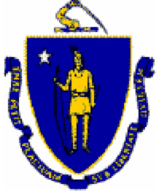
Commonwealth of Massachusetts

Board of Registration In Medicine

Annual Report
~ 2007 ~



Deval L. Patrick
Governor

Timothy P. Murray
Lieutenant Governor

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

Martin Crane, MD
Chairman

Randy Wertheimer, MD
Secretary

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 2007. The Board remains dedicated to all areas of public health protection and health care quality assurance. The 2007 Annual Report can be found online on the Board's web site at: www.massmedboard.org.

In 2007, the Board took 72 disciplinary actions against the licenses of 67 physicians. Close to 200 other physicians received non-disciplinary letters of warning, advice or concern. It is reassuring that of the Commonwealth's over 30,000 licensed physicians, only a relative few found themselves the subject of Board action, a clear indication of the high caliber of physicians in Massachusetts. In order to maintain this level of excellence the Board continues to diligently and effectively investigate allegations of physician misconduct or incompetence.

The Board resides administratively with the Department of Public Health, but is an autonomous agency. This high-level autonomy granted by statute is consistent with the recommendations of national policy experts in the area of physician regulation. National consumer watchdog agency "Public Citizen" offers the analysis that "Boards are likely to be able to do a better job in disciplining physicians if most, if not all, of the following conditions are true:

- Adequate funding (all money from license fees going to fund board activities instead of going into the state treasury for general purposes)
- Adequate staffing
- Proactive investigations rather than only following complaints
- The use of all available/reliable data from other sources such as Medicare and Medicaid sanctions, hospital sanctions and malpractice payouts
- Excellent leadership
- Independence from state medical societies and other parts of the state government
- A reasonable statutory framework for disciplining doctors (preponderance of the evidence rather than beyond reasonable doubt or clear and convincing evidence as the legal standard for discipline)."

Due to the support of the Administration and the Legislature, the Massachusetts Board of Registration in Medicine is strong on each of the Public Citizen criteria.

It is not just consumers who recognize the importance of a strong state medical board. An editorial in the *Journal of the American Medical Association* stated, "The success of boards to improve medical discipline will finally depend, of course, on the funding, staffing, and authority of state boards. These can only come from state legislatures willing to act responsibly. . . . . Those who sit in the legislatures of the various states must recognize that the effective regulation of medical practice is in their hands." Editorial 1987 *JAMA*, (Vol. 257, pp. 828-9).

The Board generates the bulk of its finding from physician licensing fees deposited in the Board's Trust Fund. Legislation passed in 2006 improved the financial position and cash flow of the Board and makes long-term project planning possible. The first result will be the introduction of online physician license renewal, which will make the licensing process more convenient for physicians, more efficient for the agency and set the stage for future online services. The system will go online within the next several weeks, and is just the beginning of the Board's ambitious agenda to enhance patient safety, improve health care delivery and upgrade services to physicians and health care facilities.

Although operating with a high level of autonomy, the Board does not act alone. A close partnership exists between the Board and the Department of Public Health that helps to protect patients and support the physicians who offer the highest quality health care to the citizens of Massachusetts. The Board also works closely with other health care organizations including the Mass Health Data Consortium, the Massachusetts Coalition for the Prevention of Medical Errors, the Massachusetts Medical Society, other licensing boards, medical specialty societies, hospitals, researchers, and many others.

Once again, I want to acknowledge the professionalism and dedication of the Board's staff. They work every day to help ensure the safety of every citizen of the Commonwealth. 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
2007 Annual Report

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Commonwealth of Massachusetts

Board of Registration in Medicine

Annual Report

2007

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.

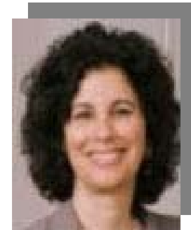
2007 Members
Massachusetts Board of Registration in Medicine

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. At the time this report was written, the Board had two vacancies.

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. U.S. Secretary of Education Spellings appointed Dr. Crane to be a member of the National Committee on Foreign Medical Education and Accreditation, and in 2007, he was appointed to the Step III Committee of the National Board of Medical Examiners. Dr. Crane serves as the Chairman of the Data Repository 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 serves on the Board of the Blue Cross Blue Shield Foundation, which focuses on accessible healthcare for all Massachusetts residents. 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.

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*. Dr. Fish 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. Dr. Paige is also Chairman of the Children's Injury Prevention and Pediatric Trauma fundraiser. He serves on the Board's Complaint Committee.

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

Dr. Herman is Associate Chief of the Department of Psychiatry at Massachusetts General Hospital, and Associate Professor of Psychiatry at Harvard Medical School. He is Medical Director for Partners HealthCare Employee Assistance Program. Dr. Herman is Board-certified in psychiatry, and is a Distinguished Fellow of the American Psychiatric Association. A graduate of the University of Wisconsin Medical School, Dr. Herman completed an internship in internal medicine at Brown University Medical School and a residency in psychiatry at MGH. A member of MGH's Psychiatry Department since 1981, for many years he directed the department's continuing education program and for a decade was Director of Adult Psychiatry Residency Training. He is co-editor of the texts 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 Residency Training. Dr Herman joined the Board in 2002. He serves as Chairman of the Board's Patient Care Assessment Committee.

The Board would like to express its great appreciation and gratitude to two members who departed the Board in 2007. Roscoe Trimmier, Esq. and Justice E. George Daher served as the two non-physician members of the Board for many years, helping to ensure that the Board acted with a deep understanding of the legal issues confronting it, and in the full spirit of due process and fairness to all parties appearing before it. Mr. Trimmier is a prominent attorney in Boston and served as the Vice Chair of the Board. Justice Daher is Chair of the State Ethics Commission, and lent his considerable experience as the former Chief Justice of the Massachusetts Housing Court to the Board's deliberations. Their integrity and dedicated service earned the fondness and respect of the entire Board and staff. The Board looks forward to welcoming two new non-physician members early in 2008.

STRUCTURE OF THE BOARD OF REGISTRATION IN MEDICINE

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

COMMITTEES OF THE BOARD

Complaint Committee

The Complaint Committee is comprised of two Board members who meet on a monthly basis to review allegations against physicians. Depending on the nature of the case, the Complaint Committee determines whether disciplinary action is appropriate and makes recommendations to the full Board. The Complaint Committee also resolves all matters that do not rise to the level of disciplinary action. It may issue letters of advice, concern, or warning and/or conduct conferences with physicians to discuss issues regarding a complaint.

Data Repository Committee

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

Licensing Committee

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

Patient Care Assessment Committee

Members of the Patient Care Assessment 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

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

Licensing Division

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

Enforcement Division

The Enforcement Division is mandated by statute to investigate complaints involving physicians and acupuncturists, and to prosecute disciplinary actions. The Enforcement Division operates under the supervision of the Director of Enforcement and is comprised of three units: the Consumer Protection Unit, the Clinical Care Unit and the Disciplinary Unit.

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

Patient Care Assessment Division

The 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

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

EXECUTIVE DIRECTOR'S REPORT

Nancy Achin Audesse

The mission statement of the Board of Registration in Medicine has two areas of focus; (1) ensuring that only qualified physicians are licensed to practice and (2) fostering an environment that maximizes the high quality of health care in Massachusetts. The first goal is accomplished through excellence in both the agency's licensing process and its ongoing oversight of physician practice. In 2007, a major focus of the agency was the development and implementation of online physician license renewal to strengthen its ability to act on applications for licensure more efficiently. This complex technological upgrade will keep the Board at the forefront of innovation and service to its physician licensees. Creating an appropriate practice environment to support Massachusetts physicians is of equal importance. The Board has supported this mission through intense improvement efforts in its Patient Care Assessment Division.

The Patient Care Assessment Division (PCA) is the Division of the Board that works with hospitals and other health care facilities to maximize physician commitment to patient safety, medical error reduction, and quality improvement efforts in the facilities. One exciting area of the PCA Division's work is its analysis of adverse events in hospitals to identify risks and to help facilities to remediate these risks. PCA then shares its findings with hospitals and other interested parties. In 2007, PCA reported on several types of adverse events, and worked to improve physician credentialing and peer review processes in Massachusetts hospitals. These two areas of Board focus over the past year are presented in greater detail below, along with the other major items on the Board's agenda.

