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“To live long, live slowly.”

— Cicero
INFORMATION FOR AUTHORS

The Editorial Committee accepts original manuscripts for consideration of publication in the Journal of Medical Licensure and Discipline. The Journal is a refereed journal, and all manuscripts are reviewed by Editorial Committee members and/or appropriate consultants. (The review process takes six to eight weeks.) Manuscripts should focus on issues of medical licensure and discipline or related topics of education, examination, postgraduate training, ethics, peer review, quality assurance, and public safety. Queries and manuscripts should be addressed to Editor, Journal of Medical Licensure and Discipline, Federation of State Medical Boards P.O. Box 619650, Dallas, TX 75261-9850, or by e-mail to epittman@fsmb.org.

Manuscripts should be prepared according to the following guidelines:

1. A cover letter should introduce the manuscript, name a corresponding author, and include full address, phone, and fax information. The 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 text length should not exceed 5,000 words, with references (in Associated Press style) and tables attached.

4. The number of references should be appropriate to the length of the text.

5. Any table or figure from another source must be referenced. Photos should be marked by label on the reverse side and up direction noted.

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. A hard copy of the submission and a PC-compatible disk copy should be submitted. The word processing program and title of the appropriate file(s) should be indicated.

8. Manuscripts are reviewed in confidence. Major editorial changes will be submitted to the corresponding author for approval. The original copy and disk will be returned if the submission is not accepted for publication.
MESSAGE FROM THE CHAIR

A GLOBAL VISION FOR MEDICAL REGULATION

Extraordinary. No other word adequately describes what is happening with IAMRA – the International Association of Medical Regulatory Authorities. A mere eighteen months ago, in June 2002, IAMRA was launched with eight founding members. Today, the organization boasts 52 members from 24 countries.

That’s astonishing growth that any association would be proud of. But to my mind, the real progress in IAMRA is occurring on the relationship level. Despite differences in terminology and significant time and language barriers, medical regulators from around the world are getting to know one another. From my experience on numerous boards and committees over the years, I can tell you that when relationships are strong, things happen! And things are truly happening in IAMRA. What we’re discovering is that while our differences may often be more significant than our similarities, our fundamental goals are the same: protection of the public, protection of the patient.

Why is it important for state medical boards in the United States to be involved in the international arena? Whether we like it or not, the dizzying pace of globalization is impacting health care around the world. In ever-increasing numbers, physicians are crisscrossing borders to fill needs in countries with chronic shortages of doctors. Thousands of physicians and other health care workers from abroad are moving to the United States to serve in a vast array of temporary and permanent capacities. How can medical regulators expedite their entrance into the U.S. medical system without compromising public safety? The need for efficient systems to safely move doctors from one international jurisdiction to another has never been more important.

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. For example, discussions about license portability and information sharing have contributed to the development of such common terminology as the proposed Certificate of Good Standing (CGS), a document that would indicate a physician is qualified to practice and has no outstanding disciplinary actions.

I strongly encourage all state medical boards to join IAMRA and capitalize on the numerous benefits of collaborating with a dedicated global audience. If your state medical board is not yet a member of IAMRA, please discuss it with your fellow board members and consider joining us in building a global vision for medical regulation.

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.

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

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**WELCOME TO IAMRA’S NEWEST MEMBERS**

Organizations that joined IAMRA during 2003 include:

**Canada**
- College of Physicians and Surgeons of Ontario

**India**
- Delhi Medical Council
- Goa Medical Council

**Korea**
- National Health Personnel Licensing Examination Board

**Netherlands**
- Royal Dutch Medical Association, Department of Postgraduate Training and Registration

**Portugal**
- Ordem dos Médicos

**United Kingdom**
- Royal College of Physicians of Edinburgh
- Royal College of Physicians of London

**United States**
- Massachusetts Board of Registration in Medicine
The vast majority of doctors in Texas will never run the risk of having their license suspended or revoked because they practice good medicine and behave professionally. They are competent, compassionate, and adhere to high standards. However, those who deviate from these standards may face a number of disciplinary consequences. The purpose of the Texas State Board of Medical Examiners (TSBME) is to protect the public by regulating the practice of medicine through licensure, discipline, and education. Soon after my term on the Texas board began in 1999 it became obvious to me that, while the licensing and disciplinary departments of the agency appeared to be humming along at full throttle, the educational efforts of the board were quiet by comparison.

To keep the public informed, we have a user-friendly and nearly encyclopedic website (www.tsbme.state.tx.us) and a biennial Web-based newsletter. Additionally, board members try to visit at least one of the eight medical schools in Texas each year to drive home important points for physicians-in-training. Despite these efforts, agency staff and board members continued to receive an inordinate number of calls and complaints regarding the licensure process. In 2002 in-house protocols were adjusted to expedite the licensure process, and the number of calls has since dropped. However, even with these improvements a fair number of frustrated license applicants, together with a small percentage of applicants who provide false or misleading information, demonstrate that some still are not well informed.

Likewise, it seemed that many of the physicians allegedly deficient in skill, knowledge, judgment, ethics, character, or self control could use a refresher course in professionalism — a code of conduct that, were it adhered to by more physicians with potential problems, would likely save precious resources used to investigate allegations, generate disciplinary orders, enforce those orders, and deal with those who fail to cooperate accordingly. As in the licensing department, other significant changes at the TSBME have resulted in tougher policies, a reduced backlog of open investigations, and quicker overall turnaround time for new investigations.

I believe my colleagues on the board would agree that our time is most often spent in a reactive posture when deciding whether or not to take action against a physician’s license, and when crafting an order that best suits a particular case. When it comes to protecting the public after the fact, we must respond to the facts presented. Board members spend up to 30 days a year for six years in Austin, working hard to do the right thing for the public. We are proud of our work, and are taking a tougher stance these days on physicians who pose a threat, including those who fail the honesty test when applying for a license. However, despite our commitment and the diligent work of board staff, there continues to be a steady

David E. Garza, D.O.,
Member,
Federation Editorial Committee
trickle of complaints to the TSBME regarding alleged medical misadventures, ethical lapses, and impairment. Often it is a combination of these flaws that brings a physician to our attention. This fuels a sense of frustration at the board that perhaps the message regarding the consequences of bad medicine and bad habits is just not getting through to some folks.

While this certainly applies to disciplinary actions, the licensing process has similar challenges, too. Although we have no control over what international and out-of-state graduates learn regarding licensure in Texas, we feel that graduates from local schools stand a better chance of successfully navigating the process. Furthermore, all applicants do have access to our website, and our application is self-explanatory, more brief than previous versions, and easier to complete. When applications for licensure do fall out for review, an air of suspicion often surrounds the decision process. Poor academic performance, negative faculty reviews, and inconsistencies on the application thrust board members and staff once more into a reactive mindset to determine if a problem truly exists. Occasionally, new licenses are granted only if the physician agrees to certain restrictions or conditions before they are allowed to practice.

No shortage exists when it comes to critics of board rules, staff, or actions, however. Occasionally, tough board members are themselves the subjects of criticism. We are either too tough or too lenient, or too late or too quick on the draw; it all depends on the source. Caution and haste, naturally, are a matter of perspective. During the past two years, board members and staff have had to react to myriad, and often conflicting, criticisms of our work from the media, consumer groups, professional organizations, legislators, and, of course, disgruntled physicians. One reason is that the board’s actions and new policies will never satisfy every individual or special interest group all the time. This is the rule rather than the exception, and not unique to the TSBME or to other types of regulatory agencies. Moreover, because this is government work, when our decisions do happen to please someone or some agency, it is likely to fall short of their expectations.

The changes within the board touched on above will be sure to satisfy some of the critics, but just their mention has enraged others. When it comes to fulfilling the mission of the TSBME, it is rare for all stakeholders to agree on any one issue. However, although we may be “caught in the crossfire,” public protection is and must remain our priority.

Recently, additional funding was approved by the 78th Legislature and has been earmarked primarily for investigation, litigation, and compliance. But with this funding also come more responsibilities, so the effectiveness of educational endeavors by the board will continue to be limited by budgetary constraints. It is the natural tendency of doctors as human beings to forget some of what was taught in school, and the problem is compounded by the fact that it is likely that those most at risk are not the ones most likely to stay current or to seek guidance.

Taking a broad view, it seemed as though the TSBME could benefit from another tool to keep physicians
informed. Although many critics would agree that the board just needs a bigger or better hammer (recent legislation has addressed this), the TSBME could also use something more along the lines of a compass to help physicians remain current on licensing and disciplinary issues.

After board meetings in Fall 1999 these educational challenges were clear. Soon thereafter fellow board member Larry Price, D.O., described the effectiveness of a well-thought-out presentation to a group of students at Texas A&M College of Medicine, who envisioned a way of addressing these challenges. Visits by board members to medical schools are sporadic, inconsistent in their message, and even less consistent in terms of attendance by medical students and residents (one meeting during a busy testing schedule in Houston was attended by a handful of students). To address these issues, the idea of making a video to present a standard, meaningful message was conceived. The original intent was to produce a video that would promote greater understanding among current and future physicians regarding the regulation of medical practice in Texas. It was hoped that the video would decrease complaints from applicants regarding licensure and about physicians holding a Texas license.

At a meeting of the board of the Texas Society of the American College of Osteopathic Family Physicians (TxACOFP) in Fall 1999, this idea was presented during casual conversation and the seed was planted. A plan of action was created, and a script was written. Because the TSBME lacked sufficient resources to produce and distribute the video, the University of North Texas Health Science Center at Fort Worth Texas College of Osteopathic Medicine agreed to donate the equipment and human resources needed to complete the project. Because our goal was to issue a copy of this video to every medical student in Texas, TxACOFP sought additional assistance through a grant from private foundations. While these efforts were underway, another TxACOFP board member, Pat Hanford, D.O., received enthusiastic support when he shared this idea with his colleagues on the board of the Texas Medical Foundation (TMF).

The TMF not only agreed to provide the necessary funding, but also graciously and enthusiastically adopted this project. During the next three and a half years, collaboration between the TMF and TSBME solidified the message and presentation. They re-wrote the script while preserving the original idea and intent. The TMF also expanded the concept of how to distribute the final product to current and future Texas physicians and to anyone else who would want a copy — all free of charge. We were overjoyed — but not surprised — by the TMF’s desire and ability to accomplish the task. The premier of The TSBME: A Glimpse of Licensure and Discipline was in Austin on July 11, 2003, at the Bob Bullock Texas State History Museum. It will also be available online soon, and physicians may receive one hour of ethics CME credit after viewing it.

After viewing the finished product, I believe the TMF has produced an excellent educational tool that will raise awareness, as well as benefiting the public and the medical profession by achieving the following:

- Guiding current and future physicians through the basics of the licensure application process
• Educating viewers regarding the most common reasons doctors get in trouble with the board
• Outlining the range of consequences of unsafe and unprofessional behavior, hopefully resulting in fewer complaints about board policy and rules, and fewer complaints about wayward physicians
• Doing all this at no cost to the public, which expects excellent health care, nor to the TSBME, whose budget is derived entirely from a fraction of physician’s registration fees

On another level, this video demonstrates the power of collaboration between the public and private sectors. In this case, entities representing professional, peer review, and government regulatory interests partnered to promote public protection through physician education. Organized medicine likewise has embraced this work, as its current and future members stand to benefit as well. It became one of those rare examples of something all parties could agree on.

On a personal level, seeing this project through from start to finish has been quite fulfilling, and has provided all who made it happen with a similar sense of satisfaction. The intent was to be proactive, practical, and innovative, while being consistent with the goals of the TSBME. Because the spirit of this endeavor was to be preventive, rather than punitive, it also was in line with the mission of the TMF. The only downside was the realization that it would take a “miniseries” to cover every important message doctors might need to hear. Nevertheless, the big-ticket issues were touched upon, and this first video lays a firm foundation for other projects that may follow, perhaps creating a ripple effect to other regulatory agencies in Texas and beyond.

Ultimately, health care professionals need to understand state laws related to their practice, maintain proficiency in knowledge and skills, know their limitations, maintain proper boundaries, be compassionate always, use common sense, and hold themselves to high personal and professional standards of behavior. A number of errant, impaired, or ethically challenged health care professionals will always pose a threat to their patients and their profession, and pose a challenge to regulatory agencies. This is human nature. It is with great hope and anticipation, though, that this video and other tools like it will have a positive impact in this regard.

Many thanks go to the TMF for their generosity and leadership. Thanks in particular go to Executive Director Phil Dunne, Director of Business Development Tom Manley, Lolly Lockhart, Ph.D., R.N., and the officers and members of the TMF board. Thank you also to the TxACOFP officers for their vision, to TSBME Executive Director Donald W. Patrick, M.D., J.D., to the TSBME staff, and to everyone else whose efforts enabled these public and private organizations to combine their efforts as good citizens, for the good of all citizens.
Achieving the Right Balance in Oversight of Physician Opioid Prescribing for Pain: A Survey of State Medical Boards

INTRODUCTION
Uncertainty regarding potential disciplinary action may give physicians pause when considering whether to treat a patient who may require long term or high doses of opioids. Surveys have shown that physicians fear potential disciplinary action for prescribing of controlled substances and that physicians will in some cases inadequately prescribe opioids due to fear of regulatory scrutiny. The prescribing of opioids for long-term pain management, particularly noncancer pain management, has been controversial, and boards have investigated and, in some cases, disciplined physicians for such prescribing. While in virtually all of these cases the disciplinary actions were successfully appealed, news of the success was not often as well publicized as news of the disciplinary actions and some physicians have remained confused about their potential liability when prescribing opioids for pain. The confusion has perhaps increased as a result of relatively recent cases wherein a physician was successfully disciplined by a state medical board for undertreatment of his patients' pain and another was successfully sued for inadequate pain treatment.

In 1999, the Oregon Board of Medical Examiners was the first in the nation to discipline a physician for failure to prescribe adequate pain relief medication. The physician, Dr. Paul Bilder, was cited for several pain undertreatment infractions, including prescribing only Tylenol for a terminally ill cancer patient's pain and prescribing only a fraction of the dose of morphine that another patient needed and the hospice nurse suggested. Dr. Bilder was ordered by the board to complete an educational program, a program on physician-patient communication, and undergo mental health treatment. Less than two years later, in June 2001, a California jury awarded $1.5 million to the surviving children of William Bergman, who sued their father's physician, Dr. Wing Chin, for undertreating Mr. Bergman's cancer pain before he died. Although the award was subsequently reduced by the court, it was a dramatic message to physicians. In addition, earlier this year (March 2003), the Medical Board of California filed charges against Dr. Eugene Whitney for failure to adequately treat the pain of Lester Tomlinson, an elderly man dying of lung cancer. Although the outcome of the case has not yet been determined, the step by the board is significant.

These cases reflect a changing attitude toward pain treatment in the United States – a recognition that patients, especially patients at the end of life, have a right to adequate pain treatment. This shift in thinking appears to have begun in the late 1980s. Prior to this time, “according to established medical opinion, the likelihood of addiction to opioids was considered too great to prescribe them to any patients but those suffering from the most serious pain.” This opinion was conveyed by a number of state medical boards to physicians who were disciplined for prescribing outside of these boundaries. This “sea change” came about “as evidence mounted that patients, especially cancer patients, were being undertreated for...
their pain, and that addiction was not a significant problem for pain patients with no prior history of substance abuse.5 In response, physicians began to prescribe greater amounts of pain medication. In addition, professional and governmental agencies established clinical guidelines encouraging the use of opioids in the treatment of cancer pain. For example, the American Society of Law, Medicine, and Ethics (ASLME), with support from the Mayday Fund, addressed the issue of pain undertreatment through a variety of educational initiatives and projects. ASLME’s joint work with the Federation of State Medical Boards (Federation) resulted in issuance in May 1998 of the policy document Model Guidelines for the Use of Controlled Substances for the Treatment of Pain on the use of opioids in pain management.7

From 1989 to 2001 there was a dramatic increase in the number of new state pain policies adopted by state boards and legislatures. Many state boards adopted policies consistent with the Federation’s Model Guidelines, which endorse a balance between preventing opioid misuse and not interfering with appropriate opioid prescribing along with multidisciplinary collaboration in treating pain patients. They also include treatment standards for chronic non-malignant pain as well as standards for acute and cancer-related pain.8 In addition to these guidelines, many state legislatures passed “intractable pain statutes.” These laws “were designed to provide physicians with some assurances by reducing both the real and perceived risks of being subjected to regulatory sanctions for treating pain with controlled substances.” Moreover, in 2001, drug enforcement officials from the Drug Enforcement Administration (DEA) and 21 health organizations issued a joint statement that they have begun to work together “to prevent abuse of prescription pain medications while ensuring that they remain available for patients in need.”10

Yet, at the same time that these new guidelines and incentives to appropriately treat pain would seem to counteract the pressures to undertreat pain, a renewed concern about drug diversion, in light of the abuse associated with Oxycontin, took shape. Pain treatment advocates voiced concerns that this abuse would lead to reinvigorated efforts by state medical boards to examine more closely physician prescribing of pain medications and impede progress in the treatment of pain. This led the authors to initiate a study of state medical boards to determine how they are balancing the need for adequate pain treatment with concerns about drug diversion and inappropriate prescribing. This article reports on the results of that survey.

The study, conducted in late 2001 and the first half of 2002, just after the high visibility given to the abuse of Oxycontin in the press, sought information regarding trends in the number and nature of complaints received by boards for inappropriate prescribing of opioids (i.e., “overprescribing” or “underprescribing”), how boards evaluate such complaints, and under what circumstances boards would discipline physicians falling into one of those categories. The focus of the survey was board experience during the past five years (1997-2001). The survey was directed (by name) to the state board medical director, or individual with a comparable title.11 Of the fifty states and the District of Columbia, 38 state medical boards participated (a 74.5 percent response rate).

SURVEY OF STATE MEDICAL BOARDS – RESULTS

Opioid Overprescribing: Complaints

Respondents were asked to estimate the number of complaints12 their board had received in 2001 related to opioid overprescribing (i.e., “physicians who allegedly prescribed opioids unnecessarily, in too high a dose, or for too long a duration”).13 Twenty-five individuals were able to give such an estimate. According to those estimates, the average number of complaints in 2001 was 3.1 per 1,000 doctors in the state (SD = 2.8, range = 0 to 13.8).14 The most common sources of these complaints were pharmacies, government regulatory agencies such as the DEA, and family members of patients.

When respondents were asked their impression of whether complaints against physicians for opioid overprescribing had increased, decreased, or stayed the same over the past five years, 17 respondents (45 percent) thought complaints had stayed the same, 14 (37 percent) thought they had increased, and four (10.5 percent) thought they had decreased (three did not know). (See Figure 1.)
Respondents were asked whether the problem of drug diversion and abuse in their state, in general, had improved, become worse, or stayed the same during the last five years. Eighteen (47 percent) thought it had become worse, 11 (29 percent) thought it had stayed the same, and five (13 percent) thought it had improved. (Four had no real impression.) Some commented that the drug diversion/abuse problem was not necessarily worse, but their board was doing more (“taking a little sterner approach than before 1996” or “pursuing it more diligently”). Fifteen of the 18 (83 percent) who thought drug diversion and abuse in their state had become worse, thought that the abuse and diversion of Oxycontin had contributed to that trend, while the remaining three thought it had not. Some thought the abuse of Oxycontin had made the public more aware of diversion issues, but had not increased their complaints or investigations. Others made reference to Oxycontin being “the drug of the month” (“20 years ago it was Dilaudid, then Percocet, once upon a time it was Demerol”). One respondent commented, “we don’t have issues with physicians abusing Oxycontin…our problem has been with patients selling or diverting the Oxycontin and physicians not tuning in to that.” A few respondents, however, described serious problems in their state with overdose deaths from Oxycontin, or of people in their state breaking into pharmacies and holding pharmacists up at gunpoint, specifically requesting Oxycontin.

INVESTIGATIONS FOR OVERPRESCRIBING

When asked whether their board had changed its approach to the investigation of physicians for opioid-prescribing in response to Oxycontin abuse and diversion, 29 (76 percent) said no and five (13 percent) said yes (four had no opinion). Those who had not changed their approach commented that they conducted the “same thorough investigation” of all valid complaints. Others felt their investigative approach had not changed but their attention to the issue had increased. One respondent identified drug diversion as a priority of the board, which was working more with law enforcement to “stay on top of what’s going on.”

A number of respondents admitted that finding the balance between identifying physicians who overprescribe opioids and those who are appropriately treating chronic pain is not always easy.

When asked whether board investigations of physicians’ opioid-prescribing practices had increased, decreased, or stayed the same over the past five years (1997-2001), 17 respondents (45 percent) said the number of investigations had stayed the same, 15 (39.5 percent) said they had increased, and three (8 percent) said they had decreased (three did not know). (See Figure 1.) Respondents were asked why they thought the number of investigations had increased or decreased. Regarding increased numbers of investigations, a commonly cited reason was increased public awareness, “patients and families are more aware,” and “people are more inclined to speak up than they have been in the past.” Some mentioned law enforcement actions (“there have been more cases where there have been convictions [of physicians] on drug trafficking and selling [opioid] prescriptions for money”). Regarding decreased investigations, one respondent cited economic factors that limited the resources the board could direct toward investigations. Changes in the board’s attitude toward opioid prescribing was mentioned as a reason for both increased and decreased investigations over the past five years. One respondent shared his impression that “the board is taking these cases more seriously than in the past…[by] cracking down on doctors who are overprescribing, and wanting us to find information to back that up.” Others pointed to their board’s
changed attitude toward the treatment of chronic pain resulting in fewer full investigations.

State pain guidelines, statutes, regulations, or policies were mentioned as providing guidance for when to proceed with a full investigation of a physician for overprescribing. All but six of the boards responding to the survey currently have some form of guideline (n = 16), statute (n = 15), regulation (n = 12), or policy (n = 9) related to pain management. For many boards, if a complaint was made against a physician who was found not to be in compliance with the board’s pain rules/guidelines, this would trigger a full investigation of that physician.

Some respondents commented that the volume or amount of opioids prescribed by a physician might trigger an investigation — for example, if there were “large numbers of patients receiving large numbers of opioids from the same individual who was seeing patients from a large geographic region, that would trigger an investigation.” Also, “if there were extremely large dosages [prescribed], that would make [the board] question if the patient could safely consume that much.” However, if there was evidence that backed up the need for the amount of opioid prescribed, most boards would not investigate further (e.g., “if we determined that they were providing therapeutic interventions, then we would close the investigation”).

In the absence of a board pain management policy or guideline, decisions about investigating or disciplining a physician were often based on deviations from the recognized standard of care. For example, a respondent from a state that had contemplated but not yet adopted pain management guidelines stated:

[An investigation is triggered by] the deviation from an accepted norm — if someone is prescribing differently from their peers in a specific specialty. As an example, the pain management people will write 10 times the amount of opioids as others. We wouldn’t waste time with that person. But if a physician’s billing as an internist and prescribing the same as a pain management person, we’re going to go find out why. And if the pain management person is prescribing way above others, we’d check that out too.

Several references were made to using judgment in each case:

You have to apply judgment; this is not an area that lends itself to cookbook approaches. You have to react to good intelligence, for example, a reliable source like a pharmacy or another health care provider — their threshold to report to the board is high. We review DEA reports for excess purchases monitored, but pure volume doesn’t necessarily indicate a problem. You have to tell whether it’s below standard of care, not just volume.

In addition to the volume of opioids prescribed, the credibility of the complaint source, and documented compliance with the pain management standard of care and/or board policies or guidelines, state regulations and statutes, boards look at the egregiousness of the physician’s conduct — one instance of highly egregious conduct may be sufficient to warrant a full investigation and subsequent discipline, whereas with milder forms of physician misconduct, a board may look at the number of complaints and evaluate patterns of inappropriate prescribing or practice. The uniqueness of each case was emphasized by many respondents.

DISCIPLINE FOR OVERPRESCRIBING

When asked whether respondents thought the number of physicians in their state who had been disciplined for overprescribing opioids had increased, decreased, or stayed the same during the past five years, 15 (39.5 percent) thought the number had stayed the same, 14 (37 percent) thought it had increased, and six (16 percent) thought it had decreased (three had no real impression). (See Figure 1.) Reasons given for increased numbers included: 1) an increase in numbers across the board, i.e., more complaints, more investigations; 2) increased awareness about the issue of drug diversion; 3) an increased level of sophistication among drug diverters/abusers; and 4) increased scrutiny by the medical board. Reasons given for a decrease in numbers of disciplinary actions taken against physicians during
the past five years for over-prescribing opioids involved the redefinition of “over-prescribing.” Respondents explained: “The board's attitude has changed; now we have pain management guidelines and have an established way of determining if a physician is deviating from those guidelines. We're more aware of the need for adequate pain management and how that should be documented. Because the quantity of opioids thought to be appropriate has increased tremendously, those who used to be disciplined now are not considered in violation. The upper limit has been raised, and we're okaying quantities now [that are] four to six times greater than before.”

Respondents were asked what factors would determine whether their board would discipline a physician for over-prescribing opioids. Several respondents commented that each case has a unique combination and presentation of facts, making it difficult to identify specific infractions that would automatically lead to a physician being disciplined — use of individual judgment was necessary. Comments included: “The board doesn’t have any policies or procedures on this. We would look at it on a case by case basis,” and “We look for records, tests, documentation, etc., and [the board] make[s] a decision about discipline. Our practices are very subjective.” There was generally less subjectivity and inconsistency involved in criminal diversion cases (“[The board is] pretty consistent, we usually get a drug profile, get records, get DEA or police to investigate that, make an arrest or investigate and get an emergency suspension for 90 days...”).

For many respondents, violation of a medical standard of care was enough to warrant disciplining a physician for opioid over-prescribing (“there's no need for a pattern or more than one case. One act or omission failing to meet the guidelines or standard of care is enough if the facts are corroborated.”). Others commented: “…we’d discipline based on failure to meet generally acceptable standards of practice, usually it's based on poor record keeping, [rather than] ‘over-prescribing opioids,’” “…it's based on adherence to medical standards of practice, and proof of that in documentation.”

Respondents mentioned various things they looked for when investigating physicians for over-prescribing opioids, including poor maintenance of patient records/poor documentation, “upcoding third party billing from a routine to a sick visit when [the visit is] under five minutes...significant findings of another disease entity not being followed, like hypertension or hyperlipidemia...” “red flags in the [patient] record like lost meds...if we see a lot of that stuff we start to think the doc doesn’t know what he’s doing. Especially whether the doctor refers out or not [to a pain specialist].”

Boards that had adopted pain guidelines referred to them in making judgments about a particular physician’s actions. One respondent stated: “We look to [our pain rules] to give us guidance as to whether there's a violation. We tend to act in formal disciplinary action with doctors who have shown egregious conduct or established a poor pattern of practice.” Another commented, “We refer to our pain guidelines. It’s not based just on dose but quantity. We realize that people are in pain and need medication for that, but there comes a point where it’s not physically possible to consume so many opioids in such a short period of time.”

The most common form of sanction imposed in over-prescribing cases was mandatory education/retraining. Other sanctions included (listed in order of frequency mentioned) license suspension, license revocation, probation, restricting opioid-prescribing, monitoring of prescribing practices, mentoring and supervision, reprimand/censure, and a fine.

**OPIOID UNDERPRESCRIBING**

**Complaints**

Nineteen respondents (50 percent) were aware of complaints to their board against physicians for undertreatment or inadequate treatment of pain in 2001. Based on the 33 respondents who were able to estimate the number of complaints, the average per 1,000 doctors in the state was .46 (SD = 1.1, range = 0 to 5.9). The major source of such complaints was patients, followed by family members. A few respondents did not perceive undertreatment of pain to warrant a serious response by the board. (“Normally those were dismissed or no action was taken because the board doesn’t perceive that circ-
cumstance as a real high threshold of some kind of negligence or incompetence”). Others demonstrated a commitment to the issue, despite the absence of complaints (“...as a cancer survivor I’m sensitive to the issue, but I don’t see complaints from cancer patients saying the doctor didn’t treat my pain carefully.”).

Twenty-five respondents (69 percent) thought there had been no change in the number of complaints the board had received in the past five years regarding inadequate treatment of pain. Six respondents thought there had been more complaints, and two thought less (three had no opinion). Those who thought the number of complaints had increased attributed it to increased public awareness (“...my husband recently had surgery and they were constantly asking him about pain — having him score his pain every time you turned around.”).

The most common form of sanction imposed in overprescribing cases was mandatory education/retraining. Other sanctions included (listed in order of frequency mentioned) license suspension, license revocation, probation, restricting opioid-prescribing, monitoring of prescribing practices, mentoring and supervision, reprimand/censure, and a fine.

Respondents were asked to estimate the number of investigations their board had ever conducted related to pain undertreatment. Nineteen respondents thought their board had never investigated a physician for undertreating a patient’s pain, and 16 thought their board had (three did not know). Of the latter 16, 11 were able to estimate the number of investigations their board had ever conducted related to undertreatment of pain. Of those, the average number of investigations per board was 1.7 (SD = 3.4, range = 0 to 13).

A number of boards appeared disinclined to consider a standard of care violation alone as a basis of disciplinary action in cases of pain undertreatment. One respondent voiced frustration with this general tendency of the board:

My problem here is we see standard of care [violation] cases all the time but we don’t discipline on [violation of] standard of care. For some reason our reviewer...says ‘well, it’s not the best medical care, but it doesn’t rise to the level of gross negligence.’ I wonder, what constitutes gross negligence?...I don’t think we do a good job at all on standard of care. I’d like to think so, but we don’t.

Some thought that the physician’s intent would be relevant (“was he trying to avoid DEA scrutiny rather than intentionally make people suffer?”), implying that lack of physician knowledge of pain management provided adequate grounds to evade board sanctions for pain undertreatment (“You would almost have to show criminal cruelty. [Giving Tylenol for cancer pain, knowing it doesn't alleviate the pain] could show that”). However, a few thought their boards would discipline if they could prove that the standard of care was violated (“yes, standard of care would be disciplined, depending on the facts;” “we do discipline standard of care issues; it’s hard to prove sometimes, but we do.”).

Those whose state medical boards had pain management guidelines or end-of-life legislation used those guidelines, policies, or legislation to benchmark the physician’s actions. One respondent stated, “our state has pain rules that were made by the board that the physician is expected to follow, and if it was verified that the physician didn’t follow them...that physician would most likely be disciplined.”

Another commented:

A doctor would have to show a pattern of practice of undertreatment, and following our pain
guidelines, if the patient's pain was 10 out of 10 and [he's] giving Tylenol or ibuprofen, that's reallyidiculous. Our consultants are in pain management and they believe in treating for pain. [But] it's
hard to gauge since we've never [disciplined for undertreatment of pain] before. There are 18
different personalities on our board, and it's hard to say how they'd go.

