. Renewal applications with affirmative answers are reviewed by the Committee to insure that the

documentation is complete. Additionally, the Committee reviews criminal, legal and malpractice issues and may recommend follow-up, additional investigation or referral to supportive services, if indicated. In 2006, the Committee provided significant and valuable modifications in streamlining the 2007-2008 full renewal application and revised the questions on legal and malpractice issues.

One hundred thirty-two renewal applications were received in 2006 which had issues that were considered necessary to address. Of those, 117 were ultimately forwarded for license approval after review. Twelve cases were referred to Physician Health Services and three cases were referred to the Enforcement Division for possible investigation.

Criminal Offender Record Information (CORI) Certifications

In 2006, the Licensing Division began the process of applying for certification from the Criminal History Systems Board to access CORI reports for every physician applying for an initial license or renewal of a license. The Board's initiative to obtain criminal background checks will further expand the Board's continuing role in protecting the safety of the public.

Massachusetts Systems for Advance Registration (MSAR)

The Licensing Division is participating in the Department of Public Health's initiative to recruit physicians who are willing to volunteer in the event of a large-scale disaster or a declared public health emergency. A letter from Dr. Martin Crane, Chairman of the Board of Registration in Medicine and a pamphlet describing the details of the MSAR volunteer initiative is included in the 2007-2008 Renewal Application packets.

Centers for Disease Control Prevention Project

The Board of Registration in Medicine is working with the Centers for Disease Control and Prevention (CDC) in conjunction with the Federation of State Medical Boards to develop an electronic directory of physician contact information to alert them about public health events warranting the attention of physicians. The CDC will store the information in an electronic database and use it in conjunction with its automated alerting system to direct e-mails, automated telephone messages and/or faxes to physician offices. The information will be stored in the database so as to enable the targeting alerts to specific sets of physicians based on their geographic location and medical specialty.

GOING FORWARD IN 2007

License Portability

The Board was instrumental in assisting the Federation of State Medical Boards in obtaining a grant from the federal government for the License Portability Project to enable physicians to obtain licensure in other states by endorsement. The increasing demand for telemedicine services and the compelling need for physicians to provide specialized services in states where there is a shortage of physicians and in underserved areas have escalated the need for license portability. The License Portability project was initiated by the Federation of State Medical Boards (FSMB) to develop a centralized data repository for storing biographical, educational, licensure and disciplinary information on each physician. The master database will facilitate license portability by allowing states to access and share information when a physician applies for licensure in another state and thus simplify and expedite the licensing process. One of the most significant obstacles identified in the sharing of licensing information is that all documents must be digitally scanned for electronic storage in order to be stored in a central data repository. In 2000, the Massachusetts Board of Registration in Medicine initiated scanning of all license applications and other license information which is now stored electronically and readily available for sharing as soon as the guidelines and legal issues are completed.

Online Renewals

In 2006, the Board finally received approval from the Legislature to retain licensing fees, beginning in fiscal 2007. This initiative will enable the Board to move forward in the development of the online renewals project which has been a top priority for several years. The ability to renew a license electronically online will be a major benefit for physicians by considerably 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 which is currently collected biannually when a physician renews his or her medical license.

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, public advocacy groups and others who have an interest in 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 investigating complaints against physicians and recommending that the Board impose appropriate discipline if the facts of a case support it. In 2006, the Board disciplined 76 physicians after investigation by the Enforcement Division, just short of the record high set in 2004, and, a mark of the Enforcement Division's commitment to patient safety and public protection. In 2006, the Enforcement Division also overcame a period of high staff vacancy and this, too, contributed to the Division's ability to process more cases.

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 docketed 650 cases for investigation in 2006, similar to the 661 opened in 2005 and consistent with the average of the past several years. In addition to the 650 docketed consumer complaints, the unit received 257 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 helps consumers identify the appropriate agencies to assist them on such cases, however. For undetermined reasons, the number of non-docketed communications from consumers jumped by over 40% in 2006.

In most cases, staff obtains responses from physicians as part of its initial review and triage process. In screening complaints, serious and priority cases are flagged and brought to the attention of the Division Director for immediate action. Urgent matters are fast-tracked and physician responses in these cases are not always obtained as part of the initial review. Rather, the physician is interviewed by Enforcement staff.

