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JOURNAL OF MEDICAL LICENSURE AND DISCIPLINE

Published Continuously Since 1915
Volume 91 Number 1 2005

The Journal of Medical Licensure and Discipline (ISSN 1547-48IX, publication number 189-120) is published quarterly by the Federation of State Medical Boards of the United States Inc., P.O. Box 619850, Dallas, TX 75261-9850
Telephone: (817) 868-4000
Fax: (817) 868-4098
Periodicals postage paid at Euless, Texas, and additional mailing offices.

Postmaster
Send address changes to the *Journal of Medical Licensure and Discipline*, P.O. Box 619850 Dallas, TX 75261-9850

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Subscriptions and correspondence about subscriptions should be addressed to the *Journal of Medical Licensure and Discipline*, P.O. Box 619850, Dallas, TX 75261-9850. Subscriptions for individuals are $70 per year; single copies are $18 each. Subscriptions for libraries and institutions are $140 per year; single copies are $36 each. Notification of change of address should be made at least six weeks in advance. Enclose new and old addresses, including ZIP code.

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"Always do right — this will gratify some and astonish the rest."

— *Mark Twain*

INFORMATION FOR AUTHORS

The Editorial Committee accepts original manuscripts for consideration of publication in the *Journal of Medical Licensure and Discipline*. The *Journal* is a refereed journal, and all manuscripts are reviewed by Editorial Committee members 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 epittman@fsmb.org or by mail to:

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2. The title page should contain only the title of the manuscript. A separate list of all authors should include full names, degrees, titles and affiliations.
3. The manuscript's pages should be numbered, and length should be between 2,750 and 5,000 words, with references (in Associated Press style) and tables attached.
4. The manuscript should include an abstract and between five and 10 keywords to aid online referencing. The abstract should be 200 words or less should describe the purpose of the study, the main finding(s) and conclusions. 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.
6. The number of references should be appropriate to the length of the text, and references should appear as endnotes, rather than footnotes.
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.
8. If sent by mail, a PC-compatible disk or CD-ROM should accompany a printed copy of the manuscript. Microsoft Word format is the preferred file format.
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MESSAGE FROM THE CHAIR

SERVING THE PUBLIC: KEEPING THE TRUST

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

THE FSMB ANNUAL MEETING

I would like to extend a personal invitation to you to join members and staff of state medical boards and numerous other colleagues and associates interested in medical licensing and regulation for the Federation of State Medical Boards' 93rd Annual Meeting, "Serving the Public: Keeping the Trust," May 12-14 at the Adam's Mark Hotel Dallas in downtown Dallas, Texas.

The program for this year explores a number of emerging issues important to the future of medical regulation, including factors that should be considered as state medical boards move forward with developing maintenance of licensure requirements; the inter-relationship between discipline and patient safety and its potential implications for medical regulators; developments in physician health, including a review of addiction treatment theory, physician-specific outcomes data, and sexual boundary issues such as classification of behaviors and management of cases involving boundary issues; and the changing role of academic institutions in providing ongoing physician education. This year's program also includes regional forums that will give attendees the opportunity to discuss common issues with board members from states in the same geographical region.

A number of nationally recognized speakers will make presentations during the meeting. The Dr. Herbert M. Platter Luncheon and Lecture will feature James P. Bagian, M.D., P.E., director of the National Center for Patient Safety at the Department of Veterans Affairs. Dr. Bagian has led the development of an innovative, systems-based patient safety program that encourages organizational learning and improvement through reporting of errors and potential safety problems through a non-punitive system now operational in all 163 VA hospitals. Carolyn M. Clancy, M.D., is the director for the Department of Health and Human Services Agency for Healthcare Research and Quality, the lead federal agency responsible for supporting research designed to improve the quality of health care, reduce its cost, improve patient safety, decrease medical errors and broaden access to essential services. Dr. Clancy will make her remarks during the opening session on Thursday morning. Randy R. Bovbjerg, researcher at the Urban Institute Health Policy Center, is working with the University of Iowa to conduct a project for the Department of Health and Human Services titled "State Medical Boards: Disciplinary Actions, Quality of Care and Medical Litigation." Bovbjerg will make his remarks on Friday during the session on "Assessing State Medical Boards Performance."