Several respondents thought that, depending on the facts of the case, a physician would likely be educat-
ed about pain management before sterner sanctions were invoked. One respondent stated, “they probably
wouldn’t suspend a doctor’s license, they would probably want re-education.”

BALANCING THE NEED FOR APPROPRIATE TREATMENT WITH PREVENT-
ING ABUSE AND DIVERSION

A few respondents thought that physicians might be hesitant to prescribe opioids to terminally ill patients
out of fears of hastening the patient's death. One respondent said that the allegations made to the board
relating to undertreatment of pain typically involved “a fundamental value system” in which physicians
“have very strong feelings about not wanting to hasten a patient’s death.” In such cases, the board “try[s]
to assure physicians that it’s within accepted practice to palliate at the end of life and this is not seen as
euthanasia or physician-assisted suicide, but often physicians really struggle with that issue.” Most
respondents, however, felt that pain management at the end of life had seen the most improvements as far
as boards being better able to distinguish adequate opioid-prescribing from overprescribing, as is evident
in the following comment:

The board’s in a tough spot. As soon as it goes after someone for overprescribing, the first reaction is
“that's chilling treatment for pain.” They duck for cover under that. But those cases are apples and
oranges. Those who are diverting opioids take cash only, they deal with patients who have a criminal
history, they don’t keep records. For example, there’s no comparison to treating a dying cancer
patient. Complete apples and oranges. It’s not like someone in hospice, dealing with a patient who
needs pain medications. Our board has a position statement on end of life that covers all this.

Some respondents commented on the difficulty in reconciling the changing attitudes and practice
standards in pain management of recent years with the ongoing problem of drug abuse and diversion. One
stated, “it’s a real challenge, finding that balance between under- and over-treating pain.” For some
respondents, their job was easier when there was a clearly established upper limit for prescribing opi-
oids, as the following comments demonstrate:

[There’s been a] tremendous change in the management of chronic pain and the attitude that
there doesn’t seem to be any upper limit on opioids. The attitude now is “whatever works.” I
have problems with that because I’m faced with figuring out whether opioids are being diverted
or not, and I have suspicions that a lot of patients are conning a lot of doctors into giving them
meds and don’t get questioned because of this “whatever works” attitude. We will have to figure
out how to counter that…We used to sanction based on the PDR limit (like 40 mg a day for
Oxycontin), but now that’s almost never the basis of our sanctions. Patients are on 700 to
800 mg of Oxycontin a day.

The numbers we're seeing, the doses are kind of unreal at times. You have a physician who's not
educated in pain management, and this might sound bad, but there is this rhetoric about serving
chronic pain patients, so physicians tend to do it. Some have good hearts and don't know how to do
it well, some don’t have the heart but see it as a way to have a practice, but they’re not following
good medical practice in prescribing, they’re just prescribing. They don’t have consults, they don’t
document about what’s going on, sometimes it’s not even based on good pharmacology, just “oh this
is good.” Under-prescribing is still an issue, but there's also the issue of people being so
overprescribed — we had one woman who was a school bus driver and she couldn't even move
[because she was so drowsy from the pain medication].
Another commented:

It’s the standard of care to take care of people’s pain just like it’s the standard of care not to be duped. That shows how colosally difficult the board’s job is here. When do you cross over from appropriately treating pain to hurting patients? I think people get into trouble with this because it’s easy money for doctors. I think the brass ring is a pain center connected with an academic center, where they’re well trained, well-managed, look at all problems, not just pain. Patients who are marginal and might be abusers are put on contracts and they have ways to keep them from participating in diversional activity...I’m always impressed with these pain centers to the point where they make it undesirable for drug-seeking individuals to [use their services].

Several respondents confirmed the difficulty boards had distinguishing valid chronic pain from drug-seeking behavior. One stated, “with the advent of new end-of-life legislation…physicians…feel freer to go ahead and prescribe the pain medications that are needed. This helps a lot. Regarding chronic pain, physicians are much more cautious about that.” Another acknowledged:

It’s easy if the patient is terminal. It’s not so easy with intractable pain. Is this a drug-seeking patient or a patient with valid intractable pain? That’s a difficult call for physicians and a difficult call for us. Maybe with time there will be more sophisticated diagnostic tools available to make it easier.

DISCUSSION

Study results indicate significant variation among the states regarding experience with and reaction to complaints about inappropriate pain treatment. While more than half of respondents (55 percent) reported that opioid overprescribing complaints had decreased or stayed the same, over a third of respondents perceived that opioid overprescribing complaints had increased in their jurisdiction over the past five years. This appeared tied to a perception that drug diversion, in general, had been increasing. A significant number of respondents believed that drug diversion on the whole was worse in their state than it was five years ago, although some attributed this to more diligent efforts to seek out such diversion. Of the 18 respondents who thought drug diversion had worsened in their state, 15 thought that Oxycontin had significantly contributed to this problem. On the other hand, of 33 respondents who had an opinion on this issue, 14 (42 percent) did not think Oxycontin was a problem in their state. This is likely due to the variation in abuse patterns of Oxycontin across the nation. A large majority of respondents stated that their board had not changed its investigative approach in light of Oxycontin concerns, but the overall tone of their comments regarding drug diversion indicated that, in general, their boards had taken more active steps to address this problem.

In regard to decisions to investigate physicians for overprescribing, it appears that a number of boards are attempting to find the appropriate balance between identifying physicians who overprescribe and those who are appropriately treating patients with chronic pain. A number referred to the fact that their board had developed a policy or guidelines for chronic pain prescribing which was a significant aid to them in deciding whether to investigate or discipline a physician. The number of boards that have adopted pain management guidelines, regulations, or policies has, in fact, increased over the last four years, with boards specifically addressing the issue of chronic non-malignant (or “intractable”) pain. In 2001, the University of Wisconsin Pain & Policy Studies Group documented a total of 82 state pain policies in the form of statutes, regulations, guidelines, or policy statements. In addition, the Group found that 12 states had adopted the Federation’s Model Guidelines in full, and nine in part. Respondents’ comments indicate that boards are focusing on making their pain policies known to physicians so that physicians are aware of what is required of them to avoid scrutiny by the board. A number of boards emphasize what should be present in the patient’s chart to avoid suspicion by the board that the physician is overprescribing (e.g., patient assessment, pain diagnosis, plan of care, evaluation, follow-up,
specialist referral, etc.). On the other hand, if a physician is accused of overprescribing and lacks proper documentation of his or her practices, a board is much more likely to investigate and potentially discipline the physician.

An encouraging result for pain management advocates was that boards appear to be moving away from volume or quantity of opioids as a primary basis for investigating physicians for overprescribing opioids. Some respondents referred to volume as a trigger but not conclusive evidence for a decision to investigate. Many respondents indicated that these were very fact-specific cases that had to be evaluated individually; that all facts, including the diagnosis of the patient, the documentation of the prescriptions ordered and consistency with established guidelines, had to be considered. Despite this positive trend away from using volume as a determinative factor in moving forward to investigate or discipline, a few respondent comments were troublesome in that they implied a continued reliance on volume and, at least one case, a lack of knowledge regarding issues of dosage and volume. Thus, misunderstandings may still exist about opioid volume and quantity upper limits (i.e., that the latter exists independently of case-specific facts, which is generally not the case).

In response to the question regarding factors that the board would consider in deciding whether to discipline in a case involving overprescribing of opioids, most respondents stated that it was a matter of judgment, that it was very fact specific, and often subjective. However, for those that had established pain management policies or guidelines, these appeared key in determining whether to discipline. Significant variation from the policies, in some cases, could be a basis for discipline. Boards varied regarding whether they would require a pattern or more than one instance of overprescribing before disciplining. Poor documentation and record keeping were also consistently cited as a key factor in disciplining physicians in these cases.

More than half of respondents (56 percent) thought the number of board disciplinary actions relating to opioid prescribing practices had either stayed the same or decreased over the past five years. Reasons respondents who observed a decrease gave were encouraging for advocates of better pain management. These board representatives stated that they thought their board’s attitude toward opioid prescribing had changed over the past five years, that their pain management guidelines helped them, in a number of cases, determine that the prescribing practices of the doctor under investigation were reasonable where prior to the adoption of the guidelines they might have disciplined the physician.

The number of estimated complaints boards received for underprescribing were significantly fewer than those received for overprescribing (in 2001, an average of .46 versus 3.13 complaints, respectively, per 1,000 doctors in the state). In addition, a significant majority saw no change in the number of complaints received for underprescribing during the past five years. While some respondents thought the problem of pain undertreatment was real and merely underreported, others did not seem to view undertreating pain (particularly chronic, non-malignant pain) as a significant problem.

In regard to disciplinary action for undertreating, many boards appear disinclined to discipline simply for violation of standard of care, which is how many respondents depicted cases of underprescribing pain medication. They would be more likely to suggest rather than mandate education to physicians in such cases. This appeared somewhat at odds with responses given to questions about disciplining for overprescribing, where respondents appeared more likely to say they would discipline for violation of standard of care, even without a pattern of poor practice. Thus, there seems to be a lack of parity in application of standard of care and patient harm as bases for discipline in cases of undertreatment vs. overtreatment. Overprescribing is more often seen as a clear violation of standard of care and a clear threat to patient harm, while many respondents, or their boards, do not view pain undertreatment, particularly for chronic pain, in the same way. They appear to apply a higher threshold of harm for undertreating pain. A number of respondents, however, did provide examples of cases they thought could be construed as gross negli-
gence or egregious behavior regarding pain undertreatment and said that such cases might lead to disciplinary action.

This type of attitude may contribute to a shortage of physicians who are able and willing to treat patients who have chronic pain. While advocacy for pain management on the part of many state boards may ease physicians’ fears about being disciplined for opioid overprescribing, many physicians may decide that their safest (or “least burdensome”) course is to refer patients with chronic pain to a pain specialist. With the number of patients suffering from chronic pain greatly outnumbering the number of qualified pain specialists, the results do not add up in favor of those with chronic pain.

We cautiously conclude from our survey results that medical board attitudes and practices toward physician prescribing of opioids have changed for the better during the past several years. Respondents’ references to the need for “balance” between ensuring appropriate treatment of pain and disciplining physicians who are inappropriately prescribing opioids are illustrative of this movement. Moreover, the abandonment of opioid quantity as a marker of questionable practice and replacement by an emphasis on individual assessment of whether the physician has appropriately evaluated the patient, prescribed consistent with board guidelines, and appropriately documented his or her prescribing, further indicates progress in board recognition of the need for adequate pain treatment.

At the same time, some board attitudes and practices remain problematic — in particular, a continued tolerance of undertreatment. While many boards are becoming more proactive in educating physicians about pain management issues, the focus is on what physicians who choose to prescribe opioids for pain must do to avoid board scrutiny. There appears to be a discrepancy in the weight given to violation of standard of care, patient harm, and gross negligence for overprescribing issues as compared to pain undertreatment issues. Specifically, boards seem to have a higher threshold for patient harm in cases involving pain undertreatment — particularly for chronic, non-malignant pain. To this extent, physicians may be getting mixed messages from boards: on the one hand, that effectively managing their patients’ pain is the expected standard of care, and on the other, that the board is more concerned about opioid overprescribing than pain undertreatment. Perhaps this is unavoidable given the realities of opioid diversion practices. Reformers may simply have to accept that management of chronic pain inevitably carries with it more entanglement with licensing and law enforcement authorities than management of cancer pain, given the higher risks of diversion.

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References
1. Several physician surveys have provided evidence of the chilling effect of sanctions against physicians for opioid prescribing. In 1990, physician members of the Eastern Cooperative Oncology Group were surveyed and 18% of 897 responding oncologists rated excessive regulation of analgesics as one of the top four barriers to adequate cancer pain management. See J.H. Von Roenn et al., “Physician Attitudes and Practice in Cancer Pain Management. A Survey from the Eastern Cooperative Oncology Group,” Annals of Internal Medicine, 119 (1993): 121-126. In a 1991 survey of members of the American Pain Society, 40% of surveyed physician members said concerns about
regulatory scrutiny rather than medical reasons led them to avoid prescribing opioids for chronic non-cancer pain patients. D.C. Turk et al., “Physicians’ Attitudes and Practices Regarding the Long-Term Prescribing of Opioids for Non-Cancer Pain,” Pain, 59 (1994): 201-08. In a survey of Wisconsin physicians conducted in the same year, over half reported decreasing the dose, quantity, or number of refills, or switching to a lower scheduled medication, due to fear of regulatory scrutiny. D.E. Weissman et al., “Wisconsin Physicians’ Knowledge and Attitudes About Opioid Analgesic Regulations,” Wisconsin Medical Journal, 90 (1991): 671-75. And, in a 1993 California survey, 69% of physician respondents felt that doctors were more conservative in their use of opioids in pain management because of fear of disciplinary action and a third felt that their own patients may be suffering from untreated pain. See Turk et al.


5. Id. at 12

6. The Mayday Fund was established in 1992 with funds from the estate of the late Shirley Steinman Katzenbach. It is dedicated to the reduction of the physical and psychological effects of pain. www.painandhealth.org/mayday/mayday-home.html.

7. FSMB’s Model Guidelines for the Use of Controlled Substances for the Treatment of Pain were adopted on May 2, 1996. They recommend evaluation of the pain patient by the physician, formulation of a treatment plan, securing informed consent for treatment, performing periodic review of therapy and outcomes, obtaining appropriate consultations or referrals for patients when necessary (e.g., patients with substance abuse history), keeping accurate and complete medical records, and maintaining compliance with controlled substance laws and regulations. See S.H. Johnson, “Introduction: Legal and regulatory issues in pain management.” Journal of Law, Medicine & Ethics, 26 (1998): 265-66.


11. In some cases, that individual identified someone else who could better answer the survey questions.

12. Twenty-two of the 38 respondents accepted complaints in the form of phone, e-mail, or anonymous complaints, although anonymous complaints were investigated in rare circumstances (i.e., regarding serious complaints when sufficient information was provided to investigate further). Some states had a formal process that first considered allegations which were transformed into complaints after a formal process in which preliminary evidence was collected.

13. This could include complaints against physicians related to prescribing opioids for pain patients they were treating, prescribing for themselves, or trading opioids for money or sex.
14. The actual range of values was 0 to 250. To correct for the outlier values of 100 and 250, these values were “windsorized” to the next highest values of 57 and 58, respectively. Those numbers were then divided by the number of physicians per state (http://www.education-world.com/a_lesson/TM/WS_census_states.shtml data) and multiplied by 1000.


16. The respondent conveyed that referral to a pain management specialist would be expected for primary care physicians treating patients with complex chronic pain.

17. Eighteen (18) thought their boards had not received any such complaints — their pain undertreatment complaint estimate was entered as zero. Of the 19 who thought their boards had received such complaints, 15 were able to give a 2001 estimate — if a range was given, the median of the range was entered. The actual range of values was 0 to 25. To correct for the outlier value of 25, that value was “windsorized” to the next highest value of 13. Raw values were then divided by the number of physicians per state (http://www.education-world.com/a_lesson/TM/WS_census_states.shtml data) and multiplied by 1000.

EMedicine: Can State Boards Untangle the Web?

