



# Massachusetts Board of Registration in Medicine

## Progress and Activity Reports

Six Month Update: January - June 2000

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**Peter Madras, MD**  
**Chair, Board of Registration in Medicine**

My colleagues recently elected me to serve as Chairman of the Massachusetts Board of Registration in Medicine. I am grateful for their confidence and support. I would like to acknowledge my predecessor Dr. Mary Anna Sullivan, an exemplary Board Chair, and the extraordinary efforts of the staff under the leadership of our new Executive Director. During the next year, I hope to address the following issues:

- ◆ More expedient response to consumer complaints;
- ◆ Greater efficiency in our Licensing Systems;
- ◆ More effective use of technology to meet the Agency's goals;
- ◆ Organizing volunteer physicians to expedite Board work ;
- ◆ Greater involvement of the general public and health care advocacy organizations in education and outreach work of the Board of Registration in Medicine.

On behalf of all members of the Board of Registration in Medicine, I would like to acknowledge the support and guidance of the Governor, our legislative leaders, and our partners throughout Massachusetts who are committed to health care excellence.

In this turbulent time for medical care, we are proud of our national leadership position in profiling physicians and patient safety.

**Peter Madras, MD**  
Chair

**Peter Gelhaar, JD**  
Vice Chair

**Arnold S. Relman, MD**  
Physician Member

**Rafik Attia, MD**  
Secretary

**Martin Crane, MD**  
Physician Member

**Mary Anna Sullivan, MD**  
Physician Member

**Dorothy Keville**  
Public Member

Massachusetts Board of Registration in Medicine  
 Compared To  
 National Averages

Category of Information	1999 Mass.* Performance	National Average Performance
<b>\$ Spent per Physician</b>	<b>\$160</b>	<b>\$248</b>
% Spent in Licensing	15%	29%
% Spent on Discipline	78%	45%
% Spent on Administration	7%	26%
<b>Staffing</b>		
Licensing-(FTEs/1,000 physicians)	0.47	1.16
Discipline-(FTEs/,1000 physicians)	0.75	1.48
Investigators (FTEs/5,000 physicians)	0.47	3.67
Legal Staff (FTEs/5,000 physicians)	2.58	2.51
<b>Caseload Analysis</b>		
Cases per Investigator	35	42
<b>Cases Investigated</b>	1,409 **	481
% Cases with Disciplinary Action	4.5%	20.0%
Disciplinary Actions / Investigator	32.0	13.7
Disciplinary Actions / Attorney	5.8	17.9
Per Total Enforcement Staff	4.0	5.9
<b>New Complaints received</b>	472	899

*Mass. Board of Medicine Expenditures vs. National Average.  
 Source: Federation of State Medical Boards*

\*Based on expenditure of \$3,396,117 and 21, 225 physicians practicing in Massachusetts.

\*\* The Board undertook a closed case review project that required re-investigating approximately 300 cases in 1999

## Executive Director's Report

The first half of 2000 has been a period of progress for the Board of Registration in Medicine. At the end of 1999 the Board had 700 open cases, many of them quite old. An aggressive plan to address the most complicated cases – those with allegations of substandard care – was put into place. Through the RFP process, an outside resource was identified to assist the Board in the review of approximately 500 cases. To date, the project is extremely successful. Although the launch of the full review project was delayed due to the complexity of a full RFP, the entire project is on target for completion by the end of calendar year 2000. By the end of June, the Board still had over 700 open cases involving 587 physicians, but this total includes the cases that are being reviewed and summarized by the outside experts. Every performance indicator is on target to attain the Agency's goal of 300 physicians with open cases by the end of 2000. By the end of 2001, the Board hopes to carry a caseload of fewer than 300 physicians at any time.

During the first six months of the year, the Board forwarded eight cases for full evidentiary hearings to the Division of Administrative Law Appeals (DALA). As of the end of June 2000, there were 19 cases in process at DALA. These nineteen cases contain over sixty individual open complaints. The DALA process, particularly how to improve timeliness of cases, remains a challenge to better performance by the Board of Registration in Medicine.

