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"WE HAVE COMMITTED THE GOLDEN RULE TO MEMORY; LET US NOW COMMIT IT TO LIFE."

— *Edwin Markham*

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MESSAGE FROM THE CHAIR

IMPROVING ACCESS TO CARE

Doris C. Brooker, M.D., *Chair, Federation of State Medical Boards*

Improving patient access to physicians and reducing barriers to telehealth practice across state lines certainly are noble pursuits. The evolution of regional and nationwide health care delivery systems has increased awareness that improving license portability will likely require more consistent licensing standards and greater cooperation among licensing boards. The escalation of telemedicine practice, telephone triage and medical practice via the Internet places increasing pressure on states to improve license portability. The Common Licensure Application Form (CLA-F) and license portability are two FSMB initiatives in support of state medical boards with the potential to create dramatic, needed reductions in the time required for physicians to obtain licensure and to be able to practice in areas that serve multiple states. The FSMB Board of Directors identified the improvement of license portability as an organizational priority for the 2004 and 2005 fiscal years.

COMMON LICENSURE APPLICATION FORM

The CLA-F has the potential to benefit state medical boards in a number of ways, including reducing the number of incomplete applications, allowing for uniform data collection, increasing license portability and adding convenience for physicians simultaneously applying for licensure in multiple states.

The CLA-F was developed in collaboration with Administrators in Medicine (AIM), which assisted with assembling a group of executives from medical boards in Alaska, California, Florida, Massachusetts, Maryland, Nevada (Osteopathic), New Hampshire, New York, North Carolina, Ohio and Texas. The result of this meeting was the current version of the CLA-F, which was distributed to boards in April 2004.

There have been two primary obstacles to incorporating the CLA-F: 1) objections that the CLA-F is a pathway toward national licensure, and 2) organizational hurdles created because some boards use centralized applications for licensure that are under the jurisdiction of a state "umbrella" agency. However, the CLA-F is not a step toward national licensure, but rather a way for states to retain their autonomy, as well as any state-specific licensing language, while expediting the licensing process. While the CLA-F serves as the "core" of the application, states have the option to use an addendum to incorporate any language required by the state but not present in the core application. Thus far, the New Hampshire Board of Medicine has adopted the CLA-F and incorporated it into their application process; the State Medical Board of Ohio is in the process of implementing it; and several other boards have expressed interest.

The next step is a pilot program, for which the FSMB currently is seeking funding, in which several participating boards (ideally in contiguous states) would post the CLA-F online. Currently, the United States Medical Licensing Examination (USMLE) Step 3 and Federation Credentials Verification Service (FCVS) have online applications. With an online CLA-F application, residents applying for the USMLE Step 3 would be able to register for Step 3 and use the same data entered for Step 3 registration to register for FCVS credentials verification, CLA-F and any state addendums — thus applying for licensure in multiple states at the same time.

The CLA-F has the potential to dramatically affect telemedicine practice and license portability. It's important to note that the form is not a static document, but one that will continue to incorporate the changing needs of member boards and evolve to best meet their.

LICENSE PORTABILITY

License portability is another important FSMB initiative. In 2002, the FSMB report *Special Committee on*

License Portability expanded on earlier FSMB recommendations related to multi-state and telemedicine licensure detailed in the *Ad Hoc Committee on Licensure by Endorsement* (1995) and *A Model Act to Regulate the Practice of Medicine Across State Lines* (1996). The special committee report proposed an expedited licensure by endorsement process for physicians who met accepted standards, assuming the development of a standard medical license application and the acceptance of established standards for primary source verification of core credentials.

With funding from the Department of Health and Human Services (HHS), the Health Resources and Services Administration (HRSA) and the Office for the Advancement of Telehealth (OAT), the FSMB hosted a January 2004 meeting in Providence, R.I., during which representatives from 12 state medical boards volunteered to design two demonstration projects to facilitate improved license portability — specifically the multi-state practice of medicine and telemedicine practice.

Thus far participants included a western group, with representatives from state medical boards in Colorado, Idaho, Iowa, Kansas, Minnesota and North Dakota, and a northeast group, with representatives from state medical boards in Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont. Both groups have developed specifications for the demonstration projects, and are currently seeking funding under Public Law 107-251 (P.L. 107-251), as well as a technical assistance grant.

The northeast group objective is to design and pilot a system to facilitate license portability for multi-state practice among state medical boards by applying common requirements, sharing information and using common tools. Once designed, the system would utilize a comprehensive information system. Participating boards will establish eligibility qualifications for applicants seeking licensure by endorsement, establish requirements regarding credentials verification, and utilize a standard online application. Anticipated benefits of such a system include reduction in barriers to telehealth practice across state lines, improved access to physicians in underserved areas, improved ability to mobilize physicians during disaster/crisis, facilitation of multi-state physician mobility and decreased redundancies associated with obtaining licensure in multiple states. The timeline for implementation would be three years.

The western group objective is similar in many respects: to design, implement and pilot a demonstration project that would facilitate license portability and create a regulatory environment favorable to multi-state medical and telehealth medical practice. The project would develop and utilize a central database that would be accessible to all participating boards. It is anticipated that such a system would provide benefits similar to those created by the northeast group project.

WORTHY INITIATIVES

Improving license portability, telemedicine practice and encouraging the acceptance and utilization of a common licensure application form are worthy goals. The FSMB will continue to support the work of the state boards and such cooperative partners as AIM in pursuing these and other initiatives. Our success will be measured in tangibles: physicians able to practice in multiple states and/or contiguous states; improved patient access to physicians in underserved areas; an examination, credentialing and licensure application process that becomes more streamlined; and an overall enhancement of care for the patients the state boards and the FSMB are dedicated to serving every day.

EDITORIAL

INTROSPECTION AND SAFETY

Stephen M. Herring, M.D., D.D.S., *President, North Carolina Medical Board*

Medical boards seek out and study positive and negative factors and parameters affecting the delivery of health care. One human factor that is accepted as a significant negative factor is the lack of introspection. Introspection is defined as the contemplation of one's own thoughts, feelings, actions and sensations. In a broader sense, and in this context, it is self-examination that should continue throughout the career of the provider, just as continuing medical education should become an integral part of the physician's life. When any provider fails to admit or understand — or simply ignores — the human condition of imperfection, no effort will be made to improve and to "do it better" the next time — and no progress or advance will be achieved.

In the field of aviation, there is a particular aircraft, and a very good one, that is known as the "flying casket" because physicians (and surgeons in particular) have developed a reputation, deserved or not, for crashing the aircraft in almost unbelievable situations and manners. Flight instructors believe that they have identified a distinct pattern here. So well known is this sad reputation that professional pilots and flight instructors cringe and roll their eyes when the words "pilot" and "surgeon" are said in the same sentence.

Some years ago, there was a well-known, talented and respected surgeon who learned to fly. This surgeon's remarkable ability in his chosen career was unquestioned, and his personal contributions to the field of medicine were widely recognized as enormous. Albeit brilliant, this surgeon also had a persona that was interpreted by most of those who knew him as arrogant. The time came when he chose to fly an aircraft that was beyond his experience level in weather conditions that were far beyond his skill level. On that occasion, he was briefed by the weather service and was told that flying into the prevailing poor weather conditions under visual flight rules was not advised. He paid no attention, and his medical brilliance did him no good from that point on — or down. The flight lasted less than four minutes and abruptly ended a distinguished career. Despite crashing into a congested area, he did not kill anyone he had so thoughtlessly and arrogantly placed at risk on the ground.

Two generally unrelated groups, medical regulators and flight instructors, have collectively reached the same independent conclusion regarding behavior patterns and safety. Confidence, or the state or quality of being certain, is an asset. Arrogance, or the state of self-assumption and presumption, is a detriment. It is a recurring theme and pattern in medicine and aviation. The story of the prominent surgeon whose flight lasted less than four minutes, based on a report from the National Transportation Safety Board database, illustrates a particularly tragic intersection of the two.

I believe many professional medical societies and other health care groups and organizations recognize the potential danger that can result from arrogance and a lack of introspection, and I know some have published statements warning of the serious problems those personal weaknesses can cause. All groups and organizations in the field of health care should address such issues, and every person involved in health care should encourage and support the process.

At the same time, while we know the physician who always reports perfect results and the pilot who always reports perfect flights share serious and sometimes fatal flaws, and that both are dangerous to others and to themselves, it is important to remember that neither is common.

Dr. Herring is a plastic surgeon, as well as a professional pilot and flight instructor. A version of this editorial originally appeared in the Number 2, 2004, *issue of* Forum, *published by the North Carolina Medical Board.*

MEDICAL ERRORS: ACCOUNTABILITY AND REFORM

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In 2002, the General Assembly of the State of Connecticut, in an attempt to be responsive to increasing concerns regarding the quality of hospital-based health care, mandated that hospitals licensed in Connecticut develop performance improvement plans and report to the Department of Public Health, on a regular basis, all adverse medical events/outcomes that resulted in unexpected mortality or morbidity (P.A. 02-125). This was an attempt to cause focus, concern and moment-to-moment interest on a genuine public health problem: medical errors, a problem that had been minimized or excused for too long. The General Assembly's initiative did not presume any listing of adverse events or errors would fix the problem. It was, effectively, nothing more than a very serious "call for action" on the part of the medical profession.

All understood the real answer to the problem of medical errors, the malpractice dilemma and the problem of the impaired medical professional is to focus once more on the creation and nurturing of a climate of excellence within the medical profession. Legislatures and regulatory agencies have a role to play in this effort by establishing the baseline, i.e., the minimum educational and performance standards for licensure. They also have the responsibility to establish reporting requirements to track performance and show trends, to create programs for the rehabilitation and monitoring of impaired professionals and to enact immunity provisions that encourage whistle blowing by colleagues when necessary. Ultimately, licensing boards have the responsibility of removing substandard providers from the practice of medicine. But even if scrupulously and attentively undertaken, these actions only ensure the minimum of adequate care.

American society demands much more than minimally adequate medical care. We support, pay for and expect the highest quality medical care. We grant limited monopolies on the practice of medicine to those who can meet minimum standards. We further grant to the medical profession the almost unique, and certainly special, right to police themselves through licensing boards composed of colleagues from their own professions. In return, we expect a rigorous, self-imposed standard of professional excellence.

The current crisis in the availability and cost of medical malpractice insurance in many states is an indicator something is not right in this balance between regulatory and professional standards. In an otherwise equal world, one would expect legislators' primary concern would be for the continued availability of high-quality medical services to their constituents, and legislators would be responsive to doctors' pleas for relief from the burden of high insurance costs and the debilitating effects of the constant threat of malpractice litigation. One would not expect to see insurance companies pulling out of the medical malpractice insurance business entirely when they have a guaranteed market in physicians, who must carry insurance in order to be licensed to practice, and, further, when those physicians have a monopoly on the provision of a critical service needed at some time in life by 100 percent of the American public. The current situation makes no sense from accepted political or business perspectives.

But there is a very strong backlash from angry patients and their attorneys that is preempting the political stage. Clearly, a significant (and very vocal) portion of the American public does not believe the medical profession deserves relief, and they are not willing to submit to medical care from these professionals without the safety net of open-ended malpractice coverage in the event something

goes wrong. They are not willing to wait for the creeping pace of regulatory investigation and discipline to deal with what they perceive as a real and immediate threat. There is a real disconnect between the medical profession's view of itself and the view held by the general public. Too many medical care consumers tell stories of oversights and errors, refusals to listen or to take their concerns seriously for the American public to trust that medical professionals can be left to themselves to ensure delivery of the highest quality health care. Submitting to medical care is an act of faith for most Americans, and that faith is being sorely tested by a system that, for too many people, does not seem to be, first and foremost, dedicated to medical excellence. Doctors have their side of the story to tell, but the public is not yet ready to listen to it.

The "system" must look inside itself for ways to reverse this image in the public's mind. Quality medicine is the goal. This does not mean miracles or freedom from unexpected outcomes, but simply means attentive, educated and competent application of evidence-based, current knowledge and care. As we will discuss further, this is the responsibility of all parts of the system: the legislators who set minimum standards for licensure and who fund the regulatory agencies and tracking systems; the regulatory agencies who are responsible for enforcing standards and investigating complaints; the professional licensing and certifying boards that attest to competency, generically as well as in a specialty, and that may impose sanctions for violating minimal professional standards; and the practitioners and institutions that provide the medical care and educate future practitioners. Hospitals and doctors should be leading this effort, as they have the most to lose if it fails.

Health care is not always as straightforward as many would like to believe. It is a complex business dependent upon many variables, some of which are unknowable until it is too late. It is dependent upon the patient, a variable that sometimes includes the patient's family, the patient's age, pre-existing conditions, financial status (insurance and the like), cultural beliefs and ability to understand and/or comply with difficult or complicated instructions (e.g. , stop smoking and/or drinking). Health care outcome depends upon the illness, the timing and presentation of it and whether there is a cure or treatment for it. It relies heavily upon the diagnosis, judgment and treatment plan devised by a physician or health care provider.

Many patients envision health care in the industrial complex model, where all elements of manufacturing are completely controlled, resources are matched to need, workers are trained and available for a task and all systems work in harmony to produce a finished product. For many repetitive medical procedures, it often works that way — but only if the patients respond in the expected physiologic manner to their treatment. In reality, patients have allergies to medications, respond somewhat unpredictably to anesthetics, bleed and develop such complications as myocardial infarctions during the course of their care. In cases where a diagnosis is not clear, treatment is even more difficult and outcomes less predictable. Is this anyone's fault? Adverse events will occur, and they will not always be someone's fault. Our job as medical professionals is to limit the occurrence of adverse events to those that cannot be avoided.

The delivery of health care within hospitals is clearly a key issue in any system-based approach to correction of this problem. What is the legitimate role of the hospital in these circumstances? There is increasing recognition of what are termed "human factors" and "latent errors" in the delivery of care. Human factors recognize the fact that people will make mistakes. Latent errors, a term introduced by James Reason, are errors that are the result of poor planning or design (e.g., staffing, staff training and competence, equipment, policies and environmental factors).[1] They are system flaws that sooner or later will lead to an adverse event that could have been avoided. Human factors and latent errors speak to the need to have a framework designed around high risk areas to prevent poor out-

Table 1.

Ideal Hospital Characteristics
1. The health care environment should be safe for patients in all its processes and at all times.
2. There should be a comparable standard of care at night and on the weekend.
3. Care should be seamless. Interdependent people must act in unison as a whole.
4. Knowledge should not be lost in inadequate handoffs, documentation or via poor communications.
5. There should be teamwork and cooperation among providers to avoid sub-optimization (one discipline holding onto authority at the expense of the total system and patients).
6. The patient as well as providers must participate in the design of the system of care.
Adapted from *Crossing the Quality Chasm*[2]

comes. The Institute of Medicine (IOM) report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, outlines a series of ideal hospital characteristics that are critical to developing this framework (Table 1).[2,3]

These recommendations recognize it is the total care delivery system that must work, and that the patient, as well as providers, is a part of that system. Flaws in any one part of the system will have a dramatic impact upon patient outcomes. (For example, simple cleaning not done well can lead to an outbreak of methicillin-resistant staphylococci infection and, in turn, excess mortality).[4]

Such powerful groups as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Leapfrog are, step by step, forcing administrators to pay more attention to patient safety and medical outcomes. The JCAHO is achieving this through its seven national patient safety goals (Table 2) and the requirement to study high-risk areas through failure modes and effects analysis. Leapfrog is demanding minimum standards by demanding ICU staffing with intensivists, the presence of computerized physician order entry (CPOE) and performance of minimum numbers of procedures for high-risk, high-morbidity procedures. These are efforts to accelerate change and focus on patient safety and outcomes in a hospital environment that is bombarded by such other challenges as rising pharmaceutical costs, staffing shortages and declining reimbursements. Safety and outcomes must be equal priorities for hospital administrators and board members.

Table 2.

2004 National Patient Safety Goals
1. Improve the accuracy of patient identification. 2. Improve the effectiveness of communication among caregivers. 3. Improve the safety of using high-alert medications. 4. Eliminate wrong-site, wrong-patient, wrong-procedure surgery. 5. Improve the safety of using infusion pumps. 6. Improve the effectiveness of clinical alarm systems. 7. Reduce the risk of health care-acquired infections. The first National Patient Safety Goals were approved by the Joint Commission's Board of Commissioners in July 2002. JCAHO established these goals to help accredited organizations address specific areas of concern in regards to patient safety.