SPECIAL COMMITTEE REPORTS

Additionally, reports from two FSMB special committees will be submitted to the House of Delegates for consideration. The report of the FSMB Special Committee on Scope of Practice, *Assessing Scope of Practice in the Delivery of Health Care: Critical Questions in Assuring Public Access and Safety*, is an informational guide outlining patient safety and quality of care issues that should be considered by health care regulatory boards and legislative bodies when making decisions about changes in scope of practice. The guidelines in the report are intended to be used by state regulatory boards and legislatures when considering requests for creation or expansion on scopes of practice, and are designed to assist policymakers in assuring that all practitioners are prepared (by virtue of education and training) to provide services authorized in their scopes of practice in a safe, effective and cost-efficient manner. In a recent special issue on the changing face of health care, *U.S. News & World Report* alerted readers to stay tuned for the committee's report.

The Special Committee on Maintenance of Licensure will submit an interim report to the House of Delegates. In 2003, the committee was given an extensive charge to develop a policy recommendation regarding the responsibility state medical boards have to ensure the ongoing competence of

physicians through the course of their professional careers, and to develop strategies for state medical boards to use in implementing programs to ensure physicians maintain an appropriate level of competence to practice medicine safely throughout their professional careers. The committee's report will form the basis for many of the issues to be discussed during the "Building a Framework for Maintenance of Licensure" session on Thursday morning at the Annual Meeting. The session will examine policy issues that will form the basis for maintenance of licensure initiatives. Issues to be debated include determining the purpose of maintenance of licensure programs, whether assessment for relicensure should be at the "GUMP" level or reflect what a physician does in practice and how best to balance the public's right to access information on physician competence with the profession's right to confidentiality.

MORE THAN A MEETING

The FSMB Annual Meeting is much more than an opportunity to meet with colleagues. It is an invaluable learning experience, a place where great ideas are born and where such working groups as the Special Committees on Scope of Practice and Maintenance of Licensure present the fruit of much hard work. In short, the FSMB Annual Meeting is an essential nexus where the brightest minds in medical regulation meet to develop and discuss an abundance of worthy initiatives with the potential to positively impact the practice of health care for years to come. I hope to see you in Dallas.

To register online for the Annual Meeting, visit the FSMB website and select the "Register Now for FSMB's 2005 Annual Meeting" link on the home page. For more information, call (817) 868-4007, or e-mail the FSMB Education Department at edu@fsmb.org.

EDITORIAL

POLITICAL PRESSURE AND PUBLIC PROTECTION

Hazem H. Chehabi, M.D., *Past President, Medical Board of California*

It may surprise most medical board appointees that there may come a time when they perceive conflict between performing the very duties they were appointed to perform and political pressures to adopt certain decisions that may not be in the best interest of the public they swore to protect.

"The mission of the Medical Board of California is to protect healthcare consumers through the proper regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous enforcement of the Medical Practice Act," reads the mandate of the board on which I was honored and privileged to serve for close to four years. I read those simple words frequently during the course of my tenure — especially when I was faced with difficult decisions that had to be weighed against some complicating factors. The mandate kept me focused on the real issues that I was appointed by my governor to pursue in the best interests of the citizens of our state. With those guiding words I was able to make the right decisions and fulfill my mission.

The task was difficult — complicated by the fiscal crisis facing California throughout most of my term. Vacant positions were eliminated; staff who retired or moved on left behind workloads to be handled by overworked staff already coping with shrinking resources. The camaraderie and fellowships that emerged helped create relations and friendships that enriched my life and gave it further purpose.

I could never think of a more noble calling than the medical profession, as our patients and their families entrust us with their most valuable possessions: their lives and the lives of their loved ones. I could never imagine serving in any other role but that of a physician. My role on the board brought me face to face with some of the darkest aspects of my chