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MEDICOLEGAL DECISIONS
“Each generation must, out of relative obscurity, discover its mission, fulfill it, or betray it.”

— Frantz Fanon
INFORMATION FOR AUTHORS

The Journal accepts original manuscripts for consideration of publication in the Journal of Medical Licensure and Discipline. The Journal is a peer-reviewed journal, and all manuscripts are reviewed by Editorial Committee members prior to publication. (The review process can take up 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 sent by e-mail to editor@journalonline.org or by mail to:

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3. The manuscripts pages should be numbered, and length should be between 2,750 and 5,000 words, with references (in Associated Press style) and tables attached.
4. The manuscript should include an abstract of 200 words or less that describes the purpose of the article, the main finding(s) and conclusion. Footnotes or references should not be included in the abstract.
5. Any table or figure from another source must be referenced. Any photos should be marked by label on the reverse side and up direction noted. Tables and figures can be supplied in EPS, TIF, Illustrator, Photoshop (300 dpi or better) or Microsoft PowerPoint formats.
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7. 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.
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9. Manuscripts are reviewed in confidence. Only major editorial changes will be submitted to the corresponding author for approval. The original manuscript and CD-ROM will be returned if the submission is not accepted for publication only if a SASE is supplied with sufficient postage.
MESSAGE FROM THE CHAIR

STATE MEDICAL BOARDS: DEVELOPING SOLUTIONS TO IMPROVE OUR NATION’S HEALTH CARE

Martin Crane, M.D., Chair, Federation of State Medical Boards of the United States

As the United States engages in a vigorous debate about health care reform, state medical boards continue to make major strides in developing solutions to improve the quality and safety of our country’s health care. By tapping into the latest technological advances and data standardization procedures, medical boards are building a robust informational infrastructure that should serve our national health care system well for years to come.

Our progress has not been limited to technological advancements, as important as those are. The FSMB and its membership are also making outstanding progress in developing effective public policy and building important relationships at the state, national and international levels. This progress is occurring because of the extremely high level of collaboration and creativity happening across the country within the state medical board community. Following is a brief overview of some of the initiatives currently propelling us forward as together we pursue solutions to positively impact our nation’s health care.

IMPROVING THE PORTABILITY OF MEDICAL LICENSURE

U.S. medical regulators have long been challenged to identify strategies that allow physicians to practice in multiple states while respecting the autonomy of each jurisdiction. In response, the FSMB and state medical boards are diligently working to make it easier for physicians to become licensed and credentialed in multiple states. I am pleased to report that the FSMB’s License Portability Project and an initiative to enhance the Federation Credentials Verification Service (FCVS) are helping move license portability from a concept to an actual reality in mainstream medicine.

A key piece of this progress has been the growing implementation by medical boards of the Uniform Application for State Medical Licensure, or UA. This application consists of one primary form common to all states with state-specific addendums – allowing states to maintain autonomy while gaining the efficiencies associated with a standard electronic application. Centralizing credentials verification is another important part of improving the licensure process. Since 1996, the FCVS has enabled physicians to establish a lifetime portfolio of verified medical credentials that can be forwarded to any medical board or health care entity. I’m pleased to report that significant progress is being made in the development of a new, enhanced version of FCVS, with more complete and powerful features to streamline the credentialing process. The newly enhanced FCVS is due to be launched in 2010.

Improved license portability has tremendous upside for everyone involved: state medical boards, physicians and the patients we serve. By participating in this national effort, medical boards are helping address some of the significant health care issues we now face, including the need to lower costs, provide care to underserved populations and facilitate telemedicine.

FSMB AS A DATA AND INFORMATION RESOURCE

Since its inception nearly a century ago, the FSMB has worked to develop what is today the most comprehensive repository of physician licensure and credentialing information in the United States. The FSMB is currently making a significant investment to enhance its overall technological capabilities to enable it to provide the highest-quality research, credentialing and licensure information to a wide array of stakeholders. Coupled with initiatives to enhance the capabilities of FCVS and the Physician Data Center, these technology upgrades will help position FSMB and the state medical board community as an important data and information resource during the implementation of...
health system reform and improved regulatory policies.

**National Advocacy for State Medical Boards**

At this pivotal time in U.S. health care, it is critical the voice of state medical boards be heard in our nation’s capital. I’m pleased to announce the FSMB is opening an office in Washington, D.C., in January 2010 to serve as the hub of our work with national legislators and policymakers on behalf of state medical boards. By maintaining an ongoing presence in Washington, the FSMB will be a more effective champion for the needs, goals and successes of our member boards. This enhanced advocacy also will help raise national and public awareness and understanding of the important work and mission of state medical boards.

In addition to broadening its national legislative advocacy efforts, the FSMB also has worked to develop an affiliation with the U.S. Uniformed Health Services to explore ways in which the FCVS and the Federation Physician Data Center could enhance the credentialing needs of various federal health agencies.

**Public Members and Public Awareness**

The FSMB recently began developing plans for an initiative that will recognize the invaluable role public members play on state medical boards across the country. This effort will include providing stipends for a number of public members to attend FSMB Annual Meetings. As part of the initiative, the FSMB Foundation will undertake development of an educational module to help orient new public members to the duties and responsibilities of public members. Recognizing that the biggest constituency of state medical boards is the public, the FSMB is laying the groundwork for an ongoing public relations campaign to raise public awareness of what state medical boards do, how they work for the public and the need for medical boards to receive adequate resources to carry out their mission of public protection.

**Assuring the Continuing Competence of Physicians**

In December, the FSMB Board of Directors accepted for dissemination and feedback a draft report developed by the FSMB Maintenance of Licensure Advisory Committee recommending various approaches state medical boards could use to assure the public that physician licensees are maintaining their competence to practice medicine. The report from the Special Committee on Maintenance of Licensure recommends state medical boards require licensees to maintain their competence in the scope of their daily practice by participating in a continuous professional development program that includes directed self-assessment, demonstration of cognitive competence and performance in practice. Significant progress has been made in identifying and resolving issues and concerns expressed by state medical boards and other stakeholders about the draft recommendations. The FSMB continues its commitment to moving this policy work forward in a thoughtful, careful manner and involving all stakeholders who could be impacted by its outcome.

**International Medical Regulation**

In addition to contributing to progressive initiatives in the United States, state medical boards play a key role in the worldwide body of medical regulators – the International Association of Medical Regulatory Authorities (IAMRA). The FSMB has been the Secretariat of IAMRA since its inception and a number of U.S. medical boards are members of the organization.

I am delighted to announce that the 9th conference of IAMRA has been scheduled for Sept. 26-29, 2010, in Philadelphia, Pa. IAMRA is partnering with the FSMB, the National Board of Medical Examiners and the Educational Commission for Foreign Medical Graduates to offer an innovative program on best practices in medical licensure.

With hundreds of attendees from medical regulatory organizations around the world, IAMRA conferences are a truly unique and highly rewarding experience. The 2010 conference will include interactive programs on registration and licensure, currency of competence and revalidation/maintenance of licensure, ethical guidance, and complaints and resolutions. I hope you will be able to participate. Please visit www.iamra.com for updates.

As you can see, the FSMB and state medical board community are extremely active in a wide variety of initiatives that are positively impacting public protection and improving physician practice. Please join us in the year ahead as we continue to participate in health care policymaking and making major contributions to improving the health care of our nation.
From Captain John Smith’s 1607 account of the “skillful diligence” of a surgeon among the early colonists in Virginia, to the story of the union in 1765 of the College of Philadelphia and the Pennsylvania Hospital to create the nation’s first medical school, to the sequence of events leading to the establishment in 1912 of the Federation of State Medical Boards (FSMB), a spirit of optimism and incremental dynamism is discernible in the descriptions of the historians of their day about the evolving role of medical education, licensure and regulation in the United States.1,2,3 As the first decade of this millennium comes to a close, and I begin my role to help lead the FSMB, I am struck by how this same energy is alive and well, equally incremental in its dynamism but more collaborative, comprehensive and collegial than before. The FSMB, in fact, stands at the nexus of many of the dynamic changes that are under way in organized medicine today and -- by virtue of its role in representing the 70 state medical and osteopathic boards of the United States and its territories, in their efforts to protect the public through medical licensure and regulation -- has a critical role to play in many of these areas. The FSMB’s current mission seeks “continual improvement in the quality, safety and integrity of health care through the development and promotion of high standards for physician licensure and practice.”4 That charge places us at the center, if not the lead, of many of these efforts.

In the area of undergraduate medical education, there are now 131 accredited M.D.-granting, and 26 accredited D.O.-granting, medical schools in the United States and more to follow in the decade ahead. The Association of American Medical Colleges’ (AAMC) Center for Workforce Studies, like other prominent organizations that have studied health care workforce needs, has predicted a shortage of 124,000-159,000 physicians by 2025.5 Though such bodies as the Council on Graduate Medical Education in 2007 called for an increase in Medicare-funded graduate medical education (GME) positions, and decentralization of training sites, removal of regulatory barriers limiting flexible GME training programs, and accountability for the public’s health as the driving force for GME,6 it is not certain at press time that any of these changes will be included in the health system reform bills currently being debated in Washington, D.C.

Since its formal inception in the last century, GME in the United States has been different than what is offered and available in many parts of the world. Following completion of an accredited GME residency or fellowship training program, each physician in the United States is prepared to enter, following medical licensure by a state medical or osteopathic board, the unsupervised practice of medicine. In the United Kingdom, by contrast, those who complete GME may remain under supervision of teaching faculty in a hospital for several years as a “registrar” until they achieve posting as a consultant. The GME procedures in the United States, consequently, require an additional degree of diligence by state medical boards to comprehensively and thoroughly assess the competency and qualifications of physicians seeking medical licensure.

Recognizing the need to assess more than knowledge elements, both the Accreditation Council on Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) recently adopted six core competencies for every physician that all GME training programs in the U.S. should integrate into their curricula: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice.7 Recognizing that medical education is part of a broad continuum, the FSMB, the National Board of Medical Examiners (NBME) and the National Board of Osteopathic Medical Examiners (NBOME) have adopted these same competencies (the NBOME frames them within an osteopathic
context) for assessment in forthcoming updates to their licensing examinations.

The Medical College Admissions Test (MCAT), the stand-
dardized, multiple-choice examination that is produced by
the AAMC, continues to be required of applicants to almost
al allopathic and osteopathic medical schools in the United
States. While the MCAT does a laudable job of assessing an
examinee’s problem solving, critical thinking, writing skills
and knowledge of science concepts and principles that are
felt to be prerequisite to the study of medicine, for only
the fifth time since its inception in 1928 the exam will undergo
a review and evaluation of all of its elements in a process
called the Fifth Comprehensive Review of the MCAT
Exam (MR5). While periodic reviews of examinations are
recognized as a best practice, the 21-member committee
appointed by the AAMC to conduct this review, chaired by
Steven Gabbe, M.D., of the Ohio State University College
of Medicine, will be developing plans to “solicit broad input
about the current and future tests, gather relevant data and
research, and regularly communicate” their progress with
the aim to produce a new test “no earlier than 2014” that
keeps pace “with advances in medical education and prac-
tice.”6 An annual meeting of the AAMC, the NBME and
the FSMB is only one way in which the FSMB is staying abreast of such important changes.

The United States Medical Licensing Examination
(USMLE), created in 1991 through a partnership between
the FSMB and the NBME, is currently administered in
three “steps” and four “events” and effectively used by state
medical boards to make decisions at the time of entry into
supervised practice and at the time of initial medical li-
censure. The examination also serves additional purposes,
in its utility for medical school deans in gauging academic
progress during undergraduate medical education and in
its value in helping residency program directors select can-
didates for GME residency training positions. From 2004
to 2009, the USMLE’s Composite Committee, a Planning
Task Force and a Committee to Evaluate the USMLE Pro-
gram (CEUP) thoughtfully reviewed the exam’s purpose,
structure and format. Recognizing that the “first priority of
the USMLE” is “to assure licensing authorities that candi-
dates possess the capacity for safe and effective patient care
in both supervised and unsupervised settings,” the com-
mittee agreed following much deliberation and input from
multiple stakeholders that the USMLE exam “must con-
tinue to reflect evolving national consensus of what it takes
to be a physician.”7 The committee was chaired by Alfred
F. Tallia, M.D., M.P.H., of the University of Medicine and
Dentistry of New Jersey, and its primary recommendations,
adopted by the FSMB and the NBME, call for two patient-
centered decision points, adoption of a general competen-
cies-based schema for exam questions, and the importance
of including the scientific foundations of medicine in all
components of the assessment process.8 These changes
will take us several additional years to implement but the
process is well under way. The FSMB has five of its re-
presentatives, including myself, serving on the USMLE’s
Composite Committee. The Comprehensive Osteopathic
Medical Licensing Examination (COMLEX), produced
by the NBOME, has also recently undergone a compre-
hensive review and is undertaking similar changes.

In 2004, the FSMB’s House of Delegates agreed on a pol-
icy statement that “state medical boards have a responsi-
bility to the public to ensure the ongoing competence of
physicians seeking relicensure.” The term “relicensure” is
better known as “license renewal” to differentiate it from
physician re-entry, an area the FSMB has also looked at.
Since 2004, several committees, task forces, surveys and
working groups have included thoughtful comments by
representatives of state medical boards and other stake-
holders representing a wide array of individuals, includ-
ing practicing physicians and representatives of organized
medicine. They have comprehensively reviewed and eval-
uated possible options for state medical and osteopathic
boards for a process that has come to be known as “main-
tenance of licensure” and which a more recent Advisory
Group established by the FSMB has termed “continued
competence of licensed physicians.” The Advisory Group,
whose members were appointed by Martin Crane, M.D.,
chair of the FSMB’s Board, includes a wide representa-
tion of individuals from various organizations and was
chaired by J. Lee Dockery, M.D., a past member of the
Florida Board of Medicine. The Advisory Group’s recom-
mendations were reviewed at the December meeting of
the FSMB’s Board of Directors and accepted for dissemi-
nation to state medical and osteopathic boards for discus-
sion and consideration at the FSMB’s House of Delegates
meeting on April 24, 2010, in Chicago.

The FSMB has actively been involved in promoting the
principles and practices of medical licensure and regula-
tion not only in the United States and its territories but also
abroad, helping establish the International Association
of Medical Regulatory Authorities (IAMRA), for which the
FSMB has served as its Secretariat since the group’s in-
cision in 2000. Of course, the international community
has a long and rich history in the advancement of medi-
The purpose of IAMRA, which currently has members from multiple medical regulatory authorities and jurisdictions based in 31 countries, is "to support medical regulatory authorities worldwide in protecting the public interest by promoting high standards for physician education, licensure and regulation, and facilitating the exchange of information among medical regulatory authorities." The Management Committee of IAMRA is chaired by Dr. John Hillery, former president of the Medical Council of Ireland, and I serve as secretary. The IAMRA leadership is pleased to announce that the organization will hold its 9th International Conference from Sept. 26-29, 2010, in Philadelphia, Pa., the first time it has held its meeting in the United States. The meeting is being co-hosted by the FSMB, the NBME and the Educational Commission for Foreign Medical Graduates.

Closer to home, I have discovered that the two biggest strengths of the FSMB are its staff and the state medical boards we serve. The dedication and commitment I have seen among these linked groups have been inspiring and energizing. As we approach a century in operation, I am honored and humbled to have been selected by the FSMB’s Board of Directors, was appointed U.S. Surgeon General in 2009 following her nomination by President Obama.

In the months and years ahead, more details will emerge about the changes elucidated here as allopathic and osteopathic medical schools increase in number and increase their class sizes, the MCAT undergoes a comprehensive revision, the USMLE and COMLEX undergo comprehensive revisions, “continued competence of licensed physicians” moves forward, the FSMB’s vital products and services (e.g., FCVS, UA) are further enhanced and improved as part of a comprehensive concerted effort and, last but not least, health system reform, possibly, is passed by Congress and signed into law by President Obama, a change agent himself. While the FSMB has many members, institutional and individual, our success derives from everyone’s effort and we are committed to our members’ mandate to protect the public through effective, streamlined, evidence-based and quality-focused medical licensure and regulation.

FSMB has become a trusted data repository, maintaining vital information about our nation’s physician workforce. As we enter a new decade of medical regulation in the United States, the FSMB has committed itself to evolving its data process to a completely new level - incorporating new technologies and recognizing the emergence of electronic information as a vital priority for our organization.

A year after the FSMB was founded, The New York Times said, “Recognition of the fact that the treatment of disease is a public rather than a private concern is becoming steadily clearer, day by day, and the Federation’s privilege will be to emphasize and extend this truth.” I am honored and humbled to have been selected by the FSMB’s Board members to serve in my position and look forward to working with them, our state medical and osteopathic boards, our staff, our many partner organizations, governmental agencies and the public to emphasize and extend this same truth.

Happy New Year and Happy New Decade.
ABSTRACT
Complementary and Alternative Medicine (CAM) has increasingly become a popular option for many Americans. A 2007 study showed that a majority of Americans used at least one form of CAM during that year. In response, many states opted to license practices that had previously been unlicensed, such as acupuncture, massage therapy and naturopathy. In addition, some states passed legislation to regulate and discipline unlicensed CAM practitioners. Minnesota spearheaded these efforts in 1999 by passing a law that set guidelines and standards for unlicensed health care practitioners, while protecting the public’s right to choose to use CAM. California, Rhode Island, Louisiana, New Mexico and Puerto Rico all followed with similar legislation.

The federal government’s attempts at regulation of CAM have been varied. In 1994, Congress passed the Dietary Supplement Health and Education Act (DSHEA) as a result of intense lobbying by health food manufacturers and the public. While it limited the claims manufacturers could make on labels, the law also severely curtailed the FDA’s ability to regulate nutritional and dietary supplements. Partially due to the adverse effects of DSHEA, President Bush signed the Dietary Supplement and Nonprescription Drug Consumer Protection Act (DSNDCPA) into law on Dec. 22, 2006.

INTRODUCTION
Many Americans have increasingly turned to the field of Complementary and Alternative Medicine (CAM). This field, unlike conventional medicine, is largely unregulated and uses techniques and treatments that are not typically used in U.S. medical schools or hospitals. However, five states and one territory, Minnesota, California, Rhode Island, Louisiana, New Mexico and Puerto Rico recently passed legislation that attempts to regulate unlicensed health care. The laws passed not only protect consumers’ choice to use CAM, but also outline standards and rules applicable to unlicensed health care practitioners. In 1994, Congress passed the Dietary Supplement Health and Education Act (DSHEA). The result of DSHEA was an environment in which nutritional and dietary supplements became widely available to the public and, as a result, the supplement industry flourished. This act also led to decreased public protection by the U.S. Food and Drug Administration. The act impaired the FDA’s ability to regulate supplements because it allowed the manufacturers to determine the safety of the supplement before it is marketed. The FDA became responsible for taking action against an unsafe supplement only after it is on the market. The FDA’s post-marketing responsibilities include safety (voluntary adverse event reporting) and labeling. The Federal Trade Commission regulates dietary supplement advertising. Consequently, in 2006, the Dietary Supplement and Nonprescription Drug Consumer Protection Act (DSNDCPA) was passed into law. This law specifically addressed the serious adverse-event reporting requirements for nonprescription drugs and dietary supplements.

STATE RESPONSES TO UNLICENSED HEALTH CARE
The use of CAM is widespread throughout the United States. In 1990 there were approximately 425 million visits to practitioners of CAM. Since then the number of people using some form of CAM has steadily continued to increase. The revenue from professional services for alternative medicine totaled $22.6 billion in 1990 and increased to $32.7 billion in 1997, three years after DSHEA was enacted. Furthermore, between 1990 and 1997, the annual visits to primary care physicians in the United States remained steady at approximately 385 million. However, visits to CAM practitioners totaled approximately 427 million in 1990 and rose to more than 629 million in 1997.
In addition, a large number of Americans also use supplements. In one study, sales of nutritional supplements in 1994 totaled $8.8 billion; and in 2000 that amount nearly doubled to $15.7 billion.\(^3\) The sale of supplements continued to escalate, and totaled $18.8 billion in 2003.\(^4\)

According to a study by the National Center for Complementary and Alternative Medicine, through the U.S. Department of Health and Human Services, about 38.3 percent of adults used some form of CAM one or more times in 2007.\(^5\) In the study, CAM was defined as including alternative medical systems, such as acupuncture and naturopathy; biologically based therapies, such as folk medicine and diet-based therapies; manipulative body-based therapies, such as chiropractic care and massage; and mind-body therapies, such as meditation and hypnosis. The research found that though CAM usage was fairly evenly spread among the demographic groups, “CAM use was more prevalent among women, adults aged 30-69, adults with higher levels of education, adults who were not poor, adults living in the West, former smokers, and adults who were hospitalized in the last year.”\(^5\) Furthermore, the use of CAM was more prevalent when the cost of conventional care was an issue, though many people who used CAM did so in addition to conventional care. These statistics are very similar to results found in a 2002 study by the National Center for Complementary and Alternative Medicine, showing that the use of CAM has remained fairly consistent.\(^5\) Although the study included both licensed and unlicensed forms of CAM, the information is still relevant to show the rising popularity of unlicensed health care.

Some states have responded to CAM’s popularity by passing laws to regulate unlicensed health care in order to protect the public. Prior to 1999, limited legislation existed to regulate unlicensed health care. Minnesota was one of the first to enact such legislation, passing a law titled Minnesota Freedom of Access to Complementary and Alternative Health Care Practitioners.\(^6\) It has since become a “model” act and other states and territories that have adopted similar legislation include California, Rhode Island, Louisiana, New Mexico and Puerto Rico.\(^7\) In addition, similar legislation has been considered by state legislatures in Arizona, Georgia, Hawaii, Idaho, Illinois, Iowa, Maine, Montana, Nevada, North Carolina, Ohio, Texas, Virginia, Washington and Wisconsin.\(^11-23\) However, a few states have taken a different approach by making certain types of CAM illegal. Tennessee and South Carolina, for example, have outlawed the practice of naturopathy, which is commonly defined as an “alternative medical system” where the purpose is “that there is a healing power in the body that establishes, maintains, and restores health.”\(^15\) Tennessee law states that the practice of naturopathy is a Class B misdemeanor, and in South Carolina, one could be fined or imprisoned for up to one year.\(^24\)

A combination of public health concerns about the use of CAM and the activities of large corporations, which have targeted the public for monetary gain, have led to legal actions. An example is the Mannatech case. Mannatech, a company that produces and sells supplements, made claims that its products had proven health benefits. Mannatech is invested in the field of glycobiology, which is the study of “glycan structure, metabolism, and function by developing and applying rigorous scientific tools and standards.”\(^25\) One type of glyconutrient that the company was marketing claimed to “cure, mitigate, treat or prevent disease.”\(^25\) However, Samuel Caster, one of the founders of Mannatech, acknowledged in evidence presented to the District Court of Travis County, Texas, “that the products do not cure any diseases.”\(^26\) In the petition, the Attorney General of Texas cited the Texas Food, Drug and Cosmetic Act, which states that “claims cannot be made that dietary supplements are intended to cure, mitigate, treat or prevent disease.”\(^26\) Mannatech settled the lawsuit for $11.25 million.\(^27\)

Aside from large companies targeting the general public with outlandish promises, Rhode Island has two important cases in which legal action was taken against two unlicensed health care practitioners. Prior to Rhode Island passing its unlicensed health care law, certain naturopathic practitioners sought legislation that would license them and grant their industry legitimacy. However, there were other naturopathic practitioners who were strongly opposed to this and preferred to stay unlicensed and unregulated. A committee was commissioned to consider testimony from both sides and resolve the matter. An issue that was subsequently raised was public safety, as the training of naturopaths was found to be inconsistent and informal. However, health officials had few resources to regulate these unlicensed health care practices. Rhode Island opted for a compromise and the legislature passed the Unlicensed Health Care Practices Act. The Act regulates certain CAM practices through the Department of Health, but does not offer licensure. Representative Arthur Corvese, who helped guide legislation through the enactment process in Rhode Island, said: “The state has a responsibility to protect the safety of its citizens. With
the rise in popularity of alternative medical therapies, this legislation is a necessary first step towards achieving that protection.”

The Rhode Island Unlicensed Health Care Practices Act was enacted in 2003 and not only established guidelines and standards for unlicensed health care practitioners, but also protected the public’s right to choose to use CAM. Rhode Island’s Unlicensed Health Care Practices Act, RIGL §23-74, includes, “but is not limited to, (i) acupressure; (ii) Alexander technique; (iii) aroma therapy; (iv) ayurveda; (v) cranial sacral therapy; (vi) crystal therapy; (vii) detoxification practices and therapies; (viii) energetic healing; (ix) rolfing; (x) Gerson therapy and colostrum therapy; (xi) therapeutic touch; (xii) herbolology or herbalism; (xiii) polarity therapy; (xiv) homeopathy; (xv) nondiagnostic iridology; (xvi) body work; (xvii) reiki; (xviii) mind-body healing practices; (ix) naturopathy; and (xx) Qi Gong energy healing ... Unlicensed health care practices do not include surgery, x-ray radiation, prescribing, administering or dispensing legend drugs or controlled substances, practices that invade the human body by puncture of the skin, setting fractures ... [and] the manipulation ... of joints or the spine.” Unlicensed health care practitioners may not provide a medical diagnosis or advise clients to disregard or discontinue the medical treatment of their primary care doctor.

Furthermore, this law provides that clients of these unlicensed health care practitioners must be presented with a patient’s bill of rights that must also be posted in the practitioner’s office. A patient is entitled to know, “the degrees, training, experience, or other qualifications of the practitioner regarding the unlicensed health care being provided.” The notice must include “the following statement in bold print: The state of Rhode Island has not adopted any educational and training standards for unlicensed health care practitioners. This statement of credentials is for information purposes only; ... a brief summary, in plain language, of the theoretical approach used by the practitioner in providing services to clients; ... notice that the client has a right to complete and current information concerning the practitioner’s assessment and recommended service that is to be provided, including the expected duration of the service to be provided.”

The Unlicensed Health Care Act in Rhode Island has been used to protect the public in two important cases. In both cases the health of the public was at risk due to the false claims that were procured. In the first case, the Rhode Island Department of Health and the Board of Medical Licensure and Discipline (BMLD) investigated John Curran’s practices and contacted the Food and Drug Administration’s Office of Criminal Investigations (FDA-OCI). The BMLD worked with the FDA-OCI, Internal Revenue Service, Office of the U.S. Postal Inspector, and U.S. Attorney for the District of Rhode Island in a joint state and federal investigation in the matter of John Curran.

John Curran, a self-proclaimed naturopath and medical doctor, used certain CAM diagnosis and treatments in order to bilk money out of his patients. John Curran posed as a medical doctor to gain his patients’ trust. He had fake diplomas and certificates on his office walls from multiple prestigious medical schools, such as Harvard University, Brown University and Duke University, as well as a diploma from St. Luke School of Medicine, an unaccredited medical school that he never attended. Curran also referred to himself as an M.D. and a Ph.D., using those titles on his nametag, office door, business cards, prescription pads, and pamphlets -- though he had never earned either title.

When patients came to see Curran he would first perform a $950 full-body exam. Parts of this exam included such techniques as live blood analysis, which state health regulators and federal authorities had previously told him he was not permitted to perform. He used these “test results” to inform his patients that they had some form of disease or abnormality of the blood, including parasites and “pre-cancer.” Curran told the majority of his patients that they had “live parasites, double-headed parasites, worms, holes, big eggs, green-tinted cells, red crystals, dying cells, dormant cells, severely reduced blood cells, and/or no white blood cells.”

He also purported to diagnose deficient body functions or immune systems, fungus of the liver, defective lungs and kidneys, or organs in distress. An expert witness in the federal court trial testified that the presence of parasites in the blood is extremely rare and Curran’s diagnosis of such parasites in two thirds of his patients is statistically impossible. Occasionally he would also tell his patients that they had life-threatening diseases such as cancer.

After frightening his patients with these diagnoses, Curran would prescribe “medically frivolous remedies designed for defendant’s financial benefit rather than his clients’ well-being.” He would prescribe such remedies as the “green drink,” which was a commercially produced liquid that he told his patients he invented and made, and “specially energized water,” which was distilled water he ran through a blender. Curran would then charge his patients exorbitantly high prices for these products.