Clinical Care Unit

The Clinical Care Unit (CCU) investigates complaints that allege substandard care. It received 100 new complaints in 2006, up from 91 in 2005. 120 complaints were closed during 2006, nearly double the number in 2005, reflecting CCU's return to full staffing. At the end of 2006, 156 complaints remained under investigation.

The CCU is staffed by the Unit Nurse/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 issues concerning a physician's delivery of care or the running of his or her practice that may not require formal disciplinary action, but are of concern to the Board.

Disciplinary Unit

The Disciplinary Unit investigates and litigates all cases that may result in disciplinary actions being taken against licensed physicians and acupuncturists. In 2006, the Board disciplined 76 physicians, 10 percent higher than 2005, and double the number disciplined in 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 interviews witnesses, gathers evidence, works with local, state and federal law enforcement agencies on coordinated investigations and presents 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

Seventy-six different physicians were involved in 79 separate disciplinary actions in 2006. 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. A complex case involving allegations of substandard care, for example, may involve many of hours of input from expert witnesses, Board clinical reviewers, Board prosecutors, investigators and support staff. Cases of inappropriate prescribing are also extraordinarily time-consuming as they may require review of hundreds of pages of pharmacy records from multiple pharmacies, interviews with many individuals, medical record reviews and expert analyses.

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 2006, 41 physicians entered into such Consent Orders, one-third more than 2005. 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. Sixteen cases were referred to DALA in 2006, 10 decisions were returned, and 39 cases were pending at DALA as of Dec. 31, 2006. 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, the revenue from which does not support Board operations, and is deposited directly in the Commonwealth's General Fund.

Disciplinary Actions, Voluntary Agreements and Related Activity

CATEGORY	2006	2005	2004	2003	2002	2001
Doctors Disciplined	**76**	69	77	60	68	55
Statements of Allegations Issued	**57**	58	60	36	57	39
Summary Suspensions	**1**	5	2	4	5	7
Voluntary Agreements Not to Practice	**26**	25	10	14	16	4
Voluntary Agreements for Practice Restriction	**2**	8	4	1	4	2

Prioritization and Management of Cases

Team Approach

The team approach is widely used, particularly on complex or emergency cases. Complaint counsels, paralegals, investigators, nurse-investigators, supervisors and support staff 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.

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.

Caseload Statistics

The 650 complaints opened in 2006 represent a slight decrease over 2005, but is in line with the historical norm. At the end of the year, 479 complaints were awaiting final action by the Board, a

5.5% decrease from the end of 2005. This is still not in accordance with the agency's goal to keep pending complaints below 425, but is a step along the path to that goal. Staff vacancies in Enforcement over the past two years, growth in the number of cases referred to DALA, and the complexity of a number of recent cases have impeded swifter case disposition.

Each of the Board's investigators was assigned approximately 60 cases in 2006

Docketed Complaints Opened, Closed, and Pending

COMPLAINTS	2006	2005	2004	2003	2002
Docketed	**650**	661	760	650	677
Closed	**678**	562	682	673	680
Pending as of 12/31	**479**	507	406	328	358

Cases Alleging Substandard Care

The Board continues to use the services of Maximus, a peer-review organization based in New York that provides expert medical opinions by board-certified physicians in cases alleging substandard care. Cases are reviewed using de-identified records, meaning neither physicians nor patients nor health care facilities are named. This ensures no conflict of interest can arise in the review. 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 cases and allowing the Enforcement staff to work more intensively with local experts on more serious cases that have the potential for disciplinary action to be taken.

Number of Complaints Alleging Substandard Care

Status	2006	2005	2004	2003	2002
Opened	**100**	91	98	83	101
Closed	**120**	69	62	69	90
Pending	**156**	177	158	125	110

Cases alleging substandard care, as distinct from criminal charges, substance abuse or inappropriate behavior, for example, have remained relatively static over the past several years. In 2006, they accounted for approximately 15% of all complaints opened by the Board. Patient safety is the Board's highest priority, and while substandard care is serious and not to be tolerated, the fact that it represents a small fraction of the Board's caseload speaks to the high quality of health care delivery in the Commonwealth.