Online License Renewal

For much of 2007, staff in the Licensing, Legal and Information Technology Divisions worked to develop a system by which physicians can renew their licenses online. The project is nearing completion, and should become fully operational in early 2008. Physicians will have an easier and more convenient way to renew their licenses, Board staff will be able to perform their duties more efficiently and the Board will continue its history of technological innovation and customer service. It will also 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. Once online license renewal is in place, the Board will work to extend its online licensing services to other areas, such as initial licensing and licensing of residents and fellows.

In the upcoming years, the Board hopes to use this new technology-based environment to provide services to health care organizations that will lower the administrative costs related to the credentialing of physicians. Each year, hospitals and health plans must secure information about thousands of physicians as part of the process that validates the credentials of the physicians. Surveys of the data requirements of the health plans and hospitals demonstrate that many of the data fields being reviewed by these organizations are already verified and held by the Board of Registration in Medicine. Clearly, there is an opportunity for the Board to reduce the administrative burden on both organizations and facilities through the electronic transmission of this information.

License Portability Project

The Board is participating in the New England Regional License Portability project to enable physicians to obtain licensure in other states with a minimal amount of duplicative effort by the physician. 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 a central data repository. In 2000, the Board initiated scanning of all license applications and other license information which are now stored electronically and readily available for the portability project. The foresight of the Board in technological innovation has been a strong catalyst for progress for the License Portability Project. Due to the leadership of the Massachusetts Board, all other states in the project will use compatible technology, giving Massachusetts physicians a strong advantage in making use of this exciting opportunity.

In 2007, the policy for the License Portability Grant Program was completed, as well as the compilation of comparison data from participating state Boards to identify any potential barriers in state regulations for the sharing of licensing documents. The technical capacity of each Board has been evaluated for conformity with a centralized data management platform. Interstate information sharing-agreements and performance measures are being developed to validate that the license portability project will reduce the paperwork for physicians eligible to participate in telehealth services.

Patient Care Assessment

In 2007, PCA reported 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.

Credentialing Expert Panel

The Patient Care Assessment Division has the mandated responsibility for overseeing the credentialing process for hospitals, health plans and nursing homes. PCA exercises its authority by reviewing adverse event reports, and semi-annual and annual reports of quality indicators. By examining these reports and communicating with health care facility leadership, PCA determined that the credentialing process in many hospitals is inadequate to identify and deal with physicians whose practices are substandard. Accordingly, in late 2006, the Board created an Expert Panel on Credentialing that was charged with developing criteria and methods by which hospitals can improve their credentialing process to assure staff competence.

The Panel has met regularly and expects to complete its work in early 2008. The expectation is that the Panel will develop a standardized framework that includes specifications for credentialing that all health care facilities would be required to meet. One of the recommendations for a credentialing structure is to use the set of six domains of competency endorsed by ACGME, JCAHO, and the FSMB. These are Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and Systems-Based Practice.

The Panel conducted a survey of health care facilities to understand the spectrum of credentialing criteria. From this feedback and work being done at the national level, the Panel has developed specific criteria for primary (initial) and secondary (continuing) credentialing.

Medical Spa Task Force

In 2006, legislation sponsored by Senator Joan M. Menard was passed that created a task force to examine issues surrounding the operation of so-called medical spas. This relatively new type of business enterprise presents a host of challenges to regulators charged with protecting patient safety. Medical spas can offer services from traditional hair and nail care to more complex procedures such as tissue filler injections and laser skin treatments. Like most states, Massachusetts

has no comprehensive regulatory structure in place to address the special challenges and potential risks of medical spa treatments, the manner in which such treatments are performed and supervised, or where such treatments take place. The Task Force consists of representatives of the Boards of Registration in Medicine, Nursing and Cosmetology, legislators, physicians, nurses, an electrologist and other medical and public health experts, and worked throughout 2007 to develop recommendations for legislation to be presented to the Legislature. The Task Force final report is due in March 2008.

Distinguished Service Award

In 2007, Rose Foss, the Board's Director of Physician and Acupuncture Licensing was presented with an award by the Federation of State Medical Boards. Ms. Foss was recognized by the Federation for her outstanding service to the Massachusetts Board of Registration in Medicine, and for her contributions to the field of medical licensure and discipline. Ms. Foss is considered by many to be one of the nation's leading experts on physician licensing and credentialing. Her tireless work on behalf of the Massachusetts Board of Registration in Medicine has greatly elevated the reputation of the Commonwealth among health care regulators.

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.

Never content to accept less than the top ranking, the Board upgraded its Profiles website and related online services for consumers in 2007 by expanding the data fields to provide even more detailed information about physicians. The upgrade made it easier for consumers to search for a physician using multiple criteria. Multiple physician specialties and subspecialties are now listed instead of just one. Similarly, listing unlimited hospital affiliations, insurance plans accepted and translation services offered is now possible. Another feature new in 2007 is posting the public documents regarding Board physician disciplinary actions, which consumers can now access and download from the Board's website. In 2008, another new functionality, made possible by listing all of a physician's specialties, will be added: medical malpractice payments will be more accurately attributed to the specialty in which the payment was made.

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.

Looking to the Future

In 2008 the Board hopes 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.

In 2008 the Board will issue the third in a series of reports on medical malpractice payment data, adding the years 2004 through 2007 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 cases referred to it by the Board. In 2007 the number of complaints sent to DALA increased from 16 to 28.

LICENSING DIVISION REPORT

Rose M. Foss, Director of Physician and Acupuncture Licensing

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

Physician Demographics

Total Licensed	**30,354**	**(100%)**
Men	**20,072**	**(66%)**
Women	**10,282**	**(34%)**
Age Groups		
<40	**8,194**	**(27%)**
40-49	**8,440**	**(29%)**
50-59	**7,826**	**(26%)**
60-69	**4,217**	**(14%)**
>69	**1,677**	**(5%)**
Board Certified		
Yes	**25,556**	**(84%)**
No	**4,798**	**(16%)**

As of January 2008

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

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

Licensing Division Statistics

License Status Activity	2007*	2006	2005*	2004	2003*
Initial Full Licenses	**1,950**	1948	1,775	1,812	1,628
Full Renewals *	**20,676**	9,371	19,648	9,645	20,188
Lapsed Licenses	**204**	206	192	113	112
Initial Limited Licenses	**1,629**	1,587	1,549	1,521	1,476
Limited Renewals	**2,841**	2,811	2,751	2,701	2,611
Temporary (initial) Licenses	**10**	13	21	22	21
Temporary Renewals	**13**	11	17	6	12
Voluntary Non-renewals	**517**	320	561	390	709
Revoked by Operation of law	**1,090**	874	1,084	869	848
Deceased	**203**	155	265	162	148
TOTAL	**29,133**	17,296	27,863	17,241	27,753

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

From 2006 to 2007, there was no statistically significant change in the number of new full licenses issued. There was a 2.65 % increase in initial limited licenses and a 1.06 % increase in limited renewals as compared with the 2006 licensing statistics. The majority of full licenses are renewed on the odd-numbered years which accounts for the 20,676 licenses renewed in 2007. These statistics indicate a strong, consistent physician population.

Licensing Committee

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

Physicians applying for an initial limited license or renewing a limited license who had competency issues or substandard clinical performance in a training program are reviewed by the Licensing Committee. In such cases, the Licensing Committee customarily interviews the physician and may

invite the program chairperson to attend before making a recommendation on issuance of a limited license to the full Board. The Committee may recommend approval or denial of a limited license, depending on 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.