The director of Health deemed John Curran’s practices to be an immediate threat to the public health and issued a compliance order suspending his right to practice unlicensed health care. An administrative hearing was conducted in which John Curran was called as an adverse witness. After approximately two hours of testimony, which included the time, place, manner and methods in which he procured his phony credentials, he consented to the terms of the immediate compliance order that stopped his practices. The case then moved to federal court, where he was charged with money laundering and wire fraud.29

The court used Curran’s own records of patient purchases and calculated that between 2003-2004 Curran treated 340 patients for a profit of approximately $1.4 million in fees for his “services.” The U.S. Court of Appeals for the First Circuit held that RIGL §23-74-1(a) prohibited Curran from “holding himself out as a licensed physician and from diagnosing disease or treating it.”29 The U.S. District Court for the District of Rhode Island convicted Curran on multiple counts of wire fraud and money laundering, saying that “Curran was a menace who took advantage of [the patients’] worst fears and preyed on them for reasons of greed as he undertook a scam of the worst kind.”29 Curran was sentenced to 150 months in prison as well as having to pay restitution fees totaling $1,425,061.62.29

In another case, Dr. Long V. Mai, a licensed acupuncturist, was concurrently practicing herbology and selling herbs, which is an unlicensed health care practice in Rhode Island.9 Rhode Island bestows the honorary title of Doctor to licensed acupuncturists even though few, if any, have matriculated through a doctoral level training program. Dr. Mai had advertised in Vietnamese newspapers presenting not only a Rhode Island Department of Health license for acupuncture but also giving the impression that he could treat more serious diseases, such as cancer. In this case, there were multiple incidents where patients were charged thousands of dollars for supplements along with visits to the practitioner’s office in order to treat diseases such as liver cancer and paralysis.31

Dr. Tierney Tully, an expert witness and a doctor of acupuncture and Oriental medicine, testified about the proper method of diagnosis, including a four-step method. It was clear in the testimony from two of Dr. Mai’s former patients that Dr. Mai did not complete all of the steps.31 Furthermore, in regards to curing diseases, specifically liver cancer, Dr. Tully testified that “Acupuncture and Oriental Medicine do not make any claims to cure this disease [liver cancer].”31 Another acupuncturist, Dr. Ming Li, also concluded that “with respect to a patient with liver cancer, an acupuncturist would provide support treatment to the person but would not attempt to cure the underlying disease.”31

The final decision by Justice Thompson in the Superior Court of Rhode Island agreed with the Rhode Island Department of Health and with the permanent revocation of Dr. Mai’s license. The false advertising that was used by Dr. Mai was deemed unethical and false. He claimed that he could cure diseases but, after charging patients for many expensive treatments and/or visits, he was never able to do so. The Superior Court upheld the revocation of his license to practice acupuncture and engage in herbology and the sale of nutritional supplements. The court ruled that unlicensed health care practitioners can “educate and explain the uses of those products; however, education and explanation could not extend to medical diagnosis or treatment.”32

Apart from public health concerns like the cases in Rhode Island, courts in the state of New York have found civil liability in cases dealing with CAM. The case of Charell v. Gonzalez was heard by the New York Supreme Court in 1998. Julienne Charell was suffering from cancer. She refused the treatment recommended by her oncologist and instead opted to receive alternative medical care from Nicholas Gonzalez. Charell sued Gonzalez for malpractice and the jury found Gonzalez civilly liable. The jury awarded Charell more than $4 million in compensatory damages and $150,000 in punitive damages. On appeal, the court overturned the punitive damage award but upheld the $4 million in compensatory damages. The appeal also found that by foregoing conventional medicine and choosing alternative medicine, even without the complete risk information, Charell had assumed some of the risk.33

FEDERAL LEGISLATION FOR NUTRITIONAL AND DIETARY SUPPLEMENTS

In 1994, noting that many Americans regularly consume dietary supplements, Congress passed the DSHEA.34 The Act praised the healthful benefits of nutritional and dietary supplements while also stating that “safety problems with the supplements are relatively rare.”34 The Act further stated that “the Federal Government should not take any actions to impose unreasonable regulatory barriers limiting or slowing the flow of safe products and accurate information to consumers.”34 Thus, the overall purpose of the Act was to protect the consumer’s right of access to dietary supplements while limiting FDA’s ability to regulate. In
one regard DSHEA accomplished precisely what it set out to do: The deregulated environment that followed permitted the nutritional supplement market to expand rapidly and provided wide access to consumers. In particular, unlicensed health care providers could now suggest and sell more nutritional supplements to patients, at great profit, to complement their alternative health care practices.

Unfortunately, DSHEA also had negative consequences. First, manufacturers were no longer required to submit to testing prior to marketing their product. DSHEA also defined “dietary supplement” broadly. It was defined as “a product (other than tobacco) intended to supplement the diet that bears or contains one or more of the following dietary ingredients: (a) a vitamin, (b) a mineral, (c) an herb or other botanical, (d) an amino acid, (e) a dietary supplement used by man to supplement the diet by increasing the total dietary intake or, a concentrate, metabolite, constituent, extract, or combination of any ingredient described in clause (A), (B), (C), (D), or (E).” Due to the broad definition within the law, the producers of dietary supplements did not need to demonstrate prior to marketing a product that it is beneficial or effective.

This Act also made it harder to ban potentially harmful supplements from the public. The most prevalent example was when the government attempted to ban ephedra. A review in the New England Journal of Medicine by Haller and Benowitz examines the effects of ephedra. The conclusion was that, of the symptoms experienced by the 140 participants, 31 percent of the symptoms were deemed “definitely or probably” related to ephedra, another 31 percent “possibly related” to ephedra, and 17 percent were deemed “unrelated.” Of the 31 percent of symptoms considered “definitely or probably” related to ephedra, the majority of the complaints were related to cardiovascular symptoms that included hypertension and even cardiac arrest. Even with a review that showed that there were harmful effects from this substance, the FDA’s powers were limited and, although ephedra was ultimately banned by the federal government, it was difficult to get this substance off the market.

Similar to ephedra, the Chinese herb Aristolochia fangchi or A. fangchi had been banned in many European countries. In Europe, this substance had been used for weight loss, but was thought to cause severe kidney damage in some patients. Further research published in the New England Journal of Medicine showed the link between this same Chinese herb and cancer, specifically urothelial carcinoma. Under DSHEA, however, this supplement was not tested before it was made widely available in the United States and was only under investigation after several people who used the supplement filed complaints. Even after complaints were made and the FDA issued a warning, the substance was still sold on the Internet worldwide.

Due somewhat to the difficulty of banning ephedra, Congress enacted the Dietary Supplement and Nonprescription Drug Consumer Protection Act (DSNDCPA) in 2006. This Act requires manufacturers to report “serious adverse effects” of supplements to consumers. Serious adverse effects are defined by the DSNDCPA as: “(A) i) death; (ii) a life-threatening experience; (iii) inpatient hospitalization; (iv) a persistent or significant disability or incapacity; or (v) a congenital anomaly or birth defect; or (B) requires, based on reasonable medical judgment, a medical or surgical intervention to prevent an outcome described under subparagraph A.” Thus, where previously manufacturers of supplements were under no obligation to furnish such information, under DSNDCPA they are required to do so.

Prior to the enactment of DSNDCPA, Pharmavite LLC, the company that makes Nature Made Vitamins, praised the proposed bill by stating it would “validate the dietary supplement industry’s strong safety record.” The president of the Consumer Healthcare Products Association, Linda Suydam, noted that “this legislation… will ensure the FDA has the tools it needs to fulfill its public health mission to more aggressively monitor the medicines and nutritional supplements it regulates.”

The DSNDCPA was put to use by the FDA against Matrixx Initiatives, Inc., and its Zicam nasal products. Matrixx Initiatives discovered the possible side effect of loss of smell and taste from more than 800 reports. Under the DSNDCPA, Matrixx Initiatives had a legal obligation to report the possible side effect to the FDA once the company had become aware of it, which they failed to do. After learning about these long-lasting and possibly permanent side effects, Matrixx Initiatives also was required to file a new drug application listing the side effects, which the company also neglected to do. The FDA advised consumers against using Zicam nasal products on June 13, 2009, because of possible side effects involving loss of smell and taste in some consumers. Three days later, the FDA issued a warning letter to Matrixx Initiatives stating that Zicam created a serious risk to consumers. Matrixx Initiatives has since recalled its Zicam nasal products.
CONCLUSION
With the rise in popularity of CAM, some companies and individuals have attempted to take advantage of medically compromised patients in order to profit through false claims. By using laws such as the Unlicensed Health Care Practices Act in Rhode Island, state health regulators have been able to protect the public from false health claims and criminal behavior. Since Minnesota began this effort in 1999, the few states that have enacted such legislation now have tools to protect the public and provide access to CAM in a safer, regulated environment.

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THE ROLE OF STATE MEDICAL BOARDS IN REGULATING PHYSICIAN PARTICIPATION IN EXECUTIONS

Ty Alper

ABSTRACT
The recent increase in calls for physician participation in lethal injection executions is likely to place a spotlight on state medical boards, the only entities empowered to discipline doctors for ethical violations. This article begins by recounting the history of physician participation in lethal injection executions, as well as the opposition of most medical professional organizations to the practice. The current state of the law suggests, however, that the role of state medical boards is quite circumscribed, at least in the majority of states with death penalty statutes that appear to contemplate some level of physician participation in executions. In order to further determine the legality of medical board action, a comprehensive study was conducted of the statutes and regulations governing state medical boards in all 50 states. The study reveals that only a handful of states — and only seven death-penalty states — explicitly incorporate the AMA’s ethical guidelines into their own state ethical codes. The study concludes by suggesting that, where doctors who participate in executions are doing so in order to relieve pain and suffering, it is not clear that a state medical board should intervene even in the rare instance when it would be legally possible to do so.

INTRODUCTION
In recent years, two related phenomena have contributed to the growing debate about physician participation in executions in the United States. First, legal challenges to states’ lethal injection practices have raised serious questions about the qualifications of execution team members to perform lethal injections using medical equipment and dangerous controlled substances. Second, a series of high-profile botched executions and one botched execution attempt have further exposed lethal injections as far more problematic and prone to error than most people had previously assumed them to be. These phenomena have contributed to an increased call for the involvement in executions of trained medical professionals, namely physicians.

Indeed, lawyers for death row inmates routinely argue that skilled anesthetic-monitoring is an essential component of a constitutional three-drug execution protocol, particularly where one of the three drugs is a neuromuscular blocking agent that paralyzes the condemned inmate during the execution. Doctors are also necessary when peripheral venous access is too difficult to achieve; gaining intravenous access through a central line in most instances requires a physician. Many states do employ doctors in various capacities, though few, if any, rely on doctors to perform the kind of anesthetic monitoring requested by lawyers for death row inmates. Other states, however, resist calls for physician participation, claiming that doctors are unable to participate and any court order that they do so will lead to a de facto moratorium on the death penalty.

State medical boards find themselves in the middle of this political and legal debate, yet the boards have thus far favored a decidedly hands-off approach. The vast majority have declined to take an explicit public position on the right of doctors to participate in executions and few, if any, have seriously investigated complaints of physician participation that have been brought to their attention.

Recent events, however, suggest that calls for medical board action may increase. Earlier this year, for example, a national abolitionist organization founded by Sister Helen Prejean launched a campaign to persuade medical licensing boards in each state to declare it unethical for doctors to participate in executions. The stated goal of the campaign is to “make it impossible for states to carry out their own protocols for capital punishment.”

As calls for medical board involvement increase, the need
for legal clarity on the medical boards’ role is apparent. This article begins by recounting the history of physician participation in lethal injection executions, as well as the opposition of most medical professional organizations to the practice. The ethical guidelines of those membership organizations, however, are not themselves enforceable. Only the state medical boards have the power to discipline doctors for alleged ethical violations. The article next studies the current legal landscape with respect to the role of state medical boards in disciplining doctors who participate in executions. The current state of the law suggests that, in most instances, the role of state medical boards is quite circumscribed, at least in the majority of states with death penalty statutes that appear to contemplate some level of physician participation in executions. In those states, courts are likely to conclude that the medical board does not have legal authority to discipline doctors who participate in lawful, state-sanctioned executions. Moreover, a comprehensive study of the statutes and regulations governing state medical boards in all 50 states reveals that only a handful of states – and only seven death-penalty states – explicitly incorporate the AMA’s ethical guidelines into their own state ethical codes. Finally, despite the positions of most national medical associations, there are compelling reasons for medical boards to refrain from intervening in this debate. Where doctors who participate in executions are doing so in order to relieve pain and suffering, it is not clear that a state medical board should intervene even in the rare instance when it would be legally possible to do so.

BACKGROUND

States that employ lethal injection typically use a three-drug formula to carry out executions. The first drug in the formula is intended to anesthetize the inmate; the second one paralyzes the inmate; and the third drug stops the inmate’s heart, killing him or her. One primary legal challenge to this method rests on the allegation that most states do not employ adequate safeguards to ensure that the person being executed is properly anesthetized before the second and third drugs are administered. Because the second drug in the three-drug formula paralyzes the inmate, the concern is that an inadequately anesthetized person “may have the sensation of paralysis without anesthesia . . . and may feel the burning of the highly concentrated” third drug, potassium chloride. In such a state, the paralyzed inmate is unable to indicate to correctional staff that he or she is experiencing the suffocating effects of the paralyzing drug and the excruciatingly painful effects of the potassium chloride.

States generally do not dispute that an un-anesthetized execution – using these particular drugs – would constitute cruel and unusual punishment under the Eighth Amendment. Lawyers defending states’ lethal injection procedures do dispute, however, how likely it is that the delivery of the first drug, the anesthetic, will somehow go awry, and this is typically where the question of the participation of medical professionals enters the equation.

Lawyers for death row inmates have generally taken the position that, given the degree of skill needed to adequately deliver, monitor, and maintain anesthesia, as well as the widely publicized problems with the administration of anesthesia in the lethal injection setting, states that insist on using the three-drug formula must employ the services of highly-trained medical personnel – often, but not always, doctors – in order to ensure that the risk of severe pain to the person being executed does not become “substantial." If the states do not want to employ medical professionals, the argument goes, they should switch to a different protocol for lethal injections that would not require skilled anesthetic monitoring. However, as long as states insist on the three-drug formula, the litigation position taken by lawyers for death row inmates is that only the supervision of qualified medical personnel can reduce the risk of severe pain to a constitutional level.

Lawyers representing states and defending the lethal injection status quo, however, have resisted mandated physician participation on the grounds that doctors are unable to participate. “The goal of death penalty opponents,” claimed a spokesman for the California Attorney General in 2006, “is to get a court order that says that lethal injections can only be administered by licensed professionals, because the ethics of medical professionals prohibit them from participating.”