The reality is hospital systems across the United States are in different phases of evolution on the issue of patient safety. In some hospitals, systems like CPOE are already in place, while for other hospitals the expense of these systems seems exorbitant despite the fact that CPOE (which will integrate physician orders with a patient's historical medical data, current laboratory values and drug use, and, thereby, can detect and prevent inappropriate medication orders) has the estimated potential to eliminate more than 50 percent of serious medical errors and decrease adverse events by almost 20 percent. Hospital reimbursement has been under attack for the past decade. Reductions in reimbursement have forced administrators to balance the need for new equipment, new technologies, sometimes-expensive new medications, staffing and the like. The problem, in part, is to ensure hospital administrators focus on what is really important and to prioritize investments first in patient safety and medical outcomes. Federal investment in information technology for hospitals to augment quality is absolutely critical.

Hospitals have a responsibility to ensure that the environment is as supportive as possible for patient care, staff are well trained and available during all shifts, that systems that enable care are available (CPOE, smart IV pumps, beds with alarms and fall protections, automated systems to draw up medications, etc.), policies are developed collaboratively and make sense for patients and providers and there are systems in place to monitor and measure the effectiveness of care. Hospitals also have a responsibility to ensure that health care providers are competent to treat and care for patients during their hospitalization.

What exactly is competency? For the most part, hospitals rely on proxies for competency. For example, the JCAHO requires age specific competencies for nursing. Loosely translated, this addresses the question of whether a nurse is capable of treating a specific age group — for instance, performing cardiopulmonary resuscitation or administering medications to a pediatric as compared to a geriatric patient. Increasingly, these competencies are assessed by hands-on training, simulators or computerized testing (which is what we do at the University of Connecticut Health Center's hospital, the John Dempsey Hospital). We also rely on licensure. To be a part of our nursing or advanced practice staff, our therapy staff (radiology technicians, physical and respiratory therapists, medical technicians, dieticians, etc.), our social service or psychology staff, you must be licensed

and maintain that license. The question is whether maintaining a license is enough. In some cases, there is a requirement for a minimum number of continuing education credits, but often no practical competency testing is required. The latter is typically judged variably by on-the-job reviews. Some supervisors provide excellent monitoring, feedback and instruction for continuous competency/improvement, while others do not. At John Dempsey Hospital, we mandate annual in-services (e.g., safety, infection control, cardiopulmonary resuscitation) and annual performance assessments requiring an evaluation of knowledge, skills and abilities. Even so, it is sometimes difficult to know if everyone is as competent as we might like. If anyone in the chain of providing care is slightly off, there may be no negative impact on care, but then again, there might be. Hence, redundant systems with multiple checkpoints are necessary to ensure safe care.

At John Dempsey Hospital, we are attacking four high-risk areas: medication errors, patient falls, nosocomial infections and pain management. By tackling these four areas, we anticipate a significant reduction in adverse events and better patient care quality. Our approach is to develop a focused, highly visible initiative embodied in a new center, the Collaborative Center for Clinical Care Improvement (CCCCI). CCCCI will marshal the talents of physicians, nurses, information management staff, management engineers, facilitators, researchers and an external advisory panel to focus on improving patient safety and medical outcomes.

To minimize medication errors, we are midway through the installation of an electronic medical record with physician order entry and rules-based algorithms. These rules, we expect, will prevent the majority of medication errors (i.e., dosing errors, drug-drug, drug-food allergy interactions), eliminate legibility errors, time date stamp all activities, enable tracking of compliance with evidence-based protocols and facilitate immediate system-wide communications. As importantly, performance improvement data will be gathered about providers to better train, coordinate and improve safety and care. These data will be incorporated into staff competency assessments.

We recognize that it is impossible to completely eliminate patient falls, particularly as we use fewer and fewer patient restraints. Our falls strategy is to minimize patient injury (high-risk screening tool for at risk patients, beds lower to the floor, floor pads, nightlights, bed alarms, hip pads, etc.). The solution to nosocomial infections is well known: attention to detail. This includes frequent 15-second hand washes, appropriate timing of perioperative antibiotics, use of appropriate antibiotics and appropriate cleaning agents, etc.[6] We, with others, are developing Web-based tools to teach about the neurobiology of pain, the pharmacology of opioids and management of chronic pain in specialized populations of patients.

We support the JCAHO and IOM strategies and believe that over time they will lead to improved outcomes.[2,3] Hospitals need to embrace these concepts. IOM's six aims are well thought out and should be universally adopted. They include the delivery of safe, effective, patient-centered, timely, efficient and equitable care.[2]

But hospitals are not exclusively responsible for the care and outcomes of patients treated within their walls. They are part of a system with many degrees of freedom and patient variables. Hospitals are responsible for assuring that the system and its providers have collaborated to create an environment to maximize patient outcomes. The nature of health care will evolve and so, too, will hospitals. Blame, however satisfying, will not solve America's problems. A relentless pursuit of performance improvement and systems thinking is the solution.

Ultimately, quality medicine is the goal, but, as we have seen, statutory and regulatory systems have inherent limits. Uniformity of standards does well for most cases, but cannot predict or take into account outlying cases or differences in individual patient response to standard therapies. Databases are only as good as the questions asked, the responses received and the ability of those who manage them to draw reasonable conclusions from the data. Regulatory authorities, whether state agencies or licensing boards, are dependent upon adequate financing and staffing to be able to do their jobs. Hospitals can only do so much and are not, in our opinion, the core issue in the problem of medical errors/adverse events.

Physician education and the systematic routine monitoring and accountability associated with education through medical school, graduate medical education and, perhaps most important, the subsequent 35-40 years of each physician's active career, also lies at the heart of the issue and certainly cannot be minimized or overlooked for significant performance improvement to occur and be maintained.[5] Medical school curriculums deliver a rather stan-

dard and traditional educational product that is carefully monitored for educational consistency and adherence to agreed competencies by the Liaison Committee on Medical Education (LCME). Further, competency of potential graduates is tested by the National Board of Medical Examiners (NBME) and the Federation of Sate Medical Boards (FSMB) that now includes USMLE Step 2 CS, a test of clinical skills in addition to standard tests of cognitive biomedical knowledge.

Medical schools, for the most part, offer dedicated, bright men and women a comprehensive, dynamic and exciting body of biomedical knowledge and basic diagnostic skills; the combination of the two prepare most students well for more specialized and sophisticated training in graduate medical education (GME). Medical schools, certified by the LCME, are not the cause of medical errors or the erosion of public trust.

On the other hand, variability in GME could be a significant contributor. To be sure, the fund of knowledge required in any specialty can be assessed in standardized examinations. A small snapshot in time regarding problem-solving skills can also be determined via written or oral exams. Moreover, in the short-run, weaknesses in these areas can and will be corrected, presuming physician compliance, by electronic medical records, integrated mobile devices and electronic clinical decision support — all of which will facilitate speedy, accurate communication, allow standardization of care, increase efficiency, enhance patient safety and improve outcomes. They will allow evidence-based medicine (best practices) to literally be at one's fingertips.

But, what does this say about skills ranging from a comprehensive, exact, patient-centered history and physical examination to such more threatening interventions as advanced cardiac life support (ACLS), advanced trauma life support (ATLS), central line placement, airway management and intubation, ventilator management, thoracentesis — let alone routine and advanced surgical procedures, interventional cardiology, interventional radiology and shock management? Is it enough to merely count the number of times an individual has performed an intervention to ensure skill and competency? Moreover, is the word or signature of the program director of any residency training program enough to ensure skill, as well as knowledge, in their graduates? That hospital staff credentialing offices accept such well intended but often not fully critical attestations from program directors or others when physicians apply for medical staff privileges, and specialty boards also accept them rather blindly without challenge or seeming concern, falls short of expectations given the increasing complexity of the diseases treated and the technologies used. Likewise, what determines such core attributes of medical professionalism as altruism, sense of duty, compassion, honesty and equanimity have not been replaced by cynicism, self-centeredness and even greed during three to 10 years of grueling training in GME?

While graduate medical education is a significant area of educational concern and accountability, the ongoing education, or lack thereof, throughout 35-40 plus years of most practicing physicians' careers may be the major contributor to medical error and adverse events. Certainly the physician education during this time frame is highly variable. How is competence measured during that interval? Again, by written multiple choice, recertification examinations that most everyone passes and by renewal of licenses to practice that are, at best, associated with a yearly listing of CME participation where competency is often not assured. Competence is also measured by delineation of privileges in hospital departments that, for the most part, attest to past competence that is rarely challenged — and all this when the pathobiologic and bioethical complexity of the diseases we treat and the medical and surgical diagnostic and therapeutic tools we use are becoming increasingly complex. Moreover, medicine has protected itself and its members. Even today, when electronic tools allow end results reporting and individualized morbidity and mortality reporting with easy, case-adjusted quality analysis and comparison, the profession has shied away from such information, even when it could be used so well, departmentally and individually, as an educational tool. More tragically, established character disorders, mental illness and even dependency on alcohol and drugs are too often ignored, rather than confronted for the practitioner's and the patient's well being.

One possible answer: United States medical and osteopathic schools, working closely with the Association of American Medical Colleges (AAMC), the American Board of Medical Specialties (ABMS), American Medical Association (AMA), the Federation of State Medical Boards (FSMB), the American Hospital Association (AHA), the American Osteopathic Association (AOA) and the National Board of Medical Examiners (NBME) must take ownership of the entire educational continuum and be accountable for it. An educational system across the

continuum that is focused on "continuous competency" must be developed. The multiple self-protective and self-perpetuating silos that currently exist are a serious impediment. One group must be responsible for integration of the parts into a cohesive whole.

Medical and osteopathic schools working collaboratively with specialty boards might develop and deliver the didactic knowledge content tests and the practicum, by which we mean the practical test of the skills required in a particular specialty. Tests would be rigorous and continually updated. They should be required every five years at a minimum and should be prepared for continuously, not episodically, through Web-based electronic educational offerings regarding the latest knowledge, the most current technical skills and case-based learning. Specifically, such preparation, therefore, would occur not only when necessary at the time of the examination, but on an ongoing basis. Failure to be re-licensed as a result of failure to master fair, evenhanded tests of clinical competence, including knowledge and skills, would ensure the public understands that the health care community took their concerns about medical errors and adverse events seriously. But, even more so, the threat of loss of license would cause all physicians to take their continuing medical education seriously. They might also take their mentoring and teaching responsibilities of students and residents, as well as hospital staff at all levels, who are their direct agents in the care of their patients, more seriously.

In short, rigorous competency-based re-licensure must become an imperative. This process must be specific for what a physician does and not only must one pass tailor-made examinations but personal practice performance data must be regularly examined. CME alone is not enough. Recertification in a specialty would then have some teeth and, more importantly, some credibility.

In conclusion, we must promote systems of conduct and operation in medical education and evaluation, and in health care delivery, that will self-correct as much as possible, thus minimizing the points at which outside intervention is necessary. Although many specific approaches are being developed, we must also change the personal climate as well as the physical climate. Hospitals should make it as comfortable for a nurse or other staff member to report questionable physician behavior as they do to report sexual harassment. All members of a treatment team should be regularly included in discussions of patients' treatment programs; all opinions should be valued equally; and all should be held accountable for the behavior of every member of the team. Medical schools must emphasize and teach students the importance of patient safety, as well as patient autonomy, and include cases on reporting impaired colleagues in their medical ethics courses. Regulatory systems, specialty certifying and licensure boards should require real and substantive continuing medical education. They must further require a demonstration of skill and experience before allowing the unsupervised practice of complicated, high-risk procedures. Demonstration of continuous competency throughout the life of the physician's practice must be the norm — and the profession must aggressively and swiftly deal with practitioners and institutions that fail to meet minimum professional standards. Certainly when all this is in place, and is working, malpractice reform would seem to follow quite naturally and easily.

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MAKING THE CASE: BOARD INVESTIGATORS AND ATTORNEYS

Linda Wasmer Andrews

Across the country, medical boards are picking up the pace when it comes to handling complaints. In 2003, boards took 4,590 prejudicial actions such as revocations, suspensions and reprimands directly affecting a physician's license to practice medicine. That figure is 10 percent higher than the previous year and almost 50 percent higher than in 1993.[1] Of course, there are more physicians today than there were a decade ago. However, the recent rise also reflects procedural changes that have allowed a number of boards to resolve complaints more expeditiously.[2] Many of these changes involve the way board investigators and attorneys do their jobs. The pressure is on to turn around cases more quickly and efficiently. In state after state, investigators and attorneys are rising to the challenge.

And what a challenge it is, given the limited manpower and resources at many boards. In Kentucky, for example, there are five investigators whose caseloads include physician assistants and athletic trainers in addition to M.D.s and D.O.s. Their responsibilities involve not only conducting investigations and testifying at hearings, but also supervising professionals after the board has taken action, making sure that licensees comply with board orders or stop practicing after their licenses have been suspended or revoked. It adds up to a heavy workload. "We might have 25 to 30 investigations that we're conducting at one time," says Bonnie Reitz, an investigator whose cases are scattered throughout eastern Kentucky. "In addition, I'm currently supervising 47 people in my region."

SECRETS OF THEIR SUCCESS

Put the most productive investigators under a magnifying glass, and you are apt to find a combination of dedication, experience, and training. Reitz, for instance, spent 23 years in law enforcement before joining the Kentucky Board of Medical Licensure two years ago. In her current job, she juggles a demanding caseload that includes a number of tough prescribing cases. About half of her time is spent on the road. Yet, despite the difficulties, Reitz echoes the sentiments of many investigators interviewed for this article when she says, "It's the busiest job I've ever had, but I love it."

When hiring new investigators, most boards want prior experience in law enforcement, administrative investigation or health care. "If you've got some experience and already understand how to go about conducting an interview, that helps you get productive a little sooner," says Jeffrey Lane, director of investigations for the Georgia Composite Board of Medical Examiners. "But what I look for even more than that is attitude, motivation and self-discipline." Because investigators often travel and work on their own, being a self-starter is especially critical.

Once you've hired the right people, the next logical step is to provide them with adequate training. As a practical matter, however, the nature and extent of the training that is offered varies widely from state to state. In Utah, where board investigators are sworn peace officers, "the first thing we do is send them through the police academy," says Bob Downard, an investigative supervisor for the Utah Division of Occupational and Professional Licensing. "Then we put them through an extensive field training program. If I've got a person with a law enforcement background, one of our nurses will do the field training, and vice versa." The unit Downard supervises is charged with investigating compliance cases for boards representing the whole gamut of health care professions, ranging from medicine and nursing to chiropractic and dentistry. Therefore, one focus of the field training is to familiarize investigators with the statutes, regulations, and policies of all the various boards.

In Washington, the board sends its investigators to state-run training courses modeled after programs developed by

the Council on Licensure, Enforcement and Regulation (CLEAR). At CLEAR-style courses, investigators learn the ropes of professional conduct, administrative law procedures, investigative processes, evidence gathering, interviewing, and report writing.[3] One problem, however, is that Washington's courses are only offered sporadically. "Some investigators are here several months before they have an opportunity to take a class," says James Smith, chief investigator for the Washington Medical Quality Assurance Commission. "But we try to get them in within the first year." In the meantime, newcomers work with an experienced investigator who provides on-the-job training.

In Maine, Seth Blodgett, a detective in the Office of the Attorney General, took a class in medical terminology when he was first assigned to work on cases for the Maine Board of Osteopathic Licensure and the Maine Board of Licensure in Medicine. In general, he says, "an investigation is an investigation is an investigation," so he was able to draw on his background in law enforcement. However, Blodgett says he also found the specialized lingo of medicine can be a challenge for those without a health care background, so the class came in quite handy.

INVESTIGATION 101

Whatever training method is used, one of the most important lessons taught is a clear understanding of what an investigator's job is and what it is not. Ken Spooner, assistant director of investigations for the New York Office of Professional Medical Conduct, has been responsible for training the investigative staff there for 15 years. He offers these three pieces of advice to new investigators:

- Know your jurisdiction. Says Spooner, "Realize that you can only investigate the people that the law allows." In the case of his office, that includes physicians, physician assistants and medical residents.
- Know your statutory authority. "For example, our board can authorize the use of subpoenas in aid of an investigation, but otherwise we don't have search warrant authority," says Spooner. "If you step outside the bounds of your authority, it can create all kinds of legal problems."
- Leave your bias at home. "This is otherwise known as maintaining your objectivity," says Spooner. "We all have our personal feelings about right and wrong. However, when it comes to the conduct committed by licensees, right and wrong is established by law, not by feelings."

To build a strong case, Spooner tells investigators they need to "clearly understand how misconduct is defined by statute. Then focus the investigation on proving or disproving each element of the misconduct." A laser-sharp focus becomes even more crucial in a budget-conscious era when boards are often asked to do more with less. "A lot of time is wasted investigating stuff that really isn't legally defined as misconduct," says Spooner. "All states are burdened with not enough staff and not enough resources. It does not help matters any when investigators stray away from what their authority is and how misconduct is defined by their state."