Licensing Committee Activity Report

Cases Reviewed by Licensing Committee	2007	2006	2005	2004	2003
Malpractice Issues	**30**	29	39	28	35
Competency Issues	**63**	56	78	88	81
Legal Issues	**43**	57	53	46	52
Medical Issues	**31**	22	39	42	36
6th Limited Renewals	**28**	31	23	33	18
Lapsed Licenses	**81**	59	70	73	_
Miscellaneous Issues	**97**	92	181	127	146
Total Cases Reviewed	**373**	346	483	437	368

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 to expedite the licensing process within the scope of the Board's regulations. Survey responses are tabulated using the Likert Scale from 1–5, with 1 rated as "poor," 2–3 rated as "average" and 4-5 rated in the "excellent" range. In 2007, the Licensing Division mailed approximately 1,900 surveys and received responses from 594 newly licensed physicians. In 2007, there was a 27.2% increase in survey responses and

the overall average score of the responses was 4.16% which was slightly lower than the 2006 score of 4.20%. In 2006, the licensing process was streamlined but it can still remain challenging for some physicians who have legal, criminal, malpractice or medical issues which require additional information that may significantly delay completion of the licensing process.

The implementation of online renewal services in 2008 will provide vastly improved services to currently practicing physicians. The anticipated efficiencies of the system will allow the Licensing Division to redirect some current resources to more timely completion of initial applications from physicians who wish to come to Massachusetts to practice.

Licensing Division Survey Results

Survey Questions	2007 Responses (n=594)	2006 Responses (n=467)	2005 Responses (n= 350)	2004 Responses (n= 445)
1. Was the Licensing staff courteous?	**4.18**	4.33	4.40%	4.41%
2. Was the staff knowledgeable?	**4.18**	4.11	4.28%	4.42%
3. Did the staff provide you with the correct information?	**4.12**	4.17	3.92%	4.35%
4. Did the staff direct you to the appropriate person to answer your questions?	**4.14**	4.17	4.29%	4.52%
Overall average score	**4.16**	4.20	4.22%	4.43%

2007 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 extending limited licenses 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. The first is for volunteer physicians who wish to provide uncompensated medical care in underserved areas. The second new license category is for administrative physicians who require a full license and who will not participate in direct patient care activities.

National Practitioner Identifier (NPI)

In September of 2005, Board of Registration in Medicine assumed the leadership role in assisting physicians applying for the National Provider Identifier Number (NPI) number. The Health Insurance Portability and Accountability Act (HIPAA) mandated the use of the NPI number which is a unique identifier for health care providers. As of May 23, 2007, health care providers who choose to transmit any health information in electronic form were required to use an NPI number. The Centers for Medicare Services approved the Board of Registration in Medicine as a designated repository for the NPI number. The "designated repository" status authorized the Board to request an NPI number on behalf of any Massachusetts physician. The Board of Registration in Medicine has received recognition from across the nation as the only Board in the U.S. to assist physicians in obtaining an NPI number.

National Provider Identifier (NPI) Statistics	2007
Authorized Board to apply for NPI Number	7,350
Personally applied for the NPI number	13,233
Applied for NPI number using a third party	1,067
Total number of physician NPI numbers in database	21,650

Limited License Workshops

In 2007, the Licensing Division conducted 5 regional Limited License Workshops for residency program coordinators and administrative staff who serve as the liaisons between the Board and limited licensees. The first Limited License Workshop was held at the Board of Registration in Medicine. Additional workshops were held at Children's Hospital Medical Center, UMass Memorial Medical Center, Lahey Clinic and Baystate Medical Center. An intensive workshop was held at the Board for new program coordinators to provide an in-depth review of the limited license

requirements. Residency program coordinators in teaching facilities are responsible for ensuring that residents and fellows who staff the Commonwealth's training programs complete the limited license requirements in accordance with Board regulations. The annual Limited License Workshops are crucial in providing information on changes in the limited license process, new forms and procedures.

Massachusetts Systems for Advance Registration (MSAR)

The Licensing Division assisted the Department of Public Health's initiative to recruit physicians 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 were included in the 2007-2008 Renewal Application packets. The recruitment initiative was successful in recruiting 351 physicians volunteers and will continue in 2008.

GOING FORWARD IN 2008

Criminal Offender Record Information (CORI)

In 2008, the Licensing Division will begin to implement a system utilizing its certification from the Criminal History Systems Board to access CORI reports. Development of the technology for electronic data transfer is progressing. The Board's initiative to obtain criminal background checks will further expand the Board's continuing mission to protect the safety of the public.

Continuing Medical Education (CME) Auditing

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

COMMITTEE ON ACUPUNCTURE

Rose M. Foss, Director of Physician and Acupuncture Licensing

The Board's Committee on Acupuncture is responsible for the licensure and discipline of acupuncturists. Acupuncture originated in China 2000 years ago and is unique in that it is 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 consists of seven members: a licensed physician member of the Board; a licensed physician who is actively involved in the practice of acupuncture; a public member; and four acupuncture practitioners. The role of the Committee on Acupuncture is to work collaboratively with the Board of Registration in Medicine to regulate the practice of acupuncture. The Committee on Acupuncture establishes the standards for acupuncture licensure and scope of practice, including approval of acupuncture schools, training programs and continuing acupuncture education activities.

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. c. 112 §§148-162) and regulations (243 CMR 4.00-5.00) relating to the practice of acupuncture and disciplinary process for acupuncturists who engage in misconduct. Meetings of the Committee on Acupuncture are held every three months at the Board of Registration in Medicine and are open to the public.

Committee on Acupuncture License Activity Report

License Type	2007	2006	2005	2004
Initial Licenses	**50**	65	84	89
Renewals	**374**	482	348	414
Lapsed Licenses	**1**	55	51	51
Temporary (initial) Licenses	**2**	1	2	0
Voluntary Non-renewals	**1**	5	2	1
Revoked by Operation of Law	**0**	1	0	2
Deceased	**0**	0	0	1
TOTAL	**428**	609	487	558

Acupuncture licensing and administrative functions are managed as a separate entity under the supervision of the Licensing Division. In addition to providing administrative support to the members of the Committee on Acupuncture, the Licensing Division responds to acupuncture issues raised by the licensees and the public. Legal issues are referred to the Legal Division and disciplinary issues are referred to the Enforcement Division of the Board. In 2007, the Committee on Acupuncture had an increase in disciplinary actions. The annual acupuncture legal activity report is listed below.

Acupuncture Disciplinary Actions

Legal Issues	2007	2006	2005	2004
Denial of License	**1**	0	1	0
Disciplinary Actions	**1**	0	0	0
Letter of Advice	**1**	1	0	1
Letter of Concern	**2**	0	0	0
Letter of Warning	**0**	1	0	3
Closed/No Action	**2**	0	0	4
Total Complaints	**5**	**3**	1	6

COMMITTEE ON ACUPUNCTURE ACCOMPLISHMENTS

Plastic 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.

Committee on Acupuncture Regulations

In conjunction with the Board of Registration in Medicine's plan to promulgate the proposed Board regulations, the Committee on Acupuncture (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; requiring all new applicants to be NCCAOM certified in either Acupuncture, Oriental Medicine or Chinese Herbology; increasing the requirements for acupuncturists who use herbs in their practice to complete 10 hours of CAE's in Herbology, and; adding 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 2008 and will proceed through the regulatory process.

Community Outreach

Board staff presented the first acupuncture workshop at the New England School of Acupuncture for students preparing to apply for licensure to practice acupuncture in Massachusetts. The presentation was well received and will continue as an annual event.

ENFORCEMENT DIVISION REPORT

Barbara A. Piselli, Director

The Enforcement Division is mandated by statute to investigate complaints and prosecuting disciplinary actions involving physicians and acupuncturists. It strives to pursue complaints efficiently and fairly as it assists the Board in executing its public protection mandate. The 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 is a group of dedicated professionals committed to fairly investigating complaints and recommending that the Board impose appropriate discipline when the evidence and the law support it. In 2007, the Board disciplined 67 physicians after investigation by the Enforcement Division.

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

The Enforcement Division operates under the supervision of the Director of Enforcement and is comprised of three units: the Consumer Protection Unit, the Clinical Care Unit and the Disciplinary Unit. 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. The Unit is staffed by a manager, a consumer protection coordinator and an administrative assistant.