The argument that a physician participation requirement would lead to abolition of the death penalty has surface appeal because several national medical associations have expressed their belief that physicians should not participate in executions. The American Medical Association (AMA) has, since 1980, declared the participation of doctors in executions to be a clear violation of medical ethics. The AMA’s policy, last updated in 2005, defines “participation” broadly, to include even “consulting with or supervising lethal injection personnel.” The American Society of Anesthesiologists (ASA) adopted the AMA position, and its then-president advised members to “steer clear” of participation in lethal injections.
the “correctional health professional shall . . . not be involved in any aspect of execution of the death penalty.”13 The media has well documented the positions of these national organizations.14

The AMA’s position on physician participation is not, however, legally enforceable. As a membership organization, the most the AMA could do to discipline a doctor for violating the AMA’s ethical guidelines is revoke that doctor’s membership, which would have no effect on his or her ability to practice. Indeed, only about 20 percent of doctors in the United States are even members of the association, and, according to the AMA’s chief executive officer, “[t]he other 80 percent either do not understand what we do, or they do not value what we do.”15

The ethical guidelines of the state-based medical associations, many of which mirror those of the AMA,16 are similarly unenforceable. Although a doctor who participates in an execution may violate the guidelines of his or her state medical association, the most extreme sanction the doctor faces is revocation of membership in the association. Such a sanction would have no effect on a doctor’s ability to practice in the state.

The agencies that do have disciplinary authority over physicians are the state medical boards, which award licenses to practice medicine. The study next examines the capacity of the medical boards to discipline doctors for participating in lethal injection executions, beginning with a brief history.

I. LEGAL AUTHORITY OF MEDICAL BOARDS TO DISCIPLINE DOCTORS WHO PARTICIPE

HISTORY OF PARTICIPATION

Doctors are routinely involved in executions in this country, and have been since states first started using lethal injection almost three decades ago. In fact, doctors have played a key role in the implementation of capital punishment since the eighteenth century, when Dr. Joseph Guillotine developed the machine that bore his name.17 Two centuries later, it was a doctor who developed the lethal injection procedure that all states but one currently use.18 And doctors continue to play an active role—a role specifically condemned by the AMA’s guidelines—in executions in virtually every state.19

It is impossible to report a full accounting of the extent of physician participation in lethal injection executions because restrictions public access to lethal injection protocols.20 As a result of these laws, it is very likely that doctors participate in executions to a far greater extent than is currently known. However, in addition to the anonymous participating doctors interviewed for a New England Journal of Medicine article in 2006,21 recent litigation challenging lethal injection has illuminated the extent of physician participation in certain states.

In Maryland, for example, nursing assistants and paramedics conduct the executions, although a doctor is present, monitors an EKG machine, and pronounces death, all in violation of the AMA guidelines.22 In Georgia, a doctor supervises executions, and orders the injection of additional chemicals when deemed necessary; during one execution, the doctor inserted a central line when nurses were unable to find a suitable vein.23 In Oklahoma, a licensed physician is present in the execution chamber, monitoring the inmate’s level of consciousness “by whatever means he deems appropriate.”24 In California, doctors have been present in each of the state’s eleven lethal injection executions, monitoring heart rate and respiration.25 In Missouri and Arizona, prison officials recently announced that they have found new doctors to oversee the procedures in those states.26 And at least two doctors, including regular states’ expert Dr. Mark Dershwitz, have assisted states such as Ohio and Tennessee in the development of new lethal injection protocols, including advising on how the drugs work and recommending specific changes to the protocol.27

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ciety of Correctional Physicians has for years dictated that Other, less centralized, efforts have taken similar forms. In Georgia, for example, a group of anti-death penalty doctors, led by Dr. Arthur Zitrin, filed a complaint in 2005 against a doctor who had admitted participating in several Georgia executions. The complaint was ultimately dismissed. Yet newspaper reports noted that it was part of a “recent volley in a campaign to revoke the licenses of doctors who participate in executions.” Indeed, the previous year, four death penalty opponents (one lawyer, two doctors, and a chaplain) filed a complaint with the Kentucky Board of Medical Licensure against Governor Ernie Fletcher. The complaint alleged that, because he is a licensed physician, the governor could not sign a death warrant for inmate Thomas Clyde Bowling without violating the AMA guidelines. Dr. Zitrin, also a vocal opponent of the death penalty, followed the complaint filing by publishing an op-ed in the *Los Angeles Times* titled, “Doctor, Reread Your Oath,” and arguing that Governor Fletcher’s actions violated the AMA ethical guidelines. The Kentucky medical board ultimately dismissed the complaint, ruling unanimously that although he was a physician, Fletcher was acting in his role as governor, not as a doctor, when he signed the warrant.

**STUDY OF STATE LAWS GOVERNING MEDICAL BOARDS**

The vast majority of state medical boards have taken no position on the specific matter of participation in executions, and few have ever actually considered disciplining a doctor for participating in executions. This is the case despite the fact that, as discussed above, numerous doctors have participated in hundreds of executions in various capacities over the past three decades, and anti-death penalty activists have filed complaints against specific doctors with medical boards on several occasions. The North Carolina Medical Board is the only example of a state board expressing a public interest in disciplining a doctor for participating in an execution; however, as discussed below, the North Carolina Supreme Court prohibited the board from imposing discipline on any doctors. In fact, no doctor in the United States has ever actually been disciplined by a medical board for participation in a lethal injection execution.

In an effort to further determine the relevance of the AMA guidelines in state ethical codes, a comprehensive study was conducted of the governing law in all 50 states. The study reveals that, as of 2009, only two death penalty states, Ohio and Kentucky, have incorporated the AMA ethical guidelines by statute into their state medical ethical code. For example, Ohio’s statute provides that, “to the extent permitted by law,” the board may “limit, revoke, or suspend an individual’s certificate to practice” for violating any provisions of the code of ethics of the AMA. In another five death-penalty states – Maryland, Mississippi, Nebraska, New Hampshire, and Tennessee – the regulations adopted by medical boards explicitly reference the AMA in the local ethical codes. For example, the Tennessee medical board fully adopts the AMA’s Code of Medical Ethics as its own code of ethics, at least “to the extent it does not conflict with state law.” Maryland regulations allow the medical board to “consider” the ethical guidelines of the AMA, “but these principles are not binding on the Board.”

In these few states, it is theoretically possible that a doctor participating in an execution – and thereby violating the AMA’s ethical guidelines – could be subject to medical board sanction. But in the vast majority of death-penalty states, a medical board would need to find that a doctor had violated the “catch-all” provision of the state ethics rules in order to impose discipline. Many states have such provisions, allowing, for example, discipline for a “departure from or failure to conform to the standards of acceptable and prevailing practice of a profession or the ethics of the profession.” It is highly unlikely that participation in executions would fall within that broad language given that, if anything, the prevailing practice with respect to executions is to include the participation of physicians. In any event, for the reasons discussed below, in those rare instances where a medical board both has the colorable authority to discipline and the desire to do so, it is far from clear that courts will allow such action.

**LEGALITY OF POSSIBLE MEDICAL BOARD ACTION**

With an anticipated increase in complaints to medical boards, the question arises whether the boards can take action if they are so inclined. There are two reasons to question whether state medical boards have the authority to discipline participating doctors even if the governing ethical statute or regulations appear to allow it. First, courts thus far have refused to allow medical boards to impose discipline where, as in most states, the governing death penalty statute contemplates physician involvement. Second, a growing number of states are passing “shield laws” that explicitly remove medical board jurisdiction over this issue.

1. **Governing Death Penalty Statutes**

Courts in three states have addressed the question whether
medical boards have the authority to discipline doctors who are participating in the administration of a lawful execution. All three have concluded that the boards do not have the power to discipline doctors who are essentially carrying out state law.

In 2005, Dr. Arthur Zitrin filed a claim with the Georgia Composite State Board of Medical Examiners, seeking an investigation into whether doctors who participated in Georgia’s lethal injections were subject to discipline for violating the AMA’s ethical guidelines. The board refused to open an investigation. Dr. Zitrin and several other doctors sued in state court, seeking a declaration that Georgia law prohibits physician participation in executions and requiring the Board to open an investigation. The doctors did not receive a warm welcome in court. According to a report in the Atlanta Journal-Constitution, the trial judge to whom the case was assigned noted during one hearing that “the AMA is simply a membership organization” and asked counsel for Dr. Zitrin, “How many Georgia physicians belong to the AMA? I’d say less than half. And you want to incorporate an ethical opinion of the AMA into Georgia law?” The judge ruled against the doctors, finding that they had failed to state a claim. The Georgia Court of Appeals affirmed, noting that the medical board’s position in the matter “guarantees that no physician [in Georgia] will be subject to disciplinary proceedings as a result of his or her participation in an execution.”

When a group of doctors sued in California in 1996 for a declaration that physicians who participated in executions should lose their licenses under state law, the Court of Appeal found highly significant the fact that the state penal code appeared to authorize physician participation in executions. “Surely,” the court reasoned, “the Legislature could not have expressly and implicitly provided for physician involvement in executions, and simultaneously subjected participating physicians to discipline or other legal sanctions from engaging in lawful conduct.”

Even in the one state in which the medical board publicly expressed a will to consider disciplining participating doctors, the state’s supreme court intervened. When the North Carolina Medical Board issued a statement in 2007 warning that doctors who facilitate executions “may be subject to disciplinary action,” it was sued by the Department of Corrections, which claimed that the medical board was interfering with its ability to carry out state law, which requires the presence of a physician during executions. The North Carolina Supreme Court sided with the Department of Corrections, noting that the state legislature had both written the state’s death penalty law and had created the medical board. Thus, “[t]o allow [the Medical Board] to discipline its licensees for mere participation would elevate the created Medical Board over the creator General Assembly.”

With the death penalty statutes in all but two states contemplating some form of physician participation, it is unlikely that courts will be any more sympathetic to medical board attempts to discipline doctors than the courts in Georgia, California, and North Carolina have been. Even in the few states in which state law or regulation incorporates the AMA guidelines, governing death-penalty law is likely to trump the medical board’s authority. In Ohio, for example, state law allows medical board discipline for violation of the AMA guidelines, but only to the extent “permitted by” state law. But Ohio law explicitly provides for the presence at an execution of “[p]hysicians of the state correctional institution in which the sentence is executed” in violation of the AMA guidelines. Under the reasoning of the courts that have thus far addressed this issue, it is unlikely that the Ohio medical board would be able to discipline a doctor for being present at an execution when his or her presence is specifically provided for in the governing death penalty statute.

2. Safe harbor and shield laws

Some states are not taking any chances and have preemptively protected doctors from any medical board action by enacting various laws that are intended to trump any such efforts. These laws, generally referred to as “safe harbor” laws, specifically prevent medical boards from taking disciplinary action against medical providers who opt to participate in executions. In practice, these laws immunize doctors from licensing challenges. Illinois was among the first states to adopt such a provision; it did so in response to a 1994 complaint requesting that the Illinois medical board discipline doctors willing to participate in the execution of John Wayne Gacy. Other states soon followed suit. In addition, at least eight states have adopted “exclusionary” statutes, which provide that lethal injections do not constitute the practice of medicine, thus insulating doctors who participate in executions from medical board sanctions. Finally, many states have various “shield” laws and policies in effect to ensure the anonymity of doctors who do participate in executions. These laws effectively protect such doctors against any licensing challenges by third parties.

* * *

To determine whether a particular state’s medical board
The position of the AMA and others opposed to physician participation is well-publicized. But there is another side. Even if there is a theoretical possibility of imposing discipline in a handful of states, there are compelling reasons for medical boards to refrain from interfering in the execution business. Some doctors have even expressed an obligation on the part of physicians to participate in order to ensure that the execution does not result in unnecessary pain or suffering.

For example, Dr. David Waisel, an anesthesiologist at Children’s Hospital in Boston, recently argued that organized medicine has an obligation to permit physician participation in executions “to the extent necessary to ensure a good death.” Dr. Waisel rejects the common arguments against physician participation as slippery-slope arguments that have little basis in reality. For example, he finds no evidence to support the arguments that physicians who participate in executions will lack the ability to act with compassion or independence in their normal practice, or that the public trust in the medical profession will be lost as a result. In the end, it is the capacity of the three-drug lethal injection procedure to inflict great suffering on the condemned that has convinced Dr. Waisel that physician participation in the process is necessary. Forbidding physician participation, he writes, “increases the chances of a botched execution. It seems cruel to permit capital punishment but not to permit participation of those who are capable of performing it humanely.”

Dr. Atul Gawande, a Harvard medical school professor who is himself opposed to physician participation in lethal injections, interviewed several doctors regarding their decision to participate in executions. Published in the New England Journal of Medicine, Dr. Gawande’s account provides a rare view into the motivations of doctors who actually conduct executions in the United States. One doctor, anonymously referred to as “Dr. A,” originally agreed to assist in an execution with the understanding that his role would be limited to cardiac monitoring.

One of the interviewed doctors chose not to remain anonymous. Dr. Carlo Musso, who assists with executions in Georgia, told Dr. Gawande that he participates in spite of the AMA guidelines because he feels an obligation not to abandon inmates in their final moments. As Dr. Musso explained, “[T]his is an end-of-life issue, just as with any other terminal disease. It just happens that it involves a legal process instead of a medical process. [A death penalty] patient is no different from a patient dying of cancer – except his cancer is a court order.”

A doctor recently hired by the state of Arizona to oversee executions testified in a recent deposition that he was “surprised” by the number of people who argued that it was “totally inappropriate” for doctors to participate in executions. To the contrary, the doctor testified, “I think as long as it’s something that the government thinks is appropriate and it should be done, it should be done correctly. So that’s why I’m . . . participating.”

Another prominent, and oft-cited, defense of physician participation in lethal injection executions is that offered by Dr. Kenneth Baum, who argues that under the patient-centered conception of medical ethics, physicians are obligated to participate in lethal injections. Dr. Baum echoes Dr. Musso’s analogy of a dying cancer patient: “Condemned death row inmates are, for all practical purposes, terminally ill patients, albeit under a nontraditional definition of the term, and deserve to be treated as such.” In fact, Dr. Baum notes that doctors generally are thought to have a duty to minimize suffering when a patient is dying, and that “[t]o desert these individuals [condemned inmates] in their most vulnerable hour would be antithetical to the beneficent ideals of medical practice.” It is the
doctor who turns his or her back on a dying inmate, and refuses to do what he or she can to relieve suffering, “who truly violates the ethical code of the profession.”62 Or, as another doctor put it in a response letter to Dr. Gawande’s article, “the participation of physicians seems more humane than delegating the deed to prison wardens, for by condoning the participation of untrained people who could inflict needless suffering that we physicians might have prevented, we are just as responsible as if we had inflicted the suffering ourselves.”63

III. CONCLUSION

Medical boards have broad jurisdiction and much to address in the medical profession. It is far from clear, however, that they have the legal authority to impose discipline on doctors who participate in executions. In fact, it is far more likely that they do not have that authority in the vast majority of states. Moreover, while the image of doctors participating in the execution process may spark a viscerally negative reaction in members of a profession dedicated to healing, the reality is that there is a role for doctors to play in the minimization of pain and suffering at the end of a condemned inmate’s life. For a medical board to discipline a doctor for playing that role would be, in most instances, legally untenable and a questionable exercise of the board’s priorities.

ACKNOWLEDGEMENTS

 Portions of this article are adapted from an article recently published in the North Carolina Law Review. See Ty Alper, The Truth about Physician Participation in Lethal Injection Executions, 88 N.C. L. Rev. 11 (2009). I am indebted to Carolina Rodriguez for outstanding research assistance.

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2. See Deborah W. Denno, When Legislatures Delegate

Table A: Incorporation of AMA Ethical Guidelines into State Medical Ethics Statutes

| I. Death Penalty States With Statutory or Regulatory Incorporation of AMA Guidelines |
|---------------------------------|-----------------|-----------------|-----------------|
| Kentucky*                        | Maryland        | Mississippi     |
| Nebraska                         | New Hampshire   | Ohio*           |
| Tennessee                        |                 |                 |

| II. Death Penalty States Without Statutory or Regulatory Incorporation of AMA Guidelines |
|---------------------------------|-----------------|-----------------|-----------------|
| Alabama                         | Arizona         | Arkansas        | California      |
| Colorado                        | Connecticut     | Delaware        | Florida         |
| Georgia                         | Idaho           | Illinois        | Indiana         |
| Kansas                          | Louisiana       | Missouri        | Montana         |
| Nevada                          | North Carolina  | Oklahoma        | Oregon          |
| Pennsylvania                    | South Carolina  | South Dakota    | Texas           |
| Utah                            | Virginia        | Washington      | Wyoming         |

| III. Non-Death Penalty States With Statutory or Regulatory Incorporation of AMA Guidelines |
|---------------------------------|-----------------|-----------------|
| Alaska                          | Hawaii*         | Iowa            |
| New Mexico                      | West Virginia   |                 |

| IV. Non-Death Penalty States Without Statutory or Regulatory Incorporation of AMA Guidelines |
|---------------------------------|-----------------|-----------------|
| Maine                           | Massachusetts   | Michigan        |
| Minnesota                       | New Jersey      | New York        |
| North Dakota                    | Rhode Island    | Vermont         |
| Wisconsin                       |                 |                 |

* The AMA Guidelines are incorporated by statute in these states.
Table B: Citations to State Ethical Laws

<table>
<thead>
<tr>
<th>State</th>
<th>Relevant Statutes and Regulations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>Alaska Stat. § 08.64.326 (2009)</td>
</tr>
<tr>
<td></td>
<td>Alaska Admin. Code tit. 12, § 40.955(a) (2009)</td>
</tr>
<tr>
<td>California</td>
<td>Cal. Bus. &amp; Prof. Code § 2234 (West 2009)</td>
</tr>
<tr>
<td>Indiana</td>
<td>Ind. Code. § 25-22.5-5-2.5 (West 2009)</td>
</tr>
<tr>
<td>Iowa</td>
<td>Iowa Code Ann. § 147.55 (West 2009)</td>
</tr>
<tr>
<td></td>
<td>201 Ky. Admin. Regs. 9:005(1)(a) (2009)</td>
</tr>
<tr>
<td>Maryland</td>
<td>Md. Code Ann., Health Occ. § 14-404 (West 2009)</td>
</tr>
<tr>
<td></td>
<td>Md. Code Regs. 10.32.02.10 (2009)</td>
</tr>
<tr>
<td>Mississippi</td>
<td>Miss. Code Ann. § 73-25-29 (West 2009)</td>
</tr>
<tr>
<td>Missouri</td>
<td>Mo. Rev. Stat. § 334.100 (West 2009)</td>
</tr>
<tr>
<td></td>
<td>N.M. Code R. § 16.10.8.9(A) (Weil 2009)</td>
</tr>
<tr>
<td>North Dakota</td>
<td>N.D. Cent. Code §43-17-31 (2009)</td>
</tr>
</tbody>
</table>

The American Society of Correctional Physicians has for years dictated that cause of state laws that shield the identities of doctors and


6. See, e.g., id., at 819-20 & n.20.


8. Often suggested is that states consider a one-drug, anesthetic-only procedure similar to that used in most animal euthanasia. See, e.g., Alper, supra note 5, at 833-39. Ohio recently became the first state to use such a method.

9. Another legal challenge to lethal injection protocols has to do with establishing intravenous access in inmates with compromised veins. In such cases, it is often necessary to place a central line, in, for example, the inmate’s groin. Such a procedure almost always necessitates the skill of a trained physician.


Physicians has for years dictated that the cause of state laws that shield the identities of doctors and 

19. See id. at 84-88.
33. See Gawande, *supra* note 21, at 1223.
35. See Gawande, *supra* note 21, at 1223.
36. As a result of medical boards operating independently from one another, their governing statutes and regulations are not uniform. Some states, for example, have statutory provisions exclusively addressing medical ethics and/or ethical sanctions, while others do not. States that do not have dedicated “ethics” provisions at times discuss these matters in other provisions of the statute or regulations. The statutory provisions cited in Table B pertain to those provisions that define unprofessional conduct, either generally or specifically. Note that some laws and regulations refer to “unethical” rather than “unprofessional” conduct. To determine whether a state referred to the AMA’s ethical standards, key term searches were conducted for the relevant statutes and regulations in all 50 states.
40. It is quite clear legally that a state medical board’s discretion not to pursue discipline against a participating doctor is unreviewable. See Sawicki, *supra* note 20, at 138 n. 144.
43. Thorburn v. Dep’t. of Corrs., 78 Cal.Rptr.2d 584, 590 (Cal. App. 1998).
45. See Denno, *supra* note 3, at 88-89.
49. Id. at 124-25.
50. See Denno, *supra* note 3, at 89 & n.263. It is worth noting that these statutes also serve toinsulate non-doctors from discipline for performing tasks during executions that are typically the province of the medical profession.
51. Illinois’ statute, for example, provides that “[t]he identity of executioners . . . and information contained in records that would identify those persons shall remain confidential, shall not be subject to disclosure, and shall not be admissible as evidence or be discoverable in any action of any kind in any court or before any tribunal, board, agency, or person.” 725 Ill. Comp. Stat. Ann. 5/119-5(e) (West 2009).
52. Waisel, supra note 4, at 1073.
53. Id. at 1079.
54. See Gawande, supra note 21.
55. See id. at 1225.
56. Id.
57. Id.
58. Dickens v. Brewer, No. CV07-1770-PHX-NVW (D. Ariz.) (deposition of Medical Team Member 1), at 263.
59. Id.
60. See Baum, supra note 17, at 61.
61. Id. at 62.
62. Id.
ABSTRACT
Alcohol and drug abuse and addiction among medical students have been reported extensively. This is an important topic because substance abuse can lead to impairment, which affects the well-being of many, including medical students, and because it compromises physician competency. Education and clinical training regarding substance use disorders (SUDS) has been severely neglected, especially in relation to their incidence, not only among health professionals but also among patients. Students know little about SUDS and little regarding identifying a colleague in trouble. This article presents a case of a peer medical student intervention with a successful outcome as a proximate result of a brief educational program for medical students and argues for more education regarding SUDS, professional impairment, and how to deal with a peer who has a problem. To our knowledge, peer medical student intervention for a fellow student addicted to alcohol or drugs has never been reported in the English language.

INTRODUCTION
Alcohol and drug abuse and addiction among medical students have been reported extensively.\(^1\)\(^{-}\)\(^{79}\) Studies suggest that the lifetime prevalence of substance use disorders (SUDS) among U.S. physicians is in excess of 10 percent.\(^{16}\)\(^{-}\)\(^{21}\) Alcohol and substance abuse causes physician impairment and compromises patient care.\(^{14}\)\(^{-}\)\(^{18}\) Physician abuse and addiction is important because it not only affects the life of the physician but the patients he cares for as well.\(^{17}\) Substance abuse among physicians not only creates health risks and physician impairment but creates huge social and financial problems.\(^{28}\)\(^{-}\)\(^{35}\) It is postulated that alcohol and drug abuse may make physicians less concerned about drug abuse and addiction in their own patients.\(^{29}\) According to a 1985 study by the AMA, more than 90 percent of physicians in this country believe that alcohol abuse is a problem but less than 28 percent felt adequately trained to treat it.\(^{72}\)

Some have identified SUDS as the number one health problem in the United States.\(^{72}\)\(^{-}\)\(^{80}\) The prevalence of drug and alcohol use and abuse in this country is astounding. The United States has 6 percent of the world’s population but consumes 60 percent of the world’s illicit drugs.\(^{81}\) An estimated 40 percent of hospital admissions are related to addiction.\(^{80}\) An estimated 50 million people use cocaine regularly in the United States and 50 million people are addicted to drugs. Addiction is use not compatible with the goals of treatment. Addiction to nicotine may become “the greatest health risk to the developing world, surpassing malnutrition and communicable diseases.”\(^{10}\) Alcohol abuse is a worldwide phenomenon.\(^{44}\) A characteristic of chemical dependence is the compulsive use of substances despite adverse consequences.\(^{15}\) It is a disease in which the individual is so consumed by drugs that they take on excessive importance in a person’s life.\(^{82}\) For centuries, man has used substances to obtain euphoria and has subsequently struggled with substance abuse since time began.\(^{51}\)

CASE REPORT
An educational endowment in alcoholism and addiction education and physician impairment was established at the University of Alabama School of Medicine in Tuscaloosa in 1994 by a former patient who was a recovering alcoholic. The founder recognized that medical students, residents and most attending physicians knew very little about alcoholism and drug abuse and addiction and even less about physician impairment. The program was expanded in 2006 to a one-week series of lectures for medical students, including the natural history of drug and alcohol abuse, the disease concept of addiction, physician impairment, assessment, rehabilitation, return to education and work, contracts, monitoring, support groups, Caduceus...
and Alcoholics Anonymous. The lectures also include work-hour restrictions, fatigue and exhaustion, urine drug screening and employment of recovering physicians. Students are presented with clinical scenarios involving alcohol, substance abuse, prescription writing and what to do if a colleague is suspected of abusing alcohol or drugs. The students are provided with confidential contact resources both at the medical school and the physician health program. Students are educated on identification of healthcare professionals who may possibly be impaired.

Following the course, two medical students presented to the office of one of the authors (DA) asking for assistance for a medical student in trouble. One of the students stated that the student accompanying him was an alcoholic and needed help. He described the fellow student’s excessive use of alcohol daily that had escalated to the point that his colleagues and friends did not want to be around him. This student had been involved in two recent automobile accidents, both related to alcohol. The last accident was a single-car accident near his family’s home. A group of concerned medical students and friends organized and staged an intervention on the impaired medical student. The intervention impressed the impaired student about the need for getting help. The involved student admitted to one of the authors (DA) that he was in trouble with alcohol. He understood that his friends had become worried about his excessive drinking, especially after the two recent automobile accidents. He agreed to cooperate with notification of the state physician wellness program, which was called immediately. The director of the program interviewed the impaired student on the telephone and arranged for a meeting between them the following day. The student met with the medical school administration and the medical center’s physician health officer. A physician health program and state medical society approved evaluation and assessment was carried out with the recommendation of residential treatment for alcoholism. A leave of absence for medical treatment was approved by the medical school. Approved residential treatment was completed. A contract with the physician health program was signed. The student subsequently returned to medical school to continue studies under contract with the physician health program and the medical school with appropriate aftercare and monitoring. The student has to date continued to do well and is in recovery.

ALCOHOL AND DRUG ABUSE AMONG PHYSICIANS, RESIDENTS AND STUDENTS

Airline pilots, railroad engineers, law enforcement personnel, firemen, nurses, attorneys and corporate leaders must be accountable and responsible to society because their fitness for duty affects the well-being of many; physicians are no different. Medical students, residents, fellows and attending physicians appear to be as susceptible to SUDS as the rest of society.

A recent review by Mangus, et al describes concern over physician addiction to alcohol, cocaine and morphine dating back to 1869. Alcohol abuse by physicians appears unchanged for the past 50 years and approximates that of the general population, despite education and research into alcoholism and addiction. However, drug use other than alcohol by physicians has significantly increased since the 1960s. Many feel that narcotic addiction is the most prevalent addiction among physicians after alcohol addiction. Cocaine benzodiazepine, stimulant and marijuana abuse is also a major cause of physician impairment. Many medical students do not see drug and alcohol abuse and addiction as a disease.

Self-treatment of pain and fatigue is the common reason that physicians get into trouble with drugs. Stress places physicians at risk for substance abuse and addiction. Many impaired physicians relate their initial substance abuse to stress in medical school. A family history of alcoholism is the most consistent predisposing factor for alcoholism. Some hospitals randomly screen their physicians for drugs and alcohol.

ALCOHOL AND DRUG ABUSE AMONG MEDICAL STUDENTS

Medical students worldwide abuse alcohol and drugs. In 1973, the American Medical Association published a statement describing concern over drug and alcohol abuse among medical students. Studies of alcohol and drug abuse and addiction in medical students are difficult to assess because of confidentiality concerns and requests for anonymity. Actual numbers are difficult to obtain and under-reporting or non-responses to questions regarding SUDS are frequent because of students’ fear of consequences; however, the available data approximate the lifetime risk of a physician for SUDS.

The National Clearing House for Alcohol and Drug Information (NCADI) reports that anonymity is the essential component of reliable self-reporting. If a medical student uses alcohol or substances excessively before entering medical school, he or she will probably continue to do so after entering medical school.
Alcohol is the substance used most often by medical students. A 1990 study showed that 11 percent of medical students self-reported heavy drinking and 18 percent of those met the criteria for impairment, most commonly reporting blackouts and fighting while drinking. In this study, 18 percent of the class met the criteria for alcohol abuse defined as “student self-report of alcohol-related impairment during medical school.” In one study 87.5 percent of medical students reported alcohol use within the past month, 10 percent cocaine use and 10 percent marijuana use. In another study, alcohol use by medical students approximated that of the general population for college age individuals. Other studies have suggested that medical students use less drugs and alcohol than age-matched peers. In a United Kingdom study in 2000, almost half the class self-reported drinking alcohol beyond a safe level. Percentages of alcohol use have been reported as high as 95 percent. 