Recently, Malpractice Liability Insurers in the state have begun to offer policies that include all legal fees for physicians facing Board action. In the past, the insurers only provided legal services coverage until the Board issued a statement of allegations. This change has already impacted the Agency's ability to negotiate consent orders — the most efficient means of resolving a serious case. There is now no financial incentive for a physician to negotiate with the Board. The long period between the Board's referral to DALA and the Magistrate's decision, the perceived leniency of DALA by some physicians, and the change in insurance coverage combine to create a major impediment for case management and closure. Should the trend of more cases being referred to DALA continue, it will be necessary to review whether the DALA system can manage the expected caseload. In addition, the Board may approach the Legislature for additional funding for Enforcement Division staffing increases to meet the additional work prosecute those cases which would have been resolved through negotiated settlements in the past.

The Massachusetts Legislature directed the Board to prepare comparisons of its staffing and resources to other state medical boards. The result of this analysis, performed with the assistance of the national Federation of State Medical Boards (FSMB) can be seen in the table on Page 2 of this report. Even though Massachusetts has two large, successful programs that are not part of the work of most other states, (Physician Profiles Program and the Patient Care Assessment Program), Massachusetts appears to be significantly underfunded when compared to the national average. This discrepancy is even more significant when these two programs are taken into consideration. The agency believes that it can and does operate as efficiently as any Board in the nation, but we must balance resources and performance expectations.

**Analysis of Table Comparing Massachusetts Board of Medicine to National**

**Averages:** To be merely consistent with other states (i.e. without factoring New England's higher cost of living and employment costs) the 1999 Budget comparison would be as follows:

<b>Category</b>	<b>Actual</b>	<b>Optimal</b>	<b>Difference</b>
Total Funding'99	\$ 3,396,000	5,264,000	1,868,000
FY01 Projected	\$ 3,825,327	5,422,000	1,596,673

( Comparison is to FY99 in order to fairly represent variances related to bi-annual license renewal schedule.)

The difference between Massachusetts' funding and the "optimal" level ( the national average) is improved for the FY01 projection due to increased funding realized in FY00 and continued in FY01.

The Massachusetts Board of Registration in Medicine has two programs included in its budget, Patient Care Assessment and Profiles, that do not exist at most other state medical Boards. Annual Salary costs associated with these two programs (Direct cost, only) are:

<b>Profiles</b>	\$ 112,000
<b>PCA</b>	\$ 111,500

Profiles also carries significant direct costs for systems and hardware. Total non-salary direct costs are approximately 100,000 per year. There are also indirect costs for both programs. For Profiles, the direct and indirect costs are addressed by the Legislature in a separate line item. This allocation is included in the total FY01 projections. Projected retained revenue from some licensing fees is also included.

The total direct cost for both programs is approximately \$ 333,700. When these costs are accounted for in the budget allocation, the Massachusetts performance vs. the national average is as follows:

<b>Category</b>	<b>Actual</b>	<b>Optimal</b>	<b>Difference</b>
Funding FY99	\$ 3,058,300	5,264,000	2,201,700
FY01 Projected	\$ 3,491,627	5,422,000	1,930,373

Obviously, the Board is operating extremely efficiently when compared to other states. Simply bringing the Massachusetts Board up to the national average of funding per licensee would have profound impact on the quality of service offered by the Massachusetts Board of Registration in Medicine. One major goal for the Agency is the migration of all licensing operations to an on-line environment. Massachusetts has already invested millions for a Another area of interest for the Board of Registration in Medicine is that of post-licensure assessment and remediation programs. Although Board regulations dictate that there should be a Remediation Services available through the agency, little has been done to accomplish this. Occasionally, a physician will want to return to service after years of non-practice due to health problems, Board discipline, or other factors.

Currently, the Board has few options to assess whether the physician's skills and base of knowledge are sufficient for a return to effective practice. Such an assessment requires exhaustive, specialized testing. Recently, a specialized center opened in Colorado. It is a joint project of the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME). Soon, there may be plans to expand the services through the creation of an East Coast Assessment Center. With the pre-eminence of Massachusetts in terms of health care quality and medical education, the Commonwealth would seem to be a natural choice for such a program. Not only would such a center offer greater flexibility in dealing with physicians whose skills are in question; it would certainly be an economic benefit for one of the Commonwealth's most valuable economic sectors – health care. Assessment is one part of remediation. After skills are assessed, a corrective action plan must be implemented to improve deficiencies and secure needed clinical and medical education opportunities.

The last two major areas of focus for the Board of Registration in Medicine are related to important policy issues. The Board hopes to undertake a major revision of its regulations to build the foundation for effective regulation and licensure activities for the future.

Barriers to excellence, such as a lack of authority to approve temporary licenses electronically, should be removed. The regulations must also address the growing areas of telemedicine and provide appropriate protections for patients' privacy and standards of treatment.

Lastly, the Board must continue to lead the nation in the effort to continuously improve health care quality in all Massachusetts institutions. One great disappointment of the past year was the failure of organized medicine to develop a single, comprehensive response to the issue of patient safety and preventable medical error. Legislative leaders, in particular Senator Richard Moore, have challenged all health care regulators to find new ways to protect the people of Massachusetts from medical error and substandard care. As outlined in the report on the Patient Care Assessment Program, on page 10 of this report, the Board of Registration in Medicine is ready to meet this challenge.

The work of the Board of Registration in Medicine affects every person in Massachusetts. The Board and Staff of the agency are grateful for the opportunity to serve the people of the Commonwealth in this vital work.

## Enforcement Division and Data Repository Statistics

### Types of Reports Received and Reviewed by the Data Repository Unit:

Malpractice history:	57	(55%)
Health care facility discipline:	14	(13%)
5F (peer) reports:	10	(10%)
Government agency reports:	9	( 9%)
Plaintiff jury verdicts:	5	( 5%)
Tribunal reports:	3	( 3%)
Renewal “yes” answers:	2	( 2%)
Combination of reports:	2	( 2%)
Closed claim report:	1	( 1%)
Other:	1	( 1%)

### Disposition of reports:

Closed with no action:	59	(57%)
Still open (more information):	19	(18%)
Referred to Enforcement:	15	(14%)
Closed w/ a Letter of Concern:	9	( 9%)
Closed with a Letter of Advice:	2	( 2%)

Action Taken	Jan	Feb	Mar	Apr	May	Jun	Six Month Total
Consent Order	5		5	1		11	<b>22</b>
Dismissed	28	16	19	7	15	32	<b>117</b>
Dismissed Letter of Acknowledgement		1	0	0	0	0	<b>1</b>
Dismissed/ Letter of Advice	3	3	5	2	4	9	<b>26</b>
Dismissed/ Letter of Concern	2	1	2	1	3	8	<b>17</b>
Dismissed/ with Letter of Information	3	1	1				<b>5</b>
Dismissed/ with Letter of Warning	1				2		<b>3</b>
Final Decision and Order		3	1	5			<b>9</b>
Resignation		1	1	1	1		<b>4</b>
Mediation					1		<b>1</b>
Filed, no case opened	2				13	1	<b>16</b>
							<b>0</b>
Month Total	<b>44</b>	<b>26</b>	<b>34</b>	<b>17</b>	<b>39</b>	<b>61</b>	<b>221</b>

## Disposition of Enforcement Division Open Complaints

Allegations of substandard care or misconduct come to the Board of Registration in Medicine from the public in the form of consumer complaints or as statutorily mandated reports into the Data Repository Unit. In either instance, the complaint or report is “triaged” and forwarded to the appropriate staff or Committee for processing. Last year, a new management team was brought to lead the staff of the agency. One of the immediate goals of the new leadership was the development of a plan to review and resolve a staggering number of open cases. Nearly 700 old cases were open at the end of 1999; most of these were complicated substandard care cases. The agency had to resolve these cases while addressing 408 new cases that arrived. The Board and Staff continue to implement new case tracking and management techniques to improve the agency’s record in responding to patient complaints and mandated reports quickly and appropriately. To assist the agency in meeting its goal of reducing its backlog of open cases, third-party medical review experts have been contracted to summarize the old cases. This two-fold attack on the backlog — existing staff and one-time outside resources — will allow the Board of Registration in Medicine to succeed in efforts to improve the performance of the Enforcement Division.

Clearly, funding and staffing patterns affect results for a disciplinary unit. As seen in the national comparison figures found on page 2 of this report, the Agency is woefully understaffed in terms of investigators. Support from the Legislature has allowed the Board to add two investigators to the Staff; taking total staffing from 1.5 to 3.5 FTEs. The national average for Investigators per 5,000 licensees is 1.16. Currently, Massachusetts has approximately 25,000 physicians. This would result in a need for 18 investigators to meet the national average for staffing.

With appropriate staffing, the Board could resolve cases more quickly, providing appropriate protection for patients. To begin to address the staffing inequity, the team of nurse reviewers who comprise the Clinical Care Unit have been moved into the Enforcement Unit to work directly with the investigators on substandard care cases. This change brings three additional FTEs to the effort to investigate and resolve cases, but more must be done. The Enforcement Division of the Board of Registration in Medicine must add at least ten additional staff members to its case investigation team in order to provide the high level of service that patients and other Massachusetts residents expect and deserve.

## Patient Care Assessment Program

The Patient Care Assessment Unit of the Board works with hospitals and other health care facilities to monitor the strength of Quality Assurance programs within the facilities. The primary goal of the PCA Committee and Staff is to ensure that all licensed physicians in Massachusetts have the opportunity to practice medicine in institutions that are safe, provide high quality health care, and strive toward constant quality improvement.

This goal is met by working with the facilities to develop and implement a Quality Assurance program that addresses issues of physician review and credentialing, staff training and oversight, and peer-review of medical care. These diverse elements affecting health care quality are all part of the Quality Assurance Program that must be approved by the Patient Care Assessment Committee as a condition of licensure.

An important part of the PCA program is the review of major incident reports. These reports summarize specific adverse outcome in hospitals and explain why the outcome occurred and what, if any, corrective actions the facility took to ensure that a preventable adverse outcome does not recur. The timing of the submission of these reports is not as easily defined as other Board performance measures because the Committee requires that the facility undertake and finalize an extensive internal investigation before reporting to the Board. The PCA is more interested in the quality of the investigation and the success or failure of the internal systems of checks and balances intended to prevent medical errors than in immediate reporting. Therefore, the major incident reports received during the first six months of 2000 represent investigations completed during this period; the underlying adverse events may have occurred much earlier.

### Major Incident Reports Received

January–June 2000 244

January– June 1999 218

During this period, the Committee also had major meeting with the Trustees and medical leaders of two facilities identified as having below average PCA programs within their institutions. The Committee also issued an advisory to all facilities, called a PCA Update, on problems identified through the review of major incident reports from multiple facilities. The alert addressed issues of adequate Radiological Services for Emergency Rooms.

## Health Care Quality and Error Prevention – A Massachusetts Success Story

In November 1999, A report titled “To Err is Human” was released by the Institute of Medicine. The report suggested that as many as 98,000 patients die in American hospitals as the result of preventable medical error. Although experts debate the actual number of error-related deaths, the public has demanded a response from organized medicine. The Board of Registration in Medicine operates an adverse event reporting and analysis program, the Patient Care Assessment Program, that has become a national model for effective response to any of the crucial issues raised in the IOM report.

Although the PCA program is considered a model for medical error prevention programs, PCA has a mission beyond mere error identification . The Committee works with health care facilities to achieve continuous quality improvement. The most important tool the PCA Division uses to ensure that a facility’s PCA program is functioning effectively is the review of major incident reports. All regulated health care facilities must submit an in-depth report on serious, unexpected patient outcomes known as “major incidents”. The incidents reviewed through the program are not always the result of medical errors. Instead, the PCA program reviews *all* adverse outcomes meeting certain criteria and works with the facility to identify any lapses in the systems of checks and balances needed to maximize quality assurance. Often, the adverse outcome was not the result of any preventable medical error. The program does not exist to assign blame; it exists to promote health care quality through extensive systems review.

The PCA Division’s responsibility for institutional quality assurance (QA) was mandated by the Medical Malpractice Reform Act of 1986 and is unique among the nation’s state licensing boards. The rationale for its existence at the Board is the fundamental principle that without physician leadership and participation, institutional quality assurance systems cannot and will not be successful. In addition to calling for physician participation, the PCA regulations also mandate that each facility’s governing body assumes responsibility for institutional quality assurance. A Board-approved quality assurance plan is condition of hospital licensure; moreover, no licensed physician in the state may work at a health care facility that does not have an approved PCA plan.

