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"When there is no reason, the people perish."

— *Proverbs 29:18*

Information for Authors

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1. An e-mail or letter should introduce the manuscript, name a corresponding author and include full address, phone, fax and e-mail information. The e-mail or letter should disclose any financial obligations or conflicts of interest related to the information to be published.

2. The title page should contain only the title of the manuscript. A separate list of all authors should include full names, degrees, titles and affiliations.

3. The manuscript's pages should be numbered, and length should be between 2,750 and 5,000 words, with references (in Associated Press style) and tables attached.

4. Any table or figure from another source must be referenced. Any photos should be marked by label on the reverse side and up direction noted. Tables and figures can be supplied in EPS, TIF, Illustrator, Photoshop (300 dpi or better) or Microsoft PowerPoint formats.

5. The number of references should be appropriate to the length of the text, and references should appear as endnotes, rather than footnotes.

6. Commentary, letters to the editor and reviews are accepted for publication. Such submissions and references should be concise and conform to the format of longer submissions.

7. If sent by mail, a PC-compatible disk or CD-ROM should accompany a printed copy of the manuscript. Microsoft Word format is the preferred file format.

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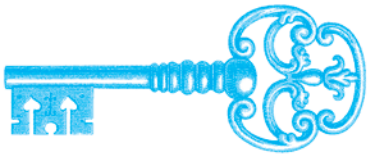
Message from the Chair



A GOOD YEAR FOR PUBLIC PROTECTION

A SUCCESSFUL YEAR

It has been an exciting and inspiring year to serve as Chair of the Federation of State Medical Boards. During the 2003-04 fiscal year, the Federation and its member medical boards made great progress in several areas which have the potential to change the face of medical regulation and licensure as we now know it. Working together, we have helped lay the foundation for measures that will positively impact public protection for years to come.

THE USMLE STEP 2 CLINICAL SKILLS EXAMINATION

In just a few short months, the USMLE Step 2 Clinical Skills Examination will finally become a reality after years of development and millions of dollars of investment. The first testing center opens in Philadelphia in June, and four more centers will open in other areas around the country in ensuing months.

The Step 2 CS is the most substantive change made in 40 years to the way we evaluate physicians for medical licensure. It mirrors a physician's typical workday in a clinic and other settings using "standardized patients." In essence, Step 2 CS assesses whether a physician-in-training can demonstrate the fundamental clinical skills essential to safe and effective patient care under supervision.

The USMLE does an outstanding job of measuring cognitive and analytical skills, but the fact is that the best multiple-choice examinations cannot adequately assess clinical and communication skills. Step 2 CS will identify the small but significant number of examinees who can pass the cognitive knowledge exams, but lack basic clinical and communication skills necessary to practice medicine safely.

Thomas D. Kirksey, M.D.
Chair, Federation of State Medical Boards

LICENSE PORTABILITY

I'm pleased to report that the Federation and its member boards have made significant progress in advancing an important public policy adopted by the House of Delegates – license portability. This issue is becoming increasing important, as advances in the development of telemedicine, telephone triage, e-health and Internet medical practice are escalating pressure on states to reduce the burdens of interstate licensure. Recently, concerns about homeland security and emergency preparedness have further magnified the need for health care practitioners to be able to provide services across state lines.

Executives from six medical boards in the West and six boards in the Northeast met in January to design two demonstration projects for facilitating license portability between states. The two groups are now working with Federation staff and MARC Associates to obtain funding through the Health Care Safety Net Act of 2002 so that they may implement the demonstration projects. Key congressional representatives from each of the participating states have been identified and contacted to solicit their support for funding the appropriation requests. This is an exciting initiative and one that represents significant progress in efforts to facilitate license portability.

In another development, a Federation and Administrators in Medicine (AIM) workgroup is nearing completion of an online common license application. Sorting through and finding common ground on this issue

was a gargantuan task, and I applaud the executives from 11 boards who have stayed the course to see this task through completion.

MAINTENANCE OF LICENSURE

Finally, I'd like to touch briefly on an issue that is close to my heart – maintenance of licensure. In one of my first acts as the Federation's new Chair in 2003, I formed the Special Committee on Maintenance of Licensure. I felt it was essential for the Federation and its member boards to take a leadership role in this issue. The public is demanding that we as a profession demonstrate our competence through our professional lifetimes, and medical boards need to play a leadership role in framing the debate to come.

At this year's Annual Meeting, the House of Delegates will consider a recommendation from the special committee that, if approved, would mean that for the first time in its history the Federation would have public policy in support of states ensuring the ongoing competence of licensed physicians. This would be a truly historic happening and would send a loud and clear signal to the public that we hear them.

Speaking of the Annual Meeting, I would like to personally invite you to attend this year's three-day session in beautiful Washington, D.C. The line-up of educational events is outstanding. Homeland Security Secretary Tom Ridge is going to address attendees about the important role of medical boards in preparing for national emergencies. And attendees will have the opportunity to personally meet with their Congressional representatives on Capitol Hill. Visit www.fsmb.org for more information. I do hope to see you there.

ALL GOOD THINGS

All good things must come to an end. On May 1 my term as Federation Chair will draw to a close and Dr. Doris Brooker will assume the duties of this office. It has been a rare pleasure and a privilege to serve you in this capacity during the past year, a year that has seen great strides and innumerable small steps toward safer medical practice. The progress we have made is not always immediately apparent to the public we serve, and acknowledgement and appreciation for your efforts can often be long in coming. Your tireless dedication to public protection is an inspiration to us all. I would be remiss if I didn't make a special acknowledgement of the Federation staff for their resolute dedication to public safety and the cause of medical regulation. They too are a cause of inspiration. I look forward to bearing witness to our continuing progress in the years to come.

EDITORIAL

COMMENTARY ON PHYSICIAN REGULATION IN DELAWARE

E. Wayne Martz, M.D.

On May 22, 2003, ***The News Journal*** in Dover, Del., published a short article by Randall Chase of the Associated Press indicating that Delaware ranked 50th among the 50 states in number of doctors disciplined by its medical licensing board. The article quotes Public Citizen, which in turn is passing along information provided by Sidney Wolfe, M.D., well-known leader in the campaign to point out flaws in the medical profession and its governance. The assumption is made that because Delaware draws its doctors from the same pool that other states do, there are probably a lot of Delaware doctors who should be disciplined but are not. I propose to take issue with that assumption, offer some reasons why it may not be valid, try to identify some reasons for the low numbers and offer ideas for correction, if it is deemed advisable.

My own background was in private practice of internal medicine (Pittsburgh) followed by a career in medical education, mostly in Delaware, 1962-1986, and an attempt to improve the Delaware Board of Medical Practice (BMP) as the last physician executive director, from 1992-1995.

Articles such as the Chase/Wolfe piece appear in the press about once a year. They purport to reflect public opinion, although actually they reflect only the opinions of a few people, some of whom may have a hobby horse to ride while others an axe to grind. I am not sure how one judges public opinion. Many think they know it by intuition, but my own intuition is that many of the concepts of how medicine controls itself date to 100 years ago when the medical profession had little to offer but mystery and compassion, and therefore was clannish and protective. Things have come a long way since then, and most doctors today have more patients than they can comfortably deal with. They recognize there may be a fringe 1 percent of doctors who practice marginal medicine. These doctors are an embarrassment to the other 99 percent, who would like to see them dealt with in some humane fashion so they could not hurt the public or damage the reputation of the 99 percent. The 99 percent recognize the importance of public confidence in their work and are willing to make whatever changes are necessary to achieve it. The history of the Delaware board during at least the past 30 years, to my knowledge, shows change after change intended to assure the public that the medical profession is not some "old boys' club" out to protect their own, but a body of dedicated, hard working professionals striving for the best for their patients (the public). Most of the changes made have been patching up a basically flawed system and have consisted of adding more and more lay people to the board and its governance.

The basic fault with the board is a confusion of goals. It originally was for quality control, but now a new goal is proposed by Chase/Wolfe: the punishment of physicians. A lot of thought went into constructing the Delaware board and it still works — albeit with difficulty — but function follows structure, and an organization designed to ensure a high quality standard of medical care may not work well if we are trying to get minimum response time to complaints or maximum number of doctors disciplined. There must first of all be some agreement on goals, and the yardstick that will be used to measure progress toward these goals.

The following is a description of the organization and operation of the board, intended to illustrate how little control medicine actually has over its own discipline. Those familiar with this may want to skip to

"How Delaware is Different."

DELAWARE BOARD OF MEDICAL PRACTICE: ORGANIZATION AND OPERATION

Actionable complaints can be considered in two major categories: 75-80 percent relating to physician behavior, and about 20-25 percent relating to patient care.

The present organization of the board may seem a bit unusual to say the least. Every state function must be under some cabinet position, presumably to facilitate communication with the executive branch, and to identify someone to speak for and support that function. The Delaware board falls under the Department of Administrative Services. Some say that each secretary should have at least one function that is self-supporting, not dependent on tax revenue, and the secretary for Administrative Services has the Division of Professional Regulation (DPR), among others. The division director, like the cabinet secretary, is a political appointee, and may change from time to time according to changes in the state government. The DPR issues licenses, and many groups want the prestige that goes with licensure as well as the control of competition. If they all cost the state money, the tax burden might be formidable, so they are all grouped under DPR and licensure income is pooled to cover operating expenses. Some are too small to pay their own way while others generate a surplus, but overall the DPR breaks even. The biggest income producer is nursing; the second biggest is medicine. To change this could impact all the other 30-some licensing boards. For better or worse, the doctors are in there with the boards controlling gaming, massage/body works, adult entertainment and all the rest. The lawyers somehow escaped and report directly to Superior Court, where they answer to other lawyers. The position of executive director of the Delaware board is a career position that requires an advanced degree and rigorous screening. The board consists of 15 persons, 10 of whom are physicians, and the rest are lay people, usually with no prior health care experience. All are appointed by the governor from a short list and serve virtually without pay (10 meetings per year in Dover, can request $50 per meeting attended plus mileage; nothing for other time and expenses). They elect one of their members, physician or layman, as their president.

As complaints are received, they are assigned to a physician board member as principal co-investigator. This assignment can vary at the discretion of the executive director. Complaints are also assigned to one investigator from a panel of former police and others skilled in criminal investigation. The length of the investigation depends on the complaint, but can be long and tedious. When all necessary information has been collected, it is given to a designated representative of the attorney general's office, and it is he or she who sets the agenda from then on. He or she has professional medical opinion from outside the board available on request as to whether the medical care rendered meets community standards or not. It is the attorney general who decides if formal, legal disciplinary action is to be taken, and great care is taken that only the principal investigator knows the identity and the charges against any given doctor. This is to keep the rest of the board untainted so they can vote impartially if there is a formal hearing and action.

The board has essentially two major functions: first, receiving applications for medical licensure, processing them, interviewing the applicants and approving or disapproving them for licensure; and second, receiving, processing and resolving complaints. Actionable complaints can be considered in two major categories: 75-80 percent relating to physician behavior, and about 20-25 percent relating to patient care. A partial list of behavioral items would include such things as unseemly public conduct, substance abuse, molesting patients, failure to organize or supervise office staff, breeches of confidentiality, misrepresentation and failure to keep up with medical education. Patient care would include errors of judgment, faulty diagnosis or treatment and neglect of care of a patient. In general, a doctor is not prosecuted for a single error in care unless it is grossly negligent or outrageous. The error may be called to his attention and corrective action urged. Repeated errors, defiance of suggestions or a pattern of care that could prove hazardous or detrimental to patients or the public, merits disciplinary action. It is in this area,

where judgment enters, that state medical boards differ, being harsh or lenient. Some are prone to punish for a single infraction. Others are not. Some states, like Alaska, which needs doctors, may be more lenient than Florida or California, which have plenty. The latter can be very impersonal and mechanical in their processing.

Once formal disciplinary action is taken against a doctor, the action is a matter of public record. It is reported to three data banks: the quickest, the Federation of State Medical Boards; the second, the American Medical Association; and the third, the National Practitioner Data Bank. If a doctor holds a license in more than one state, all are automatically notified of the action of the disciplining state and take similar action against the doctor's licensure in their own state.

I simply do not agree with the premise of the Chase/Wolfe article that we should have the same proportion of miscreant physicians as every other state.

HOW DELAWARE IS DIFFERENT

Each state is in some ways different from other states, and people who have lived in many areas recognize some of the ways Delaware is unique. We do not have the same resources or population as some other areas, so we have had to develop our own methods of coping. Certainly this is true in medicine, and for many years we have tried to make ourselves attractive to good doctors. For example, Christiana Care Health System, which includes more than half the doctors in the state on its staff, was formed out of three average-sized hospitals in 1965, and in 2002 was named by a national agency as 34th in the nation in quality of care and organization. Delaware still interviews every doctor licensed in the state. Most other states do not do this. Our state medical society is the only state society that jointly sponsors with hospitals to provide quality education for physicians. All other states accredit hospitals to conduct their own intra-hospital programming, but Delaware is singularly the only state that chooses to bypass this step to ease the burden on the hospitals. There are more than 1,000 hours of accredited CME per year in New Castle County alone, and Kent and Sussex counties have their own. Most of these are free of charge to encourage physician attendance. It takes 20 hours per year to qualify for license. The Medical Society of Delaware keeps a computer record of conference attendance for all of its members and, as the licensure biennium approaches, sends out to all members a tabulation to remind them of any hours they are short of legal qualifications. All hospitals in the state conduct quality control programs, department by department, with confidential review of patient records by small committees. The confidentiality is important as it encourages doctors to report irregularities. Any careless or marginal doctors are called in for counseling. This can be as specific as a surgeon being advised not to do a particular type of surgery until he has gone for further intensive training. If he fails to comply, he may find that he is simply not scheduled in the operating room. If he is so resistant that action is taken, it is reported to the board as a complaint, and this is the single most productive source of complaints. Other complaints may involve personal antagonisms, misunderstandings or technicalities, but these are really patient care.

All of this is not descriptive of statewide conditions in any other state. They may have this high quality in some areas, but not statewide. Thus, the overall quality is better in Delaware. Good doctors like to practice with good doctors. Each year our residency programs attract new graduates from across the country. When they see the quality of medicine practiced here, many of them stay. I simply do not agree with the premise of the Chase/Wolfe article that we should have the same proportion of miscreant physicians as every other state. Without criticizing other states, it is clear that each state has its own problems, and in some high-density areas the only way they can deal with them is wholesale processing of disciplinary actions.

Having made the point that Delaware is different, the fact remains that we do have a smaller number of actions. The Chase/Wolfe-type article will be back every year, and if we let them stampede us into some hasty action, we could easily wind up worse off. We must decide and agree what our most important goal

is and how we (and not Dr. Wolfe) want to measure it. Perhaps incremental change toward a final model would be best. We need open discussion. If we decide to go for the numbers game, that certainly would require an expensive and extensive reorganization.

I should like to try to give a feel for day-to-day operations of the board and summarize 30 consecutive cases disciplined in another state and how they might have been handled here. Like every job, the executive director of the board has good and bad features. Dealing every day with people who feel they have been wronged, and their contentious relationship with those accused of the wrongdoing, is hardly pleasant work. Add to that the bureaucratic constraints of government service and the legalistic restrictions of the attorney general and you can get a frustrating environment. However, all this goes with the territory and has to be accepted.

Dealing every day with people who feel they have been wronged, and their contentious relationship with those accused of the wrongdoing, is hardly pleasant work.

In sharp contrast to all this unpleasantness is the irrepressible good nature of the people of central and southern Delaware who work at the DPR and make it a fun place to work. They work hard, but they are not uptight about it. After all, this is part of what makes our beach communities and our racing and gambling activities so inviting and pleasurable to vacationers. The very fact that we lump our gaming, massage and adult entertainment boards in with medicine, real estate, nursing, riverboat piloting and all the others, says something about the attitudes that prevail.

I recently had the opportunity to review 30 consecutive disciplinary actions by the medical board of a bigger state. It would take 10 to 15 years for Delaware to accumulate that many "bad doctors." Of the 30 actions, only six were for defects in medical care, and five of those were for single errors. Delaware does not usually punish single errors unless the doctor is grossly negligent or outrageous. The harm done to thousands of patients by suspending the doctor's license outweighs the benefit from appeasing one who feels wronged, unless the doctor's actions are clearly dangerous. Depending on the specific circumstances, some of those six would have been warned or advised, but not disciplined. Another six were out-of-state doctors who happened to have licenses in the disciplining state. They would be disciplined in Delaware or anywhere else. Of the remaining 18 that were not for patient care at all, about half would have been punished in Delaware, but the other half would have simply been corrected or would not have come up in the first place (errors by office staff, insufficient CME hours, application errors, etc.).

