Testimony of Physician Health Services, Inc. (PHS)

Proposed Regulations of the Board of Registration in Medicine

243 CMR 2.00

May 18, 2017

Physician Health Services, Inc. (PHS) appreciates the opportunity to provide testimony to the Board of Registration in Medicine on the proposed regulations at 243 CMR 2.00 as follows:

1. **Physician Health Services Opposes the Licensing Board Creating an Affirmative Duty to *Demonstrate* “Good Moral Character” as a Requirement for Licensure** - 243 CMR 2.02(1)(b)[[1]](#footnote-1)\*

Good moral character has always been a prerequisite for physicians seeking licensure in Massachusetts. However, creating an affirmative duty to *demonstrate* good moral character is misplaced in the regulatory structure. The purpose of governmental regulations is to create a set of standards to inform applicants of the requirements for licensure, and to measure applications on equal footing. This purpose is already fully and adequately defined by the current “purpose” statement at 243 CMR 2.01:

“The purpose of 243 CMR 2.00 – 2.15 is to prescribe substantive standard which will promote the public health, safety and welfare and inform physicians of the Boards expectations and requirements.”

The board, however, enters risky ground by seeking to add:

“…to ensure that the Board issues certificates of registration **only to qualified, competent physicians of good moral character**…” (243 CMR 2.01(1) *proposed language*)

Undoubtedly the purpose of the regulations is to issue licenses only to qualified individuals, and it can do so by confirming that applicants meet the enumerated objective criteria set forth in 243 CMR 2.02. However, adding a “good moral character” requirement, which is undefined in the regulatory structure, opens the board to potentially arbitrary and extremely subjective interpretations of what is moral, or good, or reflective of one’s character. Not only are there no definitions within the regulatory structure for this term (which is capitalized throughout the regulations), the definition of what is “moral” and what is “good” is typically subjective and construed differently by each of us.

Furthermore, there are no provisions in the regulations as to what will meet the Board’s expectations for an adequate “demonstration” of this vague and inadequately defined requirement. Will a letter of character from a friend suffice? Will an applicant need to contact clergy from a particular religion to obtain a verification of good moral character? Do the sitting board members intend to rely upon their own personal sense of morality when considering applications? The language in the regulations suggests the latter as it states,

“The Board shall determine whether an applicant is of good moral character …” 243 CMR 2.02(6)(a)[[2]](#footnote-2)\*

As Board members change with rotating terms, and their personal definitions of morality will necessarily vary, this provision is clearly improper. The inevitable arbitrary application of this undefined requirement emphasizes the legal fragility of this provision, which should be stricken from the regulatory structure.

1. **Physician Health Services Opposes the Licensing Board Creating an Undefined Requirement of “Competence” Beyond That Already Demonstrated By Meeting the Qualifications for Licensure** - 243 CMR 2.02(1)

In this same vein, the BRM should not impose its own, undefined perspective of “competence.”

“The Board shall determine whether an applicant is … competent to hold a … license to practice medicine.” 243 CMR 2.02(6)(a)[[3]](#footnote-3)\*

The qualifications for licensure in 243 CMR 1.00 *et seq*. already establish clear parameters for demonstration of competence to practice medicine. They include standardized criteria (such as defined years of approved education, and passing scores on standardized tests) that apply equally to all applicants. By then including the ability of any sitting board to decide that there is something different, or additional to these published qualifications that might be needed to demonstrate an undefined concept of “competence” introduces an element of arbitrary application that again puts the board on shaky legal ground. It should not be a discretionary matter for the BRM to determine that an applicant who meets all of the published and defined qualifications for licensure, lacks “competence,” from their personal perspective, for reasons that are undefined, unpublished, and indeterminate.