Ultimately, of course, the responsibility for deciding whether a given piece of physician conduct is actually misconduct rests with the board, not the investigators. However, the investigators are still crucial players, because it's up to them to collect the evidence on which the board's decision is based. Different states differ in the degree to which they take a police-like approach to evidence gathering. In Georgia, for instance, medical board investigators are sworn peace officers. "We have the authority to make arrests, execute search warrants, and work cases through the criminal process as well as the administrative process," says Lane. When there is a criminal angle to a case, they can collaborate directly with law enforcement in a way that investigators from most other states cannot. However, even in other states, Lane believes investigators may benefit from forging alliances with law enforcement agencies. For example, Lane gets the word out about who the medical board is and what it does by giving talks to local law enforcement associations and writing articles for local police journals.

At the Arizona Medical Board, a somewhat different philosophy prevails. As in most states, board investigators in Arizona are not sworn peace officers. Senior medical investigator Robin King, for one, prefers it that way: "I believe it's a much fairer system for the physician. When you go into an investigation with the idea that the doctor is a perpetrator and the patient is a victim, I think it sets you up for antagonistic interactions with the different parties." King's boss, board assistant director Barbara Kane, uses the term "clients" when talking about physicians under investigation. But while this softer approach might be anathema to hardliners, it still seems to get the job done. The number of prejudicial actions taken that year was more than double the number just four years earlier.[4]

ATTORNEYS AT LAW

Once the evidence has been gathered, it is time for the

attorneys to step in. Several boards have beefed up their legal staff in recent years.[5] For example, Texas' litigation team has grown from five attorneys in 2002 to 11 in 2004. The growth was necessitated by new legislation requiring that cases be resolved within a set time frame. In the past, a backlog had accumulated. "We were behind because the number of complaints was huge, and the staff was low," says Michele Shackelford, general counsel for the Texas State Board of Medical Examiners. With the additional staff, she says, "we got all of our backlog caught up in 2003." And although the cases just kept coming in 2004, "we're now able to get them out in a timely fashion."

New board attorneys, like novice investigators, are sometimes stymied by unfamiliar medical jargon. "I took several courses in medical terminology and in anatomy and physiology. I think it helps when it comes to reading medical reports and understanding what doctors are talking about," says Steve White, former chief of litigation for the Texas medical board. In addition, all boards have medical experts on hand to answer questions about medical practices and procedures. White says, "If you don't have a medical background, don't be afraid to ask the experts."

One way in which boards can stretch their legal resources is by prioritizing how they use their attorneys' time. In Texas, "we now have all our standard-of-care cases reviewed by a panel of two or three experts, at least one of whom has the same specialty as the respondent. It's no longer a single expert opinion saying this is below the standard," says White. "As a result, by the time standard-of care cases get to us, they're more likely to be clear violations of the Medical Practice Act."

Once a complaint is filed, most physician-respondents get attorneys of their own. Sometimes, the physicians' attorneys try to put up roadblocks for the board's legal and investigative staff. At this stage, "it's not unusual for an attorney to file a continuance, and we try to work with them on that," says Mari Robinson, manager of investigations for the Texas board. "However, while it's not the majority of cases, it's not uncommon for an attorney to still turn over records late or a physician not to respond at all." If a licensee ignores a subpoena, the Texas board will open a new complaint against the physician for failing to respond. "Eventually, we'll either get the information or we'll be at trial seeking disciplinary action for not turning over the information," says Robinson. If the person ignoring a subpoena is not a licensee, the Texas board refers the matter to the attorney general for prosecution.

In addition to using delay tactics, "some physicians' attorneys will try to divert attention from the licensee and his misconduct to the investigator and the caliber of his work," says Spooner. "During the course of a hearing, the licensee's attorney may start criticizing the manner in which the investigator handled a particular interview or wrote up a report." Spooner says the only surefire way to counter this maneuver is by making sure that your investigative technique is above reproach. "Maintain your objectivity, and always be professional," he advises. In addition, it is essential to follow proper procedures, keep scrupulous notes, and write clear, accurate reports.

CLEARING HURDLES

One problem that many board investigators face is the need to cover a large geographical area with a relatively small staff. In Alaska, for instance, there are only two investigators to cover an area almost one-fifth as large as the entire rest of the United States. "It is impossible to travel to all the locations from which complaints are generated," says Colin Matthews, senior investigator for the Alaska State Medical Board. "If there is a complaint involving sexual misconduct or some other very serious breach of patient boundaries, we will go to the complainant or conduct in-depth telephonic interviews." In other cases, however, the investigators rely heavily on certified mail. Despite the limitations, Matthews says, "what we do works well for us."

Texas not only is the second-biggest state by size, but also has the third-largest number of licensed physicians. To monitor more than 51,000 licensed physicians, nearly 40,000 of whom are currently in practice,[6] the Texas board has 21 field investigators scattered throughout the state. These investigators work out of their homes rather than a central office. Geographic proximity makes it easier for them to conduct face-to-face interviews or personally serve subpoenas. In addition, Robinson notes that investigators who live in the regions they cover "become familiar with the physicians there and know what's going on in the community."

Another problem faced by many boards is a limited budget. Some states try to overcome this barrier by pooling the talents of investigators for several boards. In South Carolina, for instance, a July 1, 2004, reorganization within the Department of Labor, Licensing and Regulation brought investigators from 16 health-related boards under one umbrella. Henry Morgan, chief of investigations for the new unit, says the change should cut out duplicated and

conflicting efforts. As an example, he cites a recent complaint involving two physicians and a nurse. In the past, two investigators — one from the medical board, and one from the nursing board — would have made the 70-mile trip to gather evidence, and both boards would probably have issued subpoenas for the same records. Now, a single investigator is handling the whole case.

In Colorado, board are refocusing from specialist investigators to generalists. Although board investigators there all work for a central office, in the past, individuals have tended to focus primarily on one board or another. Since early 2004, however, a new policy has been in place to discourage this kind of specialization. Linda Volz, program director for the Office of Investigations, says the policy allows for greater flexibility in distributing the workload. "I can depend on a lot of different people if something happens," says Volz. "If my regular board of medical examiners investigator is tied up and I get a priority case in, for example, I can depend on somebody else to take it up with little, if any, guidance." In addition, Volz says she hopes the change will reduce the impact of staff turnover. "If someone specializes and we lose them, we lose that expertise, and we have to start over from the ground up," says Volz. To prevent this situation in the future, "we're doing a lot of cross-training, so that all our investigators have at least a good basic knowledge of the practice acts of all the boards."

If there is one point that everyone seems to agree upon, it is that being a medical board investigator or attorney is a highly demanding job that requires considerable skill, motivation, and dedication. "In a very general sense, I estimate that it takes about three years for an investigator to really learn this job," says Joan Jerzak, chief of enforcement for the Medical Board of California. It can be a challenge for boards to find, train, and retain good investigators and attorneys. Yet the payoff in successfully resolved cases and stronger board actions is well worth the effort.

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SUCCESS STORIES

A board's investigative and legal team can make or break the case against a dangerous doctor. These examples illustrate the system at its best.

• In New York, one case involved a physician with an alcohol problem, who was clearly impaired but stubbornly resisted all recommendations for treatment. Eventually, the board had no choice but to summarily suspend her license. "When our investigator went to the physician's house to serve the order, he found a moving van in the driveway," says Spooner. Talking with the van driver, the investigator soon learned that the doctor was headed for North Carolina, where she also held a medical license. "When we found that out, we notified North Carolina and got our documents down to them," says Spooner. "Almost before the doctor was able to unpack the truck, the North Carolina board summarily suspended her license and stopped her from practicing there."

• In Texas, the medical board recently took on an orthopedic surgeon who has reportedly been sued for malpractice several dozen times. Among other things, it was alleged that this surgeon had performed numerous unnecessary operations. "Some of his patients had three or four back surgeries, none of which were really necessary, and there were a number of bad outcomes," says Steve White. "What made the case tough, however, is that almost all the surgeries had been approved through the workers comp system." Arguably, then, the surgeries had been deemed reasonable and necessary — even though most experts agreed that they actually weren't. To counter this argument, "we had multiple experts testify rather than just one," says White. He also stressed the quality of the experts' testimony. "Many administrative law judges don't have medical backgrounds, either," says White. "You have to educate the judges why this was unnecessary and why it was below the standard of care and put the patient in jeopardy."

THE ROLE OF LICENSING BOARDS IN THE EVALUATION AND DISCIPLINE OF THE EXPERT WITNESS

William J. Wenner Jr., M.D., J.D.

There has been an ongoing and increasing concern that the unregulated activities of expert medical witnesses are degrading both the legal system and the practice of medicine.[1,2]

Suggested solutions have included 1) greater oversight by physicians such as a) peer review of expert testimony,[3] b) local licensure for expert witnesses, c) mandatory membership in the medical society of the state of the trial; 2) greater oversight by attorneys, such as civil lawsuits; and 3) greater oversight by the judiciary (either through legislative mandate or common law opinion) such as a) court appointed experts as opposed to separate plaintiff/defense experts, b) changing the judicial standards to require a reasonable degree of medical certainty to meet a stricter standard, c) greater use of disciplinary sanctions and d) a stricter application of the standard commonly used in many state courts to determine if the opinion of an expert is legally valid, the Frye standard of generally accepted knowledge. Specific structural changes such as a public data bank of all expert medical opinions[4] and removal of the economic incentives to testify have also been proposed.[5]

Despite frequent discussion of corrective measures to assure reliable expert witness testimony, most suggested solutions have not progressed beyond the proposal and discussion stage and few have actually been implemented.[6,7] A primary reason for this failure to address the problem of unethical expert witnesses is that there has been no legitimate authority willing to perform the role of disciplinarian.

Recent news accounts have reported the disciplinary actions by a few medical boards against physicians for unprofessional testimony but the perspective of the boards in general has not been recently evaluated. In order to determine the current perspective of United States medical boards on expert testimony as the practice of medicine, a survey of the medical boards was conducted.

SURVEY

An e-mail survey was sent to the directors or chief counsel of the nation's osteopathic and allopathic medical boards. When necessary, the survey was followed up with phone contact. The questions included:

1) Does the board consider expert testimony to be the practice of medicine?
2) If yes, from where does the board derive the authority (nonspecific interpretation of "unprofessional conduct" or a specific legislative mandate)?
3) Has the board evaluated and/or sanctioned any provider for expert testimony during the past 5 years?
4) From whom has the board received complaints regarding expert testimony?

RESULTS

The survey generated varied response and reflected strongly held positions on the issue. Of the 70 medical boards, 37 (53 percent) provided answers to the survey while one expressed a desire not to participate and did not respond. Of the responding boards, 11 (30 percent) view expert testimony to be the practice of medicine and three (8 percent) are currently considering the issue and have not taken a position at the time of the survey.

The authority to define expert testimony as the practice of medicine could be either based on direct statutory definition or on an interpretation of "unprofessional conduct." None of the responding states had specific statutory authority but rather based their authority on the concept of unethical testimony as "unprofessional conduct." Three boards reported having disciplined an expert witness.

Many boards receive complaints about expert testimony, including boards that do not consider testimony as the practice of medicine. Many boards reported the majority

of the complaints came from other licensed physicians. Some boards reported both attorneys and lay public as sources of complaints about experts.

Previous Board Attitude

In 1997, Eitel et al published the findings of a similar survey of only allopathic medical boards.[8] The results, part of a larger review of physician attitudes towards expert witnesses, were similar to the results of this current survey, but show increasing acceptance of the premise that expert testimony is the practice of medicine and a medical board should fulfill the role of oversight and discipline.

In both surveys, more than 30 percent did not respond. It was not possible to determine if the non-responding boards were the same in both surveys. The number of boards that consider testimony to be the practice of medicine was similar (8 - 11).

Review of Board Experience with Expert Discipline

While a significant number of boards consider expert testimony to be subject to their review, few have disciplined physicians for unethical expert testimony.

In 1991, the Missouri State Board of Registration for Healing Arts sought review of a decision by the Administrative Hearing Commission that, even if the physician had given false testimony under oath while acting as a medical expert, giving of expert testimony by a nontreating physician was not considered to be the practice of medicine. The physician had falsely claimed he had passed the specialty boards on his second attempt when actually had required five. The Court of Appeals held that giving expert testimony was not "obtaining fees or other compensation by fraud, deception or misrepresentation" within the meaning of the statute allowing the board to bring disciplinary action against physicians. Because the physician did not "diagnose or treat the sick ... acting as a nontreating expert medical witness was not the practice of medicine."[9]

However, that same year, the Court of Appeals for the District of Columbia held the District of Columbia Board of Medicine could find that false testimony given by a physician acting as an expert in a medical malpractice action constituted a false report in the practice of medicine.[10] The physician had falsely testified he was a board certified thoracic surgeon and he had ranked first in his medical school class. In addressing the issue of whether expert testimony was the practice of medicine, the court held that examining X-rays and medical records were acts of "investigation and analysis of the nature of a patient's condition."

In 2002 the North Carolina Medical Board revoked the license of Dr. Gary Luftgarten, a Florida neurosurgeon, for unprofessional conduct during expert witness testimony in a medical malpractice suit in North Carolina. In 1998, Dr. Luftgarten testified for the plaintiff in a malpractice trial in North Carolina. The North Carolina board found Dr. Luftgarten repeatedly made factual assertions without an evidentiary or good-faith basis and misrepresented the applicable standard of care. The board determined this was unprofessional conduct and revoked his medical license (the revocation is currently stayed pending appeal).

Other professional boards also have disciplined licensees. The Examining Board of Psychology of the State of Washington disciplined Edward Deatherage, Ph.D., for bias and misleading testimony based upon allegations he did not verify the patients in a lawsuit by testing or interviewing prior to testifying in court. The board concluded that such conduct constituted moral turpitude relating to the practice of psychiatry. The Supreme Court of the State of Washington upheld the action of the board. It held that while the judicial immunity accorded witnesses in judicial proceedings prevented civil action against a witness, it did not include immunity from disciplinary actions based on the evaluations.[11]

DISCUSSION

Does Testifying as an Expert Constitute the Practice of Medicine?

Although state statutes, regulations and judicial opinions precisely determine what constitutes the practice of medicine, some general conclusions are possible based on facts and terms common to most states' regulatory authorities and activities. Although there are common foundations and striking similarities between expert testimony and the practice of medicine, they are not the same activity.

An expert witness forms an opinion on the application of scientific principles in diagnosing and treating physical diseases. The expert uses knowledge unique to a physician to analyze and "diagnose" the propriety of another licensed practitioner's actions. Such application of professional knowledge is similar to that of a second opinion. It is similar to filing a medical insurance report. Testifying is part of the sphere of actions associated with the practice

of medicine. It is the license to practice that enables the role of medical expert witness. As only practitioners can testify as to the standard of care and causation, expert testimony can be viewed, by its very nature, to be the practice of medicine. Courts might be inclined to defer to a board when it defines unethical testimony.[12] The meaning of "the practice of medicine" as the terms are used in statutes granting authority to boards includes the type of agency expertise and informed actions that courts often acknowledge as valid government agency actions.

However, legitimate arguments have been made that expert testimony is not the practice of medicine. These positions are frequently based on the perspective that testimony is not patient care, as it is an opinion based only on record review and without patient contact. Although it may involve diagnosis, it does not involve the actual treatment of a patient. At the time of the expert analysis the "subject" may not even be alive. Testifying is not part of a physician's "function" or "duty." It is not a moral or legal obligation, nor even an act expected of a licensed physician.

Even if the Testimony Constitutes the Practice of Medicine, Are Boards the Appropriate Forum for Evaluation and Discipline of Expert Testimony?

Licensing boards have a long history of unbiased evaluation of medical practice. A licensing board has the experience and the structure with evaluations and can guarantee due process. It would be a natural extension of a board's current activities for a board to assume the role of regulation of expert testimony.

Outside forces have been calling for boards to be more active in the traditional role of evaluation and discipline of actual patient care. Assuming new responsibilities such as regulation of expert witness testimony may consume scarce resources and lessen a board's ability to perform its primary functions. Determining that expert witness testimony is unethical is difficult, resource intensive, time consuming and often not definitive.

Although the survey found that the foundation of current board activity regarding the evaluation and discipline of expert testimony is based on an interpretation of current nonspecific regulations, a legislative or public mandate to perform this function would provide clear direction for boards. Such specific authority would also help protect against retaliatory civil action by those who have been disciplined. However, as noted below, legislatures have been slow to address the issue of expert witness regulation.

A board should consider if its assumption of the role of evaluation and discipline of an expert will undermine the public's confidence in the board as an unbiased, independent protector of health care. The medical profession has been accused of impeding appropriate civil action in the past.[13] Boards have been accused of not meeting the needs of the public due to acquiescence to the interests of the practitioners.[14] Involvement in such a controversial arena may result in accusations of bias and decrease public confidence in the board. To prevent such a perception of bias, a board might consider soliciting input from a plaintiff bar or trial lawyer associations.