Thus, of the 30 doctors disciplined in another state, about half would have been dealt with in a different way in Delaware. We need to think seriously of whether or not we want to play the numbers game. Incremental changes might well enable us to gradually achieve the changes we want without compromising what is an above average medical care system. For example, adding physician members to the board would relieve some of the pressure to leave enough members uncontaminated for decision-making. On the other hand, although the board would clearly benefit from more autonomy (vigorously denied by Administration) and the ability to determine its own fees and budget independent of the DPR, such a change would inevitably affect other boards and should be approached with caution.

SUGGESTIONS FOR CHANGE

Since about 1994 there has been a panel of 30 to 40 volunteer physicians who make themselves available to review cases in an advisory capacity at the request of the attorney general or the executive director of the board. The purpose is so that board members who may later have to vote on a disciplinary action should not have to bias themselves by becoming familiar with a case early. The panel is too large to have regular meetings, yet never large enough to have representatives of every specialty and subspecialty. Another weakness is that it has no official status, so some members feel exposed to nuisance reprisal suits by disciplined doctors. I propose that this large panel be supplemented by a five- to six-person committee representative of the broad fields of medicine and surgery. They should meet every six to eight weeks to review all patient care complaints received since the previous meeting, with privacy

and anonymity preserved. They should render an opinion whether or not each doctor's care meets the community standard. If not, was it grossly negligent or egregious? If the committee feels that a specialist or subspecialist will be needed eventually to testify, it would undertake to identify one, perhaps from the current panel. They should meet at a convenient location with the executive director of the board, a deputy attorney general and the designated investigator, who would be included for his or her education as to what sort of information is needed and how to obtain it. I propose they serve for one year at a time, renewable at their own pleasure. This could be tried first in New Castle County and, if successful, expanded to Southern Delaware.

Since about 1994 there has been a panel of 30 to 40 volunteer physicians who make themselves available to review cases in an advisory capacity at the request of the attorney general or the executive director of the board.

In order to make it feasible to recruit the best people for this committee, it should have status and prestige, and I would suggest a name such as Preliminary Review and Advisory Committee to the Board of Medical Practice, and require it to submit a quarterly progress report of its opinions. This could be implemented by the existing board under its current operating regulations as a subcommittee of the board. This would expedite the entire process, make it more open and broaden the public's understanding as to the number and nature of complaints, and some of the reasoning behind resolving them. This would introduce an incremental change in the operation of the board that could be followed up in any of various directions in future years. It should become clear that they are interested primarily in good quality, safe health care throughout the state, and not in playing some numbers or quota game. Changes could be made from time to time that are responsive to the true informed wishes of the public.

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Legislative Strategies for Medical Boards

Former U.S. Congressman Barber Conable once remarked "exhaustion and exasperation are frequently the handmaidens of legislative decision."[1] By the end of any busy legislative session, many medical board directors, staff and members would agree. Most have their share of war stories about meetings that ran until 2 a.m., AWOL bill sponsors and eleventh-hour ambushes. Yet as undeniably frustrating as the legislative process can be, it is also absolutely essential. Indeed, legislation lies at the heart of everything that boards do, so it pays to gain a deeper understanding of the process and learn some proven strategies for influencing it.

The degree to which medical boards can interact with their legislature varies from state to state. Some boards have relatively direct access. "Others are actually subdivisions of the state Department of Health, and, in that case, the department would be the entity interacting with the legislature," says Jeanne Hoferer, manager of Legislative Services at the Federation of State Medical Boards (Federation). Obviously, then, any general strategies for dealing with legislative issues would have to be adapted to a board's specific circumstances. Whether access is direct or indirect, though, boards can play an important role in shaping the laws that determine what they do, what funds they receive and how well the public is protected. Below, some savvy folks who have learned to navigate the legislative waters share their insights about what works — and what doesn't.

BUILDING RELATIONSHIPS

If the first rule of real estate is location, location, location, then it might be said that the first rule of lobbying is relation, relation, relation. "Lobbying is all about relationships and connections," says Lyle Kelsey, executive director of the Oklahoma State Board of Medical Licensure and Supervision and previously a lobbyist for the Oklahoma State Medical Association. The other experts contacted for this article all agreed that relationship building is a core skill for anyone hoping to have an impact on legislative decisions.

The first step is to identify the key players. Try to anticipate who the next session's movers and shakers — and especially the members of relevant committees — are likely to be. "In every legislature, there are people who have specialized in certain areas. Here in Alabama, I'm considered to be someone who is very interested in and knowledgeable about the health care field," says Larry Dixon, who is currently not only a state senator, but also executive director of the Alabama State Board of Medical Examiners. While the health care leaders in your state may not be quite so obvious, it is usually fairly easy to figure out who they are.

Once you have identified these key legislators, make it a point to establish and nurture relationships with them during the interim. That way, you will already be a familiar and trusted resource once the next session begins. "The first few times we make contact, we don't ask for anything," says Tina Steinman, executive director of the Missouri State Board of Registration for the Healing Arts. "We just go over to their office to introduce ourselves and let them know we're here."

Your initial goal should be simply to acquaint legislators with who you are, what the medical board does and how to reach you. "Let them get to know the board," says Dixon. "Have them meet some of your board members, and invite them to the public portion of board meetings." Dixon has even taken legislators to Federation meetings when funds allowed in the past. However, "unlike what the media would have you believe, you don't have to buy legislators dinner to get their attention." It is far better to make an impression with your sterling professionalism.

Linda Wasmer Andrews, Special Contributor to the Journal of Medical Licensure and Discipline

Don't forget the legislator's staff, either. They are often your first point of contact — and sometimes your only point, when legislators are tied up with other business. In addition to serving as middlemen for information, staff members may also be intimately involved in the nitty-gritty of policymaking. "If they know you as someone who is honest and reliable, they're more likely to turn to you when they need information fast," says Jane McFarland, special projects manager at the Texas State Board of Medical Examiners. This is an excellent way to establish the board as a resource for objective data on such issues as how many physicians are practicing in a state, how many complaints there are and whether a state is really losing doctors.

CREATING ALLIES

While you may focus a lot of attention on a few key players, don't ignore the rest. Nancy Achin Audesse, executive director of the Massachusetts Board of Registration in Medicine and a former state senator, suggests dropping off brochures on how to file a complaint in every legislator's office. Let the staff know that, if any constituents call about a problem with a physician, they can send out a brochure and direct the caller to the medical board. "It seems like a small thing, but constituent service is a big part of any legislator's day," says Audesse. "To the degree that you can make it easier, you're being helpful and showing professionalism. But the legislators also become your education and outreach arm in dealing with their constituents."

In Massachusetts, medical board staff members sometimes travel around the state giving presentations about their physician profiling program, the first of its kind in the nation.

In Massachusetts, medical board staff members sometimes travel around the state giving presentations about their physician profiling program, the first of its kind in the nation. "If we're going out to a senior citizen group or public library, we always inform the appropriate legislators that we'll be going into their district and invite them to attend," says Audesse. "It seems hostile to legislators if you don't." On the other hand, by keeping them informed, you not only make allies, but also get another chance to educate those legislators about the services your board provides.

"The number one thing that legislators hate is losing an election," says Audesse. "However, the number two thing is being surprised by something in the press." Once again, a friendly heads-up is often both appropriate and appreciated. For example, consider the worst-case scenario in which there are numerous victims from one area in a sexual misconduct case. "Once the public action has been taken, there's no harm in calling the legislator and saying, 'I just wanted you to know that there's going to be a lot of press in your district about an action the board took.'" This gives you an opportunity to tell the legislator about the action, and it gives the legislator time to collect his or her thoughts before the calls from reporters start rolling in.

Keeping in touch is good, as is making sure that legislators know about the board's vigilance and diligence. However, wearing out your welcome is definitely counterproductive. "You don't have to be at their doorstep every day," says Dixon. At the start of a busy legislative session, often all that is needed is a courteous letter reiterating that you are ready and willing to answer any questions the legislator may have, either in person or by phone, whichever is more convenient.

In all your contacts, keep your message as focused as possible. Never lose sight of your mission as an ambassador for the medical board. "I'm a single-interest person," says Trey Delap, deputy executive director of the Nevada State Board of Osteopathic Medicine. "I don't try to be their guru of health care . But I do try to be their guru of professional medical regulation for osteopathic physicians.

Your value as a resource will be greatly enhanced if you stay on top of pertinent legislation. Within your own state, make frequent use of online bill-tracking services as well as your personal contacts. For information about what is happening elsewhere, the Federation's Legislative Services Department can be very helpful. "We monitor state and federal legislation that has the potential to affect state medical boards, medical regulation or any of the issues that the Federation has a position on," says Hoferer. The Federation provides other kinds of assistance as well, such as identifying national trends, providing sample legislative language from other states, writing letters to legislative leadership, assisting in drafting testi-

mony and sometimes presenting testimony to support member board initiatives or reinforce opposition to particular issues.

FINDING SPONSORS

At times, you will need to approach a legislator about authoring a bill or championing it in the legislature. If you have been conscientious about relationship building, the groundwork should already be laid, and you should know enough about the individual interests and strengths of various legislators to find the best match for your bill. "When it's going to be a difficult bill, you want a very strong person who's well respected and probably in the majority party," says Linda Whitney, chief of legislation for the Medical Board of California. "When it's a bill that crosses party lines, sometimes it's helpful to get a member from both sides to serve as coauthors. And when it's a bill that has to do with a lot of licensure and technical kinds of things, you want to make sure you have somebody from the original policy committee carrying it, because they're the ones who really understand the technical issues."

Once you find the right author or sponsor, your job has only begun. First, you need to make sure that the sponsor is fully informed about what the bill involves, why it is important and who the opposition, if any, is likely to be.

Whitney's skill as a matchmaker is seen in her success at finding the right author for Assembly Bill 948, a board-backed bill that was signed into law in 2003.[2] This bill gives the board authority to approve fellowship programs for nonlicensed physicians who, under the supervision of a licensed physician, would provide primary care in clinics located in underserved areas. These fellowship programs are still in the discussion stage. However, this was a necessary first step in the development process, since California law requires the board to approve any such programs.

Whitney says the board would ordinarily approach a member of the Business and Professions Committee about authoring this type of bill. In this case, however, she approached Assemblyman Fabian Núñez, who is a relative newcomer and not a member of the professions committee. Nevertheless, Núñez does sit on the Future of California's Health Committee, and he is known to have a deep interest in bringing quality medical care to underserved areas, including those in his district. He turned out to be an effective champion for this particular legislation.

Once you find the right author or sponsor, your job has only begun. First, you need to make sure that the sponsor is fully informed about what the bill involves, why it is important and who the opposition, if any, is likely to be. "Then, each time the bill comes up for a hearing, we make sure we meet with the sponsor that day to go over the issues one more time," says Steinman. "We put together bullet points for them to use when they make their presentation." These points should briefly highlight the main ideas of the bill in easy-to-communicate terms.

"You don't ever want to embarrass your sponsor," adds Steinman. "You don't want them up there looking like they're sponsoring something just because they were asked to. Instead, you want it to be clear they're sponsoring the bill because they understand it and believe in it." The time invested in educating sponsors and providing a quick pre-hearing refresher is time well spent.

OVERCOMING OPPOSITION

Legislators aren't the only folks who can make or break a bill, of course. Interested parties, such as the state medical society, can certainly sink a bill by lobbying against it. As a result, medical board staff often put considerable time and energy into lining up support from these parties — or, at least, trying to head off active opposition. In Missouri, for example, the board is under the Division of Professional Registration, which is under the Department of Economic Development, whose director reports to the governor. If the board wants to pursue legislation, it must first obtain approval from the division director, department director and governor's office. "But before we even start up that flagpole, we usually run any legislation past our state medical association and state osteopathic association to get their reaction," says Steinman.

A negative reaction doesn't necessarily mean that a bill will be dropped, but it does mean that a concerted effort will be made to find a mutually acceptable compromise. "There are going to be times when you just have to agree to disagree and go against each other, but that should only happen rarely," says Steinman. It benefits everyone if the medical board and medical society have a good working relationship

based on mutual trust and two-way communication. On a pragmatic level, having the medical society's stamp of approval improves the odds that a bill will make it all the way to the top of the flagpole.

The need for compromise is even more vital when conflict arises with another governmental agency. In Montana, the medical board is one of several licensing boards under the Department of Labor and Industry. Here, too, the department and governor's office must approve any legislation sought by the board. "If it's too controversial — let's say, if it's an issue between medical and nursing — the governor may decide not to take one side or the other, so the legislation never makes it through the executive branch," says Jeannie Worsech, executive director of the Montana Board of Medical Examiners. In such cases, the board might then approach the state medical association and ask them to carry the ball. However, a better solution is to avoid getting into this position in the first place, by ironing out differences with other boards before a bill ever lands on the governor's desk.

A cooperative approach can also come in handy when a medical board opposes a bill backed by other parties. A good example of this occurred in New Mexico, where the board found itself at odds with a bill that granted limited prescribing authority to specially trained psychologists. When the psychologist prescribing bill was first introduced, "we opposed it, because it was so badly written," says medical board member Grant La Farge, M.D. "Psychotropic drugs are very complex medications, so it's important to know what the heck you're doing if you will be prescribing them." La Farge and many other physicians felt that the bill in its original form called for neither sufficient training nor adequate medical supervision for new prescribing psychologists. Nevertheless, the medical board understood the bill's grassroots appeal. "It's intended to create more access for patients," says La Farge. "There are twice as many psychologists as psychiatrists outside the major cities in New Mexico."

Once a bill finally makes it to the legislature, you still have your work cut out for you. Often, this includes testifying — one of those tasks that looks deceptively easy to do, but is actually quite difficult to do well.

The version of the bill that ultimately passed in 2002 was revised to address many of the medical board's concerns.[3] In pushing successfully for these changes, the board emphasized objective, scientific evidence. The law now mandates joint decision-making by the New Mexico Medical Board and Board of Psychologist Examiners on many critical matters, including approval of an educational program and certification exam. There are still unresolved implementation issues, which a joint committee of the two boards is currently trying to hash out. In general, though, the final version of the bill offers much better protection to the public than the original, thanks to skillful collaboration and negotiation by the medical board.

GIVING TESTIMONY

Once a bill finally makes it to the legislature, you still have your work cut out for you. Often, this includes testifying — one of those tasks that looks deceptively easy to do, but is actually quite difficult to do well. "I'll usually call over to the committee staff and try to understand what kind of witness they want," says McFarland. "Do they want the executive director there with his recognition and authority? Or do they need a detail person who can rattle off statistics about our licensing process?"

Of course, the goal is to send the best person to answer the legislators' questions. When that person is you, "make sure your remarks are clear and concise," says Whitney. "If there are any fiscal considerations, be sure to mention those. If you don't know the answer to a question, say, 'I don't know, but I can get back to you on that.'" Try to avoid this, however, by arriving well prepared. If you have strong opposition, Whitney suggests that you proactively address the main points you believe your opponents will raise, since you generally will speak before they do.

Occasionally, you may be called upon to make a very formal public statement — especially "when there is a great deal of media interest, and they are looking for clips for the evening news," says Audesse. In most cases, however, it isn't a good idea to simply hand legislators your written testimony and read it to them. "It is usually far more effective to send your technical briefing about the bill to members of the committee before the hearing," Audesse says. "Then, at the hearing, you can say something like, 'Members of the Healthcare Committee, we have previously given you our concerns. Let me briefly recount those for you.'" Quickly reiterate the high points to refresh their memory, and offer to answer any questions.

At times, you may be waylaid by comments that seem staggeringly irrelevant or even hostile. "Sometimes, legislators simply want to make a public statement about their problems with some doctor somewhere, and they just happen to pick that time to perform," says Donald Patrick, M.D., J.D., executive director of the Texas board. "I've been picked on a little bit! But I realize it's not personal, so I don't take offense. I just smile rather grimly and say, 'Well, we're doing our best to work on that. I appreciate you bringing it to my attention, and we'll work harder on it.'"

Keeping your cool at all times with legislators can be one of the more challenging parts of a medical board job.