INTRODUCTION
The Internet promises to transform the way the practice of medicine is conducted in the new millennium. State medical boards, as the administrative bodies responsible for overseeing the practice of medicine, are struggling to find ways to ensure that unscrupulous and unsafe practitioners operating online do not harm those living within their jurisdictions. This article examines the impact the Internet has on the ability of state medical boards to regulate the practice of medicine, responses at the state and federal level to these technological developments, and proposals which balance the benefits of technological advances with the ability to reasonably protect health care consumers.

AUTHORITY, ASSISTANCE, AND A NEW CHALLENGE
More than a century ago, the Supreme Court confirmed the right of states to regulate medical practice. The court’s decision was rooted, in part, in the belief that the general public is unable to assess effectively the qualifications and competence of individual physicians. According to the court, “Every one may have occasion to consult [a physician], but comparatively few can judge of the qualifications of learning and skill which he possesses. Reliance must be placed upon the assurance given by his license, issued by an authority competent to judge in that respect, that he possesses the requisite qualifications.” The case also explicitly describes how the police powers to protect the health and welfare of state denizens, and the nature of the medical profession at that time, granted states the authority to establish individualized licensure standards. While regional variation persists in physician practice patterns, the general standards for medical licensure in any particular state, thanks in part to the efforts of the Federation of State Medical Boards, are practically uniform nationwide.

The advent of the Internet has helped narrow the information gap between many patients and practitioners, and the flexibility and capabilities of computer technology offer seemingly limitless possibilities for improving and transforming health service delivery. Currently, most Internet users limit their Internet health care-related activities to the pursuit of general health-related information. While this information may be specific to a particular ailment or treatment modality, and may be written by a physician licensed in a different state from the residence of the Internet user, such information is generally not considered so specific as to constitute the practice of medicine. Some Internet users are now taking advantage of programs, run by prominent institutions such as Harvard Medical School and the Cleveland Clinic, which offer comprehensive virtual second opinions, a practice that hovers somewhere between the informational and the diagnostic. Some physicians have created primary care practices that rely heavily on telephone and electronic communication following an initial face-to-face consultation (with future office visits – and even house calls – conducted if needed). However, an increasing number of Internet users in the United States have moved beyond the pursuit of “cyber-assistance” and second opinions. These consumers seek services widely considered to constitute the practice of medicine, including patient-specific medical consultations and prescriptions. A growing number of physicians appear willing to meet this demand by providing services online, often without having developed a prior physician-patient relationship, having taken a thorough medical history or physical examination, and often without having fulfilled the licensure requirements of the states in which the consumers reside.

State medical boards, facing record budget deficits and overwhelming caseloads, are struggling to find effective means through which to address the public safety concerns raised by remote practitioners unimpeded by state borders and unconcerned with local standards of practice. At the same time, state medical
boards should contemplate whether greater interstate collaboration and federal intervention in the regulation of Internet medical practice may be necessary to effectively balance the interests of encouraging technological advances in health service delivery while protecting the public from fraudulent and substandard online practice.

LICENSURE AND REGULATION OF ONLINE MEDICAL PRACTICE

With the publication of its policy document _Model Act to Regulate the Practice of Medicine Across State Lines_ in 1996, the Federation of State Medical Boards attempted to craft a middle way that would balance these competing interests. The Federation policy document recommended that, instead of requiring that online practitioners hold full and unrestricted licenses in the state in which the patient resides, states create a new special license, with an expedited application and approval process, specifically for these physicians.

However, many concerns were raised about the limitations of current technology to adequately provide both the information necessary to make diagnoses, treatment recommendations and prescribe medications, and the safeguards necessary to protect physicians and patients from fraud. These concerns were most compellingly represented in the position of the American Medical Association (AMA), which criticized online medical practice as a means of delivering primary health care services for its inability to replicate the richness and thoroughness of a face-to-face physician-patient interaction. In 1999, the AMA set forth the following five reasons as to why an online physician-patient interaction, resulting in a prescription or treatment, falls short of generally accepted standards for medical practice:

1. There are no examinations of the patient to determine if there is a medical problem and determine a specific diagnosis.
2. There is no dialogue with the patient to discuss treatment alternatives and to determine the best course of treatment.
3. There is no attempt to establish a reliable medical history.
4. There is no provision of information about the benefits and risks of the prescribed medication.
5. There is no follow-up to assess the therapeutic outcome.

While compliance with these standards may vary (and sometimes be found lacking) in face-to-face physician-patient interactions, there is a higher likelihood that these goals will be met when a local patient interacts with a local provider.

In 2003, the AMA offered further guidance on Internet prescribing. According to the AMA, “physicians should adhere to any regulatory requirements of their individual state medical boards,” and if prescribing via the Internet, must have previously performed a physical examination of the patient “adequate to establish the diagnosis for which the drug is being prescribed and to identify underlying conditions and/or contraindications to the treatment recommended/provided.” Furthermore, the AMA believes the physician should generally possess the type of license required to practice as outlined in the licensure laws of the state in which the patient resides. The report offered an exception to this licensure requirement for treatments rendered in consultation with another physician who has an ongoing relationship with the patient. Furthermore, the report did not address the burgeoning practice of “fee-based online consultations.” In its 2003 guidance, the AMA also recognized the limitations and challenges posed by current technology in confirming the true identity of both patient and physician online, a concern best captured by a famous cartoon, in which a dog at a computer says to another dog sitting on the floor: “On the Internet, no one knows you’re a dog.”

Later Federation publications reflected the AMA’s more comprehensive standard for what constitutes acceptable online practice. In 2002, the Federation stated that “A documented patient evaluation, including history and physical evaluation adequate to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided, must be obtained prior to
providing treatment, including issuing prescriptions, electronically or otherwise.”

An alternative approach to licensure has been employed to allow greater flexibility in licensure and mobility for nurses.\(^2\) So far, 20 states have adopted the Nurse Licensure Compact, a mutual recognition licensure system developed and promoted by the National Council of State Boards of Nursing.\(^3\) Nurses working in states that adopt this compact can practice on patients (either online or in person) in any state that has adopted the Nurse Compact. The Nurses are subject to the laws of both the state in which they are licensed and the state in which they practice, and regulatory efforts are coordinated through the use of a centralized interstate database and a comprehensive communication network known as NurSys. This system acknowledges the reality that baseline practice standards are similar nationwide, and balances concerns with improving access to care with the ability to maintain both high standards for licensure, and accountability of the licensees to maintain the requisite level of practice standards. Thus far, for political and economic reasons, physicians appear less willing to contemplate such a system for their state licensure boards.

Had either the Federation’s Model Act or the Nurse Compact been adopted universally by states for use by their medical boards, there would have been an opportunity to both standardize licensure requirements nationwide and to foster greater practitioner mobility and the growth of online medical practice. However, states were almost uniformly unwilling to relax control over their local licensure process, instead following the guidance of the AMA (and their local state medical societies). Most states require those engaging in online practice to hold full and unrestricted licenses both in their home state and in the state in which the patient resides. Those states that passed the Model Act in some form took advantage of language contained therein, which allowed for modification of the statute to better reflect local medical practice standards.\(^4\) These unique local requirements eliminated the benefits of the special license status through the adoption of significant impediments to engagement in true remote medical practice: for example, all but two states which offer a Special Purpose License for Telemedicine require that the physician first conduct a physical examination prior to prescribing.

Approximately half of all states have taken action against local and out-of-state Internet providers for inappropriate medical practice online. Actions against in-state and out-of-state providers may take a number of different forms, including cease and desist requests, disciplinary action and/or fines for violation of state prescribing and telemedicine licensure rules, and fraud.\(^5\) Online practitioners are appealing targets for state disciplinary boards. Cases against online practitioners require fewer resources (such as extensive use of investigators and expert witnesses) and may be prosecuted more rapidly than a typical substandard care case. Furthermore, at a time when state boards are perpetually falling under close scrutiny from legislatures and the media for their disciplinary activity level, a high profile case brought against a physician practicing online sends the message that state medical boards are taking rapid, decisive and proactive action to protect the public.

Significant questions remain about whether state licensing boards have jurisdiction over out-of-state practitioners offering Internet services to their residents; however, this has not prevented states from pursuing and prosecuting remote doctors, sometimes in spectacular fashion. In 2003, the Medical Board of California brought action against six out-of-state physicians for improper online prescribing practices.\(^6\) Under a recently adopted California law, online practitioners who fail to conduct a good faith medical examination indicating the need for the medication or treatment prescribed prior to providing such services are subject to fines of up to $25,000 per infraction.\(^7\) The six physicians had written nearly 2000 prescriptions between them, leading to a total of $48 million in fines levied against them. The California board also took the prudent step of alerting the practitioners’ home state medical boards of their licensees’ questionable conduct, in the hope that their home states would take action against their licenses. This is a critical measure, as the law remains unsettled as to whether a state in which a physician has no license has jurisdiction over an Internet practitioner whose only contact with their state is through a patient actively pursuing health services online.\(^8\) While greater interstate coop-
eration may enhance the likelihood of prosecuting U.S.-based online practitioners, absent enthusiastic and universal commitment by state medical boards to such collaboration, some practitioners may continue to be able to engage in improper medical practice across state lines, and others who may be located offshore may remain altogether beyond the reach of state regulators.

**IS THE TIME RIGHT FOR A FEDERAL APPROACH?**

So how can states maximize the flexibility for health service delivery available via the Internet, while at the same time protect their residents from unscrupulous providers? It is unlikely that state medical boards, acting as individual entities, can check the growing wave of providers willing to engage in medical practice online: the appeal of independence, financial reward and the ever-growing demand for such services almost guarantee that online health service delivery is here to stay. Because of the limited reach and resources of state boards, increased cooperation between state and federal regulators – and the ceding of some primary authority by states to protect the public’s health and welfare from elusive out-of-state and international online providers – is likely. This approach has been considered by a number of federal authorities, including the White House, Congress, the Food and Drug Administration (FDA), the Federal Trade Commission, and the Department of Justice.

On the legislative side, Congress has demonstrated a willingness to enter into traditionally state-based issues pertaining to health service delivery when problems of a national or international scope arise. During the 108th Congress, federal tort reform legislation nearly became a reality. Congress justified its intervention into this traditionally state-based concern by finding that “the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.” A similar interstate commerce argument could be made to justify Congressional intervention into the field of professional regulation.

Congress has already demonstrated its willingness to intervene in such matters in its recent attempts to address the issue of pharmaceutical importation. In 2000, Congress passed the Medicine Equity and Drug Safety Act, which granted the secretary of Health and Human Services the power to create regulations permitting pharmacists and wholesalers to import pharmaceuticals into the United States; however, this power has gone unused as the secretary has not been willing to certify that these imports “pose no additional risk to the public’s health and safety” and would “result in a significant reduction in the cost of covered products to the American consumer.” In 2003, Congress considered two significant changes to this regulation that would make prescription drug importation a reality. One would eliminate the secretary’s discretionary power and require that the secretary adopt regulations allowing for the importation of prescription drugs within 180 days of the legislation’s enactment. A second proposal would allow international collaboration by permitting “[a]ny establishment within Canada engaged in the distribution of a prescription drug that is imported or offered for importation into the United States [to] register with the secretary the name and place of business of the establishment and the name of the United States agent for the establishment.”

Congress has also contemplated the preemption of state licensure laws in an effort to improve nationwide adoption of telemedicine services. The Comprehensive Telehealth Act of 1999 proposed a study of state telemedicine licensure policies and usage by the Secretary of Health and Human Services, and stated “[i]f...the Secretary determines that States are not making progress in facilitating the provision of telehealth services across State lines by eliminating unnecessary requirements, adopting reciprocal licensing arrangements for telehealth services, implementing uniform requirements for telehealth licensure, or other means, the Secretary shall include in the report recommendations concerning the scope and nature of federal actions required to reduce licensure as a barrier to the interstate provision of telehealth services.”

Close collaboration is already under way in the related field of policing of online pharmacies and U.S.-
based branches of Canadian “storefront” operations which ship and/or import prescription drugs from abroad. Like state medical boards, pharmacy boards have attempted to offer the public and their licensees guidance on proper pharmacy practice via the Internet. In 1999, the National Association of Boards of Pharmacy (NABP) enacted the Verified Internet Pharmacy Practice Sites (VIPPS) program, which offers certification for online U.S.-based pharmacies that meet stringent practice standards. This certification serves as a seal of quality that consumers can rely upon when making online purchases of their medications. However, the authority of the NAPB cannot reach deeply into the World Wide Web; consequently, VIPPS certification is only available for U.S.-based online pharmacies. In late 2002, Canada’s National Association of Pharmacy Regulatory Authorities adopted a similar program. However, this certification will help reinforce the status quo, rather than foster greater international cooperation to improve access to affordable quality health services, as the Canadian organization states directly “any Internet pharmacy that dispenses prescriptions for cross-border shipment into the United States will be denied the VIPPS Canada certification.”

On the administrative side, federal agencies such as the FDA, the Drug Enforcement Administration, the U.S. Bureau of Customs and the U.S. Postal Service have worked together with state pharmacy boards to attempt to stem the flow of pharmaceuticals across the U.S. border. They are having limited success in this endeavor, and finding that regulating Internet pharmacies can be “like trying to nail Jell-O to the wall.”

These efforts largely have been directed toward stopping suppliers of these services — the pharmacies and U.S.-based storefront operators — rather than the purchasers and the physicians who are writing or cosigning the U.S. consumers’ prescriptions. For example, while state pharmacy boards have had limited success in closing down Canadian pharmaceutical importation storefronts within their own states, the FDA recently filed a complaint for injunction against a national chain of storefronts under the Federal Food, Drug and Cosmetic Act. Furthermore, the FDA has indicated it would not sue cities and states that set up drug importation programs; however, they also wished to make clear this concession is not an indication of diminishment in the agency’s pursuit of the suppliers of imported and reimported medications. However, in spite of the fact that the learned intermediary physicians may be involved in the process of circumventing state and federal rules pertaining to prescriptions, pharmacies and U.S.-based storefront importers appear to be garnering far more attention from these federal agencies than the physicians who may be providing the associated diagnoses and prescriptions. There are compelling reasons for regulators to move now to create a national, if not an international, system through which to license and regulate Internet practitioners. The Internet can offer opportunities for improving access to primary and specialty care for a wide range of populations, such as the rural and urban underserved and the aged. Internet-based monitoring systems can help the chronically ill better manage their diseases. As Congress and state legislatures attempt to plan for the financial strain of adding 70 million Baby Boomers to such federal and state benefit programs as Social Security, Medicare and Medicaid, a national Internet provider system will offer an appealing medium through which to create larger economies of scale and greater efficiencies within the health service delivery market.

The political time is right for Congress to step in to create a standardized system for regulating online health practitioners nationwide. As mentioned earlier, the federal government, in its tort reform effort, has demonstrated its willingness to step into traditionally state-based health service delivery concerns. Furthermore, with states facing historic budget crises, Congress could use the power of the purse — holding out funding for related services via conditional block grant mechanisms — to per-
suade states to adopt uniform licensure and disciplinary rules.