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 case 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 reviewing the matter, 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	2006	2005	2004	2003	2002
Closed	**403**	384	462	440	458
Letter of Advice	**59**	48	37	63	53
Letter of Concern	**37**	27	45	21	41
Letter of Warning	**67**	29	24	1	30

Special Projects and Initiatives

Recruitment of Expert Witnesses

Members of the Enforcement Division have convened an Expert Witness Working Group for the purpose of recruiting expert witnesses to assist in the investigation of complex substandard care cases. As a first step towards this goal, the group is drafting a brochure summarizing the Board's need for experts to review its cases and explaining the role of an expert witness. It will also contain the ten most commonly asked questions by experts, along with brief answers. Physicians who have served as Board experts believe their service contributes toward making the practice of medicine safer.

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, the Federation of State Medical Boards Conference, and a variety of professional development and bar association seminars. In addition, the nursing staff attended continuing medical education courses. Staff also continued participation in the FBI's Health Care Fraud Working Group, and in ongoing coordinated investigations with local and state law enforcement agencies, as well as the Attorney General of Massachusetts and the federal Drug Enforcement Administration.

Taylor's Law

Enforcement staff have been coordinating with patients and other victims of physician misconduct in an effort to facilitate their right to make an impact statement before the Board imposes final discipline. As a result, more consumers took advantage of this opportunity during 2006.

> ***As a victim, it was essential for me to be able to communicate to the Board, in person, the ways in which my life and the lives of my family members were forever changed as a result of my physician's actions. It was a chance for me to have my voice heard. For the Board to see me as a real person, not just a name on a case file.***
>
> *Patient Impact Statement 2006*

The Enforcement and Legal Divisions continue to hold working group meetings, begun in 2005, to identify procedural and substantive issues and provide recommendations to assist the Board in its ongoing implementation of this important patient rights legislation. As a result of the group's efforts, the Board has altered the way it considers decisions from the Division of Administrative Law Appeals, and provides for a separate decision path for cases in which impact statements will be received. While this extra step in the process slows the Board's disposition of such cases, considerations of patient rights override any concern over delay.

Enforcement of Subpoenas

The Director of Enforcement is a special assistant attorney general, which enables the Enforcement Division to initiate actions in the superior court to enforce the Board's investigative subpoenas and subpoenas issued to compel the appearance of witnesses at hearings.

This past year, the Board filed an action in Suffolk Superior Court to compel a hospital to produce a physician's employment credentialing information after the hospital had reported to the Board that it had disciplined a particular physician. The report provided only a brief explanation about the basis for the hospital's disciplinary action. The Board initiated an investigation based on the disciplinary action report in an effort to obtain more information about the hospital's disciplinary action. The Board has statutory authority to issue subpoenas for the appearance of witnesses and production of documents in the course of the Board investigations. The Board served the hospital with a subpoena for documents, and the hospital refused to produce the document claiming that they were protected by the peer review privilege, although the documents requested by the Board were not discussions, conclusions or other work product of the peer review committee or its member. The superior court judge determined that the Board was entitled to the documents requested in the subpoena and found that the hospital failed to obey a lawful subpoena of the Board.

The Board also filed an action in Suffolk Superior Court to compel production of medical records from a physician. The Board served the physician with a subpoena for the records of twenty-five patients to whom the physician had prescribed questionable quantities of narcotics. The physician refused to produce the records claiming that he was a psychotherapist and that the records were protected by the psychotherapist-patient privilege. A superior court judge determined that the physician was not a psychotherapist and that, even if he was, the Board was entitled to the records.

In the course of another investigation, the Enforcement Division discovered that the Department of Social Services had information about a physician under investigation. Because of the confidential nature of the Department of Social Services information, the Board petitioned the Juvenile Court to obtain the information relating to the physician and was successful in obtaining an order for release of that information.

During the course of an administrative hearing in another case, the Board issued subpoenas for the testimony of two witnesses. When neither witness appeared, the Board obtained court orders for their appearances. When the witnesses again failed to appear, the Board initiated contempt proceedings, which prompted the witnesses to appear and testify at the administrative hearing.

Designated Agency Requests

The Enforcement staff is responsible for responding to all designated agency requests submitted to the Board. Although Board investigative information is confidential during the pendency of an investigation, the Board is authorized by law to share that information with other state and federal agencies. The Board, in its regulations, has designated 22 agencies that may receive information,

including medical boards in other states. The designated agencies must send a request to the Board's Executive Director, who determines whether Board staff will be allowed to provide confidential information to the designated agency. Board staff then reviews the Board files to determine exactly what information should be shared. The regulations require that the agencies that receive information maintain the confidentiality of the information provided by the Board.

In 2006, the Board fulfilled 145 requests from designated agencies. This is in addition to other requests for public information, which are processed by the Board's public information officer.

DIVISION OF LAW AND POLICY REPORT

Brenda A. Beaton, 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.

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 2006, the Board took 79 disciplinary actions against 76 physicians. The Board issued 12 Final Decisions and Orders and entered into 41 Consent Orders. 57 Statements of Allegations were issued, and 16 cases were referred to the Division of Administrative Law Appeals (DALA).

ADJUDICATORY FIGURES	2006	2005	2004	2003
1. **Total Number of Disciplinary Actions Taken:**	**79**	**73**	**82**	**62**
a. Consent Orders:	41	30	46	26
b. Final Decision and Orders:	12	17	10	8
c. Summary Suspensions:	1	5	2	4
d. Final Decision and Orders On Summary Suspensions:	0	1	2	1
e. Resignations:	10	8	9	14
f. Voluntary Agreements:	13	15	14	7
g. Assurances of Discontinuance:	2	1	1	2
h. Suspensions pursuant to violation of Letters Of Agreement (not included in total)	3	0	1	1
2. **Discipline by Type of Sanction:**				
Admonishment:	2	2	4	1
Censure:	0	0	0	2
Continuing Medical Education Requirement:	4	3	5	4
Community Service:	0	2	0	0

ADJUDICATORY FIGURES CONT"D		2006	2005	2004	2003
	Costs:	0	1	0	0
	Educational Service:	0	1	0	0
	Fines:	15	12	13	6
	Monitoring:	0	4	0	1
	Practice Restrictions:	3	16	15	7
	Probation:	17	10	6	9
	Reprimand:	24	14	18	6
	Resignation – part a:	10	5	4	5
	Resignation – part b:	0	3	5	9
	Revocation:	9	10	10	5
	Summary Suspension – part a:	1	5	2	4
	Summary Suspension – part b:	0	0	0	0
	Suspension:	31	12	17	13
	Stayed Suspension:	16	5	7	7
	TOTAL PHYSICIANS DISCIPLINED:	**76**	69	77	60
3.	**Total Number of Cases referred to DALA:**	**16**	29	13	12
4.	**Total Number of Cases Dismissed:**	**0**	3	1	1
5.	**Total Statements of Allegations:**	**57**	58	60	36
6.	**Total Probation Violations/violations of LOAs:**	**3**	0	1	3

Data Repository Unit

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

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

In 2006, the DRU received 3,578 statutory reports. 158 of these reports were forwarded to the Enforcement Division for further investigation, and 10 statutory reports relating to potential impairment issues were forwarded to the Physician Health and Compliance Unit.

The number of reports received annually since 2001 has increased substantially in nearly every category of report. The Board attributes this to the various reporting sources taking seriously the responsibility to inform the Board when they take disciplinary actions against physicians. Even

though mandated by law, compliance over the years was inconsistent. Since 2002, however, the number of reports received by the Board shot up significantly. Figures for 2006 show a leveling off, but this is to be expected, once reporting compliance reached near maximum. 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	2006	2005	2004	2003	2002	2001
Renewal "yes" answers – malpractice	**919**	3,173	1,146	3,401	866	3,818
Court Reports – malpractice	**727**	962	995	912	780	654
Court Reports – criminal	**0**	1	0	1	5	0
Closed Claim Reports	**977**	854	981	988	811	1,096
Initial Disciplinary Action Reports	**155**	138	170	141	106	114
Subsequent Disciplinary Action Reports	**115**	172	198	148	117	124
Annual Disciplinary Action Reports	**678**	602	632	580	N/A	N/A
Professional Society Disciplinary Actions	**5**	0	3	5	1	0
5d (government agency) Reports	**116**	139	99	57	38	21
5f (peer) Reports	**57**	68	58	32	37	8
ProMutual Remedial Action Reports	**4**	3	8	5	3	3
Self Reports (not renewal)	**4**	8	12	10	1	0
TOTAL	**3,757**	6,120	4,302	6,280	2,765	5,838

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

Data Repository Unit Highlights

919 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. 2006 was an "off" renewal year, as only about a quarter of physicians renew in even-numbered years.