Indeed, keeping your cool at all times with legislators can be one of the more challenging parts of a medical board job. "But if you get mad or upset, you can really hurt yourself in the long run," says Kelsey. Next week, you may need that legislator again as an ally. Of course, not everyone is blessed with an even-tempered personality. "You need to size yourself up honestly and ask, 'Am I really the person who ought to be doing this?'" Kelsey says. "You may realize that you need to send in somebody who's a little less passionate, from the standpoint of not getting upset or not taking it personally if a legislator says that he or she can't support your bill.'"

SURVIVING SETBACKS

Even with the best-laid plans, however, you may sometimes run into unforeseen snags. That's what happened to the Iowa Board of Medical Examiners in 2003, when they first pursued legislation that would authorize criminal background checks on applicants for new or reinstated licenses as well as licensees who are placed on probation. [4] The board certainly tried to follow all the right steps. They worked not only with a bill writer, but also with the state Division of Criminal Investigation, attorney general's office, and the Federal Bureau of Investigation (FBI) to ensure that the language was crafted appropriately. "I also worked with a variety of professions who wanted to be included in this," says Ann Mowery, Ph.D., executive director of the Iowa board. "The bill that we came up with basically included all of the professional licensing boards in the state" — covering everyone from physicians and dentists to insurance agents and cosmetologists.

The bill passed the Iowa Senate unanimously. However, "when it went to the House, it ended up in committee with a person who is absolutely and totally opposed to the bill, and won't give any reason why," says Mowery. As a result, the bill got stuck in committee. One possible explanation, Mowery reasoned, was the inclusion of so many professions, most of which had a much less compelling need for criminal background checks than medicine. In an effort to resolve the impasse, "I offered to take out every single profession but medicine, but that didn't fix the problem." Mowery also sought advice from the governor's staff and House leadership, but she has yet to find a way to move this seemingly immovable legislator. Currently, she is looking for someone other than the board to sponsor the bill — possibly a legislator with a background in law enforcement — so that it won't be assigned back to the same committee in 2004.

This highlights another trait that can be invaluable when dealing with legislative issues: patience. Beyond that, you need persistence, an even temper, and — perhaps most importantly — a reputation for integrity and sound judgment. "We don't have any lobbying resources here other than our staff and our credibility," says Tom Dilling, J.D., executive director of the State Medical Board of Ohio. "We wouldn't get anywhere near as much accomplished if we didn't have a solid record of making prudent decisions."

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LEARN MORE ABOUT THE LEGISLATIVE PROCESS

Navigating the intricacies of the legislative process will be on the agenda at the Federation of State Medical Boards' 92nd Annual Meeting, April 29 – May 1 at the Crystal Gateway Marriott in Arlington, Va. "The Legislative Process, Building Relationships" will feature U.S. Rep. Mike Rogers, whose leadership experience and legislative record created new and unique opportunities usually not open to a relatively new member of Congress. Attendees will explore how state medical boards can be a valuable resource to policymakers, the importance of establishing effective relationships with legislators and strategies for capitalizing on collaborative opportunities to positively affect public protection.

To register or for more information, contact Carol Lucas at the Federation at (817) 868-4007 or at clucas@fsmb.org.

Patience is another trait that can be invaluable when dealing with legislative issues. Beyond that, you need persistence, an even temper, and — perhaps most importantly — a reputation for integrity and sound judgment.

Unprofessional Behavior in Medical School Is Associated with Subsequent Disciplinary Action by a State Medical Board

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The professional behavior of physicians and trainees has received increasing attention from medical school educators, the broader community of medicine and society at large.[1-4] The University of California, San Francisco (UCSF), School of Medicine has a professionalism evaluation system that monitors students' professional behavior longitudinally across their four years of medical school.[5,6] Begun in 1995, the goals of this system are to identify medical students who demonstrate unprofessional behavior, provide a uniform evaluation and response to unprofessional behavior and to remediate that deficiency. If a student receives a less-than-satisfactory rating on professional skills at the end of any course or clerkship, a Professionalism Evaluation Form is submitted. The student and the school then work to remediate the student's deficiencies. Deficiencies in professional skills identified in two or more clerkships (or two courses in the first two years and then a clerkship) are considered to reflect a pattern of deficiencies in professional behavior. At minimum, the dean's letter for application to residency programs will document these areas of concern or deficiencies. In addition, the student is placed on academic probation and, if the professional violations are severe, may be dismissed despite attaining passing grades in all courses and clerkships.

There are other professionalism assessment tools for medical students, but the adequacy of existing assessment tools is uncertain.[7,8] For example, we do not know whether professionalism inadequacies in students affect their subsequent professional performance as physicians. We hypothesized that unprofessional behavior in medical school, rather than more traditional measures such as demographic characteristics and undergraduate and medical school measures of academic performance, predicts subsequent state board disciplinary action. To test this, we conducted a case-control study of UCSF School of Medicine graduates disciplined by the Medical Board of California.

METHOD

Selection of Case Subjects

Approximately 6,330 medical students graduated from the UCSF, School of Medicine between 1943 and 1989. The 70 cases in this study were all the UCSF, School of Medicine graduates who were disciplined by the Medical Board of California from 1990–2000. They were identified through a search of the Medical Board of California's computerized database of disciplined physicians. Discipline, ranging from public reprimand to license revocation, is imposed by the Medical Board of California for violations defined in law.[9] A single disciplinary action may be imposed for multiple violations of law. The discipline history of physicians licensed in California is public as mandated by state law.[10,11]

The Medical Board of California classified its reasons for discipline into nine major categories: negligence, inappropriate prescribing, unlicensed activity, sexual misconduct, mental illness, acts endangering patients through the physician's use of drugs or alcohol, fraud, conviction of a crime and unprofessional conduct.[11] For purposes of this analysis, the staff at the Medical Board of California identified the reference violation as that which represented the highest risk to the public and, thus, subject to the most severe level of discipline.

The American Board of Internal Medicine defines professionalism as requiring "the physician to serve the interests of the patient above his or her self-interest. Professionalism aspires to altruism, accountability, excellence, duty, service, honor, integrity and respect for others."[1] The medical director of the state medical board (author Neal D. Kohatsu, M.D., M.P.H.) used this definition to determine which of the state's working definitions of the nine categories for disciplinary action were violations of professionalism. He determined that all but one, mental illness, was a violation of professionalism. From the perspective of the Medical Board of California, a physician disciplined for negligence should have known that the behavior in question could result in patient harm. For example, an anesthesiologist who chooses to ignore the repeated calls of the nursing staff to see a postoperative patient with a compromised airway is negligent. Such behavior differs from mental illness (e.g., an anesthesiologist with early dementia who has difficulty performing endotracheal intubations under usual circumstances).

Physicians with alcoholism or drug addiction who commit acts that endanger or injure patients are disciplined for those acts by the Medical Board of California.

Physicians with alcoholism or drug addiction who commit acts that endanger or injure patients are disciplined for those acts by the Medical Board of California. Physicians in this category were included as cases in our study. However, physicians with alcoholism or drug addiction who have not endangered or injured patients may be referred (or may self-refer) to the board's Diversion Program for monitored treatment and do not face board discipline. Physicians in this latter category were not included as cases in our study.

Selection of a Control Group

Members of the control group were UCSF, School of Medicine graduates chosen from a randomized sample, stratified by year of graduation (within one year) and medical specialty, from the *Directory of Physicians in the United States*.[12] We confirmed that members of the control group had not been disciplined in another state by reviewing the Federation of State Medical Boards' database of disciplinary actions.

Measurements

The UCSF, School of Medicine's Office of Student Affairs maintains academic files of graduates that contain the student's application to medical school, all course evaluation narratives, grades, administrative correspondence while in medical school and the dean's letter of recommendation for residency programs. These files remain complete even for students who graduated decades ago. Records are not purged. A research assistant with previous experience writing dean's letters of recommendation to residency programs abstracted data from these records. All investigators involved in data abstraction remained blinded to whether the files were cases or controls until the completion of the data abstraction.

We abstracted demographic data, undergraduate grade point average (GPA), raw Medical College Admission Test (MCAT) scores, medical school course and clerkship grades and raw National Board of Medical Examiners (NBME) Part 1 scores on the first attempt. Any negative excerpts about students' professional and personal attributes (defined as one or more words describing less than satisfactory professional and personal attributes) were abstracted from course evaluations, including narratives, dean's letter of recommendation to residency programs, narratives in the students' admission interviews or any other document in the students' files dated before the student graduated from medical school.

The negative excerpts were assigned a severity rank by the research assistant. Two deans of students

(author Maxine A. Papadakis, M.D. and another dean), each with at least a 10-year history of writing and interpreting student evaluations, independently reviewed all negative excerpts and assigned severity rankings. The two deans of students could refer back to the academic file, if necessary, to contextualize the excerpts. When there was discordant ranking, the two deans discussed the rationale and agreed on the appropriate classification while still blinded to the status of the subjects.

The ranking system established thresholds for the severity of the negative excerpts based on those in our current UCSF, School of Medicine professional evaluation system established in 1995. The ranks were:

Good = no adverse comments.

Trace = Student had an occasional constructive or negative comment from an isolated instructor such as "immature," but the composite evaluations and narratives from a course were good. The occasional constructive or negative comment was mild.

Concern = Student had problematic comments in one course. These comments were qualitatively serious (beyond the occasional "immaturity" above), such as "resistant to accepting feedback," "needs continuous reminders to fulfill ward responsibilities," "unnecessary interruptions in class," "inappropriate behavior in small groups both with peers and with faculty," and *would have warranted* the submission of a Professionalism Evaluation Form now used in the UCSF, School of Medicine professionalism evaluation system.[5,6]

Problem = Student had problematic comments in two or more courses at the level of Concern, demonstrating a longitudinal pattern of problematic professional behavior. These students *would have received* two or more Professionalism Evaluation Forms in the current UCSF, School of Medicine professionalism evaluation system.[5,6]

Extreme = Student has Extreme problematic comments, such as "dismissed from the Ph.D. portion of an M.D.–Ph.D. program because he could not work with peers." Student received this rating based on the severity of the comment, even if only made once.

The distribution of specialties practiced by UCSF, School of Medicine graduates was taken from the *Directory of Physicians in the United States*.[12]

Therefore, the analysis of medical school grades was performed by comparing the number of cases in each group who had one or more course grades that was less than satisfactory the first time they took the course.

Statistical Analysis

Undergraduate GPA was converted to a four-point scale (A = 4 points, D = 1 point) by adding one point to each grade when a three-point scale was used (A = 3 points, D = 0 points).

The first graduation class for which all students had MCAT scores available was 1952. This MCAT test was a four-part examination: verbal, quantitative, general and science. Medical school graduation classes since 1977 have taken a six-part examination: biology, chemistry, physics, quantitative, problem solving and reading. The scoring system changed as well: before 1977 scoring was a scale from 200–800; after 1977, it changed to a 1–15 scale. Subsequent changes in the MCAT did not affect our cohort. Because of the differences in scoring, number of subscales and percentile rank changes over time, raw score data were analyzed separately for students who took the test before and after 1977. Mean scores on the total MCAT were compared between graduates who received disciplinary action and those who did not. The MCAT scores were then dichotomized into students in the bottom quartile for each MCAT time period [i.e., test administration year (1) 1952–1976 and (2) 1977–1985]. The dichotomized MCAT scores were used in all subsequent data analyses. Variables were compared by using the *t* test or the chi-square test. The required course work and grading system (letter grades, honors/pass/provisional nonpass/fail) also changed over the decades. Therefore, the analysis of medical school grades was performed by comparing the number of cases in each group who had one or more course grades that was less than satisfactory (letter grade of D or F, or a provisional nonpass or fail) the first time they took the course.

The NBME Part 1 percentile scores were used in all analyses. Only data for graduates after 1977 were available. Mean score differences on NBME Part 1 percentile scores were compared using an independent *t* test for graduates who did and did not receive disciplinary action.

Our *a priori* hypothesis was that severity rankings of Concern, Problem or Extreme would be associated with disciplinary action. Therefore, we dichotomized the severity rankings into Good and Trace versus Concern, Problem or Extreme, and used the dichotomized ranking in all subsequent data analyses. Interrater agreement was 92 percent.

Our a priori hypothesis was that severity rankings of Concern, Problem or Extreme would be associated with disciplinary action.

We analyzed our data by running a logistic regression analysis (SSPS version 11; SPSS, Inc., Chicago, Ill.) with disciplinary action as the dependent variable (yes/no). The independent variables were (1) gender, (2) undergraduate measures (undergraduate GPA and MCAT), and (3) medical school measures (medical school grades, severity ranking) and entered into the model in one step.

An estimate of sample size showed that the study had 80 percent power to determine its primary objective if each group contained 49 subjects. To enhance power, we chose a case to control ratio of 1:3. All researchers participated in data analyses and data interpretation. The UCSF Committee on Human Research approved this study without requiring informed consent from the graduates.

RESULTS

Seventy graduates of the UCSF, School of Medicine (1 percent of the graduates) were disciplined by the State Medical Board of California between 1990 and 2000. The control group contained 200 physician-graduates. The academic files of four graduates (two from the case group and two from the control group) were unavailable for data abstraction; the remaining 68 (case) and 196 (control) graduates were included. All but two control-group graduates resided in California. Characteristics of the two groups are shown in Table 1. Graduation years ranged from 1943–1989, and most graduates were men. There was a small, but

Table 1.

Comparison of Characteristics of Cases and Controls in a Study of University of California, San Francisco, School of Medicine Graduates Disciplined by the Medical Board of California, 1990-2000

Characteristic	Group: Case (%) *n* = 68	Group: Control (%) n = 196	*p* Value
Graduation year (range)	**1944–88**	**1943–89**	
Graduation year (frequencies)			
1943–49	**6**	**18**	
1950–59	**12**	**34**	
1960–69	**16**	**42**	
1970–79	**17**	**48**	
1980–89	**17**	**54**	
Gender (%)			
Men	**60 (88)**	**159 (81)**	**.18**
Age at discipline (years)			
Mean ± SD (range)	**54 ±12 (25–77)**	**—**	
Mean undergraduate GPA	**3.3**	**3.4**	**.04**
Undergraduate GPA < 3.0	**11 (16)**	**26 (13)**	**.55**
MCAT lowest quartile	**18 (26)**	**41 (20)**	**.34**
Not passing 1 medical school course	**13 (19)**	**24 (12)**	**.16**

statistically significant, difference in undergraduate GPA (3.3 for the case group and 3.4 for the control group; $p = .04$). The specialty distributions for all UCSF, School of Medicine graduates, the case group and control group, are shown in Table 2. Two specialties (obstetrics and gynecology and psychiatry) were overrepresented among the case group when compared with the specialties entered by all UCSF, School of Medicine graduates.

The principal reason for disciplinary action in 65 of 68 disciplined physicians was a violation of professionalism (see Table 3). As shown in Table 4, the prevalence of negative comments regarding professionalism in the medical school files was 38 percent (case group) and 19 percent (control group). Disciplined physicians were more likely to have negative comments regarding professionalism in their medical school file (odds ratio, 2.15; 95 percent confidence interval, 1.15– 4.02; $p = .02$; see Table 5). The sensitivity of negative comments for disciplinary action is 38 percent and the specificity is 81 percent. The other vari-

The principal reason for disciplinary action in 65 of 68 disciplined physicians was a violation of professionalism.

Table 2.

Distribution of Specialties for All University of California, San Francisco School of Medicine Graduates, Those Disciplined by the Medical Board of California, 1990–2000, and a Matched Control Group

Specialty	UCSF, School of Medicine Graduates in This Specialty	No. (%) in Specialty	
		Cases	Controls
Emergency medicine	2%	2 (2)	6 (3)
Family practice	8%	10 (14)	26 (13)
Internal medicine	22%	13 (19)	39 (19)
Obstetrics–gynecology	4%	10 (14)*	31 (15)
Ophthalmology	3%	2 (2)	6 (3)
Pediatrics	8%	4 (5)	12 (6)
Psychiatry	9%	12 (17)*	28 (14)
Surgery	11%	8 (11)	24 (12)
Other†	25%	7 (10)	24 (12)
Not available	8%		

*$p < .05$ when comparing the frequency of all UCSF, School of Medicine graduates in the specialty to the frequency of UCSF, School of Medicine graduates in the specialty who have been disciplined by the state medical board.
†Specialty with only one case per group or specialty not specified.

Table 3.

Index Violation Leading to Disciplinary Action by the Medical Board of California for 68 Graduates of the University of California, San Francisco, School of Medicine, 1990–2000

Violation	No. (%) of Cases	
Professionalism	65 (95)	
Negligence		26 (38)
Self-use of drugs or alcohol		9 (13)
Unprofessional conduct		8 (12)
Inappropriate prescribing		8 (12)
Sexual misconduct		7 (10)
Conviction of a crime		3 (4)
Fraud		3 (4)
Unlicensed activity		1 (1)
Mental illness	3 (4)	
Total	68	

Table 4.

Index Violation Leading to Disciplinary Action by the Medical Board of California for 68 Graduates of the University of California, San Francisco, School of Medicine, 1990–2000

Violation	No. (%) of Cases	
Professionalism	65 (95)	
Negligence		26 (38)
Self-use of drugs or alcohol		9 (13)
Unprofessional conduct		8 (12)
Inappropriate prescribing		8 (12)
Sexual misconduct		7 (10)
Conviction of a crime		3 (4)
Fraud		3 (4)
Unlicensed activity		1 (1)
Mental illness	3 (4)	
Total	68	

Table 5.

Logistic Regression Analysis of Factors Used to Differentiate between 260 Disciplined and Nondisciplined Physician–Graduates of the University of California, San Francisco, School of Medicine, 1990–2000*

Predictor	Odds Ratio	Confidence Interval (95%)	*p* Value
Men	1.51	0.65–3.51	.34
Undergraduate GPA	.57	0.25–1.28	.17
MCAT lowest quartile	1.01	0.50–2.05	.98
Did not pass 1 medical school course	1.30	0.59–2.87	.52
Professionalism severity ranking of Concern, Problem, or Extreme	2.15	1.15–4.02	.02

*Predictor variables were coded as follows: male = 0, female = 1; did not pass 1 course = 0, did pass all courses = 1; MCAT lowest quartile = 0, MCAT not lowest quartile = 1; professionalism rank Concern/Problem/Extreme = 0, Trace/Good = 1. Undergraduate GPA was entered as a continuous variable from 0–4.0.

ables were not associated with disciplinary action by the state medical board. These odds ratios were essentially unchanged after removing the three physicians with mental illness from the case group.

The NBME Part 1 scores were available for graduates beginning in 1977 (119). There was no difference in mean (standard deviation) NBME Part 1 scores between case and control groups (cases, 78.1 6.7; controls, 79.6 5.5; $p = .22$). Because there was no significant difference in the NBME Part 1 scores between groups, this variable was not included in the model because of the number of missing data. In the control group, students who entered psychiatry (10 of 28) had the greatest number of comments regarding unprofessional conduct in their files (see Table 4).

DISCUSSION

We found that UCSF, School of Medicine students who received comments regarding unprofessional behavior were more than twice as likely to be disciplined by the Medical Board of California when they become practicing physicians than were students without such comments. The more traditional measures of medical school performance, such as grades and passing scores on national standardized tests, did not identify students who later had disciplinary problems as practicing physicians.

These data add validity to the assessment of professionalism in medical school and support the use of the UCSF, School of Medicine's professionalism evaluation system. We have, for the first time, demonstrated that unprofessional behavior in medical school is associated with unprofessional behavior in practice. Nonetheless, comments regarding unprofessionalism in the students' medical school files had a low sensitivity and a high specificity; therefore, the state's medical board did not discipline the majority of medical students who received comments regarding unprofessionalism. Test sensitivity and specificity depend on the threshold above which a test is interpreted to be abnormal. If the threshold is lowered, sensitivity is increased at the expense of lowered specificity. If the threshold is raised, sensitivity is decreased while specificity is increased. We believe it reasonable that the serious outcome of disciplinary action by the state medical board has a high threshold. The risk to the individual student who is identified as a false positive is low unless that student is unduly stigmatized as a "problem student." The high specificity underscores the importance of the evaluation of professionalism not only to the student but also to society because events that result in disciplinary action by the state medical board have their impact on patients. Our study did not examine whether remediation can reduce this association. However, the demonstration that inadequate professional behavior as a student portends poor professional behavior in practice can now serve as evidence to some resistant students that they must commit to professional growth.

The vast majority of the approximately 105,000 physicians licensed by the State of California practice competent and professional medicine. Only about 350 physicians are disciplined annually by the

We have, for the first time, demonstrated that unprofessional behavior in medical school is associated with unprofessional behavior in practice.

Medical Board of California.[11] Previous studies have shown that disciplined physicians are more likely to be men, in practice for more than 20 years and less likely to be board certified. The majority of actions taken against physicians are for deficiencies in professional behavior rather than for incompetence.[13,14] In our study, negligence was included as a cause of unprofessional behavior rather than incompetence. Even if negligence were not included as an unprofessional behavior, over half of disciplinary actions were for unprofessional behavior.

We can now advocate from an evidence-based position that professionalism is an essential competency that must be demonstrated for a student to graduate from medical school.

Our study has limitations. During the decades that these students attended medical school, changes occurred in the competitiveness of medical school admission, curriculum, grading system and evaluation forms. We believe, however, these changes enhance the ability to generalize our findings. To our surprise, narratives dating back to the 1940s regarding the evaluation of professionalism were available and seemed candid. Investigations and disciplinary actions by the Medical Board of California may have become more aggressive between 1990 and 2000 because the public began to demand greater accountability from the medical profession. In addition, we may have overmatched the case and control groups, particularly as it relates to psychiatry and obstetrics and gynecology, which are two of the most overrepresented specialties among disciplined physicians. Although only 6 percent of physicians are psychiatrists, 28 percent of physicians disciplined for sex-related offenses are psychiatrists. Only 6 percent of physicians are obstetricians and gynecologists, yet they represent 13 percent of physicians disciplined for sex-related offenses.[14] We chose to match by specialty practice because we could not determine its contribution as a confounder. Indeed, psychiatrists in the control group had the highest number of unprofessional comments when they were in medical school. Therefore, we probably underestimated the true differences in the frequency of unprofessional comments between the two groups.

Another limitation of our study is that physicians disciplined by a medical board comprise an unknown percentage of the total group of physicians engaging in unprofessional behavior. Furthermore, various social biases may well influence which physicians behaving unprofessionally are ultimately disciplined. Thus, we caution against generalizing the identified associations to all types of unprofessional behavior in physicians.

We have shown that problematic behavior in medical school at UCSF predicted subsequent disciplinary action of the physician by the state medical board. Our findings add to the call for better evaluation tools of personal characteristics of medical students and of applicants to medical school.[15] Although mindful that only a small number of physicians come to the attention of state medical boards, we now have evidence that medical students display warning signs of future disciplinary action. We hope this early identification will lead to improved methods of remediation and decrease their subsequent behaviors that are responsible for disciplinary action. At the same time, we can now advocate from an evidence-based position that professionalism is an essential competency that must be demonstrated for a student to graduate from medical school.

This project was funded (in part) by the NBME Edward J. Stemmler, M.D., Medical Education Research Fund grant. The project does not necessarily reflect NBME policy, and NBME support provides no official endorsement. The authors gratefully acknowledge the assistance of Bonnie Hellevig in the development of the data abstraction instrument and for the data abstraction; the expertise of Helen Loeser, M.D., M.Sc., in ranking the severity of the unprofessional behavior; the assistance of Ellen R. Julian, Ph.D., for providing corresponding MCAT percentile scores over a 40-year period, and the support and encouragement of David Irby, Ph.D. They also thank Ron Joseph, former executive director of the Medical Board of California, and his staff for assistance in data gathering.

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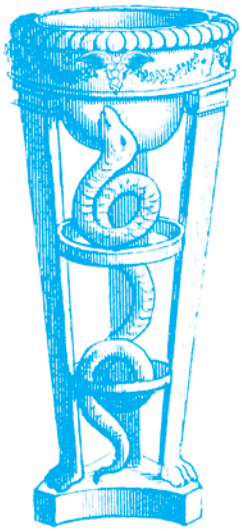


Accountability for Medical Errors: The Poorly Performing Physician

Paul M. Schyve, M.D.,

Senior Vice President,

Joint Commission on

Accreditation of Healthcare

Organizations

The topic I will speak about is the accountability for medical errors and the poorly performing physician. What should be the relationship between medical licensure and medical errors? Let me begin with a brief description of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). I notice from the Federation seal that the Federation was formed in 1912. The JCAHO is almost as old, going back to 1918 when the American College of Surgeons founded the Hospital Standardization Program. When this program became too large for a single organization to run, the JCAHO was formed in 1951. The JCAHO is a private, not-for-profit organization whose mission is to improve the safety and quality of care. It is currently governed by 28 people: six are public members and the rest are health care professionals who are chosen by the American College of Physicians - American Society of Internal Medicine (ASIM), American College of Surgeons (ACS), American Dental Association (ADA), American Hospital Association (AHA) and the American Medical Association (AMA). We are in a private sector/public sector partnership with federal and state regulatory agencies, including the state medical boards and hospital licensure agencies. We are able to be in such a partnership because we share a common goal: to improve the safety and quality of care. If we did not share this goal, we would not be able to share in the oversight of the quality of care. The JCAHO focuses on evaluating health care organizations, which is a bit different than the themes of what you have been hearing so far with respect to evaluating individual practitioners – the focus of the licensure boards.

Beginning in 1995, the JCAHO noticed there were some very serious adverse events occurring in accredited hospitals, such as cutting off the wrong foot or a patient death from an overdose of chemotherapy. So the question we faced was, "Why was this happening in good organizations with good clinicians?" Of course, this issue really came to the public's attention with the publication of the Institute of Medicine (IOM) report, *To Err is Human, Building a Safer Healthcare System*. In that report, based on existing studies, the IOM estimated that 44,000 to 98,000 patients die per year from medical errors. Even those who question some of the statistics agree there are probably at least 44,000 people who die from preventable medical errors each year. One such death is one too many; clearly 44,000 makes this a problem that health care practitioners and organizations better be doing something about on a systematic basis.

So one of the things that the JCAHO did as we struggled with this question was to ask, "What is it that goes on in health care that would lead to these kinds of risks?" We started to talk to other types of high-risk organizations and experts who looked at these high-risk settings. We talked with human factor psychologists and with engineers to identify the characteristics of any kind of endeavor that turns out to have high risk for errors. Those characteristics include having multiple steps and processes. The more steps there are in the process, the more likelihood one of them will go wrong. Other characteristics of high-risk organizations include complex processes in which there are interactive steps and choice points; time-compressed processes in which you are trying to do everything in a very short time span; tightly coupled processes, in which once step A is taken, you do not have a choice except to go immediately to step B; and finally, anything that involves human involvement because we know, as the IOM stated, "to err is human."

When a serious error occurs, we search for the cause, and most of the time we immediately find the cause is human error. The human error may result from a variety of factors: lack of knowledge and skill, forgetfulness, lack of attention (such as that which occurs from lack of sleep), poor motivation or carelessness and negligence or recklessness. The first two of these sources of errors are factors that are built into all of us. Our human hardware and software are programmed to make errors. One of the things that currently makes us superior to computers is the degree of parallel processing and fuzzy logic our brains use to figure things out, which permits us to rapidly adapt to changes in our environment in the face of incomplete information. But if you use fuzzy logic, you have to recognize that from time to time the decision that is made or the action that is taken will turn out not to be the right decision or action. It will be, in retrospect, an error. So we are actually programmed to make errors, because to eliminate all errors would mean we would need to be programmed in such a way that we would be unable to be rapidly adaptable beings. Consequently, we have to assume that error is part of being human.

In the Institute of Medicine's report, To Err is Human, Building a Safer Healthcare System, *based on existing studies, the IOM estimated that 44,000 to 98,000 patients die per year from medical errors.*

So our challenge is that when we examine adverse outcomes from mishaps, we often do find that the immediate cause is what a doctor, nurse or pharmacist did (or perhaps what all three of them did). Our temptation has been to stop at that point because we found the "cause." Why do we stop? First, because built into all of us is a desire to say that someone has to be responsible, and we have found someone (or several persons) who are responsible.

The second reason we stop at people is because those of us in health care are steeped in the ethical imperative: First, do no harm. That is what we want to do before we even start treating patients. We want to do no harm, and that is so hardwired into us that it is very easy to say, "Ah, there's the person who violated this ethical imperative and who caused the harm." If you stop at this usual immediate cause — the person — what is the usual solution? The usual solution is to first blame whoever is responsible and say, "You did it." Certainly, the responsible person feels badly and may be disciplined. Second, we retrain that particular individual so he or she will not make that error again, saying, "You prescribed these two drugs at the same time. Do you not realize there is a potential adverse interaction? Do not do that again."

What are the results of this usual solution? The first is that one person, the one who has made the error (assuming the error was based on forgetfulness or lack of skills or knowledge), will not make that error again. I happen to be a psychiatrist. I certainly would not repeat the error of prescribing a medication that would result in an adverse drug interaction after a patient has been harmed, somebody has shamed me about it and I have gone through retraining. The problem is that the retraining process has only helped me. My colleagues in psychiatry have not gone through the same retraining. They may not be able to remember, or may not even be aware of, every potential drug interaction. The consequence is that the error persists. One person – me – has improved. However, the rest of my colleagues are left with the same human frailty and the same liability to the same error. Worse than that, because of the shame I experienced related to this error, everyone else realizes they do not want to be in the same position. So, from now on both my colleagues and I are not going to want to tell anyone that errors have been committed. We are going to try to hide them. In fact, errors will even be hidden from other people within the organization – not just from the public or the state licensing board, but even from our colleagues. As a result, potentially another 44,000 people will die; but we do not know they are dying from mishaps because collectively we do not know that the errors occurred.

People who have studied errors indicate our problem has been — not just in health care, but in general — stopping at that level of the individual, the proximate cause. What we really need to do is go to the root causes. The root causes are the systems and processes in which people work. These are systems and processes that sometimes can force errors. If two potentially dangerous drugs next to each other in an emergency cart have similar names and similar packaging but different uses, I suggest that is more than just enabling an error. It is setting up someone to commit an error. If handwritten orders cannot be

read, but the pharmacist does not realize he or she is reading it wrong, an error is enabled. If we install a system that helps the physician realize when he or she has prescribed two drugs that have an adverse interaction, as with an automated order-entry system linked to a decision support system, we will help prevent these errors. In designing and evaluating systems in which we work, we have to remove the systems that force errors, we have to fix the ones that enable errors and we have to put in place systems that will prevent errors – or protect patients from the effect of errors we still make.

Errors will even be hidden from other people within the organization. As a result, potentially another 44,000 people will die; but we do not know they are dying from mishaps because collectively we do not know that the errors occurred.

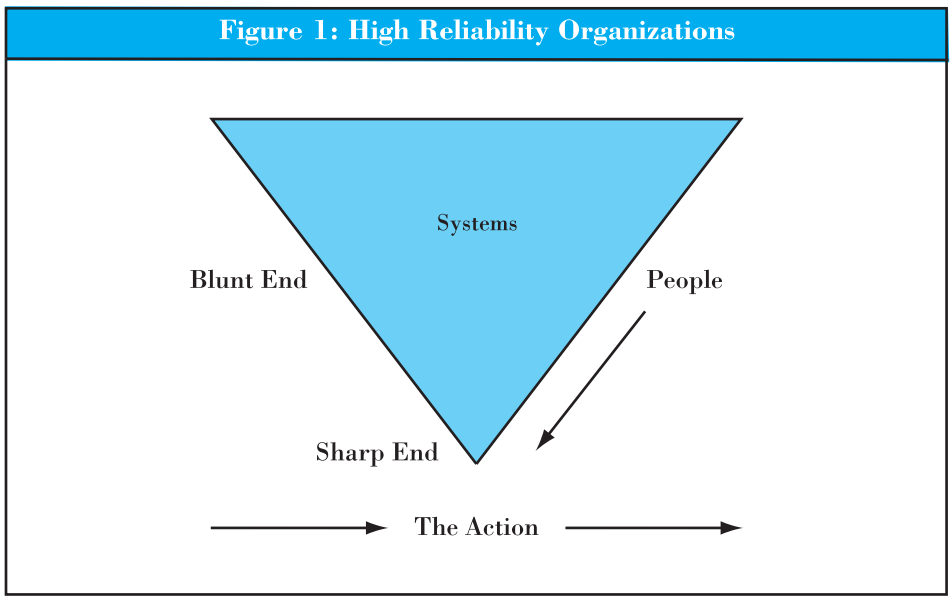
You have been talking so far today about evaluating individual performance and about continuing medical education. What is it we need to do differently to help clinicians avoid errors? Often, they result from a breakdown in the communication or information systems. Key information simply has not gotten to a person that needs to have it. Oftentimes they result from the unpredictability of the processes we work within. If we standardize procedures, staff — for example, nurses and surgeons in the operating room — would be more likely to consistently do the "right thing."