The Unit docketed 758 cases for investigation in 2007, nearly 17% more than the 650 cases docketed in 2006, and the highest number since 2004. In addition to the 758 docketed consumer complaints, the unit received 224 additional communications regarding licensed physicians that were not docketed, as the allegations did not involve conduct within the Board's jurisdiction. These communications, however, were sent to the named physicians for informational purposes.

Docketed Complaints Opened, Closed, and Pending

COMPLAINTS	2007	2006	2005	2004	2003
Docketed	**758**	650	661	760	650
Closed	**715**	678	562	682	673
Pending as of 12/31	**522**	479	507	406	328

Clinical Care Unit

The Clinical Care Unit (CCU) investigates complaints that allege substandard care. The CCU is staffed by a Nurse Manager who is an attorney, three nurse reviewers -- all experienced clinicians -- and a paralegal. Staff assist in the investigation of cases by obtaining necessary documents, reviewing patient records and physician responses, and interviewing witnesses. They work with Enforcement Division attorneys in the preparation of litigation involving complex substandard care cases. CCU staff also participate in Data Repository Committee meetings and prepare analyses of physicians' medical malpractice histories for the Licensing Committee.

CCU staff is also responsible for recruiting and working with medical experts. These experts review medical records and other relevant evidence in order to provide an opinion regarding quality of care concerns. Physicians who have served as Board experts believe their service contributes to making the practice of medicine safer.

Disciplinary Unit

The Disciplinary Unit investigates and litigates cases that may result in disciplinary actions being taken against licensed physicians and acupuncturists. The Unit is staffed by attorneys (identified as complaint counsel by statute), a Managing Attorney, investigators, a paralegal and an administrative assistant. Complaints are referred to the Unit by the Data Repository Committee, the Consumer Protection Unit and various other sources. Staff travel throughout the Commonwealth to interview witnesses, gather evidence, and work with local, state and federal law enforcement agencies on coordinated investigations. In 2007, each investigator was assigned approximately 60 cases.

At the conclusion of each investigation, complaint counsel advises the Complaint Committee with regard to the need for disciplinary action based on the evidence gathered, the relevant professional standards identified, the law and Board precedent. The Complaint Committee then determines whether disciplinary action is appropriate, and makes recommendations to the full Board. The Complaint Committee also resolves matters that are not serious enough to warrant discipline, often

taking informal actions such as issuing letters of advice, concern or warning, and/or conducting conferences with physicians.

Complaint Committee Non Disciplinary Actions

Category	2007	2006	2005	2004	2003
Closed	**443**	403	384	462	440
Letter of Advice	**73**	59	48	37	63
Letter of Concern	**56**	37	27	45	21
Letter of Warning	**52**	67	29	24	1

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

Additionally, the Director of Enforcement is a Special Assistant Attorney General, which enables the Enforcement Division to initiate actions in the Superior Court to enforce the Board's investigative subpoenas, and subpoenas issued to compel the appearance of witnesses at hearings. The Division has successfully utilized this tool for compliance in the past and will continue to do so.

Disciplinary Actions

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 2007, 31 physicians entered into such Consent Orders. These actions are public and disciplinary, and reportable to the Federation of State Medical Boards, the National Practitioners Data Bank, and the Healthcare Integrity and Protection 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. Twenty-eight cases were referred to DALA in 2007, 15 decisions were returned, and 31 cases were pending at DALA as of December 31, 2007. Once the evidentiary hearing is completed, the DALA Administrative Magistrate issues a

Recommended Decision to the Board, containing facts and conclusions of law only. 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, which are deposited directly in the Commonwealth's General Fund and do not support Board operations. The Board, not the DALA Administrative Magistrate, determines the type of disciplinary action to impose. A full listing of Board disciplinary actions can be found on pages 27 and 28.

Disciplinary Actions, Voluntary Agreements and Related Activity

CATEGORY	2007	2006	2005	2004	2003
Doctors Disciplined	**67**	76	69	77	60
Statements of Allegations Issued	**59**	57	58	60	36
Summary Suspensions	**4**	1	5	2	4
Voluntary Agreements Not to Practice (Disciplinary and Non-Disciplinary)	**21**	26	25	10	14
Voluntary Agreements for Practice Restriction	**1**	2	8	4	1

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 spectrum of the Board of Registration in Medicine's legal obligations, ranging from statutory reporting to adherence to the Commonwealth's laws and regulations and to physicians' compliance with agreements with the Board. The Division also coordinates the disciplinary work of the Board including Statements of Allegations, Consent Orders, Final Decisions and Orders, and Appeals.

In addition to the General Counsel, the Division consists of a managing attorney, a manager of the compliance unit, counsels, paralegals and administrative personnel. All staff provide advice and support to the Board and its committees. For example, Board counsel advise the Board on a variety of issues such as the disposition of adjudicatory matters, ethics considerations, interpretation of laws and regulations, and formulation of policy. Other counsel review and render advice on specific legal issues affecting the agency, while others review and draft regulations, policies and proposed legislation.

Coordination of Adjudicatory Matters

The Division of Law and Policy maintains the Board's adjudicatory case files, schedules cases to be heard by the Board, prepares its Final Decisions and Orders, and tracks its disciplinary numbers. In 2007, the Board took 72 disciplinary actions against 67 physicians. The Board issued 12 Final Decisions and Orders and entered into 31 Consent Orders. 59 Statements of Allegations were issued, and 28 cases were referred to the Division of Administrative Law Appeals (DALA).

	ADJUDICATORY FIGURES	**2007**	**2006**	**2005**	**2004**
1.	**Total Number of Disciplinary Actions Taken:**	**72**	**79**	**73**	**82**
a.	Consent Orders:	31	41	30	46
b.	Final Decision and Orders:	12	12	17	10
c.	Summary Suspensions:	4	1	5	2
d.	Final Decision and Orders On Summary Suspensions:	3	0	1	2
e.	Resignations:	14	10	8	9
f.	Voluntary Agreements (disciplinary only):	10	13	15	14
g.	Assurances of Discontinuance:	1	2	1	1
h.	Suspensions pursuant to violation of Letters of Agreement (not included in total)	1	3	0	1

ADJUDICATORY FIGURES CONTINUED		2007	2006	2005	2004
2.	**Discipline by Type of Sanction:**				
	Admonishment:	1	2	2	4
	Censure:	0	0	0	0
	Continuing Medical Education Requirement:	2	4	3	5
	Community Service:	0	0	2	0
	Costs:	0	0	1	0
	Educational Service:	0	0	1	0
	Fines:	8	15	12	13
	Monitoring:	0	0	4	0
	Practice Restrictions:	0	3	16	15
	Probation:	9	17	10	6
	Reprimand:	15	24	14	18
	Resignation:	14	10	8	9
	Revocation:	12	9	10	10
	Summary Suspension – part a:	4	1	5	2
	Summary Suspension – part b:	0	0	0	0
	Suspension:	15	31	12	17
	Stayed Suspension:	10	16	5	7
	TOTAL PHYSICIANS DISCIPLINED:	**67**	76	69	77
3.	**Total Number of Cases referred to DALA:**	**28**	16	29	13
4.	**Total Number of Cases Dismissed:**	**3**	0	3	1
5.	**Total Statements of Allegations:**	**59**	57	58	60
6.	**Total Probation Violations/violations of LOAs:**	**1**	3	0	1

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 it also ensures that appropriate hospital discipline information is accurately posted on Physician Profiles.

In 2007, the DRU received 6,338 statutory reports. 184 of these reports were forwarded to the Enforcement Division for further investigation, and 11 statutory reports relating to potential impairment issues were forwarded to the Physician Health and Compliance Unit.