All realistic options to effectively and flexibly manage online practice require that states cede some of their power to regulate health care providers. States have too many financial and legal limitations to adequately control the flourishing national and global market in Internet medical service. A number of different options may be available to protect public safety in this environment, from an international registration program, to an exclusively federal system, to a program creating federal licensure standards to be enforced by state boards, to universal adoption by states of a Model Act for Internet licensure. Another option would be to bring together all the stakeholders (providers, patients, technology companies, state and federal regulators) to develop a quasi-governmental supervisory and certification organization for Internet practitioners and health web sites, such as Medicare-eligible hospitals and HMOs possess in the Joint Commission on Accreditation for Healthcare Organizations. As it will likely be impossible to completely contain Internet practice, any adopted system will require extensive and ongoing public education efforts. Ideally, the great effort to create a uniform national system for Internet medicine practice will arise out of a collaborative effort between state boards and legislatures, the federal government, and international bodies, be flexible in its approach to online regulation (as we can never be sure what tomorrow’s technological innovations may bring), and let providers and patients have the opportunity to make the most of the innumerable benefits offered by a technology-powered health care system fashioned for the 21st Century.

References


3. 9 S. Ct. at 233.


5. 9 S. Ct. at 233.


18. Id. p. 6


22. Available at http://www.ncsbn.org/.


37. Id. at § 384(1).


41. See Id. 201(B).


What I am going to talk about is serious. I am going to talk about errors in medicine and what we can do about it. I have a little temerity — not too much, but a little — in coming to you, because I know that you are already overburdened. You have a full plate, and there is not a single state board that I am aware of that has adequate staff or adequate funding to do the things that you are asked to do; and then here comes this guy from Harvard telling you that you should be doing something else. So, I have a little bit of humility about that but, like I said, not too much.

I recently had the experience of being at the 4th Annual National Patient Safety Foundation Annenberg Conference on Medical Errors. It was really an exciting time. I heard Ed Stoltzenberg, CEO of Westchester County Medical Center, talk about the terrible experience they had when a child was killed in their MRI machine because of a tank of oxygen getting loose, how they dealt with it, how he felt about it, and how it changed his life and his whole way of thinking about medical errors. It was a powerful presentation. I heard Ken Kaiser, whom many of you know was such a dramatic and dynamic leader of the Veterans Administration (VA) health system and who turned a stodgy old bureaucracy around to become a much more effective, although still stodgy, bureaucracy. It is a much more effective organization because of the person who made safety “job one,” which is what we want all CEOs to do. The VA is the leader in safety in many ways, and I am sure many of you know that.

I heard Kaiser talk about what the National Quality Forum is doing in terms of defining best practices. We have some standards, specifics that hospitals can look to, and that is going to make a big difference. Then I heard Paul Euling speak. Euling is a cardiac surgeon in Concord, New Hampshire, and he noticed that the major problems they had with service in his area were communication problems. Sound familiar? He had an idea. His idea — which he demonstrated using the people there — was to get everyone involved in the care of the patient to see the patient at the same time, to get them all in the same place at the same time. That way, when they make rounds on their cardiac service, they have 15 people in the room: respiratory therapist, social worker, pharmacists, nurse, all the usual suspects — including the patient and the patient’s family. They talk about the patient, make their decisions with everyone’s input, and then move on.

There have been some interesting results: Patients think it is terrific, of course, because someone is listening to them and they know what is going on, whereas normally they do not. The staff thinks it is terrific and, interestingly enough, mortality and complication rates have dropped. These were exciting stories to hear. I am telling you all of this to illustrate the point that the safety movement is really accelerating; and I think that we will see tremendous changes during the next few years as we get a lot of talented and motivated people thinking in ways that before would never have occurred to us.

An obvious question is, “Where do medical boards fit into all of this?” I did not see many people at that meeting from medical boards. The obvious answer is this: Safety is what you are. Everything you do is related to safety, from licensing of doctors to continuing education to all of the programs boards have for dealing with problem doctors — everything focuses on safety. It is central to your mission; you could say it is your whole mission. How are we doing in the area of safety? I would say that we do not do well with the “problem doctor” problem, and that is what I would like to talk about with you today.

As some of you know, I am an outspoken advocate of a non-punitive approach to medical errors. I am fond of quoting the comment that the problem is not preventing bad doctors from making mistakes, it is
preventing good doctors from making mistakes. I believe that 95 percent of medical errors are made by
good people trying to do a good job. There is another 5 percent that I would not call bad doctors; I would
call them problem doctors. We do not deal with problem doctors well, and I think we need to look at that.

I would like to start first with a brief review of what I mean when talking about a new approach to patient
safety. Some of you are no doubt familiar with this. The first thing is, let us be clear on what we are talking
about. Safety is freedom from accidental injury. It is not freedom from all complications, because we do not
know how to prevent all complications, but it is freedom from accidental complications, accidental things
that should not have happened. It is not freedom from error. We will never have freedom from error. As a
matter of fact, we really are not too concerned about errors that do not hurt people. We are concerned
about are errors that hurt people. Safety means that the person feels safe and is safe from accidental injury.

Figure 1 contains a lot of information. We see the work of Rene Amalberti, a French physician, aviator,
and safety expert. He examined various industries and put them on a scale in terms of their hazards. On
the left side of Figure 1 is a scale that shows the number of deaths per year. It is a logarithmic scale, so
the first measurement is for 10 deaths per year, followed by 100, then 1,000, then 10,000, and then
100,000. The bottom indicators show the number of encounters for one fatality. So if you look at this you
see over in the lower right-hand corner the industries that we think of as safe. Let us choose scheduled
airlines. Most of us flew on an airplane to get here. If you board a scheduled airline in the United States,
your chances of dying in an accident are one in three million. If you look at scheduled airlines in Figure
1 on the left side you can see it comes out at 250 to 300, because that is the average number of people
who die each year in the United States while traveling on scheduled airliners. Actually, in the past 10
years there were two years in which no one died and some years in which more people died. So, when
you fly a scheduled airline in the United States, your chances of dying are about one in three million.

If you segue all the way over to the left side of Figure 1 you can see health care, along with some inter-
esting companions. The number that I used for health care was the number from the 2002 Institute of
Medicine report “To Err is Human: Building a Safer Health System.” The research shows that your
chances of an accidental death when you go into a hospital are one in 200, which comes out to nearly
100,000 deaths. If you do not like those numbers and you think that they are exaggerated (you might
think there are only 40,000 to 50,000 deaths) the figures for deaths caused by health care will drop
down a whole quarter of an inch. If you think there are twice as many deaths it goes up a quarter of an
inch. Even if the numbers are off by 100 percent, we are still sitting down there in that corner. We have
a big problem, and the people who work in the safety industry do not have any question about whether
or not there is a need to do something.

Why do people make mistakes? What we have learned is that mistakes do not come out of the blue; they are not acts of God; they are not lightening bolts, and they do not just happen. People make mistakes for a reason. Here are some of the reasons, the results of a number of physiological studies, although you do not have to do physiological studies to know that these are true. If you have lived on this planet for more than 10 years you are aware of the fact that you make more mistakes when you are in a hurry — like when you lock yourself out of the car. How many of you have had the experience, as I have more than once, where you set off on the weekend to drive to the cape or the mountains, and you end up driving to the hospital? You set out to do something and then you forget what it is that you set out to do because you were interrupted somewhere along the line. We know we make more mistakes when we are tired, angry, or bored. It is not a mystery. Mistakes do not just happen; they happen for a reason.

The other thing is that you do not have a lot of control over this. We try to control mistakes by being more careful, but even when we are careful mistakes will still sneak up and bite us. Knowing that people make mistakes, and that we all make a lot of them, does not get us far other than the realization that we do not make mistakes because we are bad, or because we are stupid. So I would say that Alexander Pope only got it half right. It certainly is human to make mistakes, but it is not a sin, and so forgiveness is not required.

Improving patient safety comes from trying to understand a little bit better, and the big understanding — for me at least, and I think most people would agree — was the breakthrough that came from James Reason, a psychologist from Manchester, England, who about 10 or 15 years ago coined the term “latent errors.” Reason said that we, as the individuals who make mistakes, are led to make them because of the situations in which we are put. The design of our work, the conditions, training, and other factors set us up to make mistakes. Therefore, if you want to prevent mistakes, you must pay attention to these precursors, these latent errors. This is a powerful concept. Let me put it another way, as illustrated in Figure 2, by using the terms “blunt end” and “sharp end.” The person who makes the mistake — the provider, the nurse, the doctor, or the pharmacist — is at the sharp end. This is the person interacting with the patient, the person who has the capability to hurt someone because they are providing the treatment. The sharp end is affected by many things going on above it: the so-called blunt end that involves management decisions, training, equipment design, process, and so forth. Let me paint a picture for you. Reason’s theory says there are latent errors that may cause a system defect that will then lead people to perform unsafe
acts or make errors and that, in turn, can cause an accident. There may be triggering factors for an event and there are certainly defenses that keep accidents from happening, but if the defenses are not working or have weaknesses an accident can occur. For example, we have a latent error in which we say that it is all right for surgeons on our staff to determine their own working hours and workloads. We also have a systems defect where the orthopedic service decides that its 13 orthopedists will alternate full weekends. That means that when orthopedists are on, they are on from Friday night until Monday morning — about 60 hours. That is a systems defect. It works fine if you are not too busy. But consider a triggering factor of 30 cases during the course of the weekend. Do you think that maybe after being awake for two nights and working like that an orthopedic surgeon might possibly be more likely to make a mistake? You bet. He’s not thinking straight; he wants to go to bed; he wants to get the work done. What happens is that he starts to cut corners. Maybe he has a patient with a broken leg and he takes him to the operating room but forgets to look at the chest X-ray. Unbeknownst to him the patient has a hemothorax and dies on the operating table. That really happened. It did not have to happen, because we have defenses. Maybe someone else saw the X-ray and noticed the patient had a hemothorax, or maybe the anesthetist said, “There’s something going on here,” and he tapped the patient’s chest and listened and said the patient does not have any breath sounds and we had better take a look. There are lots of defenses, and the fact is that we set the system up for the accident and the defenses work 99 percent of the time. However, when they do not work, the patient suffers. This is the concept: That person made a mistake, a serious mistake, but unless you understand why he made the mistake and do something about it, someone else is going to make that mistake later. So what we are talking about is getting the focus off punishing the person who made the mistake, because that will not accomplish anything in terms of keeping the mistake from happening again. We need to change the system so it never happens again. That is a little harder, but it is the only way to ensure safety.

The idea that medical errors are caused by bad systems and not by bad people is a transforming concept. It truly turns on its head most of what we have all been trained to think and the way we naturally react. We tend to think that when a person makes a mistake they are bad. We were taught that when we were three years old. This theory says that is sometimes true, but not most of the time. It is a system problem, and if you want to do something about it you have to shift your spotlight off the individual and really look at the system, and that is absolutely profound. The implications are straightforward. For the physician, it means that the individual doctor is a part of the system, but only a part, and in some cases not the most important part. You can achieve safety by just concentrating on the individual, and individuals can achieve safety on their own. We all need to work together to become a team operation.

What is the significance of this as far as what you can do? Let us go back to the blunt end and the sharp end. As the state medical boards, you are part of the environment that has an impact on the hospital, on the team, and on the provider. Let us take, for example, a simple situation that we are all familiar with: wrong-site surgery. If you have a surgeon who has operated on the wrong kidney, you might ask, “Did you have a policy to sign the site in your hospital, and did you follow that?” If you did not, therefore, we will punish you. On the other hand you might also ask what the system was in the hospital for preventing this. What we have learned is that if you really want to prevent mistakes you have to make it everyone’s responsibility so it is not just the surgeon that signs the site, but it is the radiologist, the anesthesiologist, and the nurse in the operating room. Everyone is keyed into this because safety is everybody’s responsibility. Safety is a team sport, not an individual exercise, so even if that doctor totally forgot about it, everybody else would not and the patient would not slip through.

Now, no system is going to be 100 percent. We can have the best system in the world and occasionally we will have a disaster. But the point is that a good system would be more useful when a mistake happens, to enable you to focus your searchlight on the hospital instead of on the doctor and ask how it was
possible for a doctor to do this in your hospital. Some of you have done that and some of the investigations have been right down that line, and that is encouraging. I think that then we get to the real question of what is occurring and how we want to have this take place. Let me start with a little story that illustrates the problem. Some of you may have read an article in the August 7, 2000, issue of the New Yorker by Atul Gawande, a surgical resident at Brigham and Women's Hospital, titled "When Good Doctors Go Bad." It should be required reading.

The fictitiously named Hank Goodman was a prominent and capable orthopedic surgeon who had a big practice. He was a well-trained, brilliant doctor, a doctor's doctor. He was the one you took your wife to, and he had a busy practice, a practice that was too busy. His practice got bigger and bigger and he worked harder and harder, and after a while he burned out. As he burned out he started to cut corners and started to do things wrong. Things started to go bad, patients started to get in trouble, he was being sued, the malpractice suits were increasing in frequency, he was the constant subject of the morbidity and mortality (M&M) conference — one thing after another. It went on like this for a long time. There were several terribly quiet chats, as they say, during which a senior physician spoke with him confidentially. He tried to straighten out, but he really wasn’t able to and so it went on and on and on — and dozens and dozens of patients were maimed and damaged and hurt.

Finally they got him on a technicality; they got him because he failed to come to M&M conferences and they kicked him off the staff. This was after 10 years of steady downhill progression. What do we see from that? The first thing that we see is that it is all too common. Marilyn Rosenthal says, in a study of more than 200 cases, this is the typical way it is. Typically it is years — not days, not weeks, not months — before it comes to something actually being done when a doctor has really fallen off the edge like that. The second of course is that early warning signs are ignored. When something really bad happens, like a wrong kidney being removed, or something like that. What do you hear around the hospital? I knew that was going to happen someday. Well, if you knew that was going to happen someday, why didn’t you do something about it? Well, you know the reason. The reason is that we do not have a system for doing something about it. It is not easy. So, there are warning signs, but they are often ignored.

Another dramatic case that I am sure everybody remembers was Alan Zarkin, who in 2000 lost his license for carving his initials into the abdomen of a woman in Beth Israel Medical Centre during a caesarian section. Here is this clearly psychopathic behavior. But I thought it was interesting what the CEO of the hospital said. When the department of health, to its credit, slapped him with an $18,000 fine, the hospital CEO said there is no quality improvement system you could have that would pick up something like this because this was such abhorrent behavior. However, investigations by the department of health showed that the operating room nurses observed this bizarre behavior 18 months earlier. So, we tend to not pay attention to the warning signs. The reason, of course, is that it is not easy to do.

It seems to me that clearly we need to do something and we need to do it better. That leads me to my first of four radical ideas. We cannot make progress in dealing with problem doctors if we only deal with problem doctors. That is the fundamental problem with the usual approach. We deal with the person who is the problem, and we have to deal with the system and change the system. What is the system? The system is that it is up to the medical staff to identify these people and get them into some type of corrective action and, if that does not work, refer them to the board. However, medical staffs do not like to do that. You know the reasons as well as I do: It is distasteful and it is emotionally draining. After all, these people are your golfing buddies, your friends, someone you might have known for 20 years. They are a member of the family, and you do not want to hurt them; you would like to help them, but you do not know what to do. It is difficult and it takes a lot of time to put everything together, to document everything. There is a real threat of retribution, that the person will fight back. People do not take this easily. They will attack you personally, and they may sue. There is no good mechanism for doing it. So, it is not too surprising that in most cases not much happens for quite some time, until it gets to the point where there are no alternatives.
We have a situation where no one really wants to deal with it, and it is quite uncomfortable. Taking on one of these things is a good way to lose a lot of sleep at night, to make your life miserable while you’re making someone else’s life miserable. Not surprisingly, people do not sign up.