The Judicial Role and Void as Disciplinarian

Outside of its role as gatekeeper of the courtroom,[15] the judicial system has not assumed the role of evaluation and discipline of the unethical expert witness. The expert witness is a vital but only a small part of the tort process. Although judges do evaluate experts for suitability in the judicial process, suitability of an expert witness by judicial procedural or evidentiary standards does not equate with suitability for the pursuit of a just and equitable outcome. Nor is judicial suitability entirely consistent with the purposes of society as a whole. Judges are experts in the field of law. They have no knowledge basis for questioning the testimony of an expert and must rely on other experts. Judges need help in screening experts.[16]

The judicial system is based on a foundational belief that truth is made evident through the adversarial system, and the adversary can expose and therefore render impotent the unethical expert. However, through its faith in and support of the adversarial foundation, the judicial system may protect the unethical witness. Most jurisdictions provide immunity to expert witnesses,[17] and such immunity often is absolute. Although some jurisdictions do specifically exempt fraudulent and grossly negligent testimony from immunity, the standards required to establish fraud or negligence are high and difficult to prove. Historically, this has had the purpose of encouraging participation in the legal system.[18] There is no reason to believe this immunity will be modified to lessen the impact of the unethical expert witness on the health care system. Therefore, many believe that the legal system is either incapable or hesitant to respond to the continued problem of unethical expert witnesses.

The Legislative Role and Void

While many states have considered or enacted tort reforms, none have attempted legislative regulation and discipline

of the unethical expert witness. There has been no analysis on why legislatures have not addressed the issue. However, it is possible that either lack of awareness, influence of powerful lobbies or even desires to avoid a politically sensitive issue are responsible for the legislative inaction.

A statute exists in at least one state that prohibits the use of a false permit, license or diploma and may be interpreted to prevent misrepresentation of credentials.[19] The implementation and effectiveness of this statute on unethical expert testimony has not been documented.

The Medical Professional Void and Recent Non-Board Response

Expert witnesses were shunned early in the medical profession's history; and the modern medical profession has, until recently, avoided the role of disciplinary oversight of the unethical medical witness. During the past few years, perhaps in response to the failure of the legal system to discipline unethical expert witnesses and the growing impact of such unethical witnesses on the ability to care for the public, the medical profession has begun to fill the role of evaluation and discipline.

The American Medical Association (AMA) has adopted the position that expert testimony in a legal proceeding is the practice of medicine. The AMA has further encouraged state licensing boards to develop effective disciplinary measures for physicians who provide fraudulent testimony.[20] Numerous professional organizations have adopted a similar position and developed guidelines for expert testimony.[21,22] One organization, the American Association of Neurological Surgeons (AANS), has evaluated about 50 members for improper testimony and, on 10 occasions has, disciplined those members who have given testimony the AANS determined to be unprofessional or unethical. One sanctioned physician expert brought a lawsuit against the AANS. However, the authority of this organization to discipline unprofessional testimony has withstood the accusation of tortuous interference from a disciplined surgeon. The 7th Circuit U.S. Court of Appeals upheld the authority of the organization to discipline its members for unethical testimony.[23] Judge Posner said, "This kind of professional self-regulation rather furthers than impedes the cause of justice."

However, professional organizations are voluntary organizations and therefore may be unable to effectively discipline wayward experts who do not belong to a professional organization. If expert testimony is truly part of the practice of medicine, then the regulation and oversight of expert testimony will need to be performed by the medical licensing boards.

CONCLUSION

Despite increasing concern about the impact of unethical expert testimony and the failure to address the issue, no legitimate authority has assumed the role of evaluation and discipline. A minority of medical licensing boards consider expert testimony to be the practice of medicine and therefore under its jurisdiction for evaluation and discipline. The number has slightly increased since the last survey but the majority of boards have not expanded their oversight activities to this area.

The expertise at administrative evaluation of the practice of medicine and the acknowledged fairness of a state licensing board makes it a natural authority to perform these functions. The need for public or legislative mandate remains unanswered and the allocation of adequate resources remains unfulfilled.

The perceived failure of the judicial and legislative systems to resolve the problem and the assumption of a role by professional groups such as the AASN may stimulate greater involvement by state licensing boards in the evaluation and discipline of expert witnesses.

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TACKLING THE DOCTOR SHORTAGE IN ONTARIO, CANADA

The College of Physicians & Surgeons of Ontario

It is now the rule, not the exception, to live in a community that does not have enough family physicians to care for all its citizens. In hospitals, the situation is just as grim, with difficulties staffing emergency departments and long waiting lists for specialist services.

Numerous factors have contributed to this province-wide physician shortage and the statistics projected for physician availability during the coming years are not encouraging. In fact, further decreases in the number of family physicians and specialists are anticipated over the next decade.

The College of Physicians & Surgeons of Ontario (College) believes decisive action must now be taken in addressing the doctor shortage. To that end, Council has drawn up a list of recommendations increasing the number of physicians who can practice in Ontario.

"The College's top priority is to tackle the doctor shortage to ensure that the citizens of Ontario have access to quality health care," said Dr. Barry Adams, president of the College. "We are committed to reducing barriers to the recruitment, registration, training and education of doctors in this province."

The College began developing strategies to provide greater opportunities for physicians to qualify to practice in this province as early as 1998. However, the College is concerned the momentum created by recent successes will be lost unless further, more aggressive, action is taken. The recommendations in this article build on the significant work done by previous task forces.

"Tackling the Doctor Shortage" identifies areas where action can be taken to deal effectively with the physician resource challenge.

For example, the supply of physicians in Ontario could be significantly improved by expanding the number of assessment and training positions for international medical graduates.

"It is key to make sure that we have an assessment process that is accessible and fair, coupled with enough training positions to accommodate all successful candidates," said Dr. Adams.

The report also includes a number of recommendations to introduce more flexibility in recognizing equivalent examinations and certifications and urges government to plan effectively for future supply and demand by appointing a Health Human Resource Planning body.

"We have worked from the premise that all solutions must maintain our existing standards of registration. We believe that the solutions we propose will not compromise the high-quality care Ontarians expect and deserve from their health care providers," said Dr. Adams.

SOLUTIONS: TACKLING THE DOCTOR SHORTAGE

Significant steps have been taken to increase the supply of physicians in Ontario. While each accomplishment will help to increase patient access to Ontario doctors, the shortage is so severe in scope that far greater action is warranted.

We urge the government to consider the following:

- Assess the qualifications of all international medical graduates;
- significantly expand available training opportunities;
- maximize existing resources and eliminate existing barriers; and,
- plan for the future.

I. ASSESS QUALIFICATIONS OF INTERNATIONAL MEDICAL GRADUATES

Ontario has hundreds of physicians who have immigrated to this province with a medical degree from a non-North American school and are unable to practice here. There are also approximately 200 Ontarians who graduate each year from medical schools outside of Canada. Both groups are needed in Ontario and have been frustrated by the lack of available assessment opportunities to enable them to qualify to practice here.

Recommendation #1: Assess All IMGs

Assessment opportunities should be made available for every eligible international medical graduate (IMG) who lives in Ontario and for Canadian citizens who have completed medical training abroad. This assessment should set a fair and transparent standard using objective methods, and successful candidates should be provided with an assessment/training position in an Ontario program.

Eligible international medical graduates have educational degrees and practice experience in other countries. Because of the huge variations in international education standards and in medical practices across jurisdictions, it is impossible for the College, simply by looking at credentials, to determine whether the skills of IMG applicants meet Ontario expectations for quality of care. Accordingly, most IMGs must undergo testing and assessment equivalent to those undertaken by all Canadian graduates to certify the level of their skills.

Ontario continues to have too few available spots for assessment of IMGs. Currently, there are only 50 specialist assessment positions available each year. In addition, the current assessments rank candidates in relation to others, and only the top achievers are eligible to continue with their training.

Many IMGs may meet acceptable clinical standards and are willing to upgrade their training, but they are ineligible because others scored higher on the testing and because of the limited number of training positions available. Furthermore, the candidates themselves cannot determine whether they have deficits in their knowledge and, if so, where those deficits may be.

In order to maximize use of this potential human resource, it is critical that within the next two years,assessments be made available for all IMGs who meet simple eligibility criteria. The assessment itself should rely on validated tools for evaluation and the detailed results should be available to the candidate. There should also be enough training positions to accommodate all successful candidates.

Access to additional assessment and training opportunities should be facilitated through the Ontario International Medical Graduate Clearinghouse.

Addressing the potential backlog of IMGs who may be capable of providing quality care to Ontario residents in this fashion would satisfy the frustration experienced by the IMG community related to the uncertainty of the current assessment process.

Assessment and training positions should also be made available for Ontario students studying at international medical schools who wish to return to Ontario.

II. SIGNIFICANTLY EXPAND AVAILABLE TRAINING OPPORTUNITIES

Expanding training opportunities for international medical graduates is a key element of the physician resource solution. While training positions for undergraduate and postgraduate programs have been increased over the past few years, more positions are required. In addition, training opportunities must be provided for IMGs as they move through the assessment and training processes in order to help ensure their success and understanding of Ontario's health care system.

Recommendation #2: Help IMGs Become Familiar with Ontario Practice Settings and Procedures

Develop guidelines to encourage IMGs to engage in observation of patient care (shadowing) in a clinical setting with members of the College.

Candidates for registration who are already in the province would be better prepared for assessments if they were able to gain experience by observing the work of Ontario physicians in a clinical setting. There is, in fact, no barrier to this taking place now. However, many physicians are reluctant to allow IMGs into such a setting because they are concerned that doing so would breach College policy.

The College proposes to disseminate guidelines that would make it clear that such arrangements are permissible. The guidelines would include a requirement of patient consent, a confidentiality agreement from the

IMGs, and a stipulation that the supervising physician is responsible for the IMG's actions at all times.

Recommendation #3: Develop Web-based Legal and Ethical Training Tools for IMGs

In conjunction with all stakeholders, facilitate the development and implementation of web-based educational and assessment tools to teach legal and ethical issues and language and communications skills to potential Ontario physicians.

As discussed above, the training and practice experience of IMGs is often very different from the practice of medicine in Ontario. This extends to the ethical and legal aspects of practice, as well as to clinical performance. The College proposes that, to assist IMGs to prepare for assessment in Ontario, web-based legal and ethical training tools should be developed that IMGs could use on their own time.

Recommendation #4: Increase Postgraduate Training Positions

On a long-term basis, the postgraduate training capacity be increased to a factor of 1.2 times the number of students graduating from Ontario medical schools, in addition to an increase for the next two or three years to accommodate everyone qualified for the proposed assessment and training opportunities.

The primary factor leading to the dramatic decrease in production of physicians (in combination with the decreased medical school enrollment) was the decrease in postgraduate training positions. There were only enough spots to accommodate Ontario graduates. Consequently those from other jurisdictions, or those who were practicing in Ontario but wished to change fields, had to compete with new graduates for residency positions.

While the number of post-graduate training positions has recently been increased, there is still a shortage of positions in relation to potential candidates. The number of training positions must be increased to accommodate more candidates. This initiative should be considered complementary to, and not a substitute for, the other recommendations in this paper.

III. MAXIMIZE THE USE OF ALL EXISTING RESOURCES AND ELIMINATE ANY EXISTING BARRIERS

The College believes that, even within the province, we can make better use of the resources that we have. In some cases, improvement may be as simple as changing a regulation. In other instances, enhancements will require a strong concerted effort from all stakeholders.

Recommendation #5: Facilitate Movement Between Fields of Practice

Introduce more flexibility in the process by which candidates both select and are allowed to switch postgraduate training positions.

In the past, many specialties relied on receiving either students transferring from generic training programs or experienced family practitioners applying to train in specialty fields, rather than accepting only candidates directly from undergraduate medical school. The ability of family practitioners to make this transition has been severely weakened in recent years. As a result, students who are not certain about their ultimate career paths choose to pursue specialties, from which they can more easily switch back to family practice if they later decide on that career path. This policy shift appears to have exacerbated the marked decrease in the number of students selecting family practice.

While this problem has been partially addressed by an increase in the availability of re-entry positions, the conditions on re-entry continue to serve as a barrier. The College recommends a further increase in the number of training positions for this sub-category of candidates, as well as a careful analysis of the accreditation system currently in place. In the College's view, the practice of family medicine may be undervalued and may warrant increased recognition in relation to specialty training requirements.

Recommendation #6: Recognition/equivalency of Screening Examinations

a) Explore recognition of the Unites States Medical Licensing Examination (USMLE), National Board of Osteopathic Medical Examiners (NBOME), Federation Licensing Examination (FLEX), Educational Commission for Foreign Medical Graduates (ECFMG) and Comprehensive Osteopathic Medical Licensing Examination (COMLEX) immediately as equivalent to the Medical Council of Canada Qualifying Examination (MCCQE) for purposes of registration.

The College believes the standards set by these examinations are equivalent to our own Ontario standards. Accordingly, we should recognize them as such and

require no further training or assessment of applicants who hold these qualifications.

b) Develop a process to evaluate screening examinations from a variety of jurisdictions to determine whether they are equivalent to those in Canada.

The College is aware there is a pool of well-trained competent physicians who wish to practice in Ontario but whose training and education comes from institutions whose standards are unknown to us. Rather than require such individuals to repeat testing and training, a more efficient way of determining whether such physicians meet the standards expected in Ontario would be to look closely at their education and training and determine whether it is equivalent to programs that the College already recognizes. This should be done in collaboration with other stakeholders.

Recommendation #7: Allow for Registration of Physicians in Practice Outside of Ontario Who have met Ontario's Standards in the Past

Create an entry pathway for physicians who were eligible for registration in the past, but whose eligibility was lost as a result of changing regulations.

There are a number of physicians who are practicing in other Canadian jurisdictions who would have qualified for an Ontario certificate of registration had they applied prior to 1992 but who do not qualify under today's regulations. These are primarily family physicians whose education included a rotating internship, which is no longer part of the Ontario medical education process. These physicians are welcome in other provinces and a significant number of exemplary physicians in Ontario have precisely these credentials.

The College is willing to amend its regulation/policy to facilitate the re-entry of this population into Ontario. To guarantee quality of care, there should be a mechanism to assess candidates prior to their receipt of an unrestricted certificate of registration.

Recommendation #8: Develop a Process to Recognize Specialists

a) Develop a process to recognize specialists who have specialty certification in their own jurisdictions and training in Accreditation Council for Graduate Medical Education (ACGME) recognized programs equivalent to Royal College requirements.

Under our current system, physicians recognized as specialists in the United States are not recognized as such in Ontario. In order to receive specialty designation in Ontario, these individuals are required to successfully challenge the certification examination of the RCPSC. Having to complete these requirements is a deterrent for specialists who might otherwise wish to practice here. Academic centers benefit from the expertise of specialists from other jurisdictions through the academic registration certification.

Similarly, physicians in Quebec may take specialty examinations and training equivalent to the RCPSC requirements. Currently, their qualifications are not recognized in Ontario.

The College proposes that our registration standards would not be compromised if we assured ourselves a physician recognized as a specialist in the United States had received training equivalent to that required by the RCPSC and have been successful in their ABMS examination. This applies equally to those Quebec physicians who fall into the category described above and have been successful with the Quebec exam.

The College could amend its regulation/policy to facilitate the recognition of this population. To ensure quality of care, there should be a mechanism to assess candidates prior to their receipt of an unrestricted certificate of registration.

b) The CPSO should develop a process to recognize specialty training from non-American Council for Graduate Medical Education (ACGME) approved programs. The CPSO should develop a mechanism to recognize physicians certified as specialists in their country of practice whose training was completed in a program accredited by the Royal College of Physicians and Surgeons of Canada (RCPSC).

The RCPSC has assessed a number of residency programs and deemed them to be equivalent to Canadian standards.

The College proposes individuals whose training took place in an RCPSC-recognized program be considered for eligibility to practice in Ontario and to be recognized as specialists. To ensure quality of care, there should be a mechanism to assess candidates prior to their receipt of an unrestricted certificate of registration, and to ensure the validity of this new policy, an appropriate follow up would need to be undertaken.

Recommendation #9: Develop a Process to Register Specialists Recruited to Practice in Academic Health Sciences centers

The Academic Health Sciences centers (AHSCs) should develop a mechanism acceptable to the College to assess physicians who are specialists in their country of practice who wish to come to Ontario and practice in an AHSC and who do not currently meet the criteria for academic registration.

There is a population of physician specialists currently in practice under academic registration whose certificates of registration will expire within the next few years. These individuals have been practicing in Ontario under supervision and there is no doubt about the quality of care they provide. Requiring these people to undergo the usual process to receive an Ontario certificate of registration could be seen as duplicative, since their capabilities in known settings could, if made explicit, provide a basis for the recognition of their full status. This recognition would avoid a cumbersome process that would be a disincentive for these physicians to remain in Ontario. It is possible to ensure practice performance in the absence of usual credentials.