The number of reports received annually since 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 increased significantly. More recent figures show a leveling off, but this is to be expected, as reporting compliance has 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	2007	2006	2005	2004	2003	2002
Renewal "yes" answers – malpractice	**3,143**	919	3,173	1,146	3,401	866
Court Reports – malpractice	**818**	727	962	995	912	780
Court Reports – criminal	**4**	0	1	0	1	5
Closed Claim Reports	**867**	977	854	981	988	811
Initial Disciplinary Action Reports	**137**	155	138	170	141	106
Subsequent Disciplinary Action Reports	**82**	115	172	198	148	117
Annual Disciplinary Action Reports	**1,002**	678	602	632	580	N/A
Professional Society Disciplinary Actions	**3**	5	0	3	5	1
5d (government agency) Reports	**245**	116	139	99	57	38
5f (peer) Reports	**31**	57	68	58	32	37
ProMutual Remedial Action Reports	**1**	4	3	8	5	3
Self Reports (not renewal)	**5**	4	8	12	10	1
TOTAL	**6,338**	3,757	6,120	4,302	6,280	2,765

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

Data Repository Unit Highlights

3,143 Physician License Renewal Applications were reviewed by the DRC pursuant to M.G.L. c. 112 §2.

137 Health Care Facility Initial Disciplinary Action Initial Reports (HCFD-1) were submitted by health care facilities pursuant to M.G. L. c. 111 §53B. These reports are required by law and are submitted in response to disciplinary actions taken against physicians, as defined by 243 CMR 3.02. Eighty-two Health Care Facility Disciplinary Action Subsequent 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.

1,002 Annual Disciplinary Action Summary Reports (HCFD-3) were received from hospitals, clinics and nursing homes. These reports are collected by the DRU pursuant to M.G.L. c. 111 § 53B and §203, and summarize the disciplinary actions taken by the facility during the past year.

245 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 2007. The Department of Public Health files the majority of these reports, which involve the investigation of major adverse events that occurred at health care facilities.

31 Peer Reports of physician violations were submitted by mandated health care providers in 2007, 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.

- 5 physicians filed self-reports in 2007, compared to 2001 when no such reports were filed. These were self-reports that were not made in the context of license renewal.
- In 2007, 3 reports of disciplinary actions taken by professional medical associations pursuant to M.G.L. c. 112 §5B, were filed.

Medical malpractice insurers submitted 867 Closed Claim Reports in 2007 pursuant to M.G.L. c. 112 §5C. This continues a relatively consistent decline in the number of these reports. The Board sees this mirrored in malpractice payment data showing a continuous drop in the number of malpractice payments made annually since 2001.

The courts filed 822 reports, a significant drop from the 977 reports received in 2006, but this tends to be a dynamic figure, rising and falling in various years, as the chart indicates on page XXX indicates.

Direct Referrals of Statutory Reports

The Data Repository counsel, in accordance with the DRC policy, review statutory reports and determine whether certain reports should be referred to other Board units.

In 2007, The DRU referred 184 reports directly to the Enforcement Division for investigation, based on DRC procedure. Direct referrals include, but are not limited to, reports of physicians who already have an open complaint pending with the Enforcement Division, reports of physicians who had been disciplined by a licensing Board in another state and reports that contain such serious allegations that a summary suspension may be needed. The DRU forwarded 11 reports to the

Physician Health and Compliance Unit, 6 reports to the Licensing Division and 238 reports to the Patient Care Assessment Unit.

Reporting Board Actions

In 2007, the DRU made a total of 311 reports of formal Board actions to the Federation of State Medical Boards (FSMB), the National Practitioners Data Bank (NPDB), and the Healthcare Integrity and Protection Data Bank (HIPDB). All formal Board actions are reported to the FSMB, and all but probation modifications are reported to the other two organizations. The DRU reported 124 actions to the FSMB, 97 actions to the HIPDB and 90 actions to the NPDB.

Physician Profiles

During the year, the DRU assures the accuracy of the malpractice payment, hospital discipline, and criminal conviction information published on the Physician Profiles. The DRU reviewed and resolved 51 Physician Profiles disputes. The vast majority of these complaints involve physician misunderstandings of the requirements of the Profiles law. While these inquiries do not result in changes to individual Profiles, they provide an opportunity for agency staff to educate physicians about Profiles.

Education and Outreach

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

Physician Health and Compliance Unit

PHC Case Presentations

The PHC Unit prepares and presents cases to the Board, serving as the agency's primary resource related to physician health. In 2007, the PHC Unit presented 73 matters to the Board.

PHC staff works closely with the Licensing Committee and reviews the licensing files of applicants who disclose problems that might affect the ability to practice, including mental health, chemical dependency, physical disability or behavioral issues. In 2007, the PHC Unit brought 49 license applications before the Licensing Committee for full review. The PHC Unit also appears before the Board's Complaint Committee to present confidential monitoring agreements, as well as any

amendment or termination of these agreements. In 2007, 27 such matters were heard by the Complaint Committee.

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. PHC Unit staff follow up on any report of impairment by requesting additional documentation and interviewing the physician. PHC interviewed 17 physicians in 2007, and reviewed a total of 35 license renewal applications.

Physician Health & Compliance Statistics 2007

Total Physicians Monitored	**116**
Behavioral Health	9
Mental Health	14
Chemical Dependency	30
Clinical Competence	15
Boundary Violations	17
Behavioral & Mental Health	6
Substance Use/Mental Health	11
Other	14
Cases Presented to the Board	73
Cases Presented to Licensing Committee	49

The Board has designated one of its members to serve as the liaison to the PHC Unit. PHC staff work closely with the Board designee with regard to any report of impairment or medical condition to determine what recommendations might be made to the full Board. In addition, the PHC Unit has been providing support to the Board's Chair in his role as an advisor to the Massachusetts Medical Society's Task Force on Establishing a Continuing Medical Education Center for Clinical Skills Assessment.

For many years Board Counsel for the PHC Unit have also worked 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. The PHC Unit meets monthly with staff from PHS to discuss cases, and also meets quarterly to discuss policy issues. The Unit also engages in educational outreach efforts by having staff speak at hospitals throughout the state, as well as speaking at PHS conferences, such as the *Caring for the Caregivers* program in 2007.

Physician Oversight

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

physicians do not abide by their agreements, the Board will take action as it deems appropriate. A total of 4 physicians were found to be in violation of their agreements in 2007, and were removed from practice.

A total of 116 physicians were being monitored by PHC in 2007, either confidentially or under a public Probation Agreement with the Board. Of the total, 14 were monitored for mental health reasons, 30 for chemical dependency and 26 for behavioral health issues, including boundary violations. Another 15 physicians were monitored for clinical competency. There were 11 physicians monitored for dual diagnoses of mental health and chemical dependency issues, and 6 physicians were monitored for both mental health and behavioral health issues.

Public Information

The Division also answers legal information requests from the public, separate from requests for basic information about the Board made to the Public Information Division. In 2007, the Division of Law and Policy responded to 1,752 requests. These were referred to the Attorney of the Day, a service by the Board where each day an attorney and a paralegal are assigned to answer questions by telephone or other means regarding legal information and interpretations of Board regulations, policies, decision and other matters.

PATIENT CARE ASSESSMENT DIVISION REPORT

Stancel M. Riley, M.D., Director

The Patient Care Assessment (PCA) Division's mission is to provide patients with safe, effective and efficient care by encouraging physicians' and health care facilities' efforts in establishing cultures of safety. The PCA Division accomplishes this goal through mandated oversight of quality programs and through review of confidential reports.

Since the Medical Malpractice Act of 1986 was written, the face of patient quality and safety has changed. With the Institute of Medicine's reports of 1999 and 2001, *To Err is Human* and *Crossing the Quality Chasm,* there has been unprecedented interest in identifying and devising strategies for improvement practices. The PCA Division has changed over time as well. Particularly over the last four years, the Division has carefully considered how it can effectively and efficiently serve health care facilities' needs to make a difference in patient care.

Overview

Since 1986, the Board has required both physicians and health care facilities to be engaged in quality improvement and patient safety programs as a condition of licensure. Known as the PCA Program, hospitals are required to have a formal plan for collecting, reviewing and reporting quality measures to the PCA Division. Safety and Quality Review (SQR) reports are submitted quarterly for all unexpected deaths, major disabilities or complications which occur to patients undergoing treatment in the facility.[1] Semi-annual and annual reports from hospitals keep the PCA Division apprised of quality measures and occurrence screens.