The mandated, confidential reporting of major incidents and the subsequent analysis by the PCA Committee provides PCA unique insight into recurrent obstacles to health care quality assurance. The Committee uses this insight to provide information distilled from many institutions into guidelines and alerts that assist individual facilities in efforts to prevent harm to patients. This sharing of information in a collaborative, non-disciplinary environment is vital to the ongoing success of the Patient Care Assessment Program.

## Licensing Statistics

Month	Beginning Limiteds	Incoming Limiteds	New Licenses Issued Limiteds	Limited Renewals
<b>Jan</b>	36	29	22	8
<b>Feb</b>	37	51	16	6
<b>Mar</b>	49	1303	20	324
<b>Apr</b>	1008	1592	155	543
<b>May</b>	1902	780	358	993
<b>Jun</b>	1331	339	682	772
<b>Total</b>		<b>4094</b>	<b>1253</b>	<b>2646</b>

Month	Beginning Fulls	Incoming Fulls	New Licenses Issued Fulls	Full Renewals
<b>Jan</b>	357	113	76	602
<b>Feb</b>	394	198	86	664
<b>Mar</b>	506	281	126	761
<b>Apr</b>	661	185	200	661
<b>May</b>	646	201	201	645
<b>Jun</b>	646	140	289	289
<b>Total</b>		<b>1118</b>	<b>978</b>	<b>3622</b>

Month	Lapsed Licenses	Temporary Licenses
<b>Jan</b>	7	2
<b>Feb</b>	12	2
<b>Mar</b>	6	2
<b>Apr</b>	12	4
<b>May</b>	14	3
<b>Jun</b>	3	2
<b>Total</b>	<b>54</b>	<b>15</b>

Month	Monitoring Agreements
<b>Jan</b>	0
<b>Feb</b>	0
<b>Mar</b>	0
<b>Apr</b>	0
<b>May</b>	0
<b>Jun</b>	1
<b>Total</b>	<b>1</b>

## Primary Categories of Medical Licensure

### **Full License**

A full license entitles a physician to practice medicine as an independent practitioner in the Commonwealth.

### **Limited License**

A limited license is issued to a physician who has received appointment as an intern, resident or fellow at a health care facility in the Commonwealth approved by the Board. Over the past two years, the Board of Registration in Medicine engaged in a joint development effort with other state agencies to create a new web-based application called the Consolidated Licensing and Regulation Information System (CLARIS).

Enhancements have since been made to the system to add new functionality, streamline the application flow, and make screen displays more informative to the users, but they have not brought CLARIS to its full potential as a true on-line licensing application.

There are important health care policy reasons to do so.

In 2010, the changing demographics of the US will result in a population with so many elderly citizens needing intensive health care services that there cannot be enough health care practitioners to meet their projected needs. Even if the US opened new medical schools today, there would not be enough time to train an adequate number of physicians to meet the need in 2010. The shortfall in nurses, home health aides, and long-term care workers is even more severe. If Massachusetts is to maintain its dominance in health care, all possible means of attracting and retaining high quality physicians must be used. The health care system drives the state's economy, employs thousands of citizens, and makes an invaluable contribution to our quality of life. Moving to a true web-based application system simplifies the application process for physicians, one more way to attract good applicants. In addition, a web-based system allows the Massachusetts BORIM to accept applications from over-seas candidates most effectively. If the projections of a severe shortage of US-trained physicians as of 2010 are correct, the state must find a creative way to identify and recruit strong foreign-trained candidates.

Providing licensing services over the Internet would be a logical extension of the CLARIS system. The CLARIS application already utilizes the fundamental tools and technologies that are required for an Internet system. The CLARIS system will provide a solid foundation for an Internet Licensing System and other related Web applications that may be created in the future.

## Licensing ~ Looking Ahead

Significant improvements were realized in both the timeliness and accuracy of Licensing operations. CLARIS, the agency's new web-based Licensing program, presents the Board of Registration in Medicine with unique opportunities for technological solutions to operational challenges.

Along with technological enhancements, strong and consistent policies have strengthened the quality of the Licensing Division's work.

In 2000, Committee members interviewed hundreds of candidates for Licensure to address areas of concern. Also, the Committee fully implemented a policy to require extensive monitoring of Limited Licensees with academic or training issues that raised concern among the Licensing Committee members .

The monitoring agreements include close supervision by and regular reports from the Program Director of the training site.