When people have looked at safety, they often refer to a diagram (see Figure 1) in which they refer to an action occurring at the "sharp end." The action could be taking care of patients in a hospital or clinic. It could be serving clients in a bank. People at the sharp end are working in a larger context of the organization's systems and processes – which are called the "blunt end." People who have studied high-reliability organizations to find out how they maintain safety within those settings have found a couple of things.

First, the high-reliability organization tries to stabilize the systems in the blunt end as much as possible. Second, it attempts to build into the blunt end systems that will prevent errors (like the automated order-entry system I described earlier). Third, it attempts to create a monitoring system that will pick up the first sign that something is going wrong so that intervention can reduce the risk or prevent harm. At the sharp end where people are, researchers talk about people "creating safety." In other words, there will always be variations and surprises that occur in the client or the patient. The person at the sharp end creates safety for the client or the patient at the intersection between the standardization of the blunt end and the variation at the sharp end.

I have added health care to the list of high-risk/high-reliability enterprises because we realize health care is a high-risk endeavor. I believe it can also become a high-reliability endeavor. What we have at the blunt end are the systems and processes in the health care system. They may be the systems and processes in place in a hospital or in an individual physician's office. They may be the way pharmaceu-

Figure 1.



ticals are packaged and labeled and named, or in the way medical equipment operates. I am reminded of one example related to equipment from the airline industry, which is a high-risk/high-reliability industry. As they started to look at why a particular type of plane was crashing, they discovered it was related to a human factor — the fact that the pupils of our eyes open when we are frightened, and as a result, our depth of focus is reduced. The dials on this particular plane's dashboard were perfectly readable as long as the pilot was calm. However, as soon as the pilot panicked, perhaps when an engine went out, the dials were too small to keep in focus. So the engineers concluded that the dials needed to be bigger so they could be read when somebody was scared. That change reduced the number of crashes occurring with that particular airplane. That was an example of human factor research that led to a change in the design of equipment.

When an adverse event occurs, we ask, "What have we learned by looking at the systems the person works in? How can we change those systems to reduce these errors?"

So, the clinician actually creates safety around the variation that occurs in the patient. What does that mean about the clinician's relationship to the health care organization? If I am going to be responsible for creating safety for my patients in response to their variation, I would like to have as firm a foundation as possible. I would like to have as little variation as possible in the blunt end. Turn the blunt end/sharp end triangle upside down. I would like to have as little variation as possible in those systems and processes that I have planted my feet on (the blunt end) so that my foundation is stable while I am trying to make adjustments for my patient. If both the foundation (the blunt end) and my interaction with the patient (the sharp end) are in constant flux, I will have a much harder time trying to create safety for my patient. What does this mean in terms of how we reduce errors? It means that we need to be able to shift from always thinking about the proximal cause (the person who we name/blame/shame) to thinking about a root-cause system analysis approach. When an adverse event occurs, we ask, "What have we learned by looking at the systems the person works in? How can we change those systems to reduce these errors?"

Retrospectively, that means when an error occurs, we need a safe environment for reporting, one in which the person does not feel if he or she has observed or committed an error, reporting it is likely to result in something bad happening to the individual. Because of the punitive environment that exists within health care organizations, the organizations themselves often do not learn about the errors. If an environment is created that facilitates reporting, then people can be *expected* to report errors internally in the organization. When an organization has discovered one of these errors – the Joint Commission calls them sentinel events – that has resulted in death or serious harm to a patient, the organization should conduct a root-cause analysis. The organization must dig down into its systems and processes, and discover what can be changed so that error will not be repeated; not just by this clinician, but by other clinicians for whom it is also human to err. Then the organization must make those changes. Finally, it makes no sense for one organization or, I would suggest, for one doctor, to figure out how to avoid a particular error and then keep that knowledge to himself. If our *ethical* obligation is to first do no harm, I would suggest that means we need to share that information with others. Health care organizations might compete over efficiency or better outcomes, but I do not think they should ever compete over how to protect patients from avoidable harm. That is information that should be readily shared. That is why, for example, the JCAHO encourages organizations that have a sentinel event and do a root-cause analysis, to share this information with us. The JCAHO keeps the information confidential. After making it anonymous, we put the information into a database we have used to produce a notice called Sentinel Event Alert to all accredited organizations that says, "Look, this is a bad event that can happen. Here is what a number of organizations found in common when they did root-cause analysis of these events, and here are changes, a number of these organizations concluded, that would help avoid a recurrence of this event. The JCAHO suggests you consider these changes and, in fact, they do. One of the first Sentinel Event Alerts we published was about undiluted KCl on in-patient units. All the hospitals that had such a death resulting from the infusion of undiluted KCl and reported it to us also reported that in their root-cause analysis they identified a common root cause: undiluted KCl on the in-

patient unit enabled a nurse to pick it up by mistake, without realizing it was undiluted, and infuse it into a patient. The organizations looked a little deeper and concluded they did not really need undiluted Potassium Chloride (KCl) on the inpatient unit. They removed it from the in-patient unit and required that it be diluted before it leaves the pharmacy." Doctors and nurses now could not make the error. As you might expect, there have been few, if any, reported KCl deaths since that Sentinel Event Alert. Why would it be appropriate to think that every hospital had to learn this on its own? That is the kind of information everybody should know. What I have described about errors, their causes, and how to prevent them has profound implications for how we think about or treat clinicians who are involved in errors. But, all that I have talked about so far is retrospective. That is, what should happen when an error has occurred? What should a good organization do? I would like to suggest that even in an office practice, when an error occurs, the clinician should do the same thing – do a root-cause analysis rather than just say, "I am fallible. I made a mistake. I hope nothing happened or I'll talk with the patient if something did happen." What can be learned that could be shared with others so the mistake does not occur again?

A prospective approach to safety is characteristic of engineers, but not, quite frankly, of health care professionals.

But there is a need to be prospective in designing systems for safety. A prospective approach to safety is characteristic of engineers, but not, quite frankly, of health care professionals. That is, we have a tendency to think when we have figured out how to do something, that it will work okay, and if it does not work okay, either I made an error or it was because of an unpredictable response of the patient. Engineers do not think that way; perhaps they are more pessimistic. When engineers design something they say, "This looks like it *should* work. What could go wrong?" They spend a lot of time trying to figure out what could go wrong, what would be the effect if it went wrong and what would happen if two or more things went wrong at once? If the effect is critical, they redesign the system, either to change how it works or to build in a redundancy in order to avoid the critical effect. The Joint Commission currently is introducing this proactive approach in its accreditation standards for particularly high-risk areas of health care.

What does all this mean for licensure? I have some thoughts and questions, unfortunately more questions than proposed solutions. Licensure still focuses on the possession of particular knowledge and skills. Our understanding of errors suggests there are knowledge and skills that specifically have to do with how the individual relates to errors, and how he or she relates to the systems within which he or she works. Should licensure continue to focus on things like criminal acts and gross negligence? Absolutely, and those things should obviously get reported to licensure agencies. What about most of the errors that occur? I would like to suggest they should, in general, not be reported to licensure agents, and I'll return to that in a minute. What about new competencies that will be required to effectively take on the role of creating safety at the sharp end? Medical school does not train to do that today, but if that is one of the roles of the individual clinician, we should be thinking not only in terms of the education of physicians, but also about the competencies we expect them to have when they complete training.

Should the licensure agency routinely get all reports of errors? Not if the result is going to be punitive, because that would result in hiding of errors rather than discovery of them. On the other hand, should licensure agencies get de-identified reports about errors? I think yes, because that tells licensure agencies where some of the patient safety issues are that should be the focus of licensure examinations. Arguably, it *might* be best for the discovery and reporting of errors, and therefore best for the safety of patients, if reporting of errors were confidential even if we erred on the side of occasionally letting somebody who is making too many errors because of incompetence continue to practice. Of course, such an oversight system would not be credible to the public. Some have suggested there may be a small list of errors that it should be mandatory to report, potentially to regulatory agencies. Some errors are clear-cut, almost always preventable and should never occur, like wrong-site surgery. Reporting of smaller sets of events may enhance the public's trust in the quality oversight system so they will trust it, even if not all errors are publicly disclosed.

Let me close with just two thoughts about upcoming issues. We have obviously heard a lot about the issue of changing technology and science. I would suggest that all new technologies bring new dangers with them; sometimes dangers that are preventable. As we employ computer systems to help us with our failing human memories, one type of problem can occur when computers are programmed incorrectly, thus creating errors that will be replicated for every patient, rather than just affecting one patient a clinician is treating when he or she makes an error. There will be a new set of errors associated with technology. The second issue has to do with telehealth. Telehealth is a new area in which we have to think about the blunt end as everything that is between the patient and the clinician. What are the risks that occur within these systems, and how can variation be reduced in the telehealth system so that the clinicians' role in the telehealth system will be able to create safety for the individual patient at the other end of the electronic connection?

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This article was reprinted from Medical Licensure in the 21st Century: Symposium Proceedings Sept. 6-7, 2000, Washington, D.C. *The symposium brought together leaders from medicine, medical education and government to help define the future of medicine, so that licensure will accurately reflect medical education and practice. You may order the hardcover book by calling (817) 868-4076, or from the Federation website at http://www.fsmb.org (from the home page, select the "Publications" link and then the "Order Form" link).*

Deadly Silence

"Putting a human face on medical mistakes can increase the pressure to do something about them."
— Hospital CEO quoted in *Wall of Silence*

What distinguishes *Wall of Silence* (LifeLine Press, 2003), by Rosemary Gibson and Janardan Prasad Singh, from other books on this topic is the human face it puts on the sometimes abstract topic of medical errors. In the authors' adept hands, a statistic suddenly becomes a three-year-old boy named Michael and the reader gasps at the chain of events that led to his tragic death stemming from a tonsillectomy.

Wall of Silence abounds with many such wrenching examples:

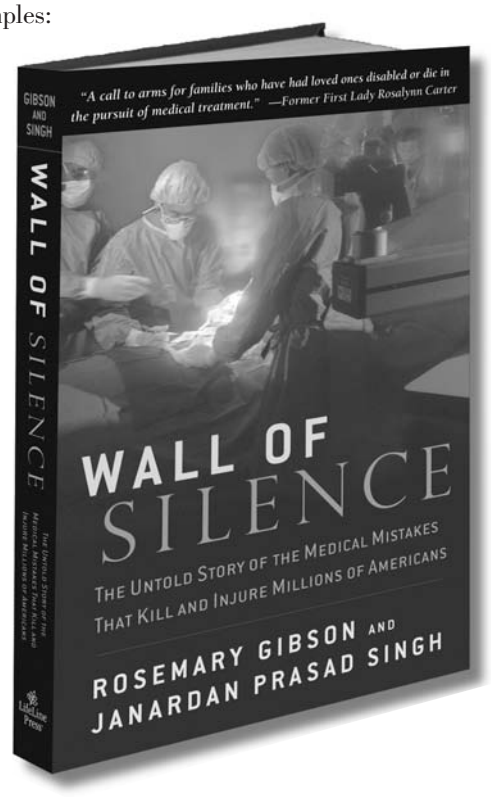
· an eight-year-old girl who was eventually paralyzed because doctors dismissed her cries of pain from kidney cancer

· a rising young star in the federal government whose elective surgery left him in unrelenting excruciating pain

· a retired manager whose botched colonoscopy resulted in a raging infection that nearly killed him

· a widower whose wife died from cancer that was spotted four years before her death, but never treated

However, *Wall of Silence* is much more than a collection of anecdotal evidence. Gibson and Singh provide a compelling analysis of the problem, explain how weaknesses in the design of health care systems can cause errors and explore how systems sometimes are actually better designed to conceal errors than to reveal or prevent them. For example, breakdowns in how a hospital hierarchy of nurses, doctors and technicians hand off – or don't hand off – information to one another can foster dangerous, and sometimes fatal, miscommunication about patient treatment.



***Wall of Silence* coauthor Rosemary Gibson will be a featured speaker during the Federation's 2004 Annual Meeting April 29-May 1 in Arlington, Va.**

As the title suggests, perhaps the biggest challenge facing the health care community with the medical errors issue is the impulse to hide errors for fear of punishment and lawsuits. According to the authors, all too frequently silence is the only remedy offered by health care practitioners when medical errors occur. *Wall of Silence* courageously ferrets out numerous tragic cases, told by patients and practitioners, about how secrecy and a code of silence among physicians, hospitals, insurance companies, HMOs and medical associations often bury medical mistakes through a host of means.

The "wall of silence" has a devastating effect on the victims of medical errors, the authors note. "All of the people and families who have been touched by medical mistakes have one thing in common. They want an acknowledgement that a terrible tragedy has occurred, they want to be told the truth so they can understand what happened, and they want someone to 'own up' to the fact that a mistake

Edward Pittman,

Editor,

Journal of Medical Licensure and Discipline

was made. With a heartfelt, 'I'm sorry, we made a mistake,' healing can begin not just for the patients and their families but also the doctors, nurses and others involved."

Doctors and nurses, too, need healing from the tremendous guilt and sadness they carry after being involved in a medical mistake that causes harm. A section entitled "Healing the Healers" discusses the profound healing that can occur when health care practitioners are honest about their mistakes and confess them to the harmed patient.

Wall of Silence demonstrates that the medical profession has not set up sufficient systems to maximize patient safety. The authors share many ideas for how to make medical errors as rare as possible. The lively discussion includes mandatory reporting, oversight of hospital reporting of errors and a call for legislatures to give state medical boards more funds to enable them to meet the public's expectations.

The book is a wake-up call for the health care profession, putting names and faces on the thousands of persons injured every year by medical errors. It should serve as an invaluable motivator for state medical boards to redouble their efforts to do their part in improving patient safety and outcomes.

The authors provide a compelling analysis of the problem, explain how weaknesses in the design of the health care system can lead to poor performance, and that the system is better designed to conceal errors than to reveal or prevent them.

From Our International Exchanges

VICTORIA, AUSTRALIA

WHISTLEBLOWER'S LEGISLATION – THE IMPACT ON DOCTORS

This article aims to make the profession aware of the *Whistleblowers Protection Act 2001* (WPA) and to consider how it might impact medical practitioners.

On Jan. 1, 2002, the *Whistleblowers Protection Act 2001* (WPA) came into operation. The WPA provides a legislative framework for individuals who wish to notify the relevant authorities about improper conduct engaged in by public bodies and their employees.

The objectives of the legislation are to:

- promote a culture in which complainants feel safe to make a disclosure;
- protect people who disclose information from recrimination or other adverse consequences;
- provide a framework for investigating disclosed matters; and
- ensure that investigated matters are properly dealt with.

The WPA recognizes that improper conduct by employees within the public service should not be tolerated, neither should actions which involve reprisals against those who come forward to disclose such conduct. The WPA defines improper conduct as:

- corrupt conduct;
- a substantial mismanagement of public resources;
- conduct involving substantial risk to public health or safety; or
- conduct involving substantial risk to environment.

The WPA requires that the improper conduct would, if proved, be a criminal offense or constitute reasonable grounds for dismissal.

HOW MIGHT THE WPA IMPACT MEDICAL PRACTITIONERS?

The WPA might impact on medical practitioners in the following circumstances:

1. Any person has a right to make a disclosure about improper conduct engaged in by a public body or its employees, including staff in public and privately-operated hospitals.

2. Any person can make a disclosure about improper conduct engaged in by a doctor in a public hospital.

3. Any person can make a disclosure against a doctor in a privately-operated hospital that provides health services to public hospital patients, but only in respect of improper conduct that relates to the health services which the practitioner provides to public hospital patients.

According to Schedule 4 of the *Health Services Act 1988,* there are currently two privately-operated hospitals in Victoria – the new Latrobe Regional Hospital and the new Mildura Base Hospital. In the case of a hospital, the Ombudsman's view is that common medical negligence is not a matter to be dealt with under the WPA. Rather, the WPA may apply where staff have sought to cover up medical negligence.

Another example may be the theft of drugs by staff, who then administer the drugs to themselves or others. In terms of hospital management, the WPA would apply to the mismanagement of major projects at the expense of the Victorian taxpayer, the theft of hospital funds, the lack of probity in the awarding of contracts and the systemic provision of jobs to friends and family.