Medical students consume excessive amounts of alcohol comparable to their age group, despite their knowledge of adverse consequences. In a United Kingdom study, the majority of students reported their first drink of alcohol before the age of 12; the earlier the age of consumption, the greater the risk of heavier consumption. Many students were already drinking alcohol excessively and trying illicit drugs before starting college. In another study, 86 percent of the students drank alcohol and approximately half of those drank excessively. 

Alcohol abuse in medical school is predicated by a family history of alcoholism, alcohol abuse before beginning medical school, availability of controlled substances, stress and emotional problems. A 1993 study examined alcoholism in parents of medical students and found that 27 percent of the students had parents that abused alcohol. This rate is twice that of the general population. Students attending church frequently usually use less alcohol. One article reported an increase in alcohol abuse with the beginning of the clinical years. Alcohol and drug abuse among medical students may affect care and safety of patients. A prominent 1986 study by McAuliffe in the New England Journal of Medicine implied medical student use of drugs “should not be a cause for great alarm”; over time, this has proven not to be the case.

Medical students often report drug abuse and dependence. A third of medical students used illicit drugs; the most commonly used illicit drug was marijuana. A minority of medical students believe marijuana and even cocaine should be legalized. A 1972 study acknowledged there was a significant difference in opinions between medical students and attending physicians about marijuana. Medical students report less substance use than comparable age-related groups except for alcohol, tranquilizers and psychedelics other than LSD. Medical education is stressful and may account for increased use of tranquilizers. Medical students using cocaine and other drugs of abuse before medical school will often continue during medical school. A 1966 study raised the question regarding whether it is coincidental that the percentage of medical students using illicit drugs is about the same percentage as attending physicians who are addicted and impaired.

In a 1989 study of medical students, more than a third reported use of cocaine. About half of medical students in 1989 reported use of stimulants to stay awake to study and take call. In the same study, marijuana was the most commonly used illicit drug and almost half of the students had at least tried it. Another study reported that medical students abused fewer drugs as they progressed through medical school. Illicit drugs and alcohol are associated with recreational use while therapeutic drugs tend to be associated with stress. “Club” drugs such as cocaine, lysergic acid diethylamide and cocaine have been reported to have been used by 17 percent of medical students. Surgery residents used less substances than did other residents with the exception of alcohol; alcohol use is thought to be related to stress and fatigue. Students, however, entering surgical residencies used more substances than did residents.

PHYSICIAN HEALTH PROGRAMS

Approximately half of the physician health programs (PHPs) in the United States officially work with medical students. In many cases medical schools provide financial support to the PHP for the services. PHPs are a heterogeneous group of agencies, typically one in every state (five states don’t have officially recognized PHPs at this time: California, Wisconsin, Georgia, Nebraska and North Dakota). PHPs provide a “clinical arm” for regulatory boards to encourage early referral and treatment of physicians with problems related to impairment. The goal is to detect problems prior to overt impairment. The PHPs market their approach to the medical community by providing education to hospitals and others. Their goal of early referral is greatly enhanced when they can offer confidential supportive care. In all states where confidential care of physicians is encouraged and permitted there are predefined...
limits to confidentiality, such that participants are reported to the regulatory board if they refuse recommendations to stop work and obtain needed treatment or if they relapse. Thorough evaluation and treatment are usually followed by long-term monitoring for years. Evidence exists that behavioral problems among medical students is predictive of problems later in practice. Working with medical students is completely consistent with PHPs’ goals of early detection, treatment and long-term monitoring.

TREATMENT PROGRAMS FOR PHYSICIANS, RESIDENTS AND STUDENTS

Comprehensive assessment and treatment programs are available for medical students, residents and physicians. Intervention and treatment in most states is overseen by a state impaired-physician committee or a physician health program under the auspices of the medical society and/or the state regulatory board. These programs designate and approve assessment and treatment programs. Most assessments are multidisciplinary and take three to four days to complete. Rehabilitative treatment can last from six weeks to three or more months. The success rates for physicians are high, due to the effective utilization of contingency management with long-term monitoring with real or tacit threat of loss of license for failure. Most physicians return to successful and rewarding practices. Recidivism rates are low. Most states require aftercare contracts, usually for five years but sometimes longer. Some malpractice insurance carriers require indefinite monitoring. Most physician wellness programs are rehabilitative and not punitive in nature.

Aftercare following treatment usually involves a contract with the PHP for a specified number of years along with random drug screen monitoring. Most malpractice insurance carriers require PHP advocacy, including urine drug testing for as long as one is covered by that company. Group therapy, individual counseling, marital therapy, aftercare groups, treatment center revisits, local physician monitors, quarterly assessments, psychiatric and psychological evaluations are all part of the recovery program. Twelve Step programs like Alcoholics Anonymous (AA), Cocaine Anonymous and Caduceus for Recovering Physicians are usually required. Ninety AA meetings in 90 days has been a time-honored successful program for those new in recovery.

HISTORY OF ALCOHOL AND DRUG ABUSE EDUCATION FOR STUDENTS

Physicians know very little about addiction; medical students know even less. They know even less about physician impairment and identifying those colleagues at risk. Medical schools have traditionally not educated medical students about alcoholism and drug addiction. In 1990, less than 25 percent of medical schools had policies for impaired students and only half of those had programs to assure and oversee treatment of those students. Before the early 1990s, there was little data on medical student substance abuse.

This lack of knowledge limits understanding of the disease concept of addiction and subsequently of timely patient diagnosis and treatment. Students often have negative attitudes regarding addicted patients. Medicine has done a poor job educating physicians about alcohol and drug abuse. Although primary care providers are those most often confronted about abuse, they know the least about it and are the least helpful to patients and families.

A need exists for education in medical school about alcoholism and drug addiction. A United Kingdom study in 2000 suggested that current education for medical students on addiction is inadequate. Medical school courses in both the basic sciences and during the clinical years are needed to better educate medical students about the risks of SUDS, and these courses must keep up with current trends. It is also important that medical education emphasize facts about professional impairment and how it can compromise patient care. Education for medical students would increase the likelihood that physicians could provide better information for patients about abuse and addiction. Students are exposed to the medical aspects of alcoholism but not the psychological, social and spiritual. It is important to educate medical students about Alcoholics Anonymous because most physicians and students do not have positive attitudes or much knowledge about the program. Education about drugs before students graduate may reduce inappropriate prescribing to patients.

Medical student participation in substance abuse treatment clinics may help educate students about the risks and consequences of drug experimentation, abuse and addiction. Ideally, more medical schools and teaching hospitals will hire faculty specializing in addiction medicine who can conduct teaching rounds with students. This type of activity would bring more stature and signal more importance to this activity. Drug and alcohol abuse education should be part of the regular medical school curriculum. Medical students can do a better job
ciety of Correctional Physicians has for years dictated that taking a social history and asking about alcohol and drugs if they are honest with themselves about their own alcohol and drug use.

MEDICAL STUDENT INTERVENTION FOR DRUGS AND ALCOHOL

Many medical schools over the years have simply not known what to do with addicted students. They have dealt with the problem in a traditional manner with disciplinary action and even suspension from school, when a nontraditional approach of rehabilitation and return to school may be needed. Other schools have not acknowledged the fact that a problem even exists. Medical students need to know how to respond when they are concerned about a fellow student or colleague. Only a minority of medical students acknowledge that there is a policy for substance abuse at their medical school. A 1990 study suggested that interpersonal intervention with alcohol abuse may meet with resistance. Most medical students want students dependent on alcohol and marijuana to receive treatment, but termination from school for those dependent on illicit drugs. Students are reluctant to report a classmate for fear of disciplinary action rather than confidential treatment.

Medical schools need programs specifically aimed at medical students for intervention and harm reduction. Schools need clear-cut written guidelines and policies that conform to the Liaison Committee on Medical Education. As of 2005, 48 states and the District of Columbia have physician health programs.

Dalhousie University Faculty of Medicine in Nova Scotia developed one of the first medical student support programs in North America in the early 1980s. This program was designed for early intervention and has served as a model for subsequent programs worldwide. The program is called the PIETA Program (Pieta means compassion).

The first program in the United States for identifying and treating medical students addicted to drugs was developed at the University of Tennessee in 1983. The program is called the AIMS Program (Aid for the Impaired Medical Student) and was designed “to provide confidential treatment for chemically dependent medical students, to assure that recovering students are able to resume their education and to protect patients and others from the harm that may be caused by impaired students.” The AIMS Council, composed of health professionals and elected medical students, run the program. The success of such programs depends on the qualities of the student representative, support of administration and faculty, assistance from the state physician health program and cooperation with treatment programs. The goals of the AIMS program include:

1. To provide compassionate assistance to chemically dependent students before they are irreversibly harmed;
2. To provide help in a way that fully protects the rights of impaired students to receive treatment in strictest confidence;
3. To assure that recovering students are able to continue their medical education without stigma or penalty; and
4. To protect patients and others from the harm that may be caused by chemically dependent students.

In this program, evaluation of students by self-referral or intervention is performed by addictionologists through an extensive assessment and the recommendation of appropriate care. Aftercare is managed by the state’s physician health program, which provides ongoing advocacy for the student. This program has been approved by the American Medical Association and other such programs around the country have been modeled after the AIMS Program. Obstacles to the development of this program have been:

1. Belief that SUDS is not a problem at that school;
2. Belief that chemically dependent students should be dismissed from school;
3. Belief that student identification and treatment will not be confidential;
4. Willingness of students to identify classmates that may be chemically dependent; and
5. Reluctance of medical students to report the personal affairs of other students.

The University of Sherbrooke Faculty of Medicine in Quebec developed a program in which medical students received weekend training as peer-counselors and were accessible to other classmates for problems.

Medical schools need programs to identify students with SUDS. Intervention needs to be encouraged with compassionate, confidential policies that aid impaired students. Self-reporting needs to be encouraged in a way that is not punitive. Early identification, assessment, treatment services and rehabilitation are important for medical students.
SUMMARY

According to a 1990 study, more than half of medical students with alcohol problems seek help.\(^7\) Although treatment for abuse and addiction are possible, the real answer is prevention by education.\(^8\) Education of medical students about the disease concept of addiction, treatment of abuse and addiction in their patients and prevention of their own abuse and addiction is critical and must be improved.

Medical schools need educational programs to identify those students at risk for abuse and addiction, information on the disease concept of addiction, screening mechanisms, referral sources, treatment capabilities, counseling and support to complete medical school in a confidential, compassionate manner.\(^12\) Medical students need a mechanism to complete treatment that is satisfactory with the medical school and state physician health program, but also acceptable. Students need to be made aware that those who satisfactorily complete treatment have a good prognosis and practice satisfying careers.\(^12,17,84\) The success rate is high and most physicians are motivated by the threat of losing their license. Medical students with an addiction can usually continue their education after satisfactorily completing treatment and practice medicine.

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FROM OUR INTERNATIONAL EXCHANGES

AUSTRALIA

GOOD MEDICAL PRACTICE: A CODE OF CONDUCT FOR DOCTORS IN AUSTRALIA

The Board has adopted a code of conduct for doctors in Australia that defines clear, nationally consistent standards of medical practice. *Good Medical Practice: A Code of Conduct for Doctors in Australia* replaces the Victorian *Good Medical Practice* issued by the Board in 2006. The Australian Medical Council (AMC) developed this code on behalf of all state and territory medical boards. The AMC will recommend the code to the Medical Board of Australia when it is established.

Subject to legislative arrangements in place in each Australian state and territory, individual medical boards will now consider adopting the code, or endorsing it in principle, ahead of the introduction of national medical registration. The code was developed by an expert working group established by the AMC and chaired by former Victorian Board President Dr. Joanna Flynn. This group included strong clinical representation (including junior doctors and medical students), medical regulators and educators, medical and health administrators, the AMA, rural and indigenous practitioners, together with consumers and community groups. The code was developed through an extensive national consultation process implemented during 2008 and 2009, which was supported financially by the Commonwealth Department of Health and Ageing. The final code has received widespread support from the community and the profession.

The Board will now apply this code as the standard against which professional conduct in Victoria will be measured, at least until national medical registration is introduced in July 2010. The Board expects all doctors registered to practice medicine in Victoria to be familiar with the contents of the code. The code is available electronically on the Board’s website at www.medicalboardvic.org.au. If you would like a hard copy, please contact the Board by e-mail at info@medicalboardvic.org.au and include the postal address to which you would like your copy sent, or make your request by telephone on (03) 9655 0500.
The Medical Council of Canada and the Federation of Medical Regulatory Authorities of Canada (FMRAC) are launching a new initiative to develop a *Good Medical Practice* manual. The Good Medical Practice Steering Committee and Working Group will produce a document that describes how physicians demonstrate their continuing professional competence to the public. This type of work has already been completed in the United States, United Kingdom, Australia and New Zealand.

Dr. Jeffrey Turnbull, chief of staff for the Ottawa Hospital, and Sister Elizabeth Davis will lead the initiative as co-chairs of the Good Medical Practice Steering Committee. Other Steering Committee members include Dr. Bryan Ward (FMRAC), Dr. Fleury-Ange Lefebvre (FMRAC), Dr. Ian Bowmer (Medical Council of Canada), Dr. Rocco Gerace (Medical Council of Canada) and Dr. Yves Robert (FMRAC).

The Working Group will be comprised of Dr. Nick Busing (Association of Faculties of Medicine of Canada), Dr. Harleena Gulati (Canadian Association of Internes and Residents), Dr. Sarah Kredentser (College of Family Physicians of Canada), Dr. James Sproule (Canadian Medical Protective Association), Dr. John Wootton (Society of Rural Physicians of Canada), Dr. Jeff Blackmer (Canadian Medical Association), Dr. Ken Harris (Royal College of Physicians and Surgeons of Canada), as well as Dr. Bowmer and Dr. Turnbull.

The *Good Medical Practice* manual will utilize many of the concepts expressed in the CanMED roles framework. This framework, developed by the Royal College of Physicians and Surgeons of Canada, looks at the qualities required of physicians and uses this information as building blocks for the development of medical curriculum. In contrast, the *Good Medical Practice* includes public consultation to find out what qualities are required of physicians and how the physician population should exhibit professionalism.
This information will be translated into a comprehensive guide for physicians in practice. In addition to building on the CanMED roles framework, the Good Medical Practice manual will build on the Canadian Medical Association’s Code of Ethics, the Collège des médecins du Québec’s Code of Ethics of Physicians, as well as work already undertaken by the College of Family Physicians of Canada.