155 Initial Disciplinary Action Reports (HCFD-1) were submitted by health care facilities pursuant to M.G. L. c. 111 §53B. These reports are required by law and are submitted in response to disciplinary actions taken against physicians.

115 Subsequent Disciplinary Action Reports (HDFD-2) were submitted by health care facilities. Such reports follow up on Initial Reports, when the discipline is of an ongoing nature, such as physician practice monitoring.

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

116 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. The majority of these reports are filed by the Department of Public Health and they involve the investigation of major adverse events that occurred at health care facilities.

57 Peer Reports of physician violations were submitted in 2006 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 2001 these so-called "peer reports" have increased sevenfold.

- 4 physicians filed self-reports in 2006, compared to 2001 when no such reports were filed. These were self-reports that were not made in the context of license renewal.
- In 2006 5 reports of disciplinary actions taken by professional societies, pursuant to M.G.L. c. 112 §5B, were filed.

Medical malpractice insurers submitted 977 Closed Claim Reports in 2006 pursuant to M.G.L. c. 112 §5C. An increase over last year, but 2005 saw a drop in these reports, and this year the number stays below the number of several years ago. The Board sees this mirrored in malpractice payment data showing a continuing drop in the number of malpractice payments made annually.

The courts filed 727 reports, another in a series of declines since 2003.

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 2006, 158 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 7 reports directly to the Physician Health and Compliance Unit.

Reporting Board Actions

In 2006, DRU reported formal Board actions to the Federation of State Medical Boards (FSMB), the National Practitioners Data Bank (NPDB), and the Healthcare Integrity and Protection Data Bank (HIPDB). All formal Board actions are reported to the FSMB, and all but probation modifications are reported to the other two organizations. In 2006, 137 actions were reported to the FSMB, 127 to the HIPDB and 92 to the NPDB.

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 44 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. While these inquiries do not result in changes to individual Profiles, they provide an opportunity for agency staff to educate physicians about Profiles.

Education and Outreach

The DRU interprets and enforces the reporting statutes for Board members, staff members, and mandated reporters, such as physicians and other health care providers, health care facilities, medical malpractice insurers, 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

PHC Case Presentations

The PHC Unit prepares and presents cases to the Board, serving as the agency's primary resource related to physician health. In 2006, the PHC Unit presented 90 cases to the Board, up from 78 cases in 2005.

Physician Health & Compliance Statistics 2006

Total Physicians Monitored	**124**
Behavioral Health	10
Mental Health	22
Chemical Dependency	23
Clinical Competence	18
Boundary Violations	21
Behavioral & Mental Health	8
Substance Use/Mental Health	16
Other	6
Cases Presented to Board	90
Cases Presented to Licensing Committee	81

PHC staff also works closely with the Licensing Committee and reviews the licensing files of applicants who disclose problems that might affect the ability to practice, including mental health, chemical dependency, Operating Under the Influence charges, other criminal charges or behavioral issues. In 2006, the PHC Unit brought 81 license applications before the Licensing Committee for full review, similar to 78 in 2005. 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 result in review of a physician's history.

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.

> ***"PHS continues to work well with the PHC Unit, which allows us to assist physicians in their recovery from substance and mental health concerns, in conjunction with monitoring what the Board requires. This relationship has allowed many physicians to continue or return to practice with effective monitoring in place."***
>
> Dr. Luis Sanchez, PHS Director

Historically, Board Counsel for the PHC Unit has worked closely with the Massachusetts Medical Society's Physician Health Services (PHS) to provide oversight of physicians in health related monitoring programs to ensure compliance of physicians in PHS contracts, and to receive and respond to reports of non-compliance with contracts. 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.

Physician Oversight

A total of 124 physicians were being monitored by PHC in 2006, either confidentially or under a public Probation Agreement with the Board. Of the total, 22 were monitored for mental health reasons, 23 for chemical dependency and 31 for behavioral health issues, including boundary violations. Another 18 physicians were monitored for clinical competency. There were 16 physicians monitored for dual diagnoses of mental health and chemical dependency issues, quadruple the 2005 number. Eight physicians were monitored for both mental health and behavioral health issues, up from six in 2005.

In 2006 PHS broadened the nature of the previously named Chemical Dependency Monitoring Contract to a new Substance Use Monitoring Contract, widening the scope of monitoring to include those at risk and/or suffering from a substance use disorder. In addition, PHS also revised a specific monitoring contract for medical students.

PATIENT CARE ASSESSMENT

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

The mission of the Patient Care Assessment (PCA) Committee is to ensure that physicians, and the health care settings in which they practice, provide patients with a high standard of care and support an environment that maximizes high quality health care in Massachusetts. The PCA Division is a central repository of many statutorily mandated public safety reports, and therefore is the one of the most comprehensive storehouses 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 to physicians, various types of health care facilities and office based practices. All of this makes PCA a key player in the patient safety arena.

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 Qualified Patient Care Assessment 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.

All information submitted to the Board under PCA requirements is confidential and not subject to subpoena, discovery or introduction into evidence. As mandated by the Legislature, PCA believes that this encourages greater reporting and more meaningful reporting. Because of confidentiality assurances, 52% of the reports PCA receives are reports of deaths due to adverse events[1]. This enables the PCA program, working with health care facilities, to make significant changes to improve quality and prevent further adverse events.

In 2006, the PCA Committee's main goals were to improve adverse event reporting compliance, create educational opportunities for health care facilities on how to comply with the PCA statute and regulations, and identify areas for health care quality improvement.

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[1] Based on an analysis of 1239 Major Incident Reports received in Fiscal Years 2003 and 2004

Health Care Facility Compliance

Reporting compliance by hospitals has continued to improve. Data for 2006 shows a 3% percent increase from 2005 in the number of acute care facilities hospitals that submitted Major Incident Reports, which describe serious, unexpected patient outcomes stemming either from medical error or from unanticipated events. Since 2003, when the Board redesigned the PCA Division, compliance has increased by 24%.

Reporting compliance by rehabilitation and specialty facilities has dramatically increased. In 2005, the PCA Division began to reach out to this segment of the health care delivery system. As a result, in one year, data shows a 61% increase in the number of rehabilitation and specialty facilities that submitted Major Incident Reports.

Health care facilities, rehabilitation and specialty facilities submitted 782 Major Incident Reports in 2006. This is a 3% decrease from 2005, but overall a 41% increase since 2003. The 3% decrease in could be attributed to closure of facilities, reduction in the number of licensed beds or decreased population. Compliance with Semi-Annual Reports and Annual Reports remained steady, and we are continuing to receive the year end Annual Reports and the Semi-Annual Reports as of the date of this publication.

The continual improvement of reporting is the result of education and outreach efforts by the PCA Committee and its staff to familiarize hospitals with the PCA Program. In addition to staff contacts, the PCA Committee Chairman regularly visits or speaks with facilities, and the PCA Division publishes a quarterly newsletter to enhance communication. The Major Incident Reports, Semi-Annual Reports and the Annual Reports are the windows into the quality oversight and improvement activities in a health care setting – assuring patients and the public that a facility is serious about providing quality, and safe, health care.

The following two tables show the number of acute care and rehabilitation and specialty facilities participating in quality improvement under the PCA statute and regulations, as well as a table of the number of Major Incident Reports, Semi-Annual and Annual Reports received by the PCA Division, from 2003 through 2006. This last chart also shows the types of Major Incident Reports we receive pursuant to our regulations, and highlights the need for continual confidentiality as part of the Massachusetts Adverse Event Reporting system so such reports can continue to be collected without fear of penalty, thus assuring quality improvements can be made.

Acute Care Hospitals

Type of Report	As of 12/31/06*	Percent Compliant
Major Incident Reports	68	96%
Semi-Annual Reports	68	96%
Annual Reports	69	97%

*Percentages based on a denominator of 71 acute care facilities.

Rehabilitation and Specialty Facilities

Type of Report	As of 12/31/06*	Percent Compliant
Major Incident Reports	26	79%
Semi-Annual Reports	31	94%
Annual Reports	31	94%

*Percentages based on denominator of 33 facilities

The following table shows the number of Major Incident Reports received by the PCA Division from 2003 through 2006.

Major Incident Reports
2003-2006*

Year	Maternal Death (Type 1)	Death from Outpatient Procedure (Type 2)	Wrong-site Surgery (Type 3)	Unexpected Death or Outcome (Type 4)	Other	Total
2003	3	9	22	443	0	477
2004	6	14	24	587	3	631
2005	10	21	31	740	4	806
2006	**5**	**17**	**27**	**733**	**0**	**782**

Educational Opportunities

The PCA Committee looked at the manner in which the PCA Program had been functioning during prior years and identified several 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. In past years, the PCA Committee focused on issuing

advisories, alerts and warnings, as well as creating newsletters and improving turn around time for responses. In 2006, the PCA Committee also wanted to create a two-way communication with health care facilities.

In 2006, the PCA Division offered seven workshops to health care facilities' employees involved in patient safety or quality improvement activities. The PCA Division offered these training sessions at no cost. The training sessions highlighted the mission of the PCA Division, what it does and how it can assist health care facilities in their quality improvement activities. It was also an opportunity to review the types of quality assurance reports that facilities submit to the PCA Division; providing examples and model reports to help facilities learn how to best analyze and report adverse events. From Semi-Annual and Annual Reports to the different types of Major Incident Reports, the Workshops enabled health care facilities to get the information and tools it needs.

Health Care Improvement Opportunities

New and improved information fosters growth and learning about medical error reporting and patient safety needs. 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. Reporting, and the investigations necessary to make reports, enables facilities to improve patient care and is the systematic basis to advance the quality of health care across the state.

The entire system can advance the quality of health care across the state because reporting allows the PCA Committee to notice trends; warnings, if you will, about failures or need for improvements in certain areas of the health care system. In 2006, the PCA Committee completed work on two task forces, and formed an expert panel, resulting from the identification of important trends.

The first was a task force on Teleradiology. A group of individuals, with expertise in health law, physician practice, and telemedicine, came together to balance the need for a more modern approach to telemedicine in Massachusetts with the necessity to maintain accountability to the public for safety and health care quality.

The second task force was on Medical Training and Education. Every year, the Board licenses over 4000 trainees. The Task Force was charged with addressing the issue of patient safety and the successful education of residents. Specific questions asked included: what should be the

responsibility of the group, in the context of “training residents for graduated responsibility?” What is currently being done on this front, and what should be done?

A third task force began in late 2006 and continues to meet in 2007. This task force is reviewing physician credentialing to identify concerns and develop opportunities for improvement that will assure that qualified and competent physicians are caring for patients in the Commonwealth. The purpose of the expert panel is to create a framework for the standardization of credentialing for health care facilities that can be used as guidelines in their internal credentialing processes. The expert panel is comprised of a select group of individuals from a medical school, a long-term care facility, and academic institutions, as well teaching and community hospital representation from various parts of the state; all of whom have expertise or responsibility over credentialing issues.

Goals for 2007

The PCA Committee’s 2007 goal is striving to fulfill its broader mandate, and public protection responsibilities, by expanding its 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 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 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 cost to patient safety.

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. All health care facilities participating in this program receive 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. Other reporting systems are limited 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 the extra step further to be a part of the solution – often before the adverse event occurs.

Creating a culture that assures the highest quality care to patients in the Commonwealth requires collaboration and teamwork. Most importantly, physicians must be "team leaders" in these joint 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, with vision, in the years ahead.

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.