WHEN DOES THE COMPLAINANT GET PROTECTION?

The complainant gets protection when the Ombudsman or the Protected Disclosure Coordinator (PDC) of the relevant public body, determines that the complainant's disclosure amounts to a 'protected disclosure.' A disclosure amounts to a protected disclosure when the Ombudsman or PDC determines that the complainant:

1. has alleged that improper conduct has been, is being or will be engaged in by a public body/officer; and
2. has demonstrated that s/he has reasonable grounds for this belief.

HOW IS A DISCLOSURE MADE?

Disclosures against a public body are made by contacting either the Ombudsman or the PDC at the relevant public body. Each public body is required to establish written procedures for handling disclo-

sures made under the WPA, including the appointment of a PDC. If a disclosure is about a Member of Parliament (MP), the disclosure must be made to either the speaker of the Legislative Assembly or the President of the Legislative Council depending on which house the MP belongs.

A disclosure can be made either orally or in writing and may be made anonymously. Disclosures should include the specific allegations, a statement in support of the allegations and any documentation that supports the allegations.

Public bodies are required to receive and assess disclosures in accordance with the WPA. They are also required to investigate disclosed matters when referred from the Ombudsman and take appropriate action when improper conduct has been found to have occurred. Finally, they are required to provide welfare management to complainants, who have made protected disclosures.

WHAT DOES THE PROTECTION INCLUDE?

When the Ombudsman or the PDC determines that a complainant has made a protected disclosure, the complainant receives the following protection:

- there is immunity from any civil or criminal liability or administrative process, including disciplinary action, for making a protected disclosure;
- there is immunity from the confidentiality provision of any agreement or Act, including the *Constitution Act 1975*, regarding the content of a protected disclosure;
- criminal charges can be brought against any person, who takes detrimental action against the complainant, where this action is taken in reprisal for having made a protected disclosure under the WPA (penalty: two years imprisonment and/or $24,000 fine); and
- criminal charges can be brought against any person who reveals the complainant's identity and/or the content of the disclosure, otherwise than in accordance with that person's statutory functions under the WPA (penalty: five months imprisonment and/or $6,000 fine).

ANY QUESTIONS?

Contact either the PDC at your hospital or the Ombudsman's office on: Tel: (03) 9613 6222, Fax: (03) 9614 0246; e-mail: ombudvic@ombudsman.vic.gov.au

Reprinted from the Vol. 3 issue of Medical Practitioners Board of Victoria *Bulletin*.

ALBERTA, CANADA

COLLEGE LAUNCHES ITS LABORATORY QUALITY ENHANCEMENT PROGRAM (ALQEP)

Since 1965, the College has monitored the performance of diagnostic medical laboratories through its Laboratory Proficiency Testing Program (LPTP).

This includes an annual review of over 12,500 results in five disciplines including chemistry, cytopathology, hematology, microbiology and transfusion medicine for over 150 laboratories.

The current name has been associated with the program since its inception in 1966 when the program's singular role was in proficiency testing performance assessment.

In keeping with our strategic planning process the LPTP Committee of the College proposed a program name change to encompass the broader scope and mandate of the program including:

- enhancing the scope of external quality assessment (EQA) monitoring;
- enhancing educational support role through the provision of enhanced resource and reference materials and the coordination of quality assurance forums and activities; and
- promoting standardization of laboratory practice.

The new name is intended to reflect and promote our strategic planning initiatives and image as a laboratory quality management reference body.

Complete program information is available on the College's website at www.cpsa.ab.ca.

CENTENNIAL CELEBRATIONS

A Centennial Celebration Steering Committee has begun planning for the medical profession's 100th birthday in Alberta. Celebrations will coincide with the province's centennial in 2005. Spearheaded by the College and the AMA, the goals of the planning committee are to raise awareness of the profession's 100th birthday and to facilitate ideas on how Alberta physicians and other groups can celebrate medicine's past, present and future. To date, the Committee has designed a centennial logo, launched a centennial website and sent a letter to all physicians and stakeholder groups inviting them to get involved. Share the pride in our medical profession by helping us highlight physicians' contributions to health care, the health system

and the economic growth and prosperity of our province. If you have suggestions for projects or ideas about how to celebrate 100 years of medicine in Alberta, contact Nancy Brenneman at (780) 482-0312 or visit www.medicine100.ab.ca.

PRESCRIBING ONLINE

Internet pharmacies and cross-border prescribing are important topic areas for physicians and pharmacists alike.

For Physicians:

According to College policy, prescribing medications based only on verbal information, fax, telephone or electronic means, is not an acceptable standard of care. An appropriate history and physical must be done first.

The only exception to this policy is when physicians are fulfilling their responsibility as a member of an on-call group.

As pertains to cross-border prescribing, therefore, signing or countersigning prescriptions written for U.S. patients by U.S. physicians may be viewed as unprofessional conduct.

For Pharmacists:

Pharmacists are responsible for ensuring that a prescription is authentic. Therefore, they will not accept prescriptions sent by e-mail, as there are insufficient security measures in place to ensure the prescription is valid.

Pharmacists are also unable to accept prescriptions printed by a computer or sent by fax unless the physician has signed the order. Physicians using electronic medical records and/or the Pharmaceutical Information Network (PIN) will still be required to create a signed prescription in order for a pharmacist to fill the request.

Cross-border prescribing continues to cause concern in the larger medical community as well.

The College supports Health Canada's Food and Drug Regulations that state that prescription drugs may only be sold at retail if prescribed by a practitioner licensed to practice in Canada.

Reprinted from the online version of issue number 107 of *the Messenger*, found on the College of Physicians and Surgeons of Alberta website.

NOVA SCOTIA, CANADA

EMERGENCY DEPARTMENT REFILLS OF CONTROLLED SUBSTANCES

The misuse, theft and diversion of controlled substances have recently made headlines in Nova Scotia. Emergency department staff have been concerned for some time with this problem and have expressed their concerns to the College. Problems arise when patients present at ER departments demanding refills for controlled substances that were originally prescribed by physicians who are unavailable. In such cases, it is very difficult for ER physicians to know what is, or is not, a legitimate request.

ER physicians may not ordinarily provide such refills. In cases where they do provide refills, they typically prescribe just enough medication to suffice until the patient can see the physician who wrote the original prescription.

The College publication *Guidelines for the Use of Controlled Substances in the Treatment of Pain* recommends that physicians have a written agreement with patients whom they determine to be at high risk for medication abuse or who have a history of substance abuse. The guidelines provide examples of such contracts or agreements, which can be tremendously useful for both the physician and the patient. It may be valuable to have such written agreements with all patients so that if an urgent refill is required in an emergency department, the agreement can be presented to emergency department staff.

Alternately, physicians planning to be unavailable during weekends or vacations should make advance arrangements for a colleague to be available to their patients in case urgent refills are required. One important concept in all pain management is that only one physician be responsible for the opioid therapy of any one patient. This point cannot be overemphasized.

Physicians are reminded of the significant and ongoing responsibility when initiating long-term opioid therapy for patients. The benefits to patients in need are tremendous, but laxity in follow-up and loose control by multiple prescribers can have terrible social consequences in terms of drug diversion, crime, substance abuse and public health.

Reprinted from the College of Physicians & Surgeons of Manitoba website.

SASKATCHEWAN, CANADA

CONTINUING MEDICAL EDUCATION REQUIREMENT

The Council of the College has established a Revalidation Committee. The task of this committee is to make recommendations to the Council respecting requirements for physicians to demonstrate ongoing education and/or competence as a condition of practice in Saskatchewan.

The Committee consists of Dr. David Ahmed of Regina, Dr. Suresh Kassett of Herbert, Dr. Prakesh Patel of Regina, Dr. Karen Shaw, Deputy Registrar and Mr. Bryan Salte, Associate Registrar.

The Committee is considering whether it should recommend to the Council that physicians be required to meet the requirements of the Maintenance of Competence Program (MOCOMP) (for physicians with specialist credentials) or Maintenance of Proficiency program (MAINPRO) (for physicians with family physician credentials). It appears that both the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada are prepared to enroll physicians who are not members of their Colleges in these programs. There would be some cost to physicians who are not members of either College to enroll in the MAINPRO or MOCOMP programs.

Most health professions in Saskatchewan have ongoing maintenance of competence requirements in order to remain in good standing with their regulatory body. It seems likely that in the near future there will be ongoing maintenance of competence requirements for physicians in other provinces of Canada.

Reprinted from the December 2003 edition of *College Newsletter*, on the College of Physicians and Surgeons of Saskatchewan website.

DUBLIN, IRELAND

IAMRA TO SPONSOR THE 6TH INTERNATIONAL CONFERENCE ON MEDICAL REGULATION

The International Association of Medical Regulatory Authorities (IAMRA) offers state medical boards an invaluable opportunity to build bridges in the international arena. The organization provides a structure to learn the terminology and regulatory structures of other nations. A little less than two years ago, in June 2002, IAMRA was launched with eight founding members. Today, the organization boasts 52 members from 24 countries.

INTERNATIONAL CONFERENCE IN APRIL 2004

An outstanding opportunity to meet fellow medical regulators from around the world will soon be here. IAMRA is sponsoring the 6th International Conference on Medical Regulation in Dublin, Ireland, April 21-24, 2004.

An ambitious program for the conference is in the process of being finalized by the Medical Council of Ireland, and will include reports by IAMRA's Working Group on the International Exchange of Information on Physicians (IEIP) and the Working Group on Medical Passports, with sessions incorporated in the program to explore these issues in more depth, generate discussion and foster new ideas and collaboration. IAMRA's second Members General Meeting will take place on the second day of the conference and will include the election of a new Management Committee.

The proceedings also will incorporate a report on developing a collaborative plan of work, with the objective of publishing a paper or a book that will serve as the basis for submitting a proposal to be a non-governmental organization in official relations with the World Health Organization (WHO).

Registration and other detailed information about the conference can be found on IAMRA's website at www.iamra.com. You also may register for the conference online and view a draft program by accessing the Medical Council of Ireland website.

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.

From Our Member Board Exchanges

ARIZONA

FILING A COMPLAINT JUST GOT EASIER

Filing a complaint against a physician is now as easy as 1-2-3. Consumers can file a complaint with the Arizona Medical Board online at www.azmdboard.org and automatically receive a receipt of the complaint and a tracking number to follow the case progression online. "Arizona is one of the first medical boards in the country to implement a system like this," said Executive Director Barry A. Cassidy, Ph.D., PA-C. "I am extremely proud of the accomplishments board staff continue to make that bring increased services to the public."

The Arizona Medical Board got the idea for the online complaint filing and tracking system while participating in the statewide initiative to bring online payment services to Arizona state agencies. The board is still working on the second piece of the project that will provide online physician licensing and renewal applications and payments. "It seemed logical to build on existing resources to bring this service to realization," said Cassidy.

The system is designed to provide information to consumers in two pieces. After filing a complaint online, consumers are e-mailed a tracking number. That number tracks the complaint through the initial steps of processing the information received, gathering additional information and opening an investigation. "All cases received by the board are opened," said Cassidy, "except for those that fall outside the board's jurisdiction."

After a case has been opened, a case number is assigned. At any time, the complainant or the physician can enter the case number and determine the case status and the date when the case first reached that status. A case can fall within one of four status categories: Case Opened, Case Under Investigation, Case Under Review and Case Closed. Each status category is hyperlinked to definitions of that status.

For those consumers who prefer the traditional approach to complaint filing, complaint forms can be downloaded from the website. Complaint forms may also be requested by calling the board at (480) 551-2700.

Reprinted from the Arizona Medical Board website.

CALIFORNIA

REVISED PAIN MANAGEMENT GUIDELINES

It has been 13 years since the Intractable Pain Treatment Act of 1990 first established laws to assist physicians in the course of treatment for a person diagnosed with intractable pain. In 1994, the board adopted guidelines for *Prescribing Controlled Substances for Intractable Pain.* In the ensuing years, the practice of pain management and the affected patient population have continued to evolve and has received much attention from the medical community and affected patients.

Effective Jan. 1, 2002, Business and Professions Code section 2241.6 (referred to as AB 487) was added requiring the Division of Medical Quality (DMQ) to develop standards to assure the competent review in cases concerning the management, including, but not limited to, the under treatment, under medication and over medication of a patient's pain. When this item was discussed at the May 2002 board meeting, a task force was established to review the 1994 guidelines and to assist the DMQ in the development of the standards. The scope of the guidelines was expanded from intractable pain patients to all patients with pain.

The task force was comprised of representatives from the American Pain Society, the American Academy of Pain Medicine, the California Society of Anesthesiology, the California Chapter of American College of Emergency Physicians, the California Medical Association, Compassion in Dying Federation, the Office of the Attorney General Health Quality Enforcement Section and the board.

The revised guidelines are intended to improve effective pain management of California patients by incorporating a series of annotations which better reflect how these guidelines should be used, and will allow for periodic update, as indicated. It is anticipated that physicians will have a higher level of comfort when using controlled substances, including opioids, in the treatment of pain. And, the revised guidelines will promote improved pain management for patients in pain, while providing better guidance to the board's Enforcement Program, in determining whether or not allegations of inappropriate prescribing are supported by evidence.

At the August 2003 board meeting, the DMQ adopted the recommendations of the task force in the revised *Guidelines for Prescribing Controlled Substances for Pain.*

GUIDELINES FOR PRESCRIBING CONTROLLED SUBSTANCES FOR PAIN

Adopted Unanimously by the Board in 1994 and Recently Revised

"No physician and surgeon shall be subject to disciplinary action by the board for prescribing or administering controlled substances in the course of treatment of a person for intractable pain." — Business and Professions Code section 2241.5(c)

PREAMBLE

In 1994, the Medical Board of California formally adopted a policy statement titled, *Prescribing Controlled Substances for Intractable Pain.* The statement outlined the board's proactive approach to improving appropriate prescribing for effective pain management in California, while preventing drug diversion and abuse. The policy statement was the product of a year of research, hearings and discussions. California physicians and surgeons are encouraged to consult the policy statement and these guidelines, which can be found at www.medbd.ca.gov or obtained from the Medical Board of California.

In May 2002, as a result of AB 487, a task force was established to review the 1994 guidelines and to assist the Division of Medical Quality to "develop standards to assure the competent review in cases concerning the management, including, but not limited to, the under treatment, under medication and over medication of a patient's pain." The task force expanded the scope of the guidelines, from intractable pain patients to all patients with pain.

Inappropriate prescribing of controlled substances, including opioids, can lead to drug abuse or diversion and can also lead to ineffective management of pain, unnecessary suffering of patients and increased health costs. The board recognizes that some physicians do not treat pain appropriately due to a lack of knowledge or concern about pain, and others may fail to treat pain properly due to fear of discipline by the board. These guidelines are intended to improve effective pain management in California, by avoiding under treatment, over treatment or other inappropriate treatment of a patient's pain and by clarifying the principles of professional practice that are endorsed by the board so that physicians have a higher level of comfort in using controlled substances, including opioids, in the treatment of pain. These guidelines are intended to promote improved pain management for all forms of pain and for all patients in pain.

A HIGH PRIORITY

The board strongly urges physicians and surgeons to view effective pain management as a high priority in all patients, including children, the elderly and patients who are terminally ill. Pain should be assessed and treated promptly, effectively and for as long as pain persists. The medical management of pain should be based on up-to-date knowledge about pain, pain assessment and pain treatment. Pain treatment may involve the use of several medications and non-pharmacological treatment modalities, often in combination. For some types of pain, the use of medications is emphasized and should be pursued vigorously; for other types, the use of medications is better de-emphasized in favor of other therapeutic modalities. Physicians and surgeons should have sufficient knowledge or utilize consultations to make such judgments for their patients.

Medications, in particular opioid analgesics, are considered the cornerstone of treatment for pain associated with trauma, surgery, medical procedures or cancer. A number of medical organizations have developed guidelines for acute and chronic pain management. Links to these references may be found on the Medical Board of California's website at www.medbd.ca.gov.