Confidentiality is the basis for reporting to PCA; names of physicians, patients and others involved in the event are not included, and the reports are not shared with other Board Divisions. Reports to PCA are confidential and protected by Massachusetts law from public disclosure in the same way records of health care facilities' peer review committees are protected. The rationale for these confidentiality protections is that limitations on public disclosure foster honest and open discussion of cases by those involved at the facility and promote better and more candid reporting to the PCA Division. Regardless of the confidentiality protections applicable to the PCA Program, however, health care providers and facilities are responsible for fully informing patients and their families when a medical error or other unanticipated complication occurs.

[1] SQR reports were formerly called Major Incident Reports, as "Major Incident Report" is the regulatory term used to describe the reports that hospitals are required to submit to the PCA Division. The rationale for the change in name is that "Safety and Quality Review" better reflects the content of these reports.

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

Structure

The PCA Division and its governing PCA Committee are responsible for assuring that health care facilities have quality and patient safety programs that conform to the Board's PCA regulations. The PCA Committee is comprised of Board members, representatives from the Board of Registration in Nursing and the Board of Registration in Pharmacy, and volunteer physicians from several specialties. The Committee meets regularly to review health care facilities' SQR, semi-annual and annual reports and to issue yearly follow-up reports back to institutions. These reports are not punitive. Rather, the aim is to provide unique out-of-institution insight about reported events and trends. The PCA Division is actively working to make this feedback from the Committee useful to facilities, with fewer detailed responses required.

The PCA Division is committed to developing a more "user-friendly" system to better serve the goal of promoting patient safety. It will be one that provides valuable comments to facilities for use in their own internal patient safety and quality improvement activities. The Division's aim is to receive and tabulate SQR reports; analyze the data to identify trends; and recommend changes in healthcare practices and procedures.

Accomplishments

In 2007 the PCA Division made several changes designed to address areas the Division believes needed improvement. Changes in the process of reviewing SQR reports were initiated. Each report is now read by a physician before going to quality analysts. The turn-around-time for all reports back to hospitals was identified as another opportunity for improvement. SQR turn-around is now at one month, whereas before 2007 it was 13 months. During 2007, the PCA Committee reviewed and discussed the SQR reports, semi-annual and annual reports submitted by all 98 hospitals (66 acute care and 32 rehabilitation, long-term care and specialty hospitals). In total, the PCA Committee reviewed 919 SQRs, 98 annual reports and 196 semi-annual reports. The Committee made recommendations to all of these facilities concerning how to improve their quality and patient safety systems.

The PCA Division has also emphasized establishing relationships with health care facilities. During the year, PCA Division staff and Committee members visited 41 hospitals to either present programs, or meet one-on-one with hospital leadership to support and explain reporting activities. The PCA Division also revised its facility report forms. They are visually easier to interpret and graphics have been added to facilitate the interpretation of data.

In June 2007, the PCA Division held a Seminar for Rehabilitation and Long Term Acute Care Hospitals that focused on the topics unique to these facilities. Eleven of the nineteen hospitals invited participated in this program. In September, 2007, the Division sponsored a program on the topic of hospital peer review systems. This program, held at the Massachusetts State House, was attended by over 200 participants from throughout the Commonwealth.

The Credentialing Expert Panel continued the work it started in 2006, producing a document and criteria for evaluating physician competency for purposes of health care facility credentialing. This work is being tested at several sites throughout the Commonwealth. The Credentialing Report has also been accepted for presentation at the Federation of State Medical Boards Annual Meeting in 2008.

The results of research conducted on PCA reports will appear in a peer-reviewed scientific paper entitled "Holding Hospitals Accountable for Improved Patient Safety: Confidential Reporting of Major Incidents." The paper was accepted for publication in the *Journal of Medical Licensure and Discipline* and is scheduled to appear in the January 2008 issue.

Trends

In 2007, the PCA Division received 826 new SQR reports from hospitals. This is a 5.6 % increase over the number of SQR reports received in 2006. (*Table 1, Figures 1 & 2*)