So, what is the answer? I do not know all of the answers. I do have some questions and some ideas that I would like you to think about. What we need to do most of all is devise a way to take that problem out of the range of the personal, individual, emotional and judgmental, and somehow depersonalize it and make it more objective. Make it based on something other than just our gut feeling and what we all know. There are several criteria that we should have up front when we try to do this that may give us some guidance. The first thing that I want is a system that is objective. That is, I do not want it based on my saying Joe is doing a bad job. Objective means based on data, some kind of evidence. We clearly need a system that is fair. When you say fair, that means that whatever system you are going to use to identify these people you want to do it in such a way that you are not just focusing on an individual, you are not zooming in on just the problem people, but you are measuring everyone by the same yardstick.

So, whatever system we have, we all have to be willing to be measured by that system. I would really like it to be proactive, and I would really like it to be a system that would identify people before they hurt someone — when the problem is young, when it is early, when the physician is just slipping off the edge, when it possibly would be easier to help the physician and, of course, most of all, to prevent others from being hurt.

What we need to do most of all is devise a way to take that problem out of the range of the personal, individual, emotional and judgmental, and somehow depersonalize it and make it more objective.

We want hospitals to do this. We really want hospitals to do two things: We want them to identify problem people and then to do something about it. If we want them to do that we must give them the tools; we have to give them the method; and we have to show them how. So, I would say that if we could have a system that is objective, that is fair, that is proactive, then maybe we are ready to get started. When I say based on data, we are talking about performance and about behavior. It is not what you know that counts; it is what you do. We are talking about performance standards, and it seems that there are distinct and separate domains. Clearly we are talking about substance abuse problems, including alcoholism; psychiatric problems; competence (which is a complex array of professional and technical performance issues, but it is doctoring in several dimensions); and interpersonal relations (which are important not just for doctors, but for everyone in the hospital), how they get along with their fellow staff and how they treat their patients. If we want to have an objective system we have to set standards for these kinds of demands. That is a big order. When you think about this you are considering several different categories. This is arbitrary, and it may not be the best way to break it down, but I find it useful in terms of thinking about it. You have certain standards that apply to everyone, whether you are a doctor, a nurse, or the floor sweeper, and these are the policies we have with regard to safety in a given hospital. Then you have the standards that are specific for physicians. Then you have different standards that are specific to individual specialties.

Examples that I have made up for discussion purposes are: In this hospital we expect that everybody will observe the safety practices that we have defined. So, if one of the practices is to sign your site, then we expect 100 percent compliance. We do not punish people for making errors; we punish people for misconduct, but we recognize that most errors are not bad, so we have a non-punitive punishment regarding errors. Non-punitive does not mean that you do not punish; it means that you do not punish for errors. We have a hospital policy that limits the hours and the amount of work you can do. Think about the orthopedist who was on for 60 hours. You cannot do that in my hospital because we limit work hours, have specific limits on staffing ratios and we do not allow a nurse to work more than one shift at a time. These are critical safety issues, therefore we have a hospital policy on it. One of our policies is openness and honesty with our patients. We tell our patients when we hurt them and we apologize. We treat all co-workers with respect. What does that mean? It means we do not allow hostile behavior, you do not throw instru-
ments in the operating room. You do that twice and you are out! We do not tolerate humiliation of residents or nurses. That is not part of good education, it is not part of good safety, it is not part of a good environment. These are just things that come to mind. They are not written in stone, they are not written anywhere. The point is that the hospital specifies these as written policies and everyone knows what they are. Department policies would be more specific.

If we want to have a safe system, what we want the hospital to do is to adopt performance standards and have the understanding with all staff, that compliance with our standards is a condition of your being here. When you come on our staff, you agree to follow the rules. Here are the rules:

Adherence is a condition of employment. We monitor adherence. We have a system for collecting data to find out if a physician is in trouble, and then we try to do something about it. We have a whole repertoire that we can use to help people because the purpose is not just to document their problem, but to remediate them, not to get rid of them, but to keep them in practice. If this system were working, you would not see many problems. Therefore, a measure of the effectiveness of your program is not how many licenses you pull, but how few you pull. It is the old ivory tower problem, so how do you get hospitals to do this? It is quite simple. You require it. Which is radical idea number three.

Require hospitals and departments to follow safety practices and policies. That is a neat idea, but I do not have any authority to do that. Maybe that should be agenda item number one: how we get that kind of authority without full legislative authority. It probably should be in statute form, so maybe that is the major agenda item. It is not going to happen otherwise. I am not sure that there is anyone else who is going to do it. That leads me to the fourth radical idea. If we are going to do this, then it does not make sense for every hospital and every clinic and every health care organization to develop their own policies. There is a tremendous benefit for having a national approach, and you, as the Federation of State Medical Boards, are ideally suited to do this. You have done some of this sort of thing already in some of the other programs, and so it is not exactly a new idea, but it is certainly a big job and I do not mean to imply that it is not. However, the real way for this to happen would be for you to take the lead in developing national performance standards. We have a lot of help. The American Board of Medical Specialties and the Accreditation Council of Graduate Medical Education have done a tremendous amount of good work in developing competency standards and measures for each of the medical specialties. A lot of that can just be moved right into this. There has been some good work in terms of monitoring and measuring patient satisfaction. Some of you are familiar with the work of Jerry Hickson, who uses a simple measure of patient complaints and shows that this correlates closely to risk of malpractice — and he has a program for working with doctors. There is a lot of material out there, and it needs to be brought together and reviewed to make sure it is valid and made available to the states. It could play an important role in this regard.

In summary, here are four radical ideas for a different way of thinking about your role, based on the concept that it is the system, and not the person, who is responsible. When it is the person, we need a system to deal with that person, and unless we focus on those systems and develop much better ones we are not going to get there. Before you reject this totally out of hand as another idea from the ivory tower, from someone who is not on the front lines, let me leave you with a thought: At its heart, safety is a moral issue. It is a moral issue because we know a lot about how to prevent injury, and we are not doing it. The moral questions are, “Why are we not doing it?” The moral question directed at you is, “What is your fiduciary responsibility to see that it gets done?” And the final question is, “If not you, then who?”

This article was originally delivered as the Galusha Lecture at the Federation of State Medical Boards 2002 Annual Meeting in San Diego.
The board is currently developing a statement on doctors treating their families. To support debate, we publish below this draft statement and invite comment from the profession and the community. Submissions on the draft statement can be emailed to Dr. Joanne Katsoris at: JoanneK@medicalboardvic.org.au or posted to her at GPO Box 773H, Melbourne, VIC, 3001. The draft policy is published on the board’s website (http://medicalboardvic.org.au).

This draft statement outlines proposed guidelines for the provision of medical care by doctors to themselves and their families.

1. All doctors should have a general practitioner.
2. The responsibility for overall care and continuity of care of a doctor and each member of their family should rest with their general practitioner. Referral for specialist consultation, care, or advice should be made through their general practitioner.
3. A doctor’s general practitioner should not be a relative nor, unless there is no practical alternative, another member of the doctor’s practice.
4. Doctors need to be aware that they become the patient in the doctor patient relationship when receiving medical care.
5. It is not appropriate for a doctor to assume responsibility for the diagnosis and management of his or her own health problems or those of their partner and immediate family, except in the most unusual circumstances (such as an emergency or when there is inability to access medical care). In such cases, ongoing care should be the responsibility of their general practitioner who should be informed about the action taken by the doctor.
6. Doctors should not damage the confidence that their relatives have in their own general practitioner by undermining the advice and treatment that they have been given.
7. Doctors must not prescribe for themselves.
8. If a doctor writes a prescription for medication for a family member, it should be in consultation with their general practitioner and except in unusual circumstances, should only be for continuation of medication prescribed by their treating practitioner. A doctor should never prescribe a Schedule 8 drug for a family member or partner except in a serious emergency, when it should be on a one-off basis only.
9. Doctors have an ethical duty, to themselves and to their patients, to ensure that their own health problems are effectively managed, that they seek competent professional advice on their health and particularly on their ability to work, and that they follow that advice.
10. Doctors should not take advantage of the access they may have to medical records to look at the records of their family and friends without their consent.

The board acknowledges the Guidelines provided by the British Medical Association Ethics Committee on Ethical Responsibilities of doctors towards themselves and their families, from which these guidelines are substantially drawn.

MORE ON PRESCRIBING...

The Pharmacy Board of Victoria recently asked the Medical Practitioners Board of Victoria to remind medical practitioners of some of their obligations when prescribing medications. The request came after hearing concerns from pharmacists unable to contact prescribing practitioners to verify the authenticity of suspicious-looking prescriptions. The medical practitioners had not completed their contact details.

As professionals, medical practitioners and pharmacists need to work cooperatively in the shared aim of optimal patient care. A positive relationship between the two professions, based on mutual understanding, good communication, and respect, can benefit the doctor, the pharmacist, and the patient.

Pharmacists are well within their legal rights to refuse to dispense medication when the documentation on the prescription is deficient.

Regulation 23 of the Drugs, Poisons and Controlled Substances Regulations 1995 defines some of the legal obligations of medical practitioners when writing prescriptions. Important obligations include:

1. Prescriptions for Schedule 4 or 8 poisons must be in the practitioner’s handwriting or in a manner approved by the Chief General Manager of the Department of Human Services, such as computer generated prescriptions which must include handwritten details for ALL drugs of dependence – not just Schedule 8 poisons.
2. Medical practitioners must write prescriptions for Schedule 4 or 8 poisons, legibly and durably and include:

(a) the name, address, and telephone number of the prescriber
(b) the name and address of the patient for whom the prescription is intended
(c) the date on which the prescription was written
(d) the handwritten signature of the prescriber
(e) full particulars of the poison or controlled substance to be supplied, including a statement of the quantity to be supplied
(f) in the case of a Schedule 8 poison, a statement of the quantity to be supplied written in words and figures
(g) directions for the precise dose or use and frequency of administration except in cases where
   (i) because of the complexity of the dosage regimen or use it is impracticable to do so and the prescriber has separately supplied the patient with written instruction, or
   (ii) the administration of the substance is to be carried out by a medical practitioner, pharmacist, dentist, authorized optometrist, or nurse
(h) the maximum number of times the prescription may be supplied if more than once, and
(i) in the case of a Schedule 8 poison, the maximum number of times the prescription may be supplied, written in words and figures.

Problems can arise when practitioners do not follow the regulations. Any resultant compromise to patient safety is unacceptable and likely to be regarded as unprofessional conduct.

Other issues related to prescribing and dispensing

Medical practitioners need to be aware that pharmacists may decline to dispense prescriptions that are presented more frequently than would be reasonably necessary if taken in accordance with the stated directions. It is therefore essential that the stated directions are an accurate reflection of the intended rate of administration.

Medical practitioners also should be aware that Regulation 25 makes it an offence to knowingly include on a prescription any particular that is false or misleading. This could apply to deliberately understating directions for use and/or post-dating prescriptions.

If you have questions about your prescribing obligations, contact the Drugs and Poisons Unit of the Department of Human Service on 1300 364 545.


ALBERTA, CANADA

PHYSICIANS AND CIVIL LITIGATION

The Alberta Information and Privacy Commissioner has recently completed an investigation into the discovery of patient health information on the hard drive of a computer. The Commissioner offered some recommendations regarding the security of computer data storage of value to physicians.

The circumstances were that a transcriptionist's computer locked up and stopped working. She was unable to access or delete files. She had used her computer to transcribe office medical notes and letters of referral.

The transcriptionist took her faulty computer to the store where it was purchased and received a new one. She understood that computers with a hard drive problem could be returned to the manufacturer and that the hard drive would be destroyed.

Unfortunately, the hard drive was not destroyed; rather, the computer was sold to a salvage company and then re-sold. The unidentified purchaser found personal health information on the hard drive. A floppy disk containing this information was provided to the media.

While the Information and Privacy Commissioner found that the medical clinic in question had policies and procedures in place regarding maintaining the privacy and security of patient information, he found that the custodians did not foresee the risk of unauthorized access to this information, and offered the view that custodians may not be aware of the proper method of disposal of a computer that contains health information.

The Commissioner made the following recommendations:

• Custodians should assess their administrative, technical and physical safeguards protecting health information and he specifically recommended that computer data storage components (e.g. computer hard drive, tapes, diskettes) be destroyed, or that the stored health information on these components be permanently deleted through use of a commercial disk wiping utility.
• Custodians should ensure that their affiliates be aware of and adhere to these safeguards, and that agreements between custodians and affiliates contain provisions to ensure compliance with the HIA and with the custodian's policies and procedures, including specific direction as to the storage and disposal of health information during the
time of the agreement, and at termination of the agreement.

- Custodians should review all policies and procedures and update them to comply with the HIA. The message, in brief, is that information on a computer hard drive must be protected as must all health information. When getting rid of an old or defective computer, it is the custodian’s responsibility to ensure that the hard drive is destroyed or that the information on the hard drive has been permanently deleted through use of a commercial disk wiping utility. The full Commissioner’s report can be accessed on the OIPC website at www.oipc.ab.ca/ims/client/upload/H2003IR002.pdf.


PHYSICIANS AND CIVIL LITIGATION

The Alberta Court of Appeal recently issued a decision that addresses issues surrounding the interview of a treating physician in a civil litigation case.

The case involved a plaintiff suing the defendant for personal injuries that resulted from a motor vehicle accident. Shortly before trial, the defendant’s lawyer wanted to interview the plaintiff’s treating physician. The plaintiff agreed to the interview, but imposed the condition that the plaintiff’s lawyer would also be present during the interview. The defendant would not accept this condition and brought the issue before the court.

The Court of Appeal decided that the plaintiff has the right to insist on his or her lawyer being present during an interview of the plaintiff’s treating physician by the defendant or his or her lawyer. The plaintiff agreed to the interview, but imposed the condition that the plaintiff’s lawyer would also be present during the interview. The defendant would not accept this condition and brought the issue before the court.

The Court of Appeal decided that the plaintiff has the right to insist on his or her lawyer being present during an interview of the plaintiff’s treating physician by the defendant or his or her lawyer. The Court of Appeal also found no distinction between a treating physician and one who had been retained as an expert to provide an opinion in the lawsuit, recognizing that often a physician may wear both hats.

Even though a patient consents to his or her doctor being interviewed by another party, the physician can decline to do so. The physician cannot decline, however, to testify in court if served with a subpoena or a notice to attend. There is always the practical consideration that agreeing to an informal interview may avoid the need to be called as a witness at trial.

Accordingly, any physician who receives a request to be interviewed by a third party should advise his or her patient that the patient has the right to insist on his or her lawyer being present during that interview, if the physician agrees to grant the interview. The presence of the patient’s lawyer adds an additional safeguard to ensure only relevant questions are asked and answered and that the interview does not become a “fishing expedition.”

Reprinted from the College of Physicians and Surgeons of Alberta website.

MANITOBA, CANADA

RELEASE OF INFORMATION TO NON-CUSTODIAL PARENTS

Members frequently call the College for advice on releasing health care information to a non-custodial parent.

The legal right of a non-custodial parent to such information is set out in s. 39(4) of The Family Maintenance Act, which states: “Unless a court otherwise orders, the non-custodial parent retains the same right as a parent granted custody to receive school, medical, psychological, dental and other reports affecting the child.” In other words, unless there is a court order restricting access, the non-custodial parent has just as much right as the custodial parent to access the child’s medical records.

Physicians are cautioned that there may be a court order restricting a non-custodial parent’s access to a child’s medical information. Physicians are responsible to make inquiries in that regard. If any uncertainty remains, the physician is advised to obtain legal advice.