1. **Criminal Findings, Rather than Charges, Should be Considered When Reviewing License Applications -** 243 CMR 2.04 (10)

We are fortunate to have a criminal justice system that provides for due process before an individual can be sanctioned for unlawful activity. This foundation of this presumption of innocence is fairness and equity for all. If the licensing board is allowed to give consideration to, or take action upon, mere allegations, this undermines these intrinsic values of fairness and due process so highly valued in our judicial structure and country. Nationwide arrest data has been shown to reveal significant racial bias. Arrests are also often made in the moment, during situations of crisis and insufficient information. We have, in our criminal justice system, a process of checks and balances that then allows us to step back and evaluate the situation with consideration and due process before imposing repercussions. If the Board is allowed to disregard the careful consideration that has come from the subsequent legal process, and instead rely upon mere allegation or arrest as a basis to deny licensure or impose disciplinary action, the Board would be violating these important values of due process and equity. If the Board does not intend to rely upon mere allegation as a basis for license sanction, then applicants should not be asked to provide information about criminal allegations alone. This is also the case for sealed records and expunged records. If the criminal justice system, which has established a complex system of checks and balances, has seen fit to seal or expunge a criminal record, the licensing board must respect the legal standard, and refrain from requiring these records as a condition for consideration of licensure.

1. **Parameters for the Denial of License Withdrawal Should be Defined in the Regulations** – 243 CMR 2.03(15)

The regulations appropriately allow for an applicant to petition the licensing committee for withdrawal of a license application, but the regulations fail to provide any parameters to be considered before such a request for withdrawal may be denied. Moreover, the regulations lack a requirement for notification to an applicant as to the reason for such denial. Accordingly, the Board has discretion to allow or deny such a request for any reason, no reason, a valid reason, or an unlawful reason, all without need for explanation. It is not the intent of a regulatory structure to provide a means by which governmental personnel can utilize personal discretion for such consequential decisions. Rather, the purpose of having a regulation is to set forth the ground rules by which these decisions will be made, and the governmental personnel are charged with carefully applying these ground rules in an equitable fashion. Without a clear basis for when such requests may be allowed or denied, or the reasons for a given decision, applicants cannot fairly evaluate the risk as to whether or not to file an application for licensure in this state.

Denial of a request to withdraw an application necessarily subjects an applicant to additional time and financial costs (they have to proceed with the licensing application, appear before the Board with counsel if requested, continue to gather documentation), all toward the goal of obtaining a license that often they do not need or want, so that they might avoid a denial (as a denial is necessarily reported to the National Practitioner Data Bank). This also consumes substantial and valuable board time, as board staff must now devote its limited resources to processing and evaluating license applications from individuals who do not plan to practice medicine in this state.

Moreover, it appears to be a current practice of the Board to presumptively deny requests for withdrawal that come before the licensing committee absent the most procedural of explanations. Presumably the Board is seeking to thwart efforts on the part of any licensee to hide information from other state licensing boards. However, there are at least as many legitimate reasons to seek withdrawal of an application as nefarious reasons, including that the licensure process sometimes takes so long that the position for which the licensee initially applied is needed is no longer available. Even in these situations, requests to withdraw applications are being presumptively denied without further explanation. Accordingly, the BRM should adopt a policy of *allowing* requests for withdrawal absent an apparent effort to thwart justice, and the BRM should adopt a regulation that sets forth the parameters the Board must consider when reviewing a request for withdrawal, and that includes a provision for explanation when withdrawal is denied.

1. **The Mandated Reporting Exception For Drug and Alcohol Matters Must Not Be Self-Negating if it is to be an Effective Approach to Encourage Early Identification and Treatment of Substance Use Disorders** – 243 CMR 2.07(23)

In considering the scope of the Mandated Reporting Law, the legislature recognized that it would benefit the health and safety of the public to create an exception to this law in the case of physicians suffering from substance use disorders (SUDs). This exception was intended to provide encouragement for physicians with SUDs to get the help they need to become well, rather than waiting for the disease to progress to the degree of harmful patient outcomes before being identified. This approach, undertaken decades ago, coincided with the recognition that SUDs are health conditions that are responsive to early intervention and treatment, not moral failings that requires discipline or sanction. The more incentives for early identification and treatment, the safer the public will be.