The College is prepared to provide a certificate of registration permitting successful candidates to practice within the scope of their specialty if a satisfactory assessment process can be developed and implemented.

Recommendation #10: Allow for Restricted Registration for Residents

Introduce a two-year pilot program allowing residents to provide service on a remunerated basis outside their educational program.

Ontario residents are another valuable human resource whose full potential has not yet been realized. Over the last several years, there has been extensive discussion about residents working additional shifts for compensation. The Physician Resources Task Force has recommended that residents be permitted to work, for pay, outside their training requirement.

The College notes it is crucial that neither patient care nor the education of the residents be compromised. In order to protect these interests while tapping this potential resource, the College proposes that a two-year pilot project be undertaken to permit resident moonlighting under limited conditions.

Recommendation #11: Consider Developing and Implementing a Physician Assistant Program

a) The government of Ontario should facilitate liability insurance funding for physician assistants.

Based on the recommendations of the Physician Resources Task Force, a pilot project was funded to allow international medical graduates to qualify and work as physician assistants in supervised practice settings. This had the benefit of increasing the human resources available to health care delivery, as well as giving IMGs experience in Ontario health care settings that might ultimately assist them in meeting criteria to gain certificates of registration to practice medicine independently.

To qualify as a physician assistant, a candidate would be required to hold a degree in medicine, to have completed the Medical Council of Canada Qualifying Examination, and to receive an objective assessment in an academic environment.

When an attempt was made to implement the project, it was found that liability insurance was not available for this group. As a consequence, the institutions prepared to accept physician assistants could not do so. Liability insurance is an absolute necessity for participation of physician assistants in our health care system.

The College recommends that the government ensure liability insurance is made available for these positions.

b) In the long term, the College should consider creating a registration category for physician assistants.

If the pilot program is successful and a consensus can be achieved with respect to a defined scope of practice, training programs and stable funding, the College should consider creating a category of registration for physician assistants.

IV. PLAN FOR THE FUTURE

The 1990s serve as a powerful reminder of the importance of being able to reasonably forecast physician numbers. In approximately 10 years we went from a projected physician surplus to a physician shortage. We believe that new tools are necessary to monitor the physician human resource situation, as well as that of other health professionals, to ensure that future needs can be met.

Recommendation #12: Create a Health Human Resources Planning Body

The College recommends that the Minister of Health should immediately establish and appoint a Health Human Resource Planning body.

With the benefit of a strategic forecast of physician human resource needs, government, universities and the health care profession licensing bodies will all be in a better position to ensure that we have the facilities and resources to educate, assess and register health care professionals in the future.

Recommendation #13: Establish the Goal of Sustainability of Physician Resources in Ontario

The province should establish a goal of sustainability of physician human resources.

To ensure Ontario has an appropriate supply of physicians, planning for an infrastructure must take into account those who will be educated in Ontario and those who will choose to move to Ontario from another province, immigrate or return to Ontario from the country of their training. The processes must be equivalent for all physicians. There should be an assessment of, and sufficient funds for, training positions from all streams, including an increase in the number of positions in medical schools as well as an increase in the capacity to evaluate those trained elsewhere.

In addition to considering the number of individuals entering the practice of medicine in Ontario, the infrastructure planning process needs to take into account those physicians who will leave the practice of medicine altogether and those who choose to leave Ontario to practice elsewhere.

Recommendation #14: Link Training Positions to Physician Resource Needs

The Health Human Resources Planning body should take, as one of its priorities, a strategic approach to the funding allocation among specialties for training positions.

One of the problems facing Ontario health care today is the balance of physicians choosing one area of practice over another area of practice. Much of the attention is focused on the shortage of family physicians, but some specialty fields are also in a crisis situation and projections suggest serious under-representation of other specialties is expected in the near future.

Rather than addressing these problems of resource allocation by shifting the number of training positions available at any given time, the College recommends that the Health Human Resources Planning body analyze the needs of the health care system over the long term and come up with a rational, multidimensional basis for the allocation of training positions.

Recommendation #15: Evaluate Alternative Delivery of Care Models

Alternative care model delivery also should be evaluated.

We recognize we may never be able to replenish the physician complement to levels previously enjoyed. More importantly, the College of Physicians and Surgeons of Ontario recognizes our health care system is changing to the degree that delivery of care no longer takes place through exclusive individual domains of practice but through multidisciplinary teams. Accordingly, we need to address delivery of care from the perspective of access to health care for patients in a multi-disciplinary environment, rather than just by physicians.

The College is prepared to evaluate and change its regulatory framework to ensure regulation methods of the past are not standing in the way of new and better modes of health care delivery.

Finally, the College urges government to consider that, due to changing practice patterns, the provision of primary health care may incorporate providers in addition to family physicians or general practitioners. Planning for future physician human resource needs must take into account the degrees to which specialists, like pediatricians or internal medicine specialists, provide primary care.

CONCLUSION

Solutions to the physician supply problem are complex and require the commitment and cooperation of a number of key players in the health care system. The College is ready to do its part and challenges the government of Ontario and its other partners in the enterprise of doctor resource management to do the same.

The government should take immediate steps to provide assessment and training opportunities for eligible international medical graduates. Clearly other stakeholders, including the College, have important roles to play here as well. We pledge to do our part to ensure that our processes are transparent and responsive.

PROGRESS TO DATE

Tackling the physician resource challenge is a top priority of the College. Beginning in 1998, the College began working with the Council of Ontario Faculties of Medicine (COFM) to find ways of assessing and training international medical graduates (IMGs) so that they could practice in Ontario.

The result of this collaboration was development of an Assessment Program for International Medical Graduates (APIMG) and a process for academic registration under which qualified candidates who would not otherwise be eligible for a certificate of registration are permitted to work in academic centers in medical education and research.

Since May 2002, 82 candidates have been accepted into the APIMG program. Thirty of these have successfully completed their assessments and are now in practice in Ontario communities. Fifty-two are still in the assessment or training phase of the program.

Between Feb. 2002 and Dec. 31, 2003, the College approved 100 applications for academic registration. As a result of this program, 182 physicians are now practicing or will be soon. In total, approximately 800 IMGs have begun practicing medicine in Ontario during the past five years.

The College Council identified the physician resource issue as a top priority and goal in its strategic plan. In pursuit of this goal, the College facilitated the creation of the Physician Resources Task Force.

The Physician Resources Task Force is comprised of representatives from the Ministry of Health and Long Term Care (MOHLTC), Council of Ontario Faculties of Medicine (COFM), Ontario Medical Association (OMA) and the CPSO. The Task Force has heard presentations from the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, the Professional Association of Internes and Residents of Ontario, the National Task Force on IMG Licensure, and the Association of International Physicians and Surgeons of Ontario.

In 2002, the Task Force produced 15 recommendations aimed at reducing barriers to the recruitment, registration, education and training of physicians in Ontario. The government of Ontario has publicly supported eight of the Task Force's recommendations.

Following is a summary of action that has been taken to date to implement the recommendations of the Task Force:

- A clearinghouse has been created to assist physician applicants through the registration, credentialing and assessment process;
- The number of postgraduate training programs has increased, allowing some qualified candidates access where positions were previously unavailable;
- The government of Ontario has increased funding for educational and infrastructure capacity to support the increase in the number of training positions that have been approved (medical school enrollment increase);
- The College has established an assessment and quality assurance program to provide accelerated registration for physicians who are currently in practice in other jurisdictions and wish to practice in Ontario;
- The College has established a policy to recognize non-family medicine specialists who have met critical educational and practical criteria but have not received the Royal College of Physician and Surgeon's specialist designation.

The Physician Resources Task Force continues to develop workable solutions to the physician resource challenge. The task force is also helping to implement initiatives that have been announced by government.

"Tackling the Doctor Shortage" originally appeared in the May/June 2004 issue of *Members' Dialogue*, published by The College of Physicians & Surgeons of Ontario.

ALBERTA, CANADA
COUNCIL HIGHLIGHTS

The Council of the College of Physicians and Surgeons of Alberta (CPSA) met May 28, 2004, in Edmonton. Some of the more significant items included:

Information Sharing

The Council approved, in principle, a report addressing responsible sharing of information among health professionals. The document was developed by a working group of the CPSA, Alberta Medical Association, Alberta College of Pharmacists and Alberta Association of Registered Nurses (with input from Alberta Health and Wellness, the Office of the Information and Privacy Commissioner and an ethicist from the University of Alberta). The approved document will be circulated to other health professionals for their consideration.

This document will establish a framework for the development or revision of formal CPSA policies or guidelines in this area.

Cosmetic Services

Following direction from Council and input from the profession, a working group reviewed the issues and debates surrounding cosmetic services. The Council approved, in principle, a number of policy recommendations identified by the working group surrounding advertising, consent for treatment, follow-up, training and informing the public.

The recommendations will be available on the CPSA website at http://www.cpsa.ab.ca/cosmetic_services_recommendations.pdf or by contacting the CPSA office, after July 1, 2004. More information on this issue will be distributed in future issues of *The Messenger*.

Revalidation

Revalidation is the term given to the process by which all physicians demonstrate their continued fitness to practice as a condition of remaining licensed.

With increasing discussions across Canada about invoking revalidation requirements, Council discussed the issues that would need attention — from what should be assessed and the content of a revalidation program to how it would be communicated and funded.

The Council sees the issue of revalidation as an opportunity to improve quality of care but will continue discussions to better understand its value.

Mandatory Performance Review

The Council discussed the concept of physician competency assessment that would be triggered by age. In Ontario and British Columbia, peer review programs target "at risk" physicians, including physicians beyond a certain age. Council directed the Secretariat to explore this concept further and report back to Council at its December meeting.

Certificates of Standing

The Council supported a policy to refine the information disclosed on a certificate of standing.

The most significant change is that the certificate will indicate whether the physician is the subject of an open complaint. Currently, only published disciplinary information is provided on these certificates. The College does not currently, and will not in the future, provide information about complaints that have been closed. The certificate of standing will state only that the physician is the subject of an open complaint. Details will only be provided to the requesting body at the consent of the physician.

COMPLAINTS AND DISCIPLINE AND THE HEALTH PROFESSIONS ACT

During the next 12-18 months, the medical profession will move from under the authority of the Medical Profession Act (MPA) to the Health Professions Act (HPA), a new omnibus legislation for all health professions.

Prior to being implemented for the College of Physicians and Surgeons, the Act will go through various stakeholder review processes, with final approval by the Alberta legislature.

When the College begins to operate under the HPA, a number of changes to our complaints process will occur. We will still require a written and signed letter of complaint in order to begin an inquiry. However, instead of an Investigation Chair — a member of College Council appointed annually by the Council — the College will have a Complaints Director. The Director will be a CPSA staff member who will receive and review all complaints.

Under the current MPA, the Investigation Chair has two broad options: 1) dismissal of a complaint or 2) referral to hearing before an Investigating Committee.

In practice, however, the College's complaints process is more complex and flexible. We regularly use informal resolution processes to review and resolve complaints. This may include meetings with the complainant and respondent physician to craft a mutually acceptable outcome, a process that has been extremely successful to date.

Under the HPA, the complaints process is more precise and prescriptive. For example, the Complaints Director (CD) may:

- Encourage the complainant and physician to communicate with each other and resolve the complaint.
- Refer the matter to the Alternate Complaint Resolution process.*
- Request review of the subject matter of the complaint by an expert (i.e., expert opinion).
- Request that the matter be formally investigated.*
- Dismiss the complaint if it is deemed frivolous or vexatious.
- Dismiss the complaint if there is no or insufficient evidence of unprofessional conduct.
- Direct that the physician undergo a mental or physical health assessment if there are grounds to believe the physician may be incapacitated.

The advantages of the HPA include:

- The ability to dismiss frivolous and vexatious complaints at a very early stage (an ability we do not have now).
- The potential to have a complainant and physician resolve the matter without College involvement.
- The opportunity to use a formal alternate complaint resolution process to address complaint issues. The HPA allows a wider range of options at the initial stages of complaint resolution. How the process then plays out will be the subject of future articles.

* The HPA has detailed sections outlining the process of alternate complaint resolution and investigation as referenced above. These will be explained in future articles in *The Messenger*.

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BRITISH COLUMBIA, CANADA
HOW CAN THEY FIND YOU?

The College of Physicians and Surgeons of British Columbia recently received an expression of concern from a consultant pathologist which focused on the difficulties that he encountered in contacting a physician who had ordered some blood work on a patient, but who was then unavailable to receive the results.

A young woman presented to a community laboratory late in the afternoon and was found to have very low hemoglobin [30 g/l]. By the time the result was verified, the walk-in clinic she had attended was closed and the pathologist found there was no after-hours contact number for the clinic or for the physician that the patient had seen in consultation. The patient herself had, in the meantime, left the laboratory and it was with great difficulty that the consultant pathologist was able to obtain her cell phone number from her place of work. The patient was eventually contacted and directed to attend the nearest emergency room where she was transfused and a gynecological consultation was undertaken.

While the outcome in this case was a satisfactory one, the Executive Committee of the College would remind the profession that after hours availability is an essential part of professional care. The situation could have been avoided if the clinic had complied with the professional requirement for physicians to establish a call rota and mechanism for after-hours availability. An obligation to provide continuity of care is inherent in every medical encounter.

DO NOT RESUSCITATE

It is clear from some of the complaints received by the College that many members of the public do not understand "Do Not Resuscitate" orders.

On the one hand, some people believe that their loved one will be neglected by the profession and that no meaningful further treatment will be given. On the other hand, some believe that the patient is being denied the miraculous procedure seen on television where the application of a defibrillator restores instant recovery without a hint of harm.

Discussion of DNR with the patient and the patient's family must dispel these illusions. The futility of resuscitation attempts if the collapse is not witnessed, and the inappropriateness of such attempts if the patient is at the end-stage of an untreatable disease process, should be pointed out.

Advanced old age is not in and of itself sufficient reason to consider a DNR designation, but many of the very elderly have chronic conditions that may make them proper candidates for a DNR status.

It is helpful to outline the various steps taken during a resuscitation and the possible complications and end results. The Vancouver Hospital has produced an excellent detailed document on this important topic.

DISPOSAL OF PATIENT INFORMATION

Periodically, the College receives complaints about physicians who have failed to take appropriate care with respect to patient information. Concerns can arise in a variety of circumstances, including relocation of medical offices or disposal of old files.

More recently, the College received concerns regarding a physician who was inappropriately using residential dumpsters for the disposal of his office garbage. While that was inappropriate in itself, the situation was exacerbated by the fact that, inadvertently, the garbage included items that contained patient information. For example, there were empty prescription bottles, requests for gynecological cytology, day sheets, faxes and incomplete patient sheets. The security of patient information is the responsibility of the physician. In this particular case, the physician acknowledged his conduct was unprofessional, admitted that he had failed to protect patient confidentiality, and accepted a formal reprimand on his professional record.

Aside from the inappropriate disposal of garbage in other individuals' dumpsters, this case highlights the importance of ensuring that any items discarded by physicians and their staff do not contain any patient-sensitive information. Physicians should ensure appropriate arrangements are made for the disposal of patient information.

FROM THE ETHICAL STANDARDS AND CONDUCT REVIEW COMMITTEE

Kickbacks

The College was informed that an orthotics supplier was offering physicians an "incentive program" to reward those who referred patients to him. This is a kickback and a conflict of interest. Any physician participating in such a program would be contravening the Conflict of Interest guidelines of the College. The guideline states, in part, that a member of this College is in conflict of interest if he or she "accepts a commission or rebate of any sort, including gifts, from any third party who renders a service to the member's patient."

The orthotics supplier quickly responded that he meant the "incentive program" for patients and not for physicians. Nevertheless, the caution written above stands. The offer to physicians was ambiguous.

Draft Copies

A physician was embarrassed when a draft of a report was circulated prematurely. The draft contained two paragraphs that were critical of another professional. It was decided by the physician that these two paragraphs were irrelevant to the main issue of the report and should be deleted. This was done and the final report sent off. Unfortunately, a copy of the original draft had arrived first and greatly upset the other professional. Be careful with draft documents and mark each page with DRAFT — NOT FOR RELEASE.

MAKE SURE IT IS SEALED

As the psychiatrist who received a misaddressed ultrasound report said, "The upsetting thing was that the envelope it came in was unsealed. Anyone could have read it." An error in an address can and does happen, but there is no excuse for putting an unsealed envelope that contains a sensitive report in the mail.

FROM THE SEXUAL MISCONDUCT REVIEW COMMITTEE

The Sexual Misconduct Review Committee recently reviewed a case that caused significant distress for a patient as well as considerable stress and cost in time for the physicians involved. The Committee determined much of the anguish for all of those concerned could likely have been prevented if the attending physician had personally introduced the resident at the first encounter with the patient, and if the resident had an identification tag readily visible to the patient. It is important that medical students and residents are introduced to patients, and that patients are given an opportunity to express any concern they might have about being examined by individuals other than the physician with whom the appointment was made.