The right to information should not be confused with a right to make health care decisions. Section 39(5) of The Family Maintenance Act makes clear that the right to information guaranteed in section 39(4) does not give the non-custodial parent any right to be consulted about or participate in the making of decisions for the child by the custodial parent.

The Personal Health Information Act recognizes the right of a parent to access his or her child’s medical information if that child has not acquired the capacity to make his/her own health care decisions. Before releasing personal health information about a child to a custodial or non-custodial parent, physicians must assess whether the child has the capacity to make his or her own health care decisions. If so, the physician should seek the child’s consent before releasing any personal health information about the child.

Reprinted from the College of Physicians and Surgeons of Manitoba website
ONTARIO, CANADA

SETTING THE RECORD STRAIGHT ON
INTERNET PRESCRIBING

Lately, College staff members have noticed a number of advertisements that suggest Ontario doctors can write prescriptions based on information provided by U.S. individuals through the Internet. Since the prices of many pharmaceuticals in Canada are much lower than the prices in the United States, there is considerable demand from American patients to purchase Canadian drugs.

Many of the advertisements suggest or state that Ontario physicians can co-sign or authorize an American prescription to be dispensed in Canada. Some require the patient to submit medical information by means of a questionnaire. Some of these advertisements go so far as to state that such arrangements are consistent with the policy of our College.

So that no doctor will be deceived or confused by these statements, it may be wise to briefly review the College policy, Prescribing Outside an Established Physician-Patient Relationship (#8-00).

If a physician wishes to sign or co-sign a prescription for an individual who is not his/her patient, basic medical principles of assessment and diagnosis must be applied. It is incumbent upon the physician to obtain an adequate history and perform an appropriate physical examination to reach a diagnosis that will ensure that the requested medications are appropriate. The physician is advised to fully document the encounter.

It is not acceptable for a physician to sign or co-sign a prescription without attending the patient.

Even in cases where this service is provided appropriately, physicians are urged to exercise due caution, existing diagnostic information about the patient may not be available to the physician providing the service. Furthermore, if there is an adverse outcome for these patients, physicians may not be legally protected from a lawsuit. Physicians in these circumstances may not be covered by existing Canadian professional liability insurance and are advised to contact the Canadian Medical Protective Association.

Physicians in any doubt about proposals made to them relating to cross-border prescribing or dispensing of medications may wish to consult with the Physician Advisory Service here at the College. As always, the Service will answer any questions and provide any help possible.

Reprinted from the College of Physicians and Surgeons of Ontario website
The Diversion Program is a statewide, five-year monitoring and rehabilitation program. It is administered by the Medical Board of California to support and monitor the recovery of physicians who have substance abuse or mental health disorders.

The Diversion Program was created by statute in 1980 as a cost-effective alternative to discipline by the board. Diversion promotes public safety by encouraging physicians to seek early assistance for substance abuse and mental-health disorders in order to avoid jeopardizing patient safety.

Physicians enter the Diversion Program by one of three avenues. First, physicians may self-refer. This is often the result of encouragement by concerned colleagues or family members who want the physician to seek help. Second, physicians may be referred by the Enforcement Program in lieu of pursuing disciplinary action. Finally, physicians may be directed to participate by the board as part of a disciplinary order.

During the fiscal year ending 02/03, 47 physicians were accepted into the program by the Diversion Evaluation Committee, signed a formal Diversion Agreement, and entered the program. Of those, 41 physicians had no open cases with the board, four physicians were diverted from discipline, and an additional two physicians entered as a result of disciplinary orders.

During fiscal year ending 02/03, the Diversion Program monitored a total of 399 physicians. Of the 51 who left the program, three are deceased and 10 were unsuccessful, while 38 successfully completed five years, with a minimum of three years of continuous sobriety and a change in lifestyle that would support ongoing recovery.

The board’s mission of public protection prompted thoughtful assessment of how the board processes incoming complaints. This past year, the board’s Central Complaint Unit was reorganized into two sections to assure quality of care cases receive the highest priority and level of review. One section is the Quality of Care Section, and is responsible for reviewing complaints that may directly relate to patient harm caused by provider negligence or incompetence. The other section is the Physician Conduct and Affiliated Healing Arts Section, and is responsible for cases involving professional misconduct, technical violations and Affiliated Healing Arts cases. Although these cases may be serious, they do not pose an immediate danger to the health and safety of patients. This new design has resulted in a more timely review of quality of care cases and more education for the physician on cases involving non-quality of care and technical violations. SB 1950 (Figueroa) was a major piece of legislation for the board and became effective January 1, 2003. It affected a number of areas of operation at the board and impacted many sections of the Medical Practice Act, which governs the medical profession. The new law added two public members to the Division of Medical Quality and called for the appointment of an Enforcement Monitor to review the operations of the Enforcement Program. It also added new information about physicians for disclosure on the board’s website, e.g., physicians’ medical specialty certifications and certain malpractice settlements. The penalty that can be imposed for criminal violations of unlicensed practice was increased. Complaints involving quality of care must now receive an initial review by a medical expert in the same field of practice as the issues raised in the complaint. For the first time, investigative priorities of the board are reflected in statute: 1) negligence/incompetence resulting in serious bodily injury or death; 2) substance abuse during practice resulting in patient injury; 3) excessive prescribing or prescribing without a good faith exam; 4) sexual misconduct during treatment; and 5) practicing while under the influence of alcohol/drugs. Many of the provisions of this law have been implemented; however, to achieve full compliance, board staff continues to make program changes.

The hiring freeze, which affected all state agencies, prevented replacement of investigative staff that retired or left the board. This reduction is reflected in the fewer number of investigations opened. The Central Complaint Unit’s careful analysis of incoming complaints has assisted in reducing this number, while ensuring other appropriate actions are taken, such as citations and fines and advisory letters. Budgetary constraints will continue to place limitations on the board’s resources; however, staff will continue to seek efficient methods to process the work received, being ever mindful of the board’s public protection mission.

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

NEW POLICIES

The Colorado Board of Medical Examiners has adopted several new policies, presented here in an abbreviated version. Please note that all board policies may be accessed online at www.dora.state.co.us/medical.

POLICY NUMBER: 20-17
Title: Issuing letters of concern for DUI, DWAI Referral of Applicants to the Colorado Physician Health Program for Evaluation Related to DUI, and DWAI Charges

Policy
It is the policy of the Colorado Board of Medical Examiners that any physician-applicant reporting that he or she has been charged within the last five years with driving under the influence (DUI), or driving while ability is impaired (DWAI), either drug or alcohol related, will be required to undergo evaluation or, at minimum, receive a letter of concern from the board. In such cases it shall also be the policy of the board to refer the physician to the Colorado Physician Health Program (CPHP) for evaluation. The CPHP evaluation of the physician applicant will be instrumental in determining whether a letter of concern is sufficient or if more serious action should be considered by the board.

POLICY NUMBER: 40-13
Title: Physicians and Physician Assistants’ Use of Alcohol and Other Mind-Altering Substances While On-Call

Policy
The Colorado Board of Medical Examiners advises against using any mind-altering medication not prescribed by the licensee’s treating doctors, and advises against the use of alcohol by licensees when on call. Although the use of these substances while on-call is not specifically defined in section 12-36-117, C.R.S., as a violation of the Medical Practice Act, the board is obligated to carefully review any allegation of alcohol/substance use by on-call physicians and physician assistants which affects the quality of patient care. The board, at its discretion, may determine if a licensee’s use of a mind-altering substance or alcohol was unprofessional. In such an instance, the board may conclude that a violation of the practice act occurred, and it retains the right to initiate disciplinary action against the licensee’s ability to practice medicine or to practice as a physician assistant.

POLICY NUMBER: 20-13
Title: Ability of Unlicensed Physician Assistants to Provide Delegated Medical Services Pursuant to 12-36-106(3)(l), CRS.

Issued: August 10, 2000; Revised August 9, 2001; Revised November 14, 2002.

Purpose
To provide guidance to applicants and staff regarding the board’s position with respect to unlicensed physician assistants providing delegated medical services pursuant to 12-36-106(3)(l).

Policy
Graduates of physician assistant programs who have not yet taken the certification examination and, thus, are not qualified for licensure, may perform delegated medical services pursuant to section 12-36-106(3)(l), CRS, until such time as they have been notified that they have passed the certification exam and are eligible for a Colorado license.

Reprinted from the Volume 11 Number 1, issue of The Examiner, published by the Colorado Board of Medical Examiners.

IDAHO

DEA REGISTRATION

The Board of Pharmacy continues to have questions from practitioners who hold a Drug Enforcement Administration (DEA) registration in Washington and want to know if they can prescribe controlled substances to patients they see in Idaho. The simple answer is no. A physician must have a DEA registration in each state in which the physician administers, dispenses or prescribes controlled substances. Even if the physician does not “maintain an office” in a state where they administer, dispense or prescribe controlled substances, federal law requires a separate DEA registration based on the fact that a physician must be licensed and/or registered to handle controlled substances in each state in which the physician administers, dispenses or prescribes controlled substances.

The only exception is a “Locum Tenens” physician who has a DEA registration in one state and who temporarily substitutes for a physician in a different state for a period not to exceed 60 days at the other physician’s DEA registered location.

In addition to the federal DEA requirements mentioned above, the Idaho Board of Pharmacy also requires a state controlled substance registration for any applicant prior to administering, dispensing or prescribing any controlled substance prescriptions in Idaho.

Compliance by physicians with the provisions of federal law with respect to all registration requirements also entitles them to be registered under the Idaho Controlled Substance Act.
In Idaho, a physician is required to have both a DEA registration issued to an Idaho address and an Idaho Controlled Substance registration prior to prescribing controlled substance prescriptions to patients they see at any practice location in Idaho.

Reprinted from the Summer 2003 issue of the Idaho State Board of Medicine Newsletter, published by the Idaho State Board of Medicine.

NEW MEXICO
BOARD CHANGES NAME TO NM MEDICAL BOARD

Senate Bill 171 made changes to the Medical Practice Act during the legislative session that ended in March. Probably the most obvious is the change in name from the New Mexico Board of Medical Examiners to the New Mexico Medical Board. The new name will be phased in as we reorder envelopes, stationery, etc. The primary reason is that we are constantly confused with the Office of the Medical Investigator, and we receive numerous calls each week concerning the location of bodies and the results of autopsies. In addition, we have not given an exam in years because everything is now done at the national level.

Other changes include the addition of a physician assistant (PA) member to the board. This will give PAs a “voting” member, instead of the Advisory Committee they have had for the past several years.

The disciplinary sections of the Act have been combined. Instead of a separate section for physicians, physician assistants, and anesthetologist assistants, there is one section (61-6-15) that covers all three types of licenses.

The revised MPA updates the duties of the secretary and gives the board authority to hire a medical director. Changes to the licensing process eliminate the mandatory personal interview. To implement this change the board has developed a process to identify applicants with a questionable history who will still be required to interview. Applicants with no gaps in their work or training history and who are “squeaky clean” in disciplinary history will no longer need to interview after July 1. To further streamline licensing a CD-ROM containing orientation material will be mailed to each applicant. They will be required to acknowledge receipt and review of this material as a requirement for licensing. When the license is approved (each application must still be reviewed by the secretary, medical director, or other authorized board member. The board gained the ability to perform criminal background checks, but we have not yet decided how to use this authority.

Of particular interest to practicing physicians may be some of the changes to Section 61-6-15, reasons why action can be taken against a license. Prohibition of sexual contact with patients has been further clarified in paragraphs (31) and (32). Improper management of medical records, including failure to maintain timely accurate, legible and complete medical records has been added (#33), as has failure to provide records on request (#34). Undertreatment of pain (#35) in a cause for disciplinary action, as is disruptive behavior that impacts the quality of care (#36). However, the requirement that a physician pay costs in disciplinary actions has been eliminated to avoid any appearance a Board decision is based on financial reasons. All changes to the Act went into effect on July 1, 2003.

Reprinted from the Volume 8, Issue 1 issue of Information & Report, published by the New Mexico Medical Board.

OREGON
PAIN CONCERNS ANSWERED

The board, its counterparts nationwide, and the Federation are committed to helping doctors serve their patients’ best interests regarding treatment for chronic and intractable pain. There are very real concerns about the fine line between underprescribing and overprescribing pain medication, and these concerns often can lead physicians to stop seeing patients with pain.

There is no reason for Oregon’s doctors to use fear of board sanction as a reason not to treat chronic pain patients. Doctors who follow statutes and rules for prescribing pain medication should have no problems with the board as a result.

Besides the letter of the law and rule, the board in 2002 approved a set of core principles for pain management. The first principle states, simply, that people should have access to appropriate and effective pain management. Secondary goals include improved quality of life for those patients who suffer from chronic pain, and lessening of the morbidity and costs associated with untreated or inappropriately treated pain.

Reprinted from the Summer 2003 issue of the BME Report, published by the Oregon Board of Medical Examiners.

WEST VIRGINIA
BOARD OPINION ON PHYSICIANS ACCEPTING LOANS FROM PATIENTS

In response to an inquiry, the board has adopted the following opin-
ion on physicians accepting loans from patients: It is probable that it is a violation of medical ethics for a physician to accept loans of money from a patient and to permit the patient to forgive repayment, and to accept loans of money with knowledge that the debt will be forgiven pursuant to the will of the patient. In the AMA Code of Ethics, Principle VIII is that “A physician shall, while caring for a patient, regard responsibility to the patient as paramount.” The existence of a lender-debtor relationship introduces elements which distract from that paramount responsibility. Further, Opinion 10.015, The Patient-Physician Relationship, states in pertinent part that, “The relationship between patient and physician is based on trust and gives rise to physicians’ ethical obligations to place patients’ welfare above their own self interest...Within the patient-physician relationship, a physician is ethically required to use sound medical judgment, holding the best interests of the patient as paramount.” The existence of a lender-debtor relationship conflicts with this ethical obligation, particularly where a large loan will be forgiven upon death. The existence of the loan and the will forgiving it may also raise questions about the patient’s death even where there may be no legitimate medical question.

PHYSICIAN ASSISTANT CONTINUING EDUCATION RULE CHANGE NOW LAW

Every two years physician assistants now must acquire a minimum of 50 hours of continuing education designated as Category I by either the American Medical Association, the American Academy of Physician Assistants, or the Academy of Family Physicians. The former rule required a minimum of 40 hours of Category I continuing education and 60 hours of Category II continuing education. Now the rule requires 50 hours of Category II continuing education. The changes became effective August 1, 2003, in the Rule 11 CSR 1B.

Reprinted from Volume 7, Issue 3 of the West Virginia Board of Medicine Quarterly Newsletter, published by the West Virginia Board of Medicine.

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.
The Louisiana Supreme Court ruled the lower courts correctly held interrogatories are not permissible in a medical panel proceeding. Moreover, the court of appeal correctly found the medical malpractice plaintiffs were not required by the Medical Malpractice Act (MMA) to allege the standard of care breached by health care providers. However, the supreme court concluded the court of appeal erred in ruling the plaintiffs could be required to respond in the trial court to exceptions of no cause of action and vagueness.

This case arose out of three medical malpractice claims filed against several health care providers where the proceedings were pending before medical review panels, in which the providers or defendants had asserted the plaintiffs’ claims did not provide sufficient notice of material facts. These cases were: 1) Perritt v. Dona, 812 So. 2d 624 (La. 2002); 2) Arnold v. Dona, 812 So. 2d 623 (La. 2002); and 3) Richmond v. Brown, 812 So. 2d 624 (La. 2002).