Accordingly, the Board drafted regulations encouraging treatment by allowing physicians with drug/alcohol problems to obtain timely treatment in a Board approved program in lieu of facing a mandated Board report. This exception to mandated reporting allowed for a mandated reporter to use the language of the exception to encourage an ill physician into prompt treatment. As the exception was not intended to be used to avoid responsibility for *other unrelated* matters, nor for matters where harm had already taken place, there was a provision clarifying that the exception would not apply to *other* matters of law, or to matters where an allegation of harm had been made.

The language of the current provision, however, has two fatal flaws. First, it removes the term “other” when referencing violations of law. 243 CMR 2.07(23)(a)(2). The exception was specifically created for individuals who we understand may have violated drug laws as a consequence of an SUD. The legislature (and board of medicine in the past), made the active decision to encourage treatment and recovery so that we can promote patient safety, avoiding a punitive stance towards individuals who, as part of their SUD, utilized drugs outside of the scope of MGL c. 94C. However, by removing the word “other” the provision now states that anyone who has violated *any* laws, *including the drug laws*, cannot be eligible for the exception. Therefore, this provision completely negates the use of the exception in any meaningful way. As this was not intended, these changes should not be implemented.

The second fatal flaw is the addition of a provision that a physician becomes ineligible for the exception if there is “Impairment in the Workplace or While on Call.” 243 CMR 2.07(23)(a)(3). While in an ideal world, those who are suffering from substance use disorders will recognize the condition on their own and affirmatively seek help, we know that denial and lack of insight are often symptoms of an SUD.

This lack of insight, which is reflective of the disease state, is such that often those afflicted need to rely on the encouragement of others, or they will wait until the disease has progressed to a dangerous level with significant negative effects before they seek help. It is this latter scenario we want to avoid at all costs, both for the physician and the physician’s patients. Therefore, we want every incentive possible to encourage recognition of a problem so that ill physicians can be encouraged to get help. The mandated reporting law exception is written so that colleagues (other health care providers) will notice and recognize symptoms of concern and encourage ill physicians to participate in treatment before there have been any negative outcomes. Colleagues, however, necessarily interact with one another *at work* and *on call*. If they recognize impairment in these situations, before there have been any negative outcomes, and can get the colleague out of work and to a board approved program with no allegations of patient harm, the system is working. However, if they are not allowed to use the exception when they recognize the problem at work, or on call, the system fails. The focus needs to be on the ultimate goal of patient safety, which requires a regulation that includes incentive and encouragement to obtain treatment at any time before harm has occurred.

1. **The Board Should Not be Characterizing the Degree of Criminal Offenses for Purposes of the Physician Profile Program.** – 243 CMR 2.15 (2)(a)(1)

The proposed regulation addressing physician profiles indicates that convictions for felonies and “serious misdemeanors” will be included on each physician’s profile. It then states,

“The Board shall determine what constitutes a serious misdemeanor.” 243 CMR 2.15(2)(1)

The Board members are not equipped to evaluate all criminal findings that may come before them, nor categorize each into a consistent context labelling each one “serious” or otherwise. The same risks exists as set forth above with respect to characterizations of “good moral character” and “competence,” should the Board aim to impose its own subjective and likely fluctuating interpretation of what is or is not “serious.” Rather, we have a criminal justice system that has already evaluated *all* potential crimes, and has already categorized each as either serious (felonies) or less so (misdemeanors). It would be a misplaced effort at best, and a failure of due process and equity at worst, for the Massachusetts Board of Medicine to attempt to re-cast every criminal act in accordance with its own, undefined standard, in a way that is clear, consistent, and fairly applied to all applicants for the purpose of public notification via the Physician Profile Program.

Thank you for the opportunity to address these topics on behalf of Physician Health Services, Inc.

Sincerely,

/s/

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Director, PHS

1. \* “Good Moral Character” additions also found at 243 CMR 2.01(1), 2.02(2)(n), 2.02(6)(a), 2.02(7)(a), 2.02 (11)(a), 2.02 (12), 2.02 (13), 2.03(1), 2.03(2), 2.03(2)(e)(1), 2.03(3), [↑](#footnote-ref-1)
2. \* See also other locations throughout 243 CMR 2.00 *et seq.* [↑](#footnote-ref-2)
3. [↑](#footnote-ref-3)