The prescribing of opioid analgesics for patients with pain may also be beneficial, especially when efforts to alleviate the pain with other modalities have been unsuccessful. Intractable pain is defined by law in California as: "a pain state in which the cause of the pain cannot be removed or otherwise treated and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by the attending physician and surgeon and one or more physicians and surgeons specializing in the treatment of the area, system or organ of the body perceived as the source of the pain." (Section 2241.5(b) of the California Business and Professions Code)

Physicians and surgeons who prescribe opioids either for acute or persistent pain should not fear disciplinary or other action from California law enforcement or regulatory agencies for the mere fact of having prescribed opioids. The appropriate use of opioids in the treatment of intractable pain has long been recognized in California's Intractable Pain Treatment Act, which provides that "No physician and surgeon shall be subject to disciplinary action by the Medical Board for prescribing or administering controlled substances in the course of treatment of a person for intractable pain." (Section 2241.5(c) of the California Business and Professions Code)

The board expects physicians and surgeons to follow the standard of care in managing pain patients.

GUIDELINES

History/Physical Examination

A medical history and physical examination must be accomplished.

This includes an assessment of the pain, physical and psychological function; a substance abuse history; history of prior pain treatment; an assessment of underlying or coexisting diseases or conditions; and documentation of the presence of a recognized medical indication for the use of a controlled substance.

Annotation One: The prescribing of controlled substances for pain may require referral to one or more consulting physicians.

Annotation Two: The complexity of the history and physical examination may vary based on the practice location. In the emergency department, the operating room, at night or on the weekends, the physician and surgeon may not always be able to verify the patient's history and past medical treatment. In continuing care situations for chronic pain management, the physician and surgeon should have a more extensive evaluation of the history, past treatment, diagnostic tests and physical exam.

Treatment Plan, Objectives

The treatment plan should state objectives by which the treatment plan can be evaluated, such as pain relief and/or improved physical and psychosocial function, and indicate if any further diagnostic evaluations or other treatments are planned. The physician and surgeon should tailor pharmacological therapy to the individual medical needs of each patient. Multiple treatment modalities and/or a rehabilitation program may be necessary if the pain is complex or is associated with physical and psychosocial impairment.

Annotation One: Physicians and surgeons may use control of pain, increase in function and improved quality of life as criteria to evaluate the treatment plan.

Annotation Two: When the patient is requesting opioid medications for their pain and inconsistencies are identified in the history, presentation, behaviors or physical findings, physicians and surgeons who make a clinical decision to withhold opioid medications should document the basis for their decision.

Informed Consent

The physician and surgeon should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian.

Annotation: A written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan and the informed consent. Patient, guardian and caregiver attitudes about medicines may influence the patient's use of medications for relief from pain.

Periodic Review

The physician and surgeon should periodically review the course of pain treatment of the patient and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the physician's evaluation of progress toward treatment objectives. If the patient's progress is unsatisfactory, the physician and surgeon should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

Annotation One: Patients with pain who are managed with controlled substances should be seen monthly, quarterly or semi-annually as required by the standard of care.

Annotation Two: Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment.

Consultation

The physician and surgeon should consider referring the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Complex pain problems may require consultation with a pain medicine specialist. In addition, physicians should give special attention to those pain patients who are at risk for misusing their medications including those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse requires extra care, monitoring, documentation and consultation with addiction medicine specialists, and may entail the use of agreements between the provider and the patient that specify the rules for medication use and consequences for misuse.

Annotation One: Coordination of care in prescribing chronic analgesics is of paramount importance. Diagnosis of opioid dependence and intractable pain, both of which are being treated with controlled substances, protections apply to physicians and surgeons who prescribe controlled substances for intractable pain provided the physician complies with the requirements of the general standard of care and California Business and Professions Code Section 2241.5.

Records

The physician and surgeon should keep accurate and complete records according to items above, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, ration-

ale for changes in the treatment plan or medications, agreements with the patient and periodic reviews of the treatment plan.

Annotation One: Documentation of the periodic reviews should be done at least annually or more frequently as warranted.

Annotation Two: Pain levels, levels of function and quality of life should be documented. Medical documentation should include both subjective complaints of patient and caregiver, and objective findings by the physician.

Compliance with Controlled Substances Laws and Regulations

To prescribe controlled substances, the physician and surgeon must be appropriately licensed in California, have a valid controlled substances registration and comply with federal and state regulations for issuing controlled substances prescriptions. Physicians and surgeons are referred to the *Physicians Manual of the U.S. Drug Enforcement Administration* and the *Medical Board's Guidebook to Laws Governing the Practice of Medicine by Physicians and Surgeons* for specific rules governing issuance of controlled substances prescriptions.

Annotation One: There is not a minimum or maximum number of medications which can be prescribed to the patient under either federal or California law.

Annotation Two: Physicians and surgeons who supervise Physician Assistants (PAs) or Nurse Practitioners (NPs) should carefully review the respective supervision requirements.

Additional information on PA supervision requirements is available at www.physicianassistant.ca.gov.

PAs are able to obtain their own DEA number to use when writing prescriptions for drug orders for controlled substances. Current law permits physician assistants to write and sign prescription drug orders when authorized to do so by their supervising physician for Schedule II-IV. Further, a PA may only administer, provide or transmit a drug order for Schedule II through Schedule V controlled substances with the advanced approval by a supervising physician for a specific patient.

To ensure that a PA's actions involving the prescribing, administration or dispensing of drugs is in strict accordance with the directions of the physician, every time a PA administers or dispenses a drug or transmits a drug order, the physician supervisor must sign and date the patient's medical record or drug chart within seven days. (Section 1399.545(f) of the California Code of Regulations)

NPs are allowed to furnish Schedule III-V controlled substances under written protocols.

POSTSCRIPT

While it is lawful under both federal and California law to prescribe controlled substances for the treatment of pain, there are limitations on the prescribing of controlled substances to or for patients for the treatment of chemical dependency (see Sections 11215-11222 of the California Health and Safety Code). The California Intractable Pain Treatment Act (CIPTA) does not apply to those persons being treated by the physician and surgeon only for chemical dependency because of use of drugs or controlled substances (Section 2241.5(d)). The CIPTA does not authorize a physician and surgeon to prescribe, dispense or administer controlled substances to a person the practitioner knows to be using the prescribed drugs or controlled substances for non-therapeutic purposes (Section 2241.5(e)).

At the same time, California law permits the prescribing, furnishing or administering of controlled substances to or for a patient who is suffering from disease, ailments, injury or infirmities attendant on old age, other than addiction (Section 11210 of the California Health and Safety Code) and the CIPTA does apply to "a practitioner who is prescribing controlled substances for intractable pain, and as long as that practitioner is not also treating the patient for chemical dependency."

The board emphasizes the above issues, both to ensure physicians and surgeons know that a patient in pain who is also chemically dependent should not be deprived of appropriate pain relief, and to recognize the special issues and difficulties associated with patients who suffer both from drug addiction and pain. The board expects that the acute pain from trauma or surgery will be addressed regardless of the patient's current or prior history of substance abuse. This postscript should not be interpreted as a deterrent for appropriate treatment of pain.

Reprinted from the October 2003 issue of the *Action Report*, published by the Medical Board of California.

KENTUCKY

SELF-PRESCRIBING AND PRESCRIBING TO IMMEDIATE FAMILY MEMBERS

The board continues to receive inquires concerning the legality or propriety of physicians self-prescribing and prescribing to immediate family members. The question becomes even more complicated when treatment involves the prescribing of controlled substances.

While not a per se violation, Kentucky law KRS 311.597 (1) (C) states that self-prescribing and prescribing to immediate family members is contrary to law when the physician "knows or has rea-

son to know that an abuse of controlled substances is occurring, or may result from such a practice."

According to the American Medical Association's Code of Medical Ethics, physicians generally should not treat themselves or their immediate families. Professional objectivity may be compromised when an immediate family member of the physician is the patient; the physician's personal feelings may unduly influence his/her medical judgment, interfering with the care provided. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise. In emergency or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. However, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

The board strongly recommends physicians make every effort to have treatment of themselves or members of their immediate family rendered by another physician who can approach the case objectively. By doing so, the physician will avoid even the appearance of impropriety and thus avoid problems with this board.

Reprinted from the Winter 2004 issue of the *Kentucky Board of Medical Licensure Newsletter*, published by the Kentucky Board of Medical Licensure.

MAINE

NEW EXAM FOCUS – LEGAL AND ETHICS

The board discontinued the practice of conducting oral interviews for new applicants and instead is using a written exam focused on legal and ethical issues. The exam, which contains 36 questions, is considered an "open book" exam and the board provides all examinees with the information needed.

The idea behind the exam is to inform physicians of the unique standards and laws that will govern their practices in Maine. It is the board's hope that by providing this information, possible problems can be avoided and fewer physicians will become involved with the board's disciplinary process. If any currently licensed physician would like a copy of the exam, please contact the board offices at (207) 287-3601.

Reprinted from the Volume 8, Number 1 issue of *Information & Report*, published by the Maine Board of Licensure in Medicine.

NEW MEXICO

THE DISRUPTIVE PHYSICIAN

While there are not many reports to the board regarding disruptive physicians, when these cases are reported, they represent real problems for other health care workers. In the past, the board could only react to the problem by using the provisions of the Impaired Health Care Provider Act. This involved an evaluation by a panel of doctors who would determine whether the physician was unable to practice with reasonable skill and safety because of a "mental illness."

There are, of course, doctors who are not mentally ill, but who can create havoc in the workplace because of their inability to collaborate with other health care providers in a supportive, helpful way. Most physicians have come across these "disruptive" physicians sometime in their career.

The law that governs the board, the Medical Practice Act, was amended this year. One of the grounds for discipline that has been added is Section 61- 6-15(D) 36 — "interaction with physicians, hospital personnel, patients, family members or others that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient."

The board can now proceed to discipline a physician (or physician assistant or anesthesiologist assistant) based on this disruptive conduct, rather than require a psychiatric evaluation of why they act as they do. While an understanding of the physician's state of mind may determine the form of discipline ordered by the board, an evaluation is no longer the required first step to stopping disruptive conduct.

The message should be clear. If you are involved in disruptive conduct, stop it. If you don't, you could lose your license. If you know of a disruptive physician and believe the board should be notified of the problem, call the board office at (800) 945-5845 for a complaint form.

Reprinted from the Fall 2003 issue of the *Notes From Your Licensing Board,* published by the New Mexico Medical Board.

RHODE ISLAND

POLICY STATEMENT ON OFFICE-BASED AESTHETIC PROCEDURES

It is the position of the board that office-based cosmetic or aesthetic procedures that require the use of medical lasers, high-frequency

radio waves or injection of sclerosing chemicals or biologically active compounds (e.g. Botulinum toxin A, Botox) are medical procedures.

Therefore, prior to undergoing such procedures, patients must receive a medical evaluation for appropriateness by a licensed and qualified physician or other practitioner acting within his/her scope of practice. Although these procedures may be performed by an appropriately trained nonphysician working under the supervision and direction of a physician or other practitioner acting within his/her scope of practice, it is the supervising physician's (or other practitioner acting within his/her scope of practice) responsibility to assure that procedures are conducted appropriately; with appropriate assessment, consent and follow-up; and upon appropriate patients; and that all patient records are maintained according to standards applicable for medical records; and that patient privacy is protected. The supervising physician or other practitioner acting within his/her scope of practice is responsible for any procedures carried out by nonphysicians under his/her direction.

Physicians (or other practitioners acting within his/her scope of practice) who perform and supervise such procedures must be able to demonstrate appropriate training and experience. Such training and experience may include, but is not limited to, residency or fellowship. The physician or other practitioner acting within his/her scope of practice is responsible to assure and document adequate training for individuals under his/her supervision.

Additionally, other cosmetic procedures such as dermabrasion or the application of potentially scarring chemical treatments (e.g. so-called chemical peels) should also meet this same standard.

Reprinted from the Rhode Island Board of Medical Licensure and Discipline website.

LET US HEAR FROM YOU

Would you like 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.

Medicolegal Decisions

DISCOVERY

United States ex rel. Chandler v. Hektoen Institute for Med. Research, No. 97 C 514 (N.D. Ill. Oct. 1, 2003) - DEx 82387, 8 pp.

The U.S. District Court for the Northern District of Illinois ruled county attorneys were not entitled to discover the records of patients in substance abuse programs as the use and disclosure of such records was prohibited by statute. A relator, Janet Chandler, Ph.D., brought a *qui tam* action on behalf of the United States under the False Claims Act, 31 U.S.C. §§ 3729 et seq., to recover funds allegedly fraudulently obtained by the defendants, Hektoen Institute for Medical Research and Cook County, in their administration of a federally funded drug treatment program known as "New Start."

A district court judge entered a protective order under which discovery would proceed. Chandler then moved for a protective order to apply to the county the restrictions of the earlier protective order and to require the county to divulge to the relator any documents that it reviewed to prepare its defense. (See 8 *HLawWk* 334, May 28, 1999, for a related decision in this case.)

The district court granted Chandler's motion. This discovery dispute turned on 42 U.S.C. § 290dd-2, which protects the confidentiality of records containing patient's identity, diagnosis, prognosis or treatment, maintained in connection with the performance of any substance abuse program or activity conducted, regulated or directly or indirectly assisted by any department or agency of the United States. Moreover, 42 C.F.R. §§ 2.63 and 2.64 governed the disclosures at issue. Under § 2.63(a), a court may order disclosure of a patient's confidential communications only if one of the three exceptions applies:

1. The disclosure is necessary to protect against an existing threat to life or of serious bodily injury...; or

2. The disclosure is necessary in connection with investigation or prosecution of an extremely serious crime…; or

3. The disclosure is in connection with litigation or an administrative proceeding in which the patient offers testimony or other evidence pertaining to the content of the confidential communications.

The district court rejected the county's argument that Chandler could have access to either patient information or confidential communications but not both. The district court found this argument went against the language and spirit of the statute and regulations. First, the absurd result would be that, as long as the patient's name, address and Social Security number were removed, the entire remainder of the patient file would be open to public perusal. The court found this contrary to the intent of the statute and regulations, which is to afford heightened protection to drug and alcohol records.

The district court also found the county may not disclose those confidential communications to its attorneys to use in preparing its defense. The attorneys were not the same entity as the county, the record holder. The regulations restricted the use and disclosure of the records, including any confidential communications contained therein. This restriction reflected Congress' legitimate concern that patients will not enter substance abuse programs if law enforcement entities may use their substance abuse records against them. Courts have long recognized a similar concern when applying the restrictions against disclosure of substance abuse records.

Thus, the district court granted Chandler's motion for entry of a protective order and held that the terms of the existing protective order, prohibiting access to confidential communications, applied to the county's attorneys. The court denied Chandler's motion for entry of a protective order to the extent that the county was not required to divulge to the relator any records it uses to prepare its defense.

Furthermore, it appeared to the district court that notice may have to be sent to the New Start participants again as the notice should inform the patients specifically to whom the information will be disclosed and the patients had not been informed that the county's attorneys will be viewing their files.

EXPERT TESTIMONY

Dawson v. Prager,
No. 88,077 (Kan. Sept. 26, 2003) - DEx 82196, 15 pp.

The Kansas Supreme Court ruled the trial court properly granted summary judgment to a doctor and clinic in a patient's medical mal-

practice action. The patient's expert testimony on standard of care was inadequate.

Marian Dawson sued Dr. Sandra Prager and The Menninger Clinic Inc., alleging malpractice and other wrongs in her psychiatric care and treatment. Dawson contended Prager did not have the professional experience to treat her severe psychiatric problems and should not have undertaken her diagnosis and treatment. Among other allegations against Prager, Dawson alleged the doctor did not provide a safe environment in which she would be protected from self-inflicted injury. According to Dr. Robert Simon, Dawson's expert witness on psychiatric matters, Dawson burned herself approximately 10 or more times in March, April and May 1995. The clinic filed a counterclaim for unpaid medical bills of $69,219.17.

The district court granted the defendants' motion for partial summary judgment on all of Dawson's claims except medical malpractice. After deposing Simon, the defendants sought summary judgment on the medical malpractice claim on the grounds that Dawson's designated expert witness on standard of care did not spend at least 50 percent of his professional time in actual clinical practice for the two years preceding the incident giving rise to the cause of action, as required by Kan. Stat. Ann. § 60-3412. In response, Dawson filed an affidavit by Simon. The defendants requested the affidavit be strickened. The trial court ordered the affidavit to be strickened and granted summary judgment against Dawson and in the defendants' favor. Dawson appealed.

The supreme court affirmed the trial court's judgment. Under the clear and unambiguous wording of § 60-3412, the supreme court noted Simon did not spend at least 50 percent of his professional time devoted to actual clinical practice in the two-year period preceding the incident giving rise to the present action. Thus, the supreme court concluded, Simon was not qualified to testify on the standard of care.