MEDICAL-LEGAL LIAISON COMMITTEE

The Medical-Legal Liaison Committee is a committee which meets two or three times per year to mediate or attempt to adjudicate concerns and disagreements between members of the legal profession and the medical profession. The Committee has representation from the BCMA, the Law Society, and the College of Physicians & Surgeons. The matters reviewed include disagreements about fees for professional services such as medical/legal letters, court appearances, expert testimony, and the like. The Committee's advice and suggestions are non-binding but are an attempt to find common ground for resolution of these disagreements. The May issue of the *BC Medical Journal* included a detailed description of the Committee and its function and readers may wish to review that publication for more detail.

The Committee has been chaired for many years by Mr. Jack Webster, Q.C., a Vancouver lawyer. The Committee members and the respective organizations that they represent are grateful to Mr. Webster for his expertise and guidance in resolving many of the issues placed before the committee.

CHRONIC PAIN PATIENTS

Inappropriate treatment of patients with substance abuse is a recurring reason for complaint to the College. Patients with chronic pain syndromes, e.g., chronic abdominal pain, chronic pelvic pain, chronic daily headaches, fibromyalgia, often have developed dependencies on analgesics. In many cases, one of the reasons for their chronic pain is the dependence itself, resulting in such symptoms as chronic daily headaches.

Frequently, the patients with these complicated problems are referred to specialists. The patient often does not disclose the full extent of medication use, and the consultation then becomes flawed as a significant underlying problem has been concealed. Part of this problem could be avoided if the referring physician made the specialists aware of all the medications and the doses that the patient is taking.

When a patient enters recovery, a frequent result is a complaint to the College alleging the previous inappropriate management of his or her symptoms and the careless way in which potentially addictive medications were prescribed.

Reprinted from the spring 2004 and summer 2004 issues of *College Quarterly*, published by the College of Physicians and Surgeons of British Columbia.

MANITOBA, CANADA

OCCUPATIONAL HEALTH PHYSICIANS AND PATIENT INFORMATION

Members should note Guideline #117, The Physician Medical Record, has been amended to include information about a patient's occupational health record. The following information was approved:

- "Occupational health records must be kept separately from general medical records in order to ensure the integrity of the occupational health record.

- Occupational health records must continue under the authority of the Occupational Health Physician and must be transferred only to a named successor.

- Information from an occupational health record must be released to the employer or other third party only with the express consent of the patient, except where the release is necessary to protect the employee or other employees, or pursuant to other exemptions contained in The Personal Health Information Act. The Occupational Health Physician is advised to strongly encourage the employer to document and distribute to employees personnel policies describing the circumstances in which information contained in occupational health records will be released to the

employer or other third parties without the consent of the employee.

- Information from an occupational health record may only be transferred to a general medical record with the patient's consent."

Members should note the last bullet applies even if the same physician is both attending and occupational health physician. Actual patient authorization should be obtained before a physician transfers information from an occupational health record to a general medical record.

Reprinted from the Volume 40, Number 1 issue of *The Newsletter*, posted on the College of Physicians and Surgeons of Manitoba website.

NEW BRUNSWICK, CANADA
ACCESS TO PHYSICIANS

The College of Physicians and Surgeons of New Brunswick has become aware that, when some physicians or clinics are considering accepting a patient who is already seeing another physician, some have required the patient to obtain permission from their current physician. Physicians are reminded of the following form of misconduct:

40. interfering, either directly or indirectly, with the patient's freedom of choice of a physician or a patient's right to consult another physician or other professional;

As a consequence, it would be considered ethically unacceptable to require the permission of another physician to accept a patient. It would be similarly unacceptable for the original physician to refuse such a request. In addition, it is understood certain physicians or clinics will contact the original physician for information prior to accepting the patient. This may also be ethically questionable until the patient has been accepted into the new practice.

Reprinted from the College of Physicians and Surgeons of New Brunswick website.

NOVA SCOTIA, CANADA
RESPONSIBILITIES OF WALK-IN CLINICS

After reviewing concerns raised by an Investigations Committee, the College's executive committee requested on May 13, 2004, that College members be notified of the following responsibilities of physicians practicing in walk-in clinics:

- A copy of the patient record is to be forwarded to the family physician.

- Any investigations ordered by the walk-in clinic must be followed up by the ordering physician.

- Results of investigations ordered by the walk-in clinic should be copied to the family physician.

Reprinted from the College of Physicians and Surgeons of Nova Scotia website.

ONTARIO, CANADA
ACCESS TO PHYSICIANS

The College in Ontario is initiating a process to assess certain physicians who are applying for licensure that includes having an assessor visit a physician's practice, review certain charts, and observe the physician with patients. If the physician's assessment is acceptable, this will then be considered in their application for licensure. In reviewing this process, Council had many concerns. While physicians will have to obtain consent from patients for the chart review, or the direct observation, there are questions as to whether this will adequately address the patient's right to confidentiality and privacy. As a consequence, Council has requested that the College in Ontario defer any such assessments until these concerns are addressed. Council has also advised physicians considered for such assessments that it would be unacceptable for them to submit to such until such time as the Council considers the procedure ethically acceptable.

Reprinted from The College of Physicians and Surgeons of Ontario website.

SASKATCHEWAN, CANADA
CANADIAN COALITION FOR QUALITY IN LABORATORY MEDICINE

In 1991, the first meeting of the provincial authorities responsible for the accreditation of medical laboratories met in Saskatoon as the Interprovincial Quality Assurance group (IPQA). The purpose was the exchange

of information and approaches to the quality improvement of medical laboratory services. Annual meetings have occurred since that time and most recently, in Saskatoon preceding the CSMLS conference.

Some years ago, discipline working groups were created to foster national consensus and the development of standards of practice.

In 2003, IPQA changed its name to the Canadian Coalition for Quality in Laboratory Medicine (CCQLM) and received official notice of Incorporation some two days before this year's meeting on June 10-11. The Articles of Incorporation and the Bylaws will be available very shortly.

In the meantime, the Working Groups cover Hematology, Transfusion Medicine, Clinical Chemistry, Microbiology, Anatomical Pathology, Information Technology and Accreditation. Work on sharing information and conducting national surveys has been very successful. Papers for peer-reviewed publication are in active preparation and guidelines have been submitted to the National Committee on Medical Laboratory Quality Systems of the Canadian Standards Association for consideration as Standards.

Reprinted from the August 2004 issue of *QA Quips*, published by the College of Physicians and Surgeons of Saskatchewan.

LET US HEAR FROM YOU

Would you like for information from your board to be considered for publication in the *Journal*? If so, e-mail articles and news releases to Edward Pittman at epittman@fsmb.org or send via fax to (817) 868-4098.

CALIFORNIA

PHYSICIAN SUPERVISOR/ASSISTANT RATIOS FOR MEDICALLY UNDERSERVED AREAS

Legislative changes contained in SB 1950 (Figueroa, Chapter 1085, Statutes of 2002) allow physicians who work in medically underserved areas to supervise up to four physician assistants. (Physician assistants, or PAs, are health care professionals licensed to practice medicine with physician supervision.) During Sunset Review hearings held in 2001, the Department of Consumer Affairs and the Joint Legislative Sunset Review Committee (JLSRC) supported a recommendation from the Physician Assistant Committee to increase the number of PAs that a physician may supervise. Both the department and the JLSRC noted, "As California's population continues to grow, the need for health care providers, particularly in hard-to-recruit areas, also increases. Many primary health care providers in these areas already rely on physician assistants to expand the number of patients they can care for on a daily basis."

They also noted that implementation of this change will increase the number of Californians receiving care in these communities. The Physician Assistant Committee commented that "Given a PA's training and the fact that many PAs come from a diverse and multi-cultural background, they are particularly suited to assist physicians in medically underserved areas of California." Legislation creating this change will be reviewed by the JLSRC at the next Sunset Review hearing for the Physician Assistant Committee in 2005. For further information, please call the Physician Assistant Committee office at (916) 263-2670.

Reprinted from Volume 89 of the *Action Report*, published by the Medical Board of California.

COLORADO

SYSTEM ERRORS/CASE STUDIES

Frequently, complaints against physicians reveal systems errors or communication breakdowns rather than physician incompetence or negligence. The Colorado Board of Medical Examiners is sharing some of these stories with you. We suggest you review these stories and use this information to eliminate the potential for these problems in your practice.

CASE 1 ISSUE: FAILURE TO FOLLOW UP ON LAB TESTS THAT WERE ORDERED.

Situation:
A female patient presents to the emergency department (ED) complaining of severe abdominal cramping. She was physically evaluated in the ED and a urinalysis and urine pregnancy test was performed and were both negative. However, a serum pregnancy test was also ordered but the patient was discharged from the ED before the results of that test returned and were reviewed. This test was positive. The patient subsequently presented to a different ED 20 days later and was diagnosed with an ectopic pregnancy.

Board Comments:
If tests are ordered, it is imperative that timely follow-up of the results occur. In the situation above, it may have been reasonable to discharge the patient prior to the availability of the serum pregnancy test results, but it is incumbent upon the treating physician to assure there is a reliable system in place to obtain the test results and bring any abnormal or concerning results to the physician's attention.

CASE 2 ISSUE: FAILURE TO PERSONALLY COMMUNICATE CRITICAL INFORMATION

Situation:
The board has seen a number of cases in the past several months in which critical diagnoses were made but were not personally communicated to the treating physician. This occurs in those specialty areas, such as radiology and pathology, where the diagnosing physician does not have direct patient contact. In the cases that have come to the board's attention, instead of the radiologist or pathologist calling the treating physician directly, the report was either added to an electronic record that the treating physician could access or a hard copy report was faxed to the treating physician's office.

Board Comments:
In those instances when a physician makes a diagnosis, such as cancer, that will be of major significance to the effective and timely treatment of the patient, the board believes it is always the best practice for the diagnosing physician to personally contact the treating physician to assure the test results have been received and understood. If the treating physician is unavailable, at a minimum, the physician should leave an urgent message on voicemail or with the answering service. Finally, it should be clearly documented in the record how the diagnosis was communicated and to whom.

THE MEDICAL MARIJUANA REGISTRY

In the November 2000 general election, Coloradans passed Amendment 20 and the Colorado Department of Public Health and Environment (CDPHE) was tasked with implementing and administering the Medical Marijuana Registry program. On June 1, 2001, the Registry began accepting and processing applications for Registry Identification cards. Since this program began, there have been numerous questions about how this law impacts physicians in Colorado, especially since it appears to be in direct conflict with federal laws surrounding the prescription of Schedule I substances.

It is clear that under Colorado law, physicians are provided protection if and when they recommend the use of medical marijuana for their patients. Specifically, Amendment 20 provides an exception from the state's criminal laws for a physician who elects to advise a patient and provide them written documentation indicating they believe their patient might benefit from the medical use of marijuana, provided that such advice is based upon the physician's contemporaneous assessment of the patient's medical history and current medical condition, and a bona fide physician-patient relationship exists. The physician must also have diagnosed their patient as having a debilitating medical condition that is covered under the current law (cancer; glaucoma; HIV/AIDS; cachexia; severe pain; severe nausea; seizures, including those that are characteristic of epilepsy; or persistent muscle spasms, including those that are characteristic of multiple sclerosis).

It is also true that physicians currently have protection under federal law. In October 2003, the U.S. Supreme Court declined to hear an appeal by the Bush Administration regarding a Ninth Circuit Court of Appeals decision pertaining to physician recommendations of medical marijuana. That decision enjoined the federal government from punishing physicians for recommending marijuana to their patients, as First Amendment rights regarding freedom of speech protect this type of communication. Also, the Drug Enforcement Administration (DEA) in Colorado has indicated that as long as doctors are not prescribing marijuana (which, according to the DEA, means using an actual prescription pad), they are not in violation of federal law. The local DEA office has received and reviewed a copy of the physician certification form and has assured the Administrator of the Medical Marijuana Registry that this form does not constitute a prescription, and that it is not something the DEA considers to be in violation of federal law.

It is extremely important for physicians to be aware that all information received by the Registry is completely confidential, and physicians' names are never shared with anyone for any reason. The Administrator of the Medical Marijuana Registry, Gail Kelsey, is available to answer questions, distribute information, and give presentations about the program and discuss its impact on doctors and patients. She can be contacted at (303) 692-2184, or via e-mail at gail.kelsey@state.co.us if you would like further information about this program.

Reprinted from the Volume 12, Number 1, issue of *The Examiner*, published by the Colorado Board of Medical Examiners.

NEW MEXICO

AMA CODE OF MEDICAL ETHICS AND BOARD RULES: INFORMING PATIENTS OF LAB RESULTS

Section 16.10.8.9 of the Rules of the New Mexico Medical Board states that the board adopts the ethical standards set forth in the Code of Medical Ethics of the American Medical Association (AMA). This means that the board will follow the guidelines articulated in the Code for issues not specifically addressed in board rules. This category includes issues like the retention of medical records, physician self-prescribing, informed consent, and many others. This column will be devoted to discussing a different issue in each newsletter.

There has been some question recently about board policy on reporting laboratory test results to patients. For

clarification, the AMA Code of Ethics guidelines are:

- Physicians should have a consistent policy about the reporting of test results, and patients should be informed of this policy before or at the time of the test.

- Policies should include when and by whom results will be given to the patient, and under what circumstances. For example, who will deliver the results if the test is negative, and who will speak to the patient if the results are positive.

- Patients should receive test results within a reasonable amount of time. Any delays that can be anticipated should be discussed with the patient at the time of the test.

- Test results should be given to the patient in language that the patient can understand, and patients must receive all the information from tests that they will need to make informed decisions about their medical treatment.

- Physicians should take precautions to ensure that patient confidentiality is maintained. For example, results should not be left on an answering machine or given to a third party without specific patient permission. They should not be sent via e-mail, or sent through the mail on a postcard.

Physicians should develop a reasonable office policy that balances the rights and concerns of patients with the needs and circumstances of their practice.

The AMA Code of Medical Ethics can be ordered and accessed online at www.ama-assn.org. If you have suggestions for future topics in this column, please call Jenny Felmley, public information officer, at (505) 827-4013 or jenny. felmley@state.nm.us.

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SOUTH CAROLINA
CONTINUED COMPETENCY REGULATION NOW LAW

The South Carolina Board of Medical Examiners introduced a regulation intended to ensure that physicians licensed in this state demonstrate continued competency either through continued medical education or other options provided in the new regulation. The General Assembly passed the legislation, and it was signed into law by Governor Mark Sanford on April 26, 2004.

81-95. Continued Competency

The continued professional competency of physicians holding a permanent license shall be assured in the following manner:

A. For renewal of a permanent license initially issued during a biennial renewal period, compliance with all educational, examination and other requirements for the issuance of a permanent license shall be deemed sufficient for the first renewal period following initial licensure.

B. For renewal of an active permanent license biennially, documented evidence of at least one of the following options during the renewal period:

1. Forty (40) hours of Category I continuing medical education sponsored by the American Medical Association (AMA), American Osteopathic Association (AOA), or other organization approved by the board as having acceptable standards for courses it sponsors, at least thirty (30) hours of which are directly related to the licensee's practice area; or

2. certification of added qualifications or recertification after examination by a national specialty board recognized by the American Board of Medical Specialties (ABMS) or AOA or other approved specialty board certification; or

3. completion of a residency program or fellowship in medicine in the United States or Canada approved by the Accreditation Council on Graduate Medical Education (ACGME) or AOA; or

4. passage of the Special Purpose Examination (SPEX) or Comprehensive Osteopathic Medical Variable Purpose Examination (COMVEX); or

5. successful completion of a clinical skills assessment program approved by the board, such as the Institute for Physician Evaluation (IPE), the Post-Licensure Assessment System (PLAS), or the Colorado Personalized Education Program (CPEP).

C. For reinstatement of a permanent license from lapsed or inactive status of less than four years, documented evidence of at least one of the following options within the preceding two years:

1. Forty (40) hours of Category I continuing medical education sponsored by the AMA, AOA or other organization approved by the board as having acceptable standards for courses it sponsors, at least 30 hours of which are directly related to the licensee's practice area; or

2. certification of added qualifications or recertification after examination by a national specialty board recognized by the ABMS or AOA or other approved specialty board certification; or

3. completion of a residency program or fellowship in medicine in the United States or Canada approved by the ACGME or AOA; or

4. passage of the SPEX or COMVEX; or

5. successful completion of a clinical skills assessment program approved by the board, such as the IPE, the PLAS or the CPEP.