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

Table 1

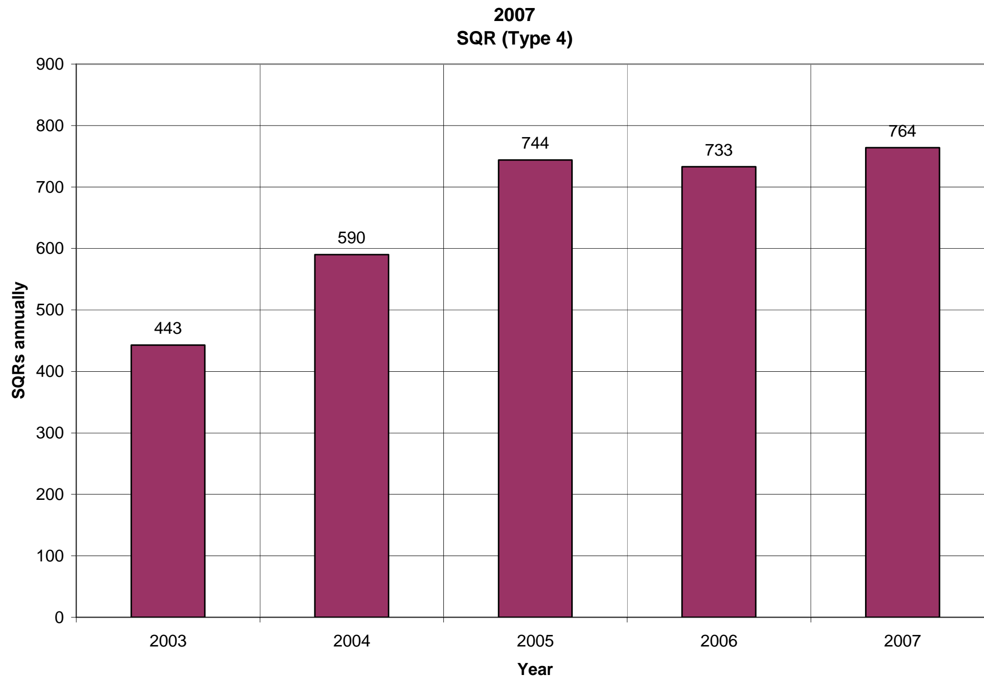


Figure 1

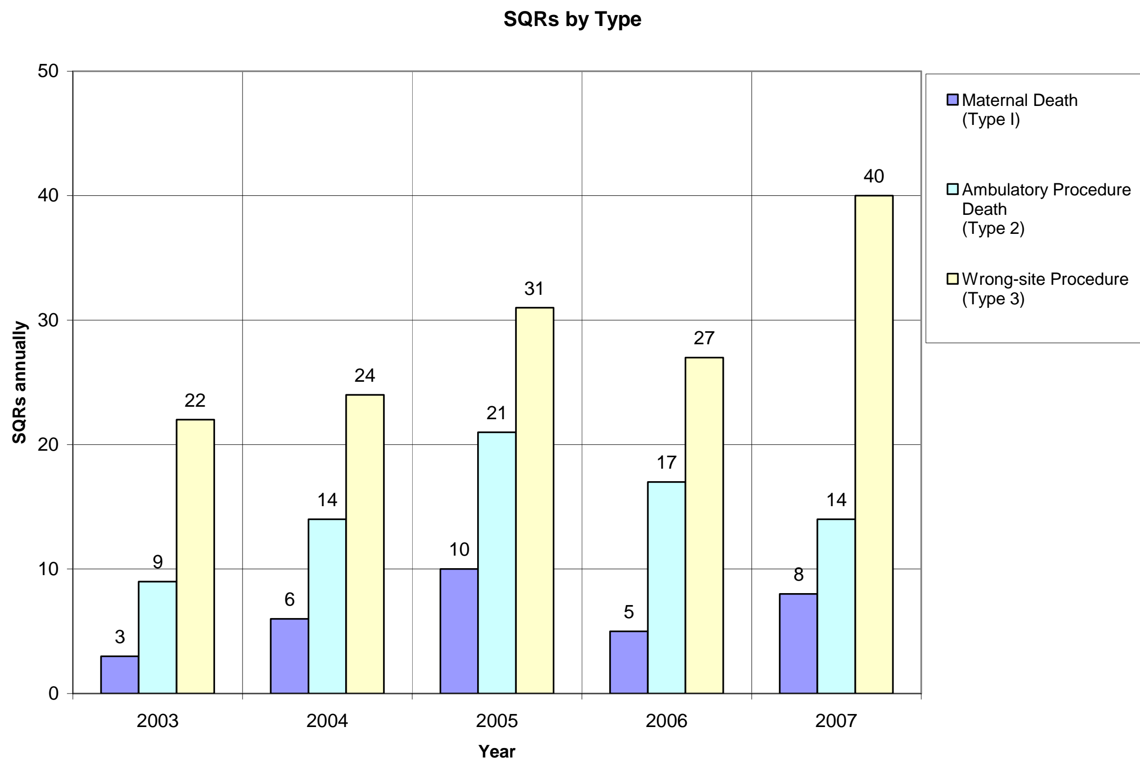


Figure 2

State mandatory reporting systems, like PCA, have used compliance by hospitals with regulations as a measure of the responsible agencies effectiveness; essentially, accountability for its facility oversight role. In actuality, compliance with regulations, particularly when there is no incentive, such as significant consequences, is a measure of the good will of the institution and the persuasive ability of the agency.

PCA over 2007 has shown growth in reporting. *(Figure 3)* But in reading the graph, it is important to know that even submitting one report was counted as compliance. For the first time, the number of reports indexed to 100 hospital beds is reported. Since early on, PCA has empirically used 5 to10 reports per 100 beds as the standard. Now with measuring the ratio, the Division will be able to give hospitals their individual indexed ratio and determine what appropriate reporting actually means.

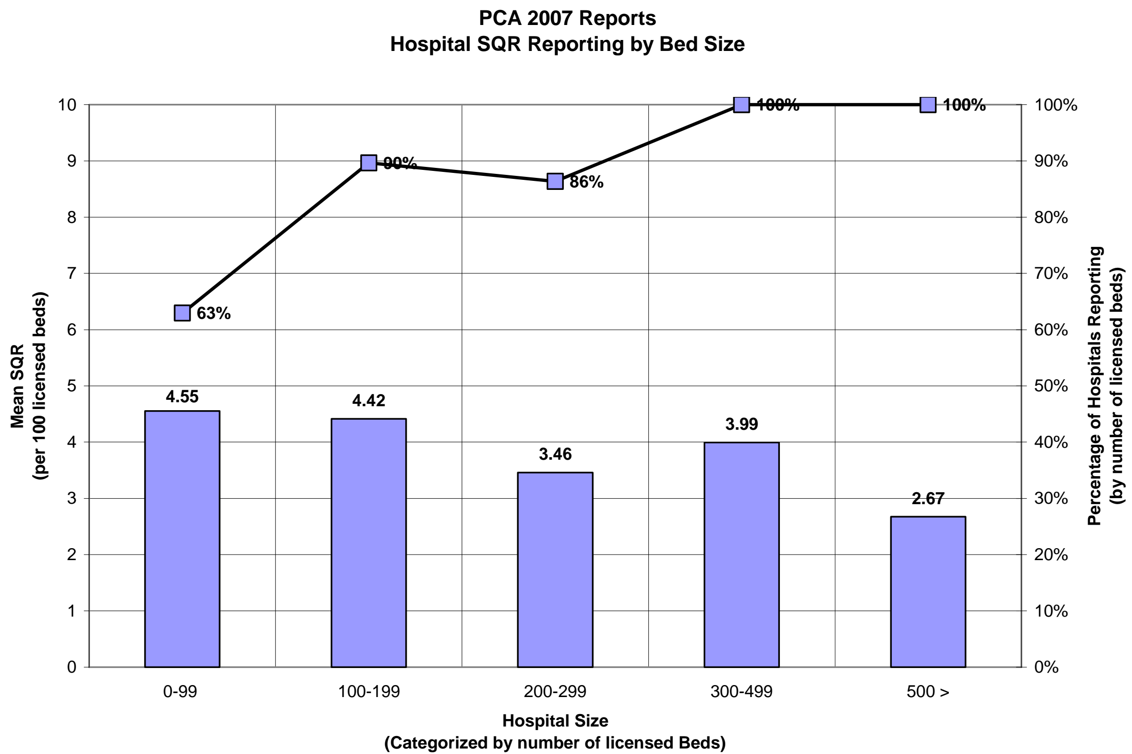


Figure 3

Since the initial publication in 2002 of the National Quality Forum (NQF) endorsed list of *Serious Reportable Events in Healthcare* a number of states and governmental entities have been using this

list to shape their incident reporting systems.[2] Cognizant of this national movement toward standardization of incident reporting systems and appreciating that Massachusetts health care facilities need unambiguous reporting requirements, the PCA Division has been carefully comparing its SQR reports to the NQF reporting criteria. The Division has determined that 214 (26%) of the 826 SQR reports submitted by hospitals to PCA in 2007 describe events that are on the NQF endorsed list. (*Figure 4, Table 2*) As a comparison, Minnesota's Department of Public Health reported 154 events, most corresponding to SREs, in their January, 2007 report. Of the facilities covered by their law, 26% reported adverse events.[3]

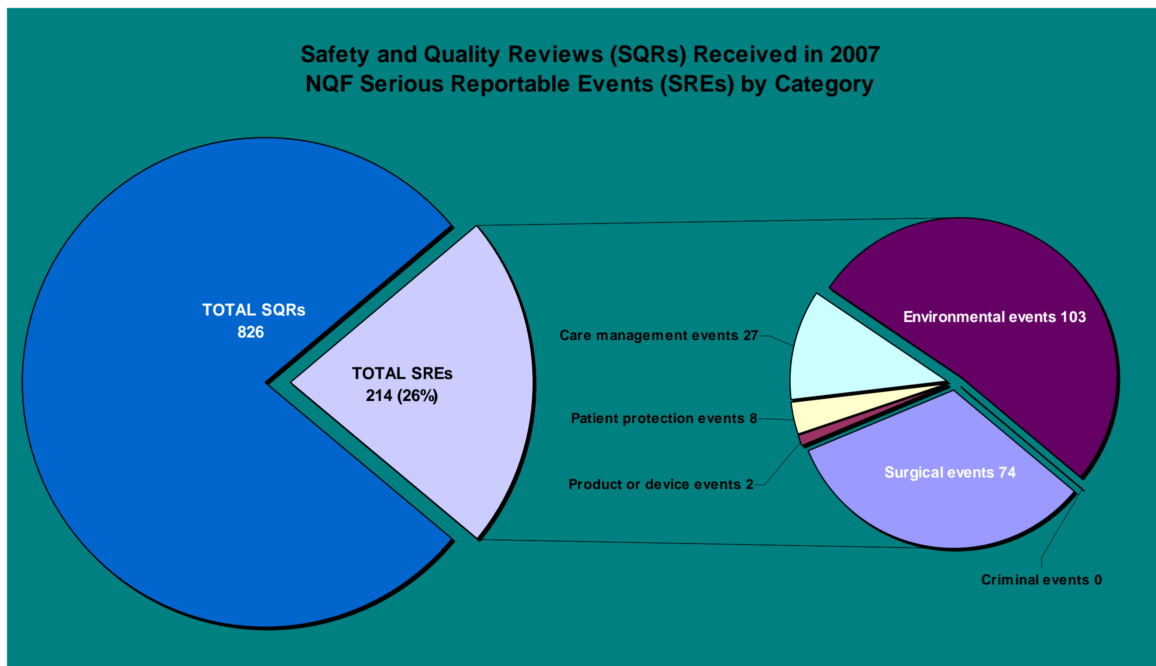


Figure 4

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

[3] Minnesota Department of Public Health. "Adverse Health Events in Minnesota, Third Annual Public Report." January,2007.