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

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

The Committee's primary function is to protect the safety of the public by ensuring that applicants applying for licensure to practice acupuncture independently are qualified, competent and possess the education, examination and training requirements established by the Committee. The Committee is also responsible for interpreting the existing laws (M.G.L. 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	2006	2005	2004
Initial Licenses	**65**	84	89
Renewals	**482**	348	414
Lapsed Licenses	**6**	6	4
Temporary (initial) Licenses	**1**	2	0
Voluntary Non-renewals	**5**	2	1
Revoked by Operation of Law	**1**	0	2
Deceased	**0**	0	1
TOTAL	**554**	440	507

Acupuncture licensing and the 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	2006	2005	2004
Acupuncture Complaints	**3**	2	4
Letter of Warning	**1**	0	3
Letter of advice	**1**	0	1
Disciplinary Actions	**1**	0	0

COMMITTEE ON ACUPUNCTURE ACCOMPLISHMENTS

Tamper Resistant Wallet Cards

Acupuncture paper wallet cards were replaced with the same heavy-duty laminated wallet cards that are issued to physicians. The new plastic wallet cards are durable, more professional and protect the licensing information from being altered. The Board is continuing to explore technologies to include an acupuncturist's photograph on the wallet card for additional security and more positive identification of the cardholder.

Full Acupuncture License Application

A more streamlined initial full acupuncture application that mirrors the physician application form was approved by the Committee on Acupuncture (COA). The new format is easy to read and questions are more concise. Acupuncturists who apply for an initial full license are now required to obtain a National Practitioner Data Bank profile in conjunction with their full license application.

Acupuncture Renewal Application

A revised Acupuncture Renewal application was also approved by the COA in 2006. The questions on the Renewal Application were expanded to capture more extensive information on legal, malpractice and medical issues to ensure the safety of the public.

Committee on Acupuncture Regulations

In conjunction with the Board of Registration in Medicine's plan to promulgate the proposed Board regulations, the COA reviewed the current acupuncture regulations and proposed several revisions. The highlights of the proposed acupuncture regulations include requirements for a baccalaureate degree (with an exception for Registered Nurses who have three (3) years of training); raising the education requirements to conform with the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) and the number of education hours from 1350 to 1490; to require all new applicants to be NCCAOM certified in either Acupuncture, Oriental Medicine or Chinese Herbology; to increase the requirements for acupuncturists who use herbs in their practice to complete10 hours of CAE's in Herbology and to add biomedicine to the regulatory definition of acupuncture. Additionally, the COA proposed a Temporary License category for acupuncturists attending education courses in Massachusetts under the supervision of a licensed acupuncturist. The proposed regulations will be forwarded to the Board in January, 2007 and will proceed through the regulatory process.

NCCAOM Certification

Ms. Betsy Smith, Associate Deputy Director of the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) was invited to the November 2, 2006 COA meeting to present an overview of the NCCAOM. Ms. Smith discussed the NCCAOM examination process and the benefits and advantages of requiring NCCAOM certification for acupuncturists. One of the most significant advantages of NCCAOM certification is that all international graduates are subject to review by the American Association of Collegiate Registrars and Admissions Officers (AACRAO). Following Ms. Smith's presentation, the COA voted to include NCCAOM board certification in the proposed COA regulations revisions.

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 over 46 million hits in 2006, almost 60% higher than 2005's 29 million, and remarkable, since the site is unadvertised. The site was upgraded in late 2006, following other improvements in 2003, to provide even more information to consumers. And hits come from Internet users all over the world. The average number of hits per day in 2006 was approximately 126,300. The average user spent about three minutes on the site and viewed four pages, and during the course of the year, users accessed over 6.5 million Profiles

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

In addition to the web site, consumers also call and write for Profiles information, as well as information on complaints, and physicians call to update their Profiles. In 2006, the agency received 22,443 calls for information (up 7% over 2005), mailed or faxed 4,673 Profiles to consumers (up 120%) and made 12,313 updates to Profiles based on changed physician information, such as address or hospital affiliation (down 60%). Updates to Profiles fell so dramatically in 2006 because fewer physicians renew their licenses in even-numbered years than in odd-numbered years, and many physicians use the renewal process to update their Profiles.

2006 Public Information Statistics	
Profiles server "hits"	46,100,201
Profiles page "hits"	13,327,897
Number of Profiles Accessed	6,500,000
Avg. daily website "hits"	126,300
Calls for information	22,443
Faxed or mailed Profiles	4,673
Updated Profiles	12,313