D. For reinstatement of a permanent license from lapsed or inactive status of four years or more, documented evidence of at least one of the following options:

1. Certification of added qualifications or recertification after examination by a national specialty board recognized by the ABMS or AOA or other approved specialty board certification; or

2. completion of a residency program or fellowship in medicine in the United States or Canada approved by the ACGME or AOA; or

3. passage of the SPEX or COMVEX; or

4. successful completion of a clinical skills assessment program approved by the board, such as the IPE, the PLAS or the CPEP.

PRE-SIGNED BLANK PRESCRIPTIONS ARE UNLAWFUL

The act of a physician pre-signing blank prescriptions as a "time-saver" or as a "convenience to staff" is not only unlawful, but can lead to criminal actions by others and result in sanctions against the physician's medical license.

Section 44-53-395 of the South Carolina Code of Laws, as amended, states in part:

"(A) It shall be unlawful: (1) for any practitioner to issue any prescription document signed in blank. The issuance of such document signed in blank shall be prima facie evidence of a conspiracy to violate this section."

An recent investigation conducted by the South Carolina Board of Medical Examiners revealed that a physician issued pre-signed blank prescriptions in his office and that an employee used the prescriptions to obtain drugs by fraud to further an addiction. The results of criminal activity by the employee and licensure sanction of the physician could not be justified as either time saving or convenient.

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NORTH CAROLINA
NORTH CAROLINA'S ALLIED HEALTH CARE PROFESSIONALS

North Carolina's health care environment is continuously evolving to include a blend of medical providers. This blend includes not only physicians, but also physician assistants (PAs), nurse practitioners (NPs), and, most recently, clinical pharmacist practitioners (CPPs). As allied health care professionals, PAs, NPs and CPPs work alongside licensed physicians, improving access to medical care services necessary to meet the needs of North Carolina and its residents.

The state of North Carolina has established regulations governing the practice of PAs, NPs and CPPs. To be granted a license or approval to practice, each practitioner is responsible for fulfilling certain criteria and complying with regulations specific to his or her chosen profession. All three are responsible for establishing and maintaining a relationship between themselves and a designated supervisory physician. This supervision must be continuous, and, although it is not necessary that the supervising physician be present when the practitioner is providing care, it is required the supervisor be readily accessible. This requirement, among others,

assures public safety in the delivery of medical care by all practitioners, and requires they take responsibility for their patients in a variety of settings. The scope of that responsibility must be delineated in terms that are consistent with the applicable statutes and rules and that are understandable to colleagues, the public, and regulatory agencies.

Physician Assistants

A PA is an individual licensed by, and registered with, the North Carolina Medical Board to perform medical acts, tasks, or functions under the supervision of a physician licensed by the board. A PA must have graduated from a physician assistant or surgeon assistant program accredited by the Commission on Accreditation of Allied Health Education Programs or its predecessor or successor agencies. (21 NCAC 32S .0101)

On completion of her or his medical education, and before performing any medical tasks in North Carolina, the PA must obtain a valid North Carolina license. This requires that the PA successfully complete the examination of the National Commission on Certification of Physician Assistants, receive acknowledgement of his or her intent to practice agreement with a primary supervising physician, and have a specific practice location approved by the board. With all criteria met, and following action by the North Carolina Medical Board, the PA will be issued a license.

The PA's intent to practice agreement with his or her supervisory physician is the most important and fundamental document required before practicing in North Carolina. There is no fee for this documentation, which includes the name, practice address, and telephone number for both the PA and the primary supervising physician. (21 NCAC 32S .0112— Notification of Intent to Practice).

Additional supervision requirements include having a written practice agreement that outlines the scope of practice for the PA. This document must be clearly identified in writing and maintained at each practice setting. The scope of practice describes the tasks delegated to the PA, the relationship the PA has with a primary supervising physician, and the process for evaluating the PA's performance. The practice agreement must be signed by the supervising physician and the PA, and, along with numerous other documents, must be readily available to the Board or its representatives upon request. Although the scope of practice is defined by the PA and her or his supervising physician, it is important to note that the primary supervising physician has responsibilities beyond continuous availability and support. According to a recently enacted rule change, a PA and supervising physician must meet every six months to discuss, among other things, clinical practice issues. However, for PAs in a new practice arrangement, the PA and supervising physician must meet monthly for the first six months. These meetings must be documented and the record of such meetings must be available for inspection by Board agents upon request (21 NCAC 32S .0110).

PAs may treat patients with prescription medications as long as they comply with North Carolina standard rules. Administrative rule 21 NCAC 32S .0109 reads: "a PA is authorized to prescribe, order, procure, dispense, and administer drugs and medical devices subject to conditions." Conditions include the requirement that there must be a written statement on prescriptive authority in which the supervising physician and the PA acknowledge they are both familiar with the laws and rules regarding prescribing. The written statement on prescribing must be reviewed periodically. Each prescription written by a PA must include, in addition to other information, the PA's name, practice address, telephone number, and license number, as well as the responsible physician's name and telephone number.

Nurse Practitioners

Subchapter 32M — Approval of Nurse Practitioners of the North Carolina Medical Board's rules, defines an NP as: "a currently licensed nurse approved to perform medical acts, consultation, collaboration, and evaluation of the medical acts performed ... under an agreement with a licensed physician for ongoing supervision...."

To be approved to practice as an NP, the NP must first have completed an approved course of study. It is also necessary she or he pass a certification examination by a national credentialing body. (However, as noted below, an NP may practice temporarily for six months while waiting to take the required examination or while awaiting the test results.) Before beginning employment, it is necessary that an NP receive written confirmation of approval to practice from the North Carolina Board of Nursing and the North Carolina Medical Board.

Each NP applying for approval may be granted interim status while the boards complete the processing of his or her application. The practice of an NP with interim status is subject to several limitations: there are no prescribing priv-

ileges; all notations in patient charts must be countersigned within two working days; and there must be documentation of weekly face-to-face consultation with the primary supervising physician. An NP with interim approval may practice for a period not to exceed six months.

For an NP who has met all other requirements for approval to practice but who is awaiting notification of successful completion of the national certification examination, temporary approval may be granted. In temporary status, an NP has limited privileges, including review and countersignature of notations by the supervising physician on every NP patient contact within seven days for the first six months, face-to-face consultation with the supervising physician weekly for a month, and, afterwards, face-to-face consultation monthly for a minimum of five months. Effective Aug. 1, 2004, temporary approval is granted for a maximum of six months. Any NP being approved to practice for the first time is subject to the guidelines outlined for temporary approval status. Should an NP have a lapse in practice, change primary supervising physicians, or change written protocols, she or he is required to follow the temporary status guidelines for a minimum of six months and to notify both boards of the changes.

Initially, as with PAs, there must be a defined collaborative practice agreement that is site-specific and serves as a guideline in defining the scope of the NP's practice. It must include a drug and device agreement and a predetermined plan for emergencies. Should a clinical practice issue arise not included in the collaborative practice agreement, the NP and the supervising physician are required to consult and document the action taken. Collaborative practice agreements must be reviewed annually. On request by the North Carolina Board of Nursing and the North Carolina Medical Board, the NP must also demonstrate the ability to perform the medical acts outlined in the agreement.

In addition, the administrative rules further require a Quality Improvement Process (QIP) to be reviewed every six months. The NP and supervising physician team must develop a process that includes the description of a clinical problem, evaluation of the treatment used, and a plan to improve outcomes. All consultations between the NP and the supervising physician, including the QIP, should be signed by both and kept for review by the boards upon request.

Clinical Pharmacist Practitioners

CPPs are newly appointed health professionals in our state authorized by the legislature to provide drug therapy management to patients under the supervision of a licensed physician. To practice, a CPP must obtain approval from both the North Carolina Board of Pharmacy and the North Carolina Medical Board. Like PAs and NPs, CPPs are required to produce a signed agreement with their supervising physician, as well as maintain a copy at each practice setting. The agreement shall be specific in regard to the physician, pharmacist, patient, and disease. In the agreement, the CPP must specify the predetermined drug therapy (including diagnosis and product selection by the patient's physician), any modifications that may be permitted, dosage forms, dosage schedules, and tests that may be ordered. In addition, weekly quality control meetings must be scheduled to review and countersign all orders.

To apply for approval, the CPP candidate must hold a current, unrestricted North Carolina pharmacy license and must meet one of the following qualifications:

1. He or she may be certified by the Board of Pharmaceutical Specialties, be a certified geriatric pharmacist, or have completed an American Society of Health System Pharmacists' residency program with two years clinical experience approved by the boards;

2. he or she may hold the academic degree of doctor of pharmacy with three years clinical experience approved by the boards; or

3. he or she may hold the academic degree of bachelor of science in pharmacy with five years clinical experience approved by the boards and have completed two NCCPC or ACPE approved certification programs. Submission of an application and an endorsement by the North Carolina Board of Pharmacy is required, along with appropriate fees and, as noted earlier, a signed supervising physician agreement (21 NCAC 32T .0101). The supervising physician is responsible for ongoing supervision and evaluation of the drug therapy management performed by the CPP, and shall review and countersign each order written by the CPP within seven days.

Conclusion

PAs, NPs and CPPs make a vital contribution to the well-being and health care management of the public. In each

field, an individual's approval to practice may be restricted, denied, or terminated should the board determine she or he has violated the related laws and rules governing that field. While practicing, these professionals must wear an identification tag displaying their professional title. North Carolina Administrative Code 32S .0113 states it is "unethical and dishonorable to represent oneself as a physician." Only an individual licensed and approved by the North Carolina Medical Board may legally identify himself or herself as a physician and serve as a supervisor for physician extenders.

Physicians who are in post-graduate training or resident training programs are not eligible to supervise PAs, NPs or CPPs. Among a variety of additional responsibilities, supervising physicians are not only accountable for their own actions, but for the actions of the practitioners they supervise. In North Carolina, all practitioners are expected to practice within the standards of care in our state. Failure to function in accordance with any provisions outlined in NCGS 90-14(a) of the Medical Practice Act or administrative rules may result in the board initiating an investigation and/or disciplinary action against the offending physician.

Each year, practitioners are required to register and pay all appropriate fees. Practitioners who change their supervising physician, scope of practice, practice address, public address, or name, must inform the board within 15 days so board records may reflect a practitioner's current information. In addition, all practitioners in these three health care professions are responsible for accumulating credit hours for continuing education. Guidelines for specific requirements for individual practitioner, as well as information on licensing, rules, and statutes, can be found on board website at www.ncmedboard.org.

Reprinted from the Number 2, 2004, issue of *Forum*, published by the North Carolina Medical Board.

TEXAS
RULE CHANGES

The board adopted the following rule changes that were published in the Texas Register:

Chapter 162
Supervision of Medical School Students: Rule review, repeal of §§162.1-162.3, and new §162.1 regarding the requirements for Texas physicians who supervise medical school students in Texas.

Chapter 163
Licensure: Amendments to §§163.1, 163.5, 163.6, 163.10, 163.13 regarding general clean up of the sections; and changes relating to relicensure and the expedited licensure process consistent with the mandates of Senate Bill 104 and Senate Bill 558 of the 78th Legislature.

Chapter 165
Medical Records: Amendments to §§165.1, 165.3, and 165.4 regarding definitions and general clean up and amendments to §§165.1 and 165.2 and new §165.5 concerning medical records. The amendments clarify the definitions for medical records and maintenance of records and add requirements of the Health Insurance Portability and Accountability Act (HIPAA) as appropriate. The new provisions of §165.5 outline the requirements concerning transfer or disposal of medical records.

Chapter 166
Physician Registration: Amendments to §§166.1-166.6 regarding biennial registration mandated by Senate Bill 104.

Chapter 168
Persons with Criminal Backgrounds: Rule review and repeal of §168.1. The text of the repeal will be incorporated into the new Chapter 190.

Chapter 171
Postgraduate Training Permits: Amendments to §171.2 regarding eligibility for postgraduate training permits and to §171.6 regarding faculty temporary permits that would allow active military physicians, holding part-time appointments at Texas medical schools, to be eligible for faculty temporary permits.

Chapter 173
Physician Profiles: Rule review and amendments to §§173.1, 173.3, and 173.4 that will make the sections consistent with the requirements of Senate Bill 104 by removing the 10-year reporting limitation in §173.1(b)(18)-(21) adding paragraph (25) regarding malpractice information, and outlining the timeline for updating the profile following the filing of formal complaints.

Chapter 175
Fees, Penalties, and Applications: Amendments to §§175.1, 175.2, and 175.4 regarding biennial registration fees for physicians; increased penalty fees for late physician registration; surcharges for physician assistant, acupuncture, and acudetox renewal; registration and

penalty fees for surgical assistants; and fees for approval of continuing acupuncture education providers.

Chapter 176

Health Care Liability Lawsuits and Settlements: New chapter consistent with Senate Bill 104 regarding reporting responsibilities for licensees against whom a health care liability complaint has been filed and a settlement has been made.

Chapter 178

Complaints: New §§178.1-178.8 concerning procedures for initiation, filing, and appeals of complaints. In addition, Chapter 188 of this title (relating to Complaint Procedure Notification) was repealed and the text regarding the process for complaint procedure notification was incorporated into this new chapter.

Chapter 179

Investigations: Repeal of §§179.1-179.5 and new §§179.1-179.7 regarding a system of procedures for the investigation of jurisdictional complaints.

Chapter 182

Use of Experts: New §§182.1-182.6 regarding the use of experts consistent with the requirements of Senate Bill 104. The new sections will establish procedures, qualifications and duties of these professionals serving as expert panel members, consultants and expert witnesses to the board.

Chapter 183

Acupuncture: Amendments to §§183.10 and 183.20 and new §183.22 concerning written instructions in medical records and continuing acupuncture education.

Chapter 184

Surgical Assistants: Amendments to §184.4 regarding examination requirements for licensure. Amendments to §§184.8 and 184.25 regarding biennial registration and annual continuing education requirements, and repeal of §§184.10 and 184.11 regarding fees related to the renewal of expired licenses and schedule of fees. The repealed sections were added to Chapter 175 relating to Fees, Penalties, and Applications as part of the adopted changes to Chapter 175.

Chapter 185

Physician Assistants: Amendments to §§185.7 and 187.15 permitting the Physician Assistant Board's designee to issue temporary licenses and concerning a physician's eligibility to supervise a physician assistant.

Chapter 187

Procedural Rules: Amendments to §§187.2, 187.9, 187.13, 187.16, 187.18, 187.24, 187.44, 187.56, 187.57, 187.60, and the repeal of §§187.5 and 187.40 concerning the timeline for scheduling informal settlement conferences; temporary suspension or restriction of licenses; required suspension or revocation of licenses for certain offenses; and ineligibility determinations for licensure applicants.

Chapter 190

Disciplinary Guidelines: Repeal of §190.1; and new Subchapter A, §§190.1-190.2; new Subchapter B, §190.8; and new Subchapter C, §§190.14-190.15 regarding disciplinary guidelines in licensure and disciplinary matters.

Chapter 192

Office-Based Anesthesia: Rule review and amendments to §§192.2-192.4 and 192.6 regarding general cleanup of the sections and the establishment of a process for biennial registration consistent with Senate Bill 104.

Chapter 193

Standing Delegation Orders: Amendments to §§193.2 and 193.6 regarding the delegation of prescriptive authority as mandated by House Bill 1095 of the 78th Legislature and applications for waiver and meetings of the Prescriptive Delegation Waiver Advisory Committee. §193.11 was added regarding delegation and supervision of the use of lasers.

Chapter 194

Non-Certified Radiologic Technicians: Rule review of Chapter 194; amendments to §§194.1-194.4 and 194.6; repeal of §§194.7-194.10 and new 194.7-194.11 regarding general cleanup and reorganization of the chapter.

Chapter 196

Voluntary Surrender of a Medical License: Amendments to §§196.1-196.3 for general clean up of the chapter.

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DISCOVERY

Atteberry v. Longmont United Hospital,
No. 03-D-488 (BNB) (D. Colo. June 15, 2004) - DEx 85569, 9 pp.

The magistrate judge for the U.S. District Court for the District of Colorado ruled a mother was entitled to discovery of a hospital's documents relating to the doctor whose allegedly negligent treatment of her son resulted in his death.

Brenda Atteberry sued Longmont United Hospital and Dr. John Leonard after the death of her son who Dr. Leonard treated in the hospital's ER after a motorcycle accident. The complaint asserted three claims for relief, including: (1) violation of the federal Emergency Medical Treatment and Active Labor Act (EMTALA) against the hospital; (2) state law professional negligence against Leonard; and (3) state law negligent misrepresentation against Leonard.

Subsequently, Atteberry requested production of the following materials:

1. Any reports, files or reviews that referred or related to Scott Atteberry's care on April 28, 2001, including, but not limited to any quality assurance reports, peer review reports and morbidity/mortality reports. 7. Any and all reports relating to Dr. Leonard, including, but not limited to, credentialing files, peer review files, quality assurance reports, morbidity/ mortality reports, hospital privileges, and any reports relating to the deaths of patients under his care.