SQRs - NQF Serious Reportable Events in Healthcare

1. SURGICAL EVENTS	Number
A. Surgery performed on the wrong body part	35
B. Surgery performed on the wrong patient	3
C. Wrong Surgical Procedure performed	8
D. Unintended retention of foreign object after surgery	27
E. Intra or immediately post op death of an ASA Class 1 patient	1
2. PRODUCT OF DEVICE EVENTS	Number
A. Death or serious disability associated with contaminated drugs, devices, or other biologics	0
B. Death or serious disability associated with the use of a device other than as intended	0
C. Death or serious disability associated with intravascular air embolism	2
3. PATIENT PROTECTION EVENTS	Number
A. Infant discharged to the wrong person	0
B. Patient death or serious disability with patient elopement	0
C. Patient suicide, or attempted suicide resulting in serious disability	8
4. CARE MANAGEMENT EVENTS	Number
A. Patient death or serious disability associated with medication error	12(8D*)
B. Patient death or serious disability associated with hemolytic reaction due to administration of blood products	0
C. Maternal death or serious disability associated with labor and delivery	12(8D*)
D. Death or serious disability associated with hypoglycemia	3
E, Death or serious disability associated with hyperbilirubinemia	0
F. Stage 3 or 4 pressure ulcers acquired after admission	0
G. Death or serious disability associated with spinal manipulative therapy	0
H. Artificial insemination with the wrong donor sperm or egg	0
5. ENVIRONMENTAL EVENTS	Number
A. Death or serious disability associated with an electric shock	0
B. Wrong gas delivered through an oxygen line	0
C. Death or serious disability associated with burn incurred while in health care facility	0
D. Death or serious disability associated with a fall	99(20D*)
E. Death or serious disability associated with use of restraints	4
CRIMINAL EVENTS	Number
A. Impersonating a licensed health care professional	0
B. Abduction of any age patient	0
C. Sexual Assault	0
D. Death or significant injury of patient or staff from physical assault (battery)	0

* D = death

Table 2

Through better collection of data from SQRs, the PCA Division can now begin to analyze and compare its reports to other sources and use its data to identify trends and share lessons learned. For example, PCA requires hospitals to submit reports describing wrong site procedures, which include all surgical and diagnostic procedures performed on the wrong organ, extremity or body part. This year PCA noted an increase in wrong site events. Hospitals reported 38 events compared to 27 in

2006. This may reflect a greater awareness of the problem or more candid reporting, rather than an actual increase in occurrences. The NQF includes wrong site surgery on its list of *Serious Reportable Events in Healthcare*. The Joint Commission requires reporting of wrong site surgery as a sentinel event. Despite the Joint Commission implementing the Universal Protocol™ for preventing wrong site surgery in 2004, there seems to be no reduction in the frequency of wrong site surgical events reported to their database or to state reporting systems, such as Pennsylvania.[4] Currently, there is a national debate about how best to prevent this problem. From the beginning the Board and the PCA Division recognized that wrong site surgery was an important event to measure. This year wrong site surgery can be compared with other kinds of events of national interest. The PCA Division will continue to track these events and participate in the national dialogue with a goal toward identifying more effective preventive strategies.

Preventing patient falls has become an important initiative in patient safety. The Joint Commission includes reducing both patient harm and absolute number of events in their 2008 National Patient Safety Goals, and the NQF includes falls with death or serious disability on its list of *Serious Reportable Events in Healthcare*. For many institutions, falls account for either the second or third most common adverse event. Usually this means about 10-15% of all events collected by reporting systems. Depending on how serious disability or harm is defined, about 1% of falls fit this definition. This is empirical data PCA has received from several facilities.

In 2007, the PCA Division received 118 SQR reports describing patient falls with injury or death, accounting for 14% of all SQR reports received (118/826). Falls associated with death occurred in 17% (20/118) of these reports. Of the deaths, 30% (6/20) were from subdural hematomas or intracranial hemorrhage, and of this category, 83% (5/6) of the patients were being treated with anticoagulants. Fall with fracture accounted for 84% (99/118) of the reported SQRs, most commonly hip fractures (60/91). Toileting was a significant contributing factor in 35% (41/118) of fall events; confusion was a factor in 31% (37/118) of patients. Medications were identified as significant contributors to falls in 12% of reports, and 61% (72/118) of patients who fell had been assessed as at risk for falls. Not surprisingly, less than 18% (21/118) of falls were witnessed. As with the wrong site procedure data, PCA will be sharing its findings and participating in efforts to not only prevent patient falls, but to have adequate assessment and treatment procedures in place in the event that a fall occurs.

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[4] Pennsylvania Patient Safety Reporting System. Patient Safety Advisory. “Dong the ‘Right’ things to Correct Wrong Site Surgery”. PA-PSRS Patient Safety Advisory, Vol. 4, No. 2, June, 2007.

The PCA Division will be reviewing more of its 2007 data in the coming months, focusing particularly on SQR reports involving endoscopic perforations, fetal demise and neonatal injury, maternal mortality and retained foreign bodies.

Goals for 2008

The PCA Division will continue its quarterly newsletter *First* and showcase best practices and solutions to issues which health care facilities have found to be effective. A new addition to the newsletter will be a "box score" highlighting the types of events reported in the previous quarter.

The Credentialing Expert Panel will continue to meet. It will collect data from the testing sites and plans to report the results in a national publication. During the last months of 2007 a Subcommittee of the Credentialing Panel met to address the issue of non-affiliated physician providers and how best to insure their competence. This group will continue to grapple with this difficult problem throughout 2008.

Because medical errors involving trainees is a topic of national concern, the Medical Training and Education Task Force will reconvene. Having completed its initial work in 2006 and submitted a report to the Board, the members will again be asked to meet and address on-going concerns of the PCA Committee.

In visits with PCA Division staff throughout the state, hospital Chief Medical Officers expressed the desire to have a colloquium where in a small group setting they could discuss their special problems and needs. The PCA Division will facilitate bringing this group together on a regular basis.

The hospital PCA Coordinator Workshops will begin again. Since they were last held in 2006, there have been many new individuals hired or selected to serve in this important role. Workshops are tentatively planned for March and May of 2008.

Following the Rehabilitation and Long Term Acute Care Hospital Workshop in June of 2007, the PCA Committee noted a significant improvement in SQRs submitted by these institutions. PCA plans a focused training event to discuss issues unique to these facilities.

Health care facilities have continually asked about the inter-relationship of Board divisions. PCA plans to participate with representatives from other Board divisions in developing a forum for the leadership of hospitals to come, learn and ask questions about how the Board works.

During 2008 the PCA Division will be setting a research and development agenda. One important area that the Division wants to examine closely is in consolidating its database of events so it is easily searchable to allow for better identification of lessons learned from aggregate facilities' experiences.

Finally, the PCA Division on behalf of the Board will be collaborating with the Massachusetts Health Care Cost and Quality Council and other governmental agencies on establishing goals for improving the quality of medical care provided to the citizens of the Commonwealth. Representatives from the PCA Division have already met with senior division heads in the Department of Public Health and the Betsy Lehman Center to discuss strategies for collecting and reporting data on the NQF's *Serious Reportable Events in Healthcare* and Hospital Standardized Mortality Rate (HSMR) and other validated measures of mortality rate. The PCA Division will participate in organizations dedicated to improving quality of patient care, such as the Coalition for the Prevention of Medical Errors, Health Care for All's Quality Committee, and the Institute for Healthcare Improvement.

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 42 million hits in 2007. 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 2007 was approximately 95,000. The average user spent about three minutes on the site and viewed four pages, and during the course of the year, users accessed over 4.3 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 2007, the agency received 20,186 calls for information, mailed or faxed 2,748 Profiles to consumers and made 6,849 updates to Profiles based on changed physician information, such as address or hospital affiliation. 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.

2007 Public Information Statistics

Profiles server "hits"	**42,348,612**
Profiles page "hits"	**14,981,930**
Number of Profiles Accessed	**4,334,558**
Avg. daily website "hits"	**95,475**
Calls for information	**20,186**
Faxed or mailed Profiles	**2,748**
Updated Profiles	**6,849**