The supreme court also found the trial court did not err in striking Simon's affidavit. Dawson's principal contention was that an affidavit is an appropriate means for supplementing deposition testimony and that Simon's affidavit was intended to supplement and clarify his deposition testimony rather than contradict it. In paragraphs three and nine of the affidavit, Simon estimated he spent more than 50 percent of his professional time in actual clinical practice during the period 1993 to 1995. His averments in the affidavit contradicted his deposition testimony, where Simon estimated he devoted 30-40 percent of his professional time to actual clinical practice during that period.

The supreme court then turned to the clinic's counterclaim for unpaid medical bills. Among the arguments made by Dawson were that she had no contract with the clinic and that it was not entitled to the difference between the actual costs of services and insurance premiums made on her behalf. Dawson also argued that at various times she had had different contracts with the clinic. She stated her contracts differed due to her changing insurance carriers and at times being uninsured. In this regard, she argued that the clinic failed to show the various contracts.

The supreme court noted Dawson's argument was that the portion of billed services she was responsible for differed from time to time depending on her insurance and she disputed the clinic's computation of the amount owed. Hence, due to Dawson's failure in opposing the clinic's motion to set forth specific facts showing there was a genuine issue as to the amount owed, it was appropriate for the district court to grant summary judgment.

Bradley v. Miller,
No. 1012133 (Ala. Sept. 26, 2003) - DEx 82330, 6 pp.

The Alabama Supreme Court ruled a doctor was entitled to summary judgment in medical malpractice plaintiffs' suit. Because the opinion of the plaintiffs' medical expert regarding proximate cause lacked an evidentiary foundation, it failed to meet the plaintiffs' burden of production.

While pregnant, Chrissy Bradley suffered preeclampsia, a pregnancy disorder, which killed the fetus on May 23, 1999. To recover for the death of the fetus, Bradley and her husband sued Dr. Rebecca Miller, Bradley's obstetrician. The plaintiffs contended that Miller, a third-year-resident in obstetrics and gynecology (OB/GYN) at the University of South Alabama, breached the standard of care by:

1. failing to classify Bradley's pregnancy as a high-risk pregnancy;

2. failing to ensure that the administrative staff of the USA Center Street OB/GYN Clinic (the Clinic), where Miller treated

Bradley, did not cancel Bradley's May 6, 1999, appointment with Miller;

3. failing to "seek out" the results of an ultrasound performed on April 28, 1999, showing the fetus was experiencing growth retardation; and

4. failing to diagnose that the onset of Bradley's preeclampsia was impending.

In moving for summary judgment, Miller contended the plaintiffs could not produce the expert medical testimony regarding proximate cause required of plaintiffs to withstand summary judgment in a medical malpractice case because the evidentiary foundation for such expert medical testimony did not exist. Miller argued the evidentiary foundation did not exist because:

1. the evidence established only that Bradley did not suffer from preeclampsia when Miller saw her for the last time on April 15, 1999, and that Bradley was suffering from preeclampsia when she was next seen by a physician on May 23, the day the child died, and

2. no evidence established when the onset of Bradley's preeclampsia began or whether the onset was gradual or sudden. Miller contended this state of the evidence foreclosed any expert medical opinion except mere speculation that the fetus probably would have been saved in the absence of the alleged breaches of the standard of care by Miller. The trial court granted Miller's motion, and the plaintiffs' appealed.

The supreme court affirmed the trial court's judgment. In essence, the plaintiffs' expert opined that, if Miller had monitored Bradley more closely for pregnancy complications other than preeclampsia, she would have incidentally detected the onset of Bradley's preeclampsia in time to effect an early delivery of the fetus before the preeclampsia killed the fetus. However, the necessary evidentiary foundation for such an opinion did not exist. The supreme court found the undisputed evidence affirmatively established Bradley did not suffer from preeclampsia as of April 15, the last time Miller saw Bradley. Moreover, there was no evidence to establish that Bradley suffered from preeclampsia before the hospital checked her blood pressure on the night of May 23 and found it above 140/90. The plaintiffs did not even present any evidence that Bradley's cramps and vaginal discharge established that she suffered from preeclampsia on May 22.

Given this state of the evidence, the supreme court noted the plaintiffs' expert could only speculate about the timing and manner of the onset of Bradley's preeclampsia and, in turn, the rapidity of the adverse effects of the preeclampsia on the fetus. This speculation, in turn, was the only available foundation for the conclusory opinion of the plaintiffs' expert that the fetus could have been saved if Miller had monitored Bradley more closely, for instance, by seeing Bradley on May 6, the date of the cancelled appointment. Because the foundation for the expert's conclusory opinion consisted entirely of speculation, the conclusory opinion itself could be only speculation. Because the conclusory opinion of Bradley's expert that the child could have been saved with closer monitoring was only speculation, it did not constitute substantial evidence of proximate causation.

MALPRACTICE

Griffin v. McKenney,
No. 2002-CA-00353-COA (Miss. Ct. App. Oct. 14, 2003) - DEx 82459, 31 pp.

A Mississippi court of appeals found no basis for reversing a jury verdict and judgment in favor of the doctor in a medical malpractice lawsuit despite a patient's arguments that the trial court had made evidentiary errors, such as excluding evidence of the defendant doctor's possible alcoholism and permitting the defendant doctor to testify as an expert in the case. Michael Griffin's doctor diagnosed him with gallstones after he suffered heartburn and nausea. He suggested Griffin consult a surgeon about having his gallbladder removed. Griffin saw a surgeon he had used several years before for a bowel obstruction surgery, Dr. McKenney. The surgeon, with Griffin's consent, scheduled a laparoscopic cholysystectomy, a surgical procedure for removing the gallbladder. During surgery, McKenney also "lysed" adhesions on Griffin's bowel and performed small bowel resection and placed two drains in his abdomen.

Griffin's recovery was marked by pain, elevated white blood cell count, a fever and blood, pus and other drainage from his drains. Over a week after surgery, Griffin developed an "acute abdomen," indicating a bowel problem. Another surgeon, on call for McKenney, performed open surgery and found small bowel content was leaking from two perforations in Griffin's bowel and had spread throughout his abdomen. He also had abscesses and a large blood clot near the site of the gallbladder removal.

Over the next month, Adkins performed four more surgeries on Griffin to control his infection and abscesses. He developed pneumonia and pancreatitis. He spent over a month in and out of the hospital, incurred $263,377.97 in medical bills, missed four months

of work and suffered continuing fatigue. Griffin and his wife sued McKenney, alleging he negligently perforated the bowel during the initial gallbladder surgery and/or negligently rendered post-operative care. Griffin's wife asserted loss of consortium.

At trial, one of the surgical nurses testified McKenney perforated Griffin's bowel, but neither the surgical staff nor the post-operative reports confirmed this. The Griffins' experts opined that McKenney had breached the standard of care in performing surgery on Griffin but McKenney's experts testified he could not have perforated the bowel during surgery or Griffin would have suffered an acute abdomen very soon after surgery, not more than a week later. Moreover, Griffin had suffered pancreatitis after his bowel surgery several years before, and one expert testified this condition can recur and could have caused his abscesses after the gallbladder surgery.

The jury found in McKenney's favor, and judgment was entered for him. The Griffins appealed, asserting the trial court had improperly excluded evidence of McKenney's possible alcoholism from the trial evidence. They also objected to McKenney's offering expert testimony during his testimony and certain other trial court rulings.

The appeals court reviewed the trial court's evidentiary rulings. The appeals court concluded it was within the trial court's discretion to disallow evidence that the doctor received inpatient treatment for alcohol addiction less than six months after Griffin's surgery. The trial court concluded the evidence was more prejudicial than probative because there was no evidence that the doctor was drinking during his treatment of Griffin. In addition, the appeals court found McKenney did offer impermissible expert testimony during his testimony but it presented no new information and did not substantially prejudice the plaintiffs, so it was not reversible error. The appeals court also found no merit in the Griffins' challenges of certain jury instructions.

Finally, the appeals court gave no credence to the Griffins' motion for a new trial, based on their argument that the verdict was against the overwhelming weight of the evidence. In a medical malpractice action, the plaintiff has the burden of proof to show the defendant physician breached the standard of care. The appeals court found the Griffins did not meet this burden, so the judgment entered on the jury's verdict should stand.

Stovall v. Clarke,
No. M2001-00810-SC-R11-CV (Tenn. Sept. 2, 2003) - DEx 82017, 11 pp.

The Tennessee Supreme Court ruled summary judgment was inappropriate in a medical malpractice action against two doctors. The plaintiff established a genuine issue of material fact as to the recognized standard of professional practice in the community in which the doctors practiced or in a similar community.

Carolyn Stovall was the wife of decedent Gerald Stovall, who had been a patient of Drs. Lois Clarke and Robert McCain. Clarke, a family medicine physician, and McCain, a pulmonologist, both practiced medicine in Franklin, Tenn. Mr. Stovall had a history of smoking cigarettes, high cholesterol and a family history of heart disease. In March 1992, Clarke ordered an electrocardiogram (EKG) for Mr. Stovall, which revealed he had sustained a possible inferior wall myocardial infarction. In October 1996, Mr. Stovall had a consultation with Clarke about a second EKG that was performed when he applied for life insurance. Mr. Stovall told Clarke he was concerned because the results of the 1996 EKG differed from the results of the 1992 EKG.

In January 1997, Mr. Stovall saw Clarke for symptoms that included shortness of breath and wheezing. Clarke diagnosed a reflux problem. Several weeks later, Mr. Stovall returned and complained of a chest cold and continued wheezing. Clarke diagnosed an upper respiratory infection and prescribed an antibiotic. In early February 1997, Mr. Stovall returned to Clarke for a third time with the same symptoms. Clarke then referred Mr. Stovall to McCain, a pulmonologist.

On Feb. 28, 1997, McCain examined Mr. Stovall, who once again reported symptoms that included shortness of breath and a persistent cough. McCain concluded Mr. Stovall had been in good health, found that his cardiac and lung evaluations were normal and determined he had never complained of chest pain. McCain diagnosed Mr. Stovall with bronchitis aggravated by smoking, for which he was being treated with antibiotics, and he did not order additional tests. On March 11, 1997, Mr. Stovall died from what was later determined to be coronary artery disease. Mrs. Stovall filed medical malpractice actions against Clarke and McCain, alleging both physicians negligently failed to perform appropriate diagnostic tests and failed to discover the coronary heart disease that caused Mr. Stovall's death.

The trial court granted summary judgment to the defendants and later denied Mrs. Stovall's motion to alter or amend the summary judgment. The appeals court reversed the grant of summary judgment to Clarke but affirmed the grant of summary judgment to McCain. The supreme court granted review.

First, the supreme court found the appeals court correctly determined the trial court erred in granting summary judgment to Clarke. It

followed then that the trial court's denial of the plaintiff's motion to alter or amend the summary judgment in favor of Clark was also erroneous. Although the trial court did not make specific findings of fact, the appeals court determined the summary judgment granted to Clarke was based on the standard of care requirement set forth in Tenn. Code § 29- 26-115(a)(1). This statute embraces the so-called "locality rule," which requires the standard of professional care in a medical malpractice action be based upon "the community in which the defendant practices or in a similar community." The supreme court agreed with the appeals court's assessment that Mrs. Stovall presented expert testimony establishing the recognized standard of acceptable professional practice in Franklin, Tenn., or in a similar community.

The supreme court also found the trial court erred in denying Mrs. Stovall's motion to alter or amend the summary judgment granted in McCain's favor. Although the trial court did not make specific findings of fact, the appeals court upheld the summary judgment in favor of McCain after finding Mrs. Stovall failed to establish causation. The court reasoned she "failed to demonstrate that she will be able to prove that any act or failure to act by McCain caused her decedent to suffer injuries that otherwise would not have occurred." The supreme court concluded that the evidence, when viewed in a light most favorable to Mrs. Stovall, raised a genuine issue of material fact with regard to causation.

PHYSICIAN LICENSING

DiBlasio v. Novello,
No. 02-9298 (2d Cir. Sept. 18, 2003) - DEx 82082, 28 pp.

The Second U.S. Circuit Court of Appeals ruled a suspended physician's substantive due process claims against state health department officials in their individual capacities were not barred by absolute immunity. In 1998, Dr. Mario DiBlasio, a licensed radiologist, was hired by radiologist Steven Bier. Bier contracted with the Bronx Healthy Women Partnership to provide breast cancer screening services for its patients, who were largely underinsured women. DiBlasio worked as a "batch reader," providing clinical interpretations of mammograms and had little or no contact with patients.

In March 2000, the New York State Department of Health launched an investigation of Bier's billing practices. In connection with that investigation, the Department turned its attention to certain radiologists employed by Bier. On March 23, 2000, the State Board for Professional Medical Conduct assigned Lisa Hampton, a Department fraud investigator and the director of the Medical Fraud Unit of the Office of Professional Conduct (OMPC), to investigate DiBlasio's rate of error in detecting cancer. Following her investigation, Hampton recommended the Department temporarily suspend DiBlasio's physician license pursuant to the summary suspension procedures in N.Y. Pub. Health Law § 230.

Subsequently, Hampton met with DiBlasio about his purported medical misconduct. Before the meeting, Hampton sent DiBlasio a letter stating that he was being investigated for professional misconduct and that the meeting was related to that investigation. The letter made no mention of DiBlasio's right to be represented by counsel, and DiBlasio attended the meeting unrepresented.

Three days later, Antonio Novello, the Department commissioner, summarily suspended DiBlasio's medical license pursuant to § 230(12)(a) and, through the Board, issued a statement of charges, specifying four instances of alleged professional misconduct. Thereafter, Novello issued two press releases and a report concerning DiBlasio's suspension and alleged incompetence.

On Dec. 18, 2000, an OMPC hearing committee suggested that, with the exception of mammography, DiBlasio be permitted to practice radiology with supervision. However, pursuant to her authority under § 230(12)(a), Novello rejected the hearing committee's recommendation and ordered the continuation of the complete suspension of DiBlasio's license. DiBlasio then initiated Article 78 proceedings in state court, seeking an injunction. The court denied his request for an injunction. After the denial, the hearing committee determined the misconduct charges against DiBlasio were unfounded and ordered the case dismissed.

DiBlasio and Mario DiBlasio, M.D., P.C. (collectively, DiBlasio) then brought a lawsuit in federal district court against Hampton and Novello. He alleged substantive due process claims based on purported misconduct during the investigation and summary suspension proceedings, a procedural due process "stigma plus" claim based on Novello's allegedly defamatory statements, and various violations of state law. The district court dismissed all of DiBlasio's claims. The court concluded that both defendants were shielded from DiBlasio's substantive due process claims by absolute immunity and that DiBlasio failed to state a claim for a "stigma plus" procedural due process violation because Novello's allegedly defamatory statements were "random and unauthorized." Thus, the random and unauthorized exception to the requirement of a pre-deprivation hearing applied. DiBlasio appealed.

The Second Circuit vacated the district court's judgment and remanded the case for further proceedings. First, the Second Circuit

found DiBlasio's substantive due process claims were barred by absolute immunity. Summary suspension pursuant to § 230 lacks sufficient similarity to the judicial process to warrant absolute immunity from suit for involved officials. Moreover, neither Novello's nor Hampton's role in the summary suspension was "functionally comparable" to that of a judge or prosecutor.

The Second Circuit also found the district court erred in dismissing the "stigma plus" claims. DiBlasio's complaint alleged that Novello's statements to the press were actionable as a component of a "stigma plus" violation. "Stigma plus" refers to a claim brought for an injury to one's reputation (the stigma) coupled with the deprivation of some "tangible interest" or property right (the plus), without adequate process. The Second Circuit found the district court erred in finding the conduct of a high-ranking official such as Novello was random and unauthorized. A commissioner of a state department is a high-level state official with final authority on many department matters, including the content of press releases and her own statements in press conferences. Moreover, pursuant to § 230(12)(a), summary suspensions are public upon issuance.

Under such circumstances, it would make little sense to characterize Novello's public statements as random and unauthorized. Because the district court dismissed all of DiBlasio's § 1983 claims, it declined to exercise supplemental jurisdiction over his state law claims. As the Second Circuit had reinstated DiBlasio's § 1983 claims against Novello and Hampton in their individual capacities, it also reinstated DiBlasio's state law claims

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