The hospital objected to the production requests, asserting the requested information was protected from discovery by (1) the federal Health Care Quality and Assurance Act; (2) the Colorado state peer review privilege; (3) the Colorado state quality management privilege; (4) the doctrine of Hawkins v. District Court; 638 P.2d 1372 (Colo. 1982); (5) the attorney-client privilege; and (5) the work product doctrine.

The district court granted the motion to compel. Initially, the court determined federal law governs the issue of privilege. Federal law also provides the rule of decision with regard to the EMTALA claim. In addition, the district court noted courts have repeatedly held the Health Care Quality Improvement Act does not create a federal peer review privilege.

The district court also found state privileges were not applicable in this case. The independent review of the record did not indicate the prerequisites to the claimed privileges had been met. Additionally, the district court found Hawkins was not applicable. Hawkins concerned a state law privilege and was factually distinct from the issues presented in the present case.

Moreover, the district court found the hospital failed to establish that any responsive document was subject to the attorney-client privilege or work product doctrine. There was no privilege log whatsoever or other attempt by the hospital to provide sufficient information "to enable the plaintiffs and the court to determine whether each element of the asserted objection is justified."

Finally, the district court found that requests for Production Nos. 1 and 7 sought materials relevant to the claims and defenses of the parties or appeared reasonably calculated to lead to the discovery of admissible evidence. The requests were within the scope of discovery permitted under Fed. R. Civ. P. 26(b).

EXPERT TESTIMONY

Christian v. Surgical Specialists of Richmond, Ltd.,
No. 031540 (Va. June 10, 2004) - DEx 85574, 9 pp.

The Virginia Supreme Court ruled a trial court erred in refusing to qualify as an expert witness Dr. Frederick Gonzalez in a medical malpractice case against Dr. Bruce Rowe and Surgical Specialists of Richmond Ltd. The trial court clearly abused its discretion in ruling Gonzalez did not demonstrate sufficient knowledge of the Virginia standard of care at issue in this case to qualify as an expert witness.

Costello v. Christus Santa Rosa Health Care Corp., No. 04-03-00597-CV (Tex. App. June 23, 2004) - DEx 85681, 3 pp.

The Texas Court of Appeals, Bexar County, ruled a trial court did not err in dismissing a patient's medical malpractice suit after it determined her expert reports did not satisfy the Texas Medical Liability and Insurance Improvement Act's requirements with respect to causation. The trial court correctly concluded the expert reports did not constitute a good-faith effort to meet the requirements of the Act.

Petrou v. South Coast Emergency Group, No. G031662 (Cal. Ct. App. June 25, 2004) - DEx 85779, 9 pp.

The California Court of Appeal, Fourth District, ruled Tom and Barbara Petrou were improperly precluded from putting on expert testimony as to the standard of care in their medical malpractice action against Dr. David Reid and South Coast Emergency Group based on treatment Mr. Petrou received from Reid in an emergency room.

The Petrous contended the trial court erred when it ruled their expert witness was not qualified under Health & Safety Code § 1799.110 because he did not have substantial experience as an emergency room physician within five years of the date of trial and disallowed his testimony. The court of appeal concluded the five-year period set out in that statute is to be measured from the date of the alleged malpractice and, therefore, reversed the judgment.

INFORMED CONSENT

Linquito v. Siegel, No. A-4860-02T1 (N.J. App. Div. June 16, 2004) - DEx 85578, 25 pp.

The New Jersey Superior Court, Appellate Division, ruled a doctor was entitled to a new trial on a wife's negligence-malpractice claim stemming from the doctor's failure to diagnose and treat her husband's cancer. Moreover, the appellate division reversed the judgment against the doctor based on lack of informed consent.

Philomena Linquito, as executrix of her late husband's estate and individually, brought an action against Dr. Andrew Siegel, a urologist. She alleged Dr. Siegel deviated from the standard of care in his treatment of her husband (decedent) for bladder cancer, thereby contributing to his death. Linquito asserted claims for survivorship, wrongful death and loss of consortium.

Following a trial, Linquito concluded Dr. Siegel was not negligent in failing to diagnose and treat the cancer. However, the jury also concluded Siegel failed to obtain decedent's informed consent regarding additional diagnostic testing which could have been performed, and that this failure "increase[d] the risk of harm posed by the [decedent's] preexisting condition." The jury attributed 10 percent of the "ultimate injuries or damages" to Dr. Siegel's failure to obtain decedent's informed consent.

The trial court entered final judgment, molding the jury's verdict and reducing the damage awards in accordance with the percentage of liability assessed by the jury. The court awarded Linquito damages in the amount of $7,285 ($6,000 in damages, that is 10 percent of the aggregate $60,000 damage award, plus $1,285 in prejudgment interest). Linquito appealed, and Dr. Siegel cross-appealed.

The appellate division reversed the judgment based on lack of informed consent but ordered a new trial on all issues on the negligence claim. The appellate division had previously held, in Farina v. Kraus, 333 N.J. Super. 165 (App. Div. 1999), that the informed consent theory of liability did not apply where the patient's claim was that the physician erred in diagnosing the patient's condition, either through an alleged failure to obtain an adequate medical history or through an alleged failure to perform a sufficient number or type of diagnostic tests.

As in Farina, the appellate division noted Dr. Siegel sought reversal of the judgment and entry of judgment in his favor, notwithstanding the verdict, based on his unsuccessful motion to dismiss the informed consent theory in the trial court. He asserted the jury properly found for him on the negligence claim and the other theory should not have been presented. In Farina, however, the appellate division held the appropriate result was a reversal of the judgment and remand for a new trial on all issues regarding the negligent diagnosis/treatment claim only.

In the present case, Linquito who was successful on the informed consent but not the negligence theory and wanted a retrial on damages and apportionment only because her recovery was too low, evidencing a "manifest

injustice." As she was unsuccessful on the negligence theory and the "informed consent" should not have been presented, the appellate division believed the Farina approach was the appropriate one to follow.

MALPRACTICE

Faggins v. Fischer,
No. 01-CV-1328 (D.C. June 3, 2004) - DEx 85439, 27 pp.

The District of Columbia Court of Appeals ruled the trial court did not abuse its discretion in ordering a new trial to a doctor found guilty of medical malpractice.

At the first trial of a survival action for medical malpractice, the jury found the defendant, Dr. David Fischer, had negligently administered excessive amounts of antipsychotic medication to Frederick Moten, the 27-year-old son of Julia Faggins, thus causing Moten's death from malignant syndrome (NMS).

The jury awarded Faggins $1.6 million in compensatory damages for Moten's alleged pain and suffering. Counsel for Dr. Fischer filed a post-trial motion for a new trial pursuant to Super. Ct. Civ. R. 59. The trial court granted the motion and ordered a new trial. A second trial resulted in a verdict and judgment in Dr. Fischer's favor. Faggins appealed.

The court of appeals affirmed the trial court's judgment. In so ruling, the court of appeals rejected Faggins' argument that the second trial should never have taken place. She argued, as she did in the trial court, that the Rule 59 motion was untimely. In the alternative, she asserted that, even if the motion was timely, the trial court abused its discretion in granting a new trial.

The court of appeals agreed with the trial court that the Rule 59 motion was timely. The determinative procedural issue was whether the "3 days [that] shall be added to the prescribed period" provided in Rule 6(e) means three calendar days, as argued by Faggins, or three business days, as argued by Dr. Fischer. The court of appeals agreed with Dr. Fischer. The time expired on Sept. 15, the very day the defendant filed his Rule 59 motion. The court of appeals also held that the trial court did not abuse its discretion in granting a new trial. The only evidence offered in support of Faggins' claim for pain and suffering was the expert testimony of Dr. Addonizio. Based on his review of certain notes contained in Moten's hospital records, it was his expert opinion that Moten was able to and did experience conscious pain and suffering caused by NMS. While Dr. Fischer did not dispute the accuracy of the observations reflected in the hospital notes regarding Moten's reaction to certain stimuli, he argued Addonizio's conclusion based on those notes, that Moten consciously experienced pain for 24 to 48 hours, was pure speculation and unsupported by the record.

The court of appeals agreed. Because the jury verdict was based on unsupported conjecture, the appeals court found the trial court properly granted Fischer's motion for a new trial on the grounds that the damages "exceed[ed] the amount reasonable under the circumstances of this case."

NEGLIGENCE

Stottlemyer v. Ghramm,
No. 031613 (Va. June 10, 2004) - DEx 85591, 9 pp.

The Virginia Supreme Court ruled a trial court did not err in refusing to permit a medical negligence plaintiff to cross-examine the defendant physician regarding his alleged prior acts of negligence and misconduct.

In her medical negligence action, Carolyn Stottlemyer filed a motion for judgment and subsequently an amended motion against Dr. John Ghramm and Winchester Medical Center Inc. She alleged the medical center breached the standard of care owed to her because it failed to adequately supervise Dr. Ghramm and because it was negligent in credentialing Dr. Ghramm. She also alleged Dr. Ghramm committed acts of negligence related to the performance of surgery on her.

Prior to a jury trial, the medical center filed a motion to sever Stottlemyer's actions against it and Dr. Ghramm. The trial court ruled Stottlemyer's cause of action for medical negligence against Dr. Ghramm would be bifurcated from her claim of negligent credentialing against the medical center. The trial court also ruled Stottlemyer was required to present her case of negligence against Dr. Ghramm, and if the jury found Dr. Ghramm was negligent, Stottlemyer would be permitted to present her case against the medical center and Dr. Ghramm for the alleged acts of negligent credentialing.

During the trial, Stottlemyer attempted to cross-examine Dr. Ghramm about certain alleged "prior bad acts" he had committed. Stottlemyer made an evidentiary proffer in support of these allegations. The trial court refused to permit Stottlemyer to cross-examine Dr. Ghramm as to these prior bad acts, and thus, the jury did not consider this evidence.

The jury returned a verdict in Dr. Ghramm's favor. The trial court entered an order confirming the verdict and dismissed Stottlemyer's claims for negligent credentialing against Dr. Ghramm and the medical center. Stottlemyer appealed. The supreme court affirmed the trial court's judgment. It held the trial court properly limited the scope of Stottlemyer's cross-examination of Dr. Ghramm because Stottlemyer did not have the right to cross-examine a witness on collateral matters. The trial court also properly refused to permit Stottlemyer to cross-examine Dr. Ghramm about his alleged prior bad acts and alleged acts of negligence against other patients because such testimony was neither relevant nor probative to the issues properly before the jury.

In view of its holdings that evidence Stottlemyer sought to elicit during her cross-examination of Dr. Ghramm was not admissible, the supreme court concluded the trial court did not abuse its discretion when it bifurcated the trial. The supreme court did not need to consider whether Stottlemyer had causes of action against the medical center for negligent supervision or negligent credentialing because the jury found Dr. Ghramm was not negligent. Therefore, those issues were moot.

PATIENT CONFIDENTIALITY

Trent v. Office of Coroner of Peoria County,
No. 3-03-0206 (Ill. App. Ct. June 3, 2004) -DEx 85446, 5 pp.

The Illinois Appellate Court, Third District, ruled a trial court did not err in ruling that individuals were not entitled, under the Freedom of Information Act, to the medical records of a child who died as the result of abuse.

Rose and James Trent and James Clark filed a pro se complaint under Illinois' Freedom of Information Act against the office of the coroner of Peoria County and Daniel Heinz, in his official capacity as the Peoria County coroner. The plaintiffs attempted to obtain medical records of C.N., a deceased minor. The trial court ruled the plaintiffs were not entitled to receive C.N.'s medical records. The plaintiffs appealed. The appellate court affirmed the trial court's judgment and rejected the plaintiffs' argument that the trial court erred in ruling that the records they sought were exempt from disclosure under the Act even though they had acquired a signed authorization from the deceased child's mother, Katrina Harden. The appellate court found the authorization signed by Harden was invalid and provided no legal basis for disclosure of C.N.'s medical records.

PROFESSIONAL MISCONDUCT

Anonymous v. Bureau of Professional Medical Conduct,
No. 96 (N.Y. June 29, 2004) - DEx 85797, 12 pp.

The New York Court of Appeals ruled physicians, who have a longstanding right to confidentiality during a medical disciplinary proceeding, do not lose the right to that confidentiality after the proceeding concludes with a determination favorable to them.

The petitioner-respondent was a doctor practicing in Manhattan. The State Board for Professional Medical Conduct brought charges against him for "willfully harassing, abusing a patient physically," "failure to maintain records," "moral unfitness," "fraudulent practice," and "practicing beyond the scope." The charges were based on the complaint of a woman who had allegedly been the petitioner's patient.

A hearing was held before a Committee on Professional Conduct. After the hearing, the Committee issued a "Determination and Order," rejecting all of the charges except for one instance to maintain a medical record.

Pursuant to the health department's policy, after the petitioner's time to seek review of the Committee's determination had expired, the charges against him and the Committee's resolution of them became available on the Internet. The petitioner did not discover this for some time.

The petitioner's attorney requested by letter that the department withdraw all references to the proceedings from its Internet site and maintain "all records pertaining to this matter … in absolute confidence." The request was rejected, and the petitioner sued, asking that the Board and the department be compelled to withdraw the materials in question from public access and to keep them

confidential. The trial court dismissed the petition. The appellate division reversed and granted the petition. It then granted leave to appeal (see 12 *HLawWk* 654, Oct. 17, 2003).

The court of appeals affirmed the appellate division's order. The statutes governing judges and lawyers clearly require that disciplinary proceedings remain confidential, even after termination, where there is no finding of wrongdoing. While the legislature had not spoken as clearly in the case of doctors, the court of appeals believed it intended the rule to be the same.

The court of appeals found this holding did not resolve the present case because one charge of wrongdoing was sustained while all the others were dismissed. The petitioner contended the department had an obligation to separate the sustained charge from the dismissed ones and to make public only materials relating to the former. Under the unusual circumstances of this case, the court of appeals agreed.

STANDARD OF CARE

Cook v. Jefferson Parish Hosp. Serv. Dist. No. 2,
No. 04-CA-17 (La. Ct. App. May 26, 2004) - DEx 85440, 4 pp.

The Louisiana Court of Appeal, Fifth Circuit, ruled a trial court did not err in finding that the nursing staff of East Jefferson General Hospital breached the applicable standard of care by not creating a "Falls Care Plan," since documentation of this plan could not be found in the patient's record. However, the court of appeal found the trial court erred in awarding that portion of medical expenses that were "contractually adjusted" or "written-off" by East Jefferson pursuant to Medicare. Thus, the court amended the judgment to delete the special damages award for those medical expenses.

Dubois v. United States,
No. 02-CV-184-B-W (D. Me. June 2, 2004) - DEx 85585, 9 pp.

The U.S. District Court for the District of Maine ruled the federal government was not liable for medical malpractice when a Veterans Affairs (VA) Medical Center prepared a patient's bowel before surgery. The bowel preparation did not fall below the appropriate standard of care.

On Oct. 3, 1997, Herve Dubois was diagnosed with prostate cancer. Dubois chose to proceed with an operation known as a radical retropubic prostatectomy (RRP).

Dr. Vickers performed the RRP on Dec. 30, 1997, at the VA medical center in Togus, Maine. Dubois had a difficult time in the immediate post-operative period. He became confused and hallucinatory. He gradually improved, however, and by Jan. 8, 1998, was discharged.

Given his "very aggressive prostatic cancer," Dr. Vickers was concerned that "residual tumor in the pelvis" might prevent proper healing of the rectal wall. He raised the possibility Dubois could develop a recto-cutaneous or recto-urethral fistula and placed him on drug therapy to promote healing. Unfortunately, Dr. Vickers' concerns were justified: Dubois developed a fistula between the rectum and the urethra.

Dubois died on Nov. 14, 2001. The cause of death was respiratory failure secondary to metastic carcinoma of the prostrate with a contributory cause of diabetes. Priscilla Dubois, widow and personal representative of Dubois, sought damages from the federal government under the Federal Tort Claims Act for what she contended was malpractice committed on Dec. 30, 1997, at the Togus VA.

The plaintiff's malpractice claim centered on whether the Togus VA adequately prepared Dubois' bowel for surgery. The plaintiff contended fecal matter escaped from the rectum and contaminated the area outside the bowel, contributing to the development of the fistula. The plaintiff's argument was buttressed by Dr. Vickers' description in the discharge summary that the "prep was inadequate."

The Togus VA responded that Dubois' bowel prep did not violate any recognized standard of medical care and, if it did, there was no proximate cause between inadequate bowel prep and Dubois' development of the fistula.

The district court granted judgment in favor of the government. It concluded Dubois bowel preparation did not fall below an appropriate standard of medical care and, in any event, did not cause injury to Dubois.