Dr. Ian Bowmer, executive director of the Medical Council of Canada, explained the rationale for developing the Good Medical Practice manual: “The relationship between physician and patient is one of extraordinary trust. As a profession, we must continually demonstrate that trust, and be worthy of that trust.”

Dr. Bowmer also described how he believes a Good Medical Practice manual will be used by practicing physicians. “This is supposed to be a comprehensive, practical guide that I hope will be a source of inspiration for physicians. When physicians read this guide, what they read should reflect their aspirations for the medical profession, how they want to be perceived as physicians and how we can reaffirm the dialogue and expectations between physicians and the Canadian public.”

The Good Medical Practice Steering Committee first met on July 2, 2009. The Steering Committee discussed setting up a timeline for the initiative and developed an agenda for the Working Group. The Steering Committee also decided that each organization on the Working Group would nominate a public member to sit on the Steering Committee to provide a public perspective on the elaboration of the Good Medical Practice manual. The Steering Committee will be responsible for creating the first draft of the manual based on current available materials.

The Steering Committee also discussed the purpose of the document, and decided that it would be used as a general principle document, directed to the public, that will assist in engendering public trust in physician competence. The document, it was decided, would not be a licensing/regulatory document.

**UPDATE ON THE NATIONAL ASSESSMENT COLLABORATION**

Members of the National Assessment Collaboration (NAC) met on June 29, 2009, in Ottawa for an update on the initiative’s progress. The purpose of the NAC is to create a more streamlined process for the assessment of international medical graduates (IMGs) wishing to enter the Canadian medical system. The NAC is provided continued funding through Health Canada. The NAC has decided to focus its efforts first on developing a national clinical examination targeted to international medical graduates applying for postgraduate training.

The June session also included a review of the governance structure of the National Assessment Collaboration Central Coordinating Committee (NAC3). This group will report to the Medical Council of Canada (MCC) and will be responsible for the national clinical examination. Later this summer, the MCC will facilitate a teleconference among the program directors of the international medical graduate programs. The teleconference will result in this group selecting their representatives for the NAC3. As per the terms of reference of the NAC3, three representatives from this group will sit on the committee.

After this teleconference and once the membership of the NAC3 has been finalized, it will approve the membership of the clinical examination test committee, called the NAC OSCE test committee. It is named as such since the specific type of clinical examination is an Objective Structured Clinical Examination. The NAC OSCE test committee’s responsibilities will include creating the blueprint for the examination, developing and validating the content and overseeing the proof of concept examination for the NAC OSCE.

Each IMG program that wants to provide the initial version (proof of concept) of the clinical examination in 2010 will have the opportunity to do so. Those who will offer the proof of concept will be required to use a common examination format. The MCC will assist with the training of standardized patients for the clinical examination, as well as with the development of clinical stations and with psychometric analysis.

In September 2009, the Medical Council of Canada will be hosting a workshop for Royal College specialty program directors. This workshop will be held during the Royal College of Physicians and Surgeons of Canada’s International Conference on Residency Education in Victoria, B.C.

While the NAC will continue to develop the NAC OSCE in the coming months, ongoing attention will also be provided on the development of an assessment for physicians seeking entry into medical practice. This assessment will be for individuals who were successful at the NAC clinical ex-
NEW ZEALAND

During May, Council members and staff took as many opportunities as possible to speak to doctors about two major initiatives: periodic assessment of performance and new supervision arrangements. We have had very valuable feedback from the profession and appreciate the good number of doctors who have turned out for the road show meetings, often on some pretty chilly evenings.

ENHANCING DOCTORS’ CLINICAL PRACTICE

The Council is proposing that a periodic assessment of performance be incorporated into the continuing professional development programs of medical colleges and branch advisory bodies. This would be a supportive and collegial review of a doctor’s practice by two peers. The primary purposes of the visits would be to enhance the clinical practice of most of us and also to help identify and remedy situations where a colleague’s practice has become unsafe.

SUPPORTING DOCTORS NEW TO NEW ZEALAND

We also are trying to establish simpler supervision arrangements to support doctors new to New Zealand and provide them with the information needed to adjust to a new country and health service. Under the Health Practitioners’ Competence Assurance Act 2003, the Council is required to have in place supervision arrangements that, as far as possible, ensure safe practice. After the discussions from the first round of consultation, we are proposing another method of supervision as an alternative to the one-on-one supervision available now. In this new option, a service would be accredited for supervision. The Council would recognize that the doctor was working in an accredited service and would receive periodic reports from the service. The service may be a clinical practice group within a DHB, across two or more DHBs, or a general practice-organized group.

Next steps

The meetings around the country have given us valuable feedback and insights into the proposals. For the periodic assessment of performance to progress we need the involvement of all colleges. It still requires considerable ongoing work and the constructive comments we received have been very useful in shaping the proposal further. So where to next? At the time of writing, submissions on the two initiatives have just closed and are about to be fully analyzed. The Council will discuss feedback from all the consultation, as well as written submissions, at its August meeting. We are meeting with the colleges and branch advisory bodies in August and also wish to meet with professional groups such as the New Zealand Medical Association, the Association of Salaried Medical Specialists, and the Resident Doctors Association. To make progress with the periodic assessment of performance proposal, we need all the colleges to be involved, volunteers who are willing to assess and to be assessed, and robust qualitative research on the process and its effects. We also need to work closely with those colleges and associations already involved in practice assessments to make best use of their experience.

UNITED STATES

2010 IAMRA CONFERENCE ON MEDICAL REGULATION

IAMRA’s 9th conference on medical regulation will take place Sept. 26-29, 2010, in Philadelphia, Pa., U.S.A. IAMRA is partnering with the Federation of State Medical Boards, the National Board of Medical Examiners and the Educational Commission for Foreign Medical Graduates to offer a very exciting and innovative program on “Best Practices in Medical Licensure.” The conference will include interactive programs on registration and licensure, currency of competence and revalidation/maintenance of licensure, ethical guidance, and complaints and resolutions. A pre-conference workshop for those newer to medical regulation is planned for Sunday, Sept. 26. Additional information will be available in the coming weeks. Please reserve these dates on your calendar if you are interested in attending the conference. For more information, please visit www.iamra.com.
KENTUCKY
STANDARDS OF ACCEPTABLE AND PREVAILING MEDICAL PRACTICE RELATING TO PHYSICAL EXAMINATIONS BY PHYSICIANS

The Board has determined that the following principles constitute the standards of acceptable and prevailing medical practice relating to physical examinations by physicians.

Patient complaints of sexual misconduct by physicians are the most sensitive and difficult the Board investigates. The incidents are rarely witnessed. Allegations of sexual misconduct are particularly difficult to prove and can lead to public humiliation for both the patient and the physician involved.

Physicians will, of course, continue to routinely perform physical examinations in the course of patient care out of medical necessity and professional responsibility. In order to prevent misunderstandings and protect physicians and their patients from allegations of sexual misconduct, the Board offers the following opinion regarding physical examinations by physicians:

1. Maintaining patient dignity should be foremost in the physician’s mind when undertaking a physical examination. The patient should be assured of adequate auditory and visual privacy and should never be asked to disrobe in the physician’s immediate presence. Examining rooms should be safe, clean and well-maintained, and should be equipped with appropriate furniture for the examination and treatment (examining table, chairs, etc.). Gowns, sheets and/or other appropriate apparel should be made available to protect patient dignity and decrease embarrassment to the patient while promoting a thorough and professional examination.

2. A third party should be readily available at all times during a physical examination, and it is suggested that the third party be actually present when the physician performs an examination of the sexual and reproductive organs or rectum. It is incumbent upon the physician to inform the patient of the option to have a third party present. This precaution is essential regardless of physician/patient gender.

3. The physician should individualize his/her approach to physical examinations so that the patient’s apprehension, fear and embarrassment are diminished as much as possible. An explanation of the necessity of a complete physical examination, the components of that examination and the purpose of disrobing may be necessary in order to minimize the patient’s apprehension and possible misunderstanding.

4. The physician and his/her staff should exercise the same degree of professionalism and caution when performing diagnostic procedures (i.e., electrocardiograms, electromyograms, endoscopic procedures and radiological studies, etc.) as well as surgical procedures and post-surgical follow-up examinations when the patient is in varying stages of consciousness.

5. The physician should be alert to suggestive or flirtatious behavior or mannerisms on the part of the patient and should not put him or herself in a compromising position.

6. The physician shall not exploit the physician/patient relationship for sexual or any other purposes. Moreover, such an allegation against a physician constitutes grounds for investigation on the basis of alleged unethical behavior. Physicians should also be aware that any failure to conform to the principles of medical ethics of the American Medical Association constitutes unprofessional conduct, in violation of Board statutes.

Reprinted from the Kentucky Board of Medical Licensure Newsletter, Summer 2009

NORTH CAROLINA
POLICY COMMITTEE OFFERS NEW POSITION STATEMENT ON TELEMEDICINE

The Policy Committee of the North Carolina Medical Board has drafted a proposed position statement on
telemedicine for consideration and possible adoption by the full Board. The Policy Committee discusses position statements in public sessions during regularly scheduled Board meetings. In addition, proposed statements are published on the Board’s website and in the Forum before they are considered by the full Board. This allows licensees and other interested parties the opportunity to provide written comments that may influence the final version presented for Board action. The full text of the proposed position statement on telemedicine appears below.

**Telemedicine**

“Telemedicine” is the practice of medicine using electronic communication, information technology or other means between a physician in one location and a patient in another location with or without an intervening health care provider.

The Board recognizes that technological advances have made it possible for physicians to provide medical care to patients who are separated by some geographical distance. As a result, telemedicine is a potentially useful tool that, if employed appropriately, can provide important benefits to patients, including: increased access to health care, expanded utilization of specialty expertise, rapid availability of patient records, and the reduced cost of patient care.

The Board cautions, however, that physicians practicing via telemedicine will be held to the same standard of care as physicians employing more traditional in-person medical care. A failure to conform to the appropriate standard of care, whether that care is rendered in-person or via telemedicine, may subject the physician to potential discipline by this Board.

The Board provides the following considerations to its licensees as guidance in providing medical services via telemedicine:

- **Training of Staff:** Staff involved in the telemedicine visit should be trained in the use of the telemedicine equipment and competent in its operation.

- **Examinations:** Physicians using telemedicine technologies to provide care to patients located in North Carolina must provide an appropriate examination prior to diagnosing and/or treating the patient. However, this examination need not be in-person if the technology is sufficient to provide the same information to the physician as if the exam had been performed face-to-face. Other examinations may also be considered appropriate if the physician is at a distance from the patient, but a licensed health care professional is able to provide various physical findings that the physician needs to complete an adequate assessment. On the other hand, a simple questionnaire without an appropriate examination may be a violation of law and/or subject the physician to discipline by the Board.

  - **Informed Consent:** The physician using telemedicine should obtain the patient’s informed consent before providing care via telemedicine services. In addition to information relative to treatment, the patient should be informed of the risks and benefits of being treated via telemedicine, including how to receive follow-up care or assistance in the event of an adverse reaction to the treatment or in the event of an inability to communicate as a result of a technological or equipment failure. The patient retains the right to withdraw his or her consent at any time.

  - **Physician-Patient Relationship:** The physician using telemedicine should have some means of verifying that the person seeking treatment is in fact who he or she claims to be. A diagnosis should be established through the use of accepted medical practices, i.e., a patient history, mental status examination, physical examination and appropriate diagnostic and laboratory testing. Physicians using telemedicine should also ensure the availability for appropriate follow-up care and maintain a complete medical record that is available to the patient and other treating health care providers.

  - **Medical Records:** The physician treating a patient via telemedicine must maintain a complete record of the telemedicine patient’s care according to prevailing medical record standards. The medical record serves to document the analysis and plan of an episode of care for future reference. It must reflect an appropriate evaluation of the patient’s presenting symptoms, and relevant components of the electronic professional interaction must be documented as with any other encounter. The physician must maintain the record’s confidentiality and disclose the records to the patient consistent with state and federal law. If the patient has a primary physician and a telemedicine physician for the same ailment, then the primary physician’s medical record and the telemedicine physician’s record constitute one complete patient record.
- **Licensure:** The practice of medicine is deemed to occur in the state in which the patient is located. Therefore, any physician using telemedicine to regularly provide medical services to patients located in North Carolina should be licensed to practice medicine in North Carolina. Physicians need not reside in North Carolina, as long as they have a valid, current North Carolina license. North Carolina physicians intending to practice medicine via telemedicine technology to treat or diagnose patients outside of North Carolina should check with other state licensing boards. Most states require physicians to be licensed, and some have enacted limitations to telemedicine practice or require or offer a special registration. A directory of all U.S. medical boards may be accessed at the Federation of State Medical Boards website: www.fsmb.org/directory_smb.html.

- **Fees:** The Board’s licensees should be aware that third-party payors may have differing requirements and definitions of telemedicine for the purpose of reimbursement.

  1) See also the Board’s Position Statement entitled “Contact with Patients before Prescribing.”

  2) N.C. Gen. Stat. 90-18(c)(11) exempts from the requirement for licensure: “The practice of medicine or surgery by any nonregistered reputable physician or surgeon who comes into this State, either in person or by use of any electronic or other mediums, on an irregular basis, to consult with a resident registered physician or to consult with personnel at a medical school about educational or medical training. This proviso shall not apply to physicians resident in a neighboring state and regularly practicing in this State.”

The Board also notes that the North Carolina General Statutes define the practice of medicine as including, “The performance of any act, within or without this State, described in this subdivision by use of any electronic or other means, including the Internet or telephone.” N.C. Gen. Stat.90-1.1(5)f.

**NCMB IMPLEMENTS CHANGES TO INVESTIGATIVE AND DISCIPLINARY PROCESSES**

A new law that modifies the North Carolina Medical Board’s investigative and disciplinary processes took effect October 1. Many of the provisions codify existing policy or interpretation of the Medical Practice Act, while other provisions create entirely new practices.

The brief article below summarizes two significant changes that affect licensees who are under investigation by the Board or who face an imminent public charge of misconduct by the Board.

**WRITTEN NOTICE OF RIGHTS, RESPONSIBILITIES**

Historically, when the Board received a complaint against a licensee, it provided the licensee with a copy and gave oral answers to any questions about the Board’s review process. For investigations initiated on or after October 1, the Board will now mail or deliver in person written notices to licensees under investigation. The notices address the licensee’s duty to cooperate with the Board, how the Board will communicate with the licensee and any legal counsel, the amount of time the investigation is expected to take and the licensee’s rights should the Board vote to take public disciplinary action.