In Perritt, the trial court ordered the plaintiff, Harold Perritt to amend his claim and provide details of the alleged malpractice. The plaintiff applied for supervisory writs, which the court of appeal denied. In the other suits, the trial court denied the health care providers’ request. The parties then applied for supervisory writs. The court of appeal denied their applications. The parties then applied for writs of review.

The supreme court consolidated the cases, granted the applications, and remanded the cases to the court of appeal to determine whether a defendant in a case pending in the medical review panel may compel the plaintiff to respond to interrogatories requesting information on the standard of care allegedly breached by the defendant. On remand, the court of appeal held interrogatories are allowed during the medical review panel proceeding. The aggrieved parties appealed.

The supreme court affirmed in part and reversed in part the court of appeal’s judgment. The defendants urged the plaintiffs’ complaint failed to set forth the basic material facts necessary to put them on notice as to the alleged malpractice asserted; thus, the plaintiffs should have been compelled to answer their interrogatories. The supreme court disagreed. The supreme court explained the governing statute, La. Rev. Stat. § 40:1299.47(D), does not expressly provide for written discovery. The statute does allow “medical charts, x-rays [sic], lab tests, excerpt of treatises, depositions of witnesses including parties, affidavits and reports of medical experts, and any other form of evidence,” but is silent as to interrogatories. A strict reading of the statute does not allow interrogatories in the medical review panel stage. Thus, the court concluded, because there was no statutory requirement allowing interrogatories, it could not conceptually compel parties to answer interrogatories.

The supreme court also found the plaintiffs could not be compelled to provide information on the standard of care breached by the defendants. La. Rev. Stat. § 40:1299.47(B)(1)(a)(i) provides:

No action against a health care provider covered by this Part, or his insurer, may be commenced in any court before the claimant’s proposed complaint has been presented to a medical review panel established pursuant to this Section.

The supreme court noted the statute says nothing further about the required formality for the “proposed complaint,” therefore, the defendants could not require the plaintiffs to specify the health care providers’ standard of care. Furthermore, the language of La. Rev. Stat. § 40:1299.47(G) suggests it is the duty of the medical review panel to determine the appropriate standard of care based on the evidence presented and whether the defendant breached that standard.

Moreover, the supreme court found the plaintiffs could not be required to respond in the trial court to exceptions of no cause of action and/or vagueness. Based upon the provisions of La. Rev. Stat. § 9:5628 and § 40:1299.47(B)(2)(a), a health care provider is allowed to only assert the preemptory exception of prescription during the medical panel review stage of the proceedings.

The supreme court further pointed out the dilatory exception of vagueness addresses the detailed sufficiency of the petition and the preemptory exception of no cause of action tests the legal sufficiency of the pleadings detailed in the petition. In the present case, there was a “claim” pending before the medical review panel for review, not a petition. Thus, it was clear the exceptions of vagueness
and no cause of action were inapplicable to the medical panel review stage of proceedings.

EXPERT TESTIMONY


The Connecticut Supreme Court ruled a trial court improperly interpreted Conn. Stat. § 52-184c to require the exclusion of an expert witness proffered by a plaintiff in a medical malpractice action because the expert was not a licensed physician in the state.

Michelle DiLieto sought medical attention because of intense and prolonged bleeding during her menstrual period. Dr. Scott Casper, an obstetrician-gynecologist employed by County Obstetrics and Gynecology Group P.C., recommended DiLieto undergo a diagnostic dilation and curettage (D&C).

After the D&C was performed, a sample of DiLieto’s uterine tissue was sent to Dr. Thomas Anderson, a pathologist, at Waterbury Hospital. He diagnosed endometrial stromal sarcoma, which is a rare and potentially deadly malignancy.

After Casper received the diagnosis from another pathologist in Anderson’s group, Casper informed DiLieto. He also told DiLieto that her pathology slides would be sent to Yale New Haven Hospital for further review. Thereafter, Casper consulted with Peter Schwartz, a professor of obstetrics and gynecology at Yale, who asked Yale’s pathologists to review DiLieto’s slides.

Subsequently, Schwartz advised Casper of the pathologists’ findings and recommended a hysterectomy, a bilateral salpingo-oophorectomy and a pelvic lymph node dissection because of the possible spread of the malignancy to the lymph nodes. Thereafter, Casper performed surgery on DiLieto and removed her uterus, fallopian tubes and ovaries. Casper then had Schwartz and Dr. Babak Edraki, a surgeon, perform a lymph node sampling, which involved the removal of two lymph nodes. Dr. Vinita Parkash, a pathologist, later examined the excised nodes along with the hysterectomy sample and concluded the lesion was likely benign.

As a result of the total hysterectomy, DiLieto experienced the symptoms of menopause, including estrogen deficiency. After DiLieto experienced other symptoms following the surgery, she sought further treatment from a neurologist and a pathologist in the Boston, Mass. area. The pathologist submitted his findings to DiLieto’s family practice physician, who advised DiLieto that she did not have cancer.

DiLieto sued Casper and County Obstetrics, Yale University School of Medicine as the employer of Parkash, Edraki and Schwartz, and Anderson. The jury returned a verdict for Anderson and Yale, finding that neither had violated the applicable standard of care. The jury was unable to reach a verdict regarding Casper and County Obstetrics. DiLieto moved for a new trial against all of the defendants and Casper moved for judgment in his favor. The trial court denied both motions and rendered judgment for Anderson and Yale and ordered a retrial against Casper and County Obstetrics. Michael Daly, a plaintiff trustee in bankruptcy appealed.

The supreme court affirmed the trial court’s judgment with respect to Yale and remanded the case for a new trial against Yale. The judgment of the trial court was affirmed in all other respects. The supreme court agreed with DiLieto that the trial court improperly interpreted Gen. Stat. § 52-184c to exclude the testimony of DiLieto’s expert witness, John Shepherd, a physician from England who was not a licensed physician in Connecticut. Shepherd was to have testified, inter alia, that Casper and Schwartz breached the prevailing standard of care when they failed to run imaging tests and other diagnostic procedures in addition to the special stains. In so ruling, the supreme court rejected the defendants’ argument that the trial court properly precluded Shepherd from testifying because he was not “a health care provider” pursuant to § 52-184c, which incorporates by reference the definition of health care provider found in Gen. Stat. § 52-184b. Section 52-184b defines health care provider as a person licensed to provide health care in Connecticut.

The supreme court found the interpretation of § 52-184c urged by the defendants would effect a radical change in the trial of medical malpractice cases in Connecticut because it would preclude expert testimony by any medical expert not licensed in Connecticut. Nothing in the legislative history of § 52-184c suggested to the court that the legislation intended such a substantial modification in Connecticut law.
Additionally, the supreme court found the trial court improperly precluded DiLieto's testimony as to what she would have done had she known her condition possibly might have been benign. The supreme court further concluded her testimony was relevant to the issue of causation. Because the jury found Anderson was not negligent, the jury never reached the issue of causation with regard to Anderson's alleged negligence. The preclusion of DiLieto's testimony about causation therefore had no bearing with regard to Anderson and was not harmful with regard to the claim against him.

**MALPRACTICE**

*Bessenyei v. Raiti,*

The U.S. District Court for the District of Maryland ruled a doctor was not liable for medical malpractice because he gave advice to another doctor as to treatment for the other doctor’s patient. A physician-patient relationship was never established, and thus, the doctor did not owe the other doctor’s patient a duty of care.

On August 7, 1998, Imre Bessenyei injured his left thumb when paint thinner was injected into the pulp of his finger. He went to Fallston General Hospital Emergency Department for medical care. After in-take at the ER, Bessenyei’s injured thumb was placed in a betadine soak. Bessenyei was then examined by Dr. Salvatore Raiti, who, according to Raiti, told Bessenyei he should report to the hand clinic at Union Memorial Hospital where the doctors were better qualified to treat the injury. Raiti claimed Bessenyei refused to go to Union Memorial and wanted instead to return to his home in Virginia. Bessenyei, however, maintained he was never told it was necessary to go to Union Memorial.

At some point, Raiti telephoned Dr. Brent Birely to receive consultation on treating the injured thumb. Birely was on staff at Fallston General, but he was not an on-call doctor the evening of Bessenyei’s injury. Raiti described the injury to Birely.

According to Raiti, Birely told him to give the patient antibiotics and pain medicine and that he (Birely) could follow up with the patient on Monday. Birely did not charge for the consultation. Raiti did not remember whether he gave Bessenyei antibiotics before or after speaking with Birely, but was sure he told Bessenyei of the advice he received from the surgeon (though he did not make an appointment for Bessenyei with Birely or give Bessenyei Birely’s phone number).

Bessenyei was discharged with instructions to follow up with his doctor and to report to the Hand Center at Union General if his condition deteriorated. He returned home that night and sought emergency medical attention for his injury again the next day. Eventually, the tip of his thumb was amputated as a result of the injury. He brought a medical malpractice action against a number of medical care providers, including Birely. Birely moved for summary judgment.

The district court granted Birely’s motion. In so ruling, the court agreed with Birely that a physician-patient relationship was never established between himself and Bessenyei. The court noted Birely did not imply his consent to enter into a physician-patient relationship when he confirmed Raiti’s diagnosis, agreed that antibiotics and pain medication were appropriate, and conveyed the fact that he would see Bessenyei on Monday of the following week.

The district court explained Birely owed no independent consultative duty to Fallston General or Bessenyei as a patient of the hospital. While Birely had privileges at the hospital where Bessenyei was seen, his on-staff status did not give him a duty to every patient admitted there. Birely was the doctor Raiti called for advice but that did not make him the on-call doctor or create the duty that might be found were he the on-call doctor.

In the end, the district court pointed out, it was Raiti who had decision-making authority over Bessenyei’s course of treatment. The conversation that took place, whatever its precise contents, was a conversation between two doctors of comparable ability and competence to handle the situation. It was Raiti who had direct contact with the patient, who rendered the initial diagnosis in the case, and who initiated contact with another health care professional. Raiti was the doctor looking at the patient, and he could override Birely by deciding to accept or reject his recommendations. It was clear Raiti had the final say in the decision to release Bessenyei with the instructions he was given. Birely should, therefore, not be regarded as a joint provider of medical services.

*Mcmackin v. Johnson County Healthcare Ctr.,*

The Wyoming Supreme Court ruled a trial court erred in granting summary judgment for the defendants in an estate’s wrongful death and medical malpractice action. The estate’s malpractice claims fell under the “loss of chance” doctrine, and an issue of fact existed as to causation.

Leslie M. Mckin, the daughter and personal representative for the estate of Harriette Brown, brought a wrongful death and medical
malpractice action against Johnson County Healthcare Center (JCHC), Jennifer Sather, R.N., Vicki Blakely, L.P.N., Dr. Mark Schueler, Dr. Lawrence Kirven, and Medical Associates of Johnson County PC, after her mother's death. In her amended complaint, McMackin averred Brown was a resident at the Ann Holt Care Center in Buffalo from 1990 until her death on March 21, 1999. The Center was a part of JCHC. Sather and Blakely were employed at JCHC and provided care to Brown at various times pertinent to this matter.

In July 1998, Brown began exhibiting symptoms of transient ischemic attacks (TIAs, also referred to as ministrokes), during which she would be confused and unable to verbalize. These symptoms were noted many times on Brown's chart, and they continued to occur at irregular intervals after July 1998. The defendants allegedly took no action to refer Brown for a neurological workup, test her for causes of the TIAs, further diagnose, or prescribe meaningful treatment for her condition. On March 7, 1999, a JCHC employee discovered Brown was having difficulty talking and was crying. This was reported to Sather, who examined Brown and noted in her chart that Brown's speech was slurred, that she was crying and suffering anxiety, had slight facial drooping on the left side, and her left eye was closed. McMackin contended there should have been an immediate medical response to her mother's condition, but there was not. Sather examined Brown periodically between 11:00 p.m. on March 7, 1999, and 4:30 a.m. the following day but took no action until 4:30 a.m., at which time she called Kirven who advised Sather to wait for Brown's treating physician, Schueler.

At 8:00 a.m. on March 8, 1999, Blakely examined Brown and noted the symptoms had persisted throughout the night. Blakely called Schueler and noted on Brown's chart that the doctor would be there in about 30 minutes. At about 9:00 a.m., Schueler examined Brown and diagnosed a cerebrovascular accident (stroke) and arranged for her to be transferred to the hospital. Brown did not recover from the stroke and died on March 21, 1999.

The trial court held there was no genuine issue of material fact with respect to the “causation” prong of the elements necessary to constitute a medical malpractice claim and, on that basis, granted summary judgment for the defendants. McMackin appealed.

The supreme court reversed the trial court's judgment and remanded the case. Generally, to prevail on a claim that a physician's failure to evaluate and treat a patient caused the patient to lose the chance for survival, a plaintiff must show (1) the patient has in fact been deprived of the chance for successful treatment; and (2) the decreased chance for successful treatment more likely than not. The Maryland Court of Special Appeals ruled the state Board of Physician Quality Assurance could reasonably conclude that a physician's having consensual sexual relations with adult patients, at times and locations other than those involving the immediate act of diagnosis or treatment, is “immoral or unprofessional conduct in the practice of medicine” within the meaning of Maryland Code, § 14-404(a)(3) of the Health Occupations Article.

Dr. Thomas Finucan was a family practitioner in Cecil County, Md. In addition to maintaining a private practice, Finucan worked evenings and weekends at Perry Point VA Medical Center and was on staff at Union Hospital in Elkton.

On October 21, 1998, the Board received a written complaint from a patient (Patient A) that Finucan engaged in a sexual relationship with her while acting as her physician. The Board investigated Patient A's complaint. The investigation revealed that, from 1993 through 1998, Finucan engaged in a series of sexual and personal relationships with several patients while maintaining a physician-patient relationship with them.

Nearly one year later, the Board charged Finucan with immoral or unprofessional conduct in the practice of medicine. An administrative law judge (ALJ) concluded Finucan had engaged in sexual relationships with three of his patients, Patients A, B and D, while serving as their primary care physician and that his conduct constituted unprofessional conduct in the practice of medicine. The ALJ recommended Finucan's license to practice medicine be revoked and that his license not be considered for reinstatement for at least three years. The Board adopted the ALJ's findings. The trial court affirmed the Board's decision, and Finucan appealed.

The court of special appeals affirmed the trial court's judgment. In so ruling, the court of special appeals rejected Finucan's argument that the Board wrongly revoked his license to practice medicine because, when the sexual conduct with his patients occurred, he was not “actually or constructively engaged in the act of the practice of medicine.” The Board concluded Finucan exploited his position of trust by engaging Patients A, B and D in sexual relationships. Finucan did so, the Board found, mindful of the imbalance of power between him and his patients, and with knowledge of their medical history, family situation, and current physical and emotional state. Giving due deference to the Board's expertise in determining when physician conduct comes within the ambit of “the practice of medicine,” the court of special appeals held the Board could reasonably conclude that Finucan's unprofessional conduct with regard to Patients A, B and D occurred “in the practice of medicine.” The court of special appeals also rejected Finucan's argument that his
due process rights were violated at a trial court hearing. It noted it had reviewed the pleadings, hearing transcripts and exhibits that made up the appellate record in this case. In the course of that review, it had neither detected any form of due process violation or other procedural error nor had it remotely sensed that Finucan received less than a full and fair hearing at each and every stage of the proceedings.

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