**PRE-CHARGE CONFERENCE FOR LICENSEES PENDING CHARGES**

Traditionally, the Board conducted informal conferences with some licensees prior to voting to initiate a public disciplinary proceeding. The new law requires the Board to provide, upon request, the licensee with the opportunity to meet with a designated Board member. Such meetings would occur after the Board votes to charge but before charges are issued and a hearing is scheduled. If a meeting is requested, it will be scheduled soon after the decision to take public action. Prior to the meeting, which may be telephonic or in person, the Board will provide the licensee and/or his or her legal counsel, with information gathered in the investigation. The purpose of the meeting will be to inform the licensee of the basis for the Board’s decision to charge and explain the process going forward.
the market. The main issue is still the involvement of the physician with the patient in the delivery of care whether personally done or through the supervision of another health professional. Do your research before entering into any practice that may have negative consequences on your license.

BOARD OF MEDICAL LICENSURE AND SUPERVISION POLICY AND GUIDELINES FOR MEDICAL SPAS AND AESTHETIC PROCEDURES

DEFINITIONS (OKLAHOMA LAW AND RULES)
Practice of Medicine – Every person shall be regarded as practicing allopathic medicine within the meaning and provisions of this act, who shall append to his or her name the letters “M.D.”, “Physician” or any other title, letters or designation which represent that such person is a physician, or who shall for a fee or any form of compensation diagnose and/or treat disease, injury or deformity of persons in this state by any allopathic legend drugs, surgery, manual, or mechanical treatment unless otherwise authorized by law.

Doctor/Patient Relationship – Means a person has a medical complaint/issue, which has been addressed by the doctor and there is a correlation between the complaint/issue and the treatment/procedure performed or drug given/prescribed/dispensed.

Surgery – The ablation or alteration of any human tissue by any means including but not limited to the use of sharp surgery, heat, cold, abrasion, laser, chemicals, injection/placement of substances subcutaneous, or the use of FDA approved devices that can only be initially purchased by physicians is the practice of medicine as defined in Title 59 O.S. Section 492. Lasers are instruments of surgery. No matter what type of laser is being utilized, a physician involved in the process should follow these guidelines.

GUIDELINES
The practice of medicine and surgery as defined above is grounded upon the doctor/patient relationship which at a minimum requires a face-to-face evaluation of the patient by the physician or a physician assistant under a physician’s supervision, prior to the determined treatment or procedure, development of a patient chart, providing patient informed consent and the process for the patient’s follow-up care.

There are several important guidelines to follow when supervising other practitioners.

- If the physician is utilizing unlicensed, trained assistants under their control and supervision, the physician must be on-site (premise) before, during and after the medical treatment or procedure.
- If the physician is utilizing an Oklahoma licensed physician assistant (PA), the physician can delegate any of the defined medical services to that licensed PA under general supervision, which does not require the physician to necessarily be on-site.
- If the physician is utilizing an Oklahoma licensed nurse, [RN, LPN, APN (advance practice nurse) or APN with prescriptive authority] and if they are functioning within the scope of their practice act, then the physician may delegate any of the defined medical services to that licensed nurse under general supervision, which may not require the physician to be on-site. It is imperative that the physician contact the Oklahoma Board of Nursing (405-962-1800) to find out the nurse’s scope of practice and level of physician supervision required.
- If the physician is utilizing any other Oklahoma recognized practitioner such as a certified micropigmentologist or licensed aesthetist, the physician must contact the Oklahoma Department of Health (405-271-6576) or the Board of Cosmetology (405-521-2441) respectively and find out the scope of their practice act and level of medical supervision required.
- In no instance may a physician allow one of the aforementioned practitioners to further delegate the medical service to another practitioner.
- Physicians who are medical directors for one or multiple medical spa and aesthetic facilities are subject to these guidelines.

When in doubt of a specific medical procedure/treatment and the corresponding level of supervision, the physician should contact the Oklahoma Board of Medical Licensure and Supervision or appropriate regulatory agency before potentially placing their medical license in jeopardy.

Reprinted from the Oklahoma State Board of Medical Licensure and Supervision Issues and Answers, Spring 2009
PHYSICIAN LICENSING

Roy v. Tenn. Bd. of Med. Exam’rs,

The Tennessee Court of Appeals ruled that the state medical examiners board properly decided to revoke a doctor’s medical license for prescribing narcotics without proper documentation.

The Tennessee Board of Medical Examiners revoked Dr. Francis Oscar Roy’s medical license based upon findings that he prescribed narcotics or controlled drugs without proper documentation and without appropriate clinical indications. Roy petitioned for judicial review. He contended that the Board violated his due process rights by admitting into evidence the deposition of the department of health’s only expert witness, whose testimony was obtained pursuant to a deficient notice of deposition. The chancery court found that Roy waived any errors and irregularities in the notice for taking the deposition because he failed to promptly object in writing as required by Tenn. R.Civ. P. 32.04(1). Roy appealed.

The appeals court affirmed the trial court’s judgment. As Tenn. R. Civ. P. 32.02(1), 6.01 and 6.05 provide, Roy was entitled to “at least” 10 days notice in advance of the expert witness’ deposition, excluding the intervening Saturday and Sunday. The assistant general counsel placed the notice of the out-of-county deposition in the mail on March 7, 2007. The notice advised that the expert’s deposition would occur on March 15, 2007, which was only eight days after the notice was placed in the mail. Therefore, the department did not provide proper notice to Roy of the expert’s deposition.

The appeals court explained that Roy was obliged to follow the same substantive and procedural rules as a represented party. He had every opportunity to promptly object to the notice of deposition, but he failed to do so until one week before the rescheduled hearing. By failing to promptly object in writing as required by Tenn. R. Civ. P. 32.04(1) requires, Roy waived his right to object.

Rea v. State,
No. 03-08-00491 (Tex. App. July 16, 2009)

Affirming the dismissal of a physician’s action to enjoin the Texas Medical Board from continuing to investigate him, the Texas Court of Appeal concluded that the physician’s claims were not ripe because no final agency decision had been made.

The Texas Medical Board informed Dr. William Rea that it was investigating a complaint against him. Following the investigation, the Board notified Rea that an expert physician panel had concluded that he violated the applicable standard of care. The Board filed a complaint against Rea at the State Office of Administrative Hearings (SOAH). The Board sought an adjudicative hearing for the purpose of taking disciplinary action. Rea sued the Board and two administrative law judges with the SOAH. He sought to enjoin the Board from continuing to prosecute him and the SOAH from adjudicating the matter. Rea alleged in part that the Board violated his due process rights by failing to notify him of the nature of the complaint. The trial court granted the Board’s motion to dismiss all of Rea’s claims on the ground that they were not ripe.

The court of appeal concluded that dismissal of the claims was proper. Rea contended that the Board’s violations of statutes and regulations constituted final administrative decisions. The court of appeal determined, however, that the Board’s acts were preliminary to the administrative hearing before the SOAH. There had been no final agency decision that inflicted a concrete injury on Rea; the Board was merely seeking the SOAH’s approval to take disciplinary action. The court of appeal found that Rea cited no authority to support his argument that, if an agency’s action could be deemed ineffective for any reason like insufficient notice, then the agency loses its power to take such action in the first instance. The trial court’s dismissal sua sponte of the claims against the SOAH administrative judges was not reversible error. The Board’s ripeness arguments applied to all of Rea’s claims. The court of appeal concluded that the holding that the claims were not ripe applied equally to the Board and the SOAH administrative law judges.
EXPERT TESTIMONY

Gicla v. United States, No. 08-1648 (7th Cir. July 15, 2009)

The Seventh U.S. Circuit Court of Appeals concluded that a district court’s refusal to exclude the testimony of a defense expert because of his alleged failure to fully disclose the basis of his opinion was not an abuse of discretion. There was no evidence that the claimant was unduly prejudiced by the unexpected disclosure.

David Gicla underwent surgery at a Veteran’s Administration Medical Center for replacement of his right ankle-joint with an implant. The implant failed to relieve Gicla’s symptoms. Gicla had five additional surgeries. Ultimately his right leg was amputated. Gicla sued the United States, alleging that he was not adequately advised of the risks of his surgery. Dr. George Vito testified as an expert for the United States. Pursuant to Federal Rule of Civil Procedure 26, Vito disclosed that his opinions relied on his review of radiological reports, not the X-rays of Gicla’s ankle. On cross-examination, Vito stated that he had reviewed the X-rays earlier that day. Gicla’s counsel moved to strike Vito’s testimony contending that Vito, in violation of Rule 26, had not disclosed previously that his opinions were based on his review of the radiological reports. Gicla’s counsel had planned to argue that Vito’s testimony should be given less weight than Gicla’s expert, who had examined the X-rays.

The district court denied the motion to strike, but offered Gicla’s counsel a recess to prepare questions concerning the X-rays that Vito reviewed. Gicla’s counsel declined the offer. The district court entered judgment in favor of the United States. Gicla appealed, arguing that the court abused its discretion in not excluding Vito’s testimony. The Seventh Circuit affirmed the district court’s judgment. The Seventh Circuit agreed that Vito’s review of the X-rays prevented Gicla from attacking the weight of Vito’s testimony. However, Gicla was not unduly prejudiced by Vito’s unannounced review of the X-rays.

The Seventh Circuit reasoned that Vito testified that the X-rays had not altered his views. Further, Vito’s testimony did not differ in any respect from the opinions that he disclosed prior to trial. The Seventh Circuit found that any prejudice to Gicla was minimized by the fact that a bench trial was conducted. The trial judge was aware of the late disclosure and understood that Vito had formed his opinions prior to looking at the X-rays.
Lockhart v. Guyden,
No. 01-08-00983 (Tex. App. July 16, 2009) unpublished

The Texas Court of Appeal ruled that a trial court abused its discretion in denying a doctor’s motion to dismiss medical malpractice and wrongful death claims brought by a decedent’s heir since the heir did not file a sufficient expert report.

Normell Guyden, individually and as heir to the estate of Natalie Guyden, brought medical malpractice and wrongful death claims against Dr. Christopher Lockhart, alleging that Lockhart was negligent in not timely transferring Natalie to an acute care facility and that this negligence proximately caused Natalie’s death. Lockhart moved to dismiss the plaintiff’s claims on the ground that he did not file a sufficient expert report. The trial court denied the motion, and Lockhart appealed.

The appeals court reversed the trial court’s judgment. The plaintiff did not file an expert report that was an objective, good faith effort to comply with Civil Practice and Remedies Code. The expert report was conclusory on the specific opinion that Lockhart was negligent in not timely transferring to an acute care facility and that this negligence proximately caused her death. Nowhere in the report was there a specific discussion of whether Natalie’s death would more likely than not have been prevented with proper medical diagnosis and treatment.

MEDICAL SCHOOLS

Abdullah v. State,
No. 20080254 (N.D. July 29, 2009)

The North Dakota Supreme Court affirmed a trial court’s grant of summary judgment, finding that a university’s school of medicine lawfully terminated a doctor from its internal medicine residency program.

Dr. David Theige informed Dr. Sarmed Abdullah that Abdullah was being terminated from the University of North Dakota School of Medicine residency program shortly before he was scheduled to graduate from the program. Abdullah appealed to the resident fair process and grievance hearing panel, which upheld Theige’s decision. Abdullah then appealed to the Dean of the School of Medicine, who upheld the hearing panel’s decision.
Abdullah then sued the state of North Dakota, d/b/a the University of North Dakota, and Theige alleging claims for, inter alia, breach of contract, violation of his substantive due process right under 42 U.S.C. § 1983, and violation of the Americans with Disabilities Act (ADA) because of his bouts with sleep deprivation. The trial court granted summary judgment for the university and Theige. Abdullah appealed.

The supreme court affirmed the trial court’s judgment. The decision to dismiss Abdullah was made after he was afforded procedural safeguards, and the record of the proceedings before the hearing panel included evidence that the substantive decision to dismiss him from the residency program was not a substantial departure from accepted academic norms. Although Abdullah claimed the dismissal was arbitrary and capricious and not in good faith, there was sufficient evidence in the record for a reasoning mind to conclude Abdullah was dismissed for incompetence in the area of professionalism. Thus, the trial court did not err in granting summary judgment on Abdullah’s breach of contract claim.

The supreme court also found that the trial court did not err in granting summary judgment on Abdullah’s substantive due process claim. Abdullah failed to demonstrate a violation of a clearly established law because the right to attend a public school is not a fundamental right for purposes of substantive due process. Moreover, the supreme court determined that the trial court did not err in granting summary judgment on his claim for a violation of the ADA. Abdullah failed to provide any facts to show that the university regarded his bout with sleep deprivation as a disability and that the university dismissed Abdullah from the residency program because of that perceived disability. The evidence before the hearing panel established that the decision to dismiss Abdullah was not based on his perceived mental health, but was based on his lack of professionalism.

EVIDENCE NOTICE

Price v. Clark,
No. 07-CA-01671 (Miss. July 23, 2009)

The Mississippi Supreme Court affirmed in relevant part a trial court’s dismissal of a former patient’s negligence action against a physician and other medical service providers arising from the allegedly late diagnosis of the patient’s pituitary tumor.

On Apr. 9, 2004, Albert Price Jr. was diagnosed with a pituitary tumor. Price died on Aug. 14, 2004. His widow, Nina Price, sued Price’s primary care physician, Dr. Steven Clark, and certain other medical service providers alleging negligent failure to timely diagnose her husband’s tumor. A trial court dismissed with prejudice those defendants subject to immunity under the Mississippi Tort Claims Act (MTCA) and dismissed without prejudice those of Nina’s claims against defendants not subject to MTCA immunity based on a finding that Nina failed to satisfy an applicable notice requirement. Nina appealed.

The supreme court concluded that Nina’s Aug. 31, 2004, complaint was properly filed and served within the applicable statues of limitations as to Clark and Cleveland Medical Clinic. Nina failed to comply with required notice requirements as to Greenwood Leflore Hospital, of which Cleveland Medical was an instrumentality, and the supreme court concluded that the trial court’s dismissal was the proper remedy for this failure. The trial court erred, however, in dismissing Nina’s complaint with prejudice given that the complaint served to toll the statute of limitations under the trial court’s July 2006 ruling.

The supreme court separately affirmed the trial court’s grant of summary judgment in favor of Clark and Cleveland Medical based on its finding that Nina’s medical expert was unable to establish any genuine issue of material fact that Clark had breached the applicable standard of care. Nina further failed to make any argument before the supreme court than a fact issue existed as to Clark’s deviation from the standard of care. Accordingly, the trial court’s dismissal of Nina’s complaint was affirmed in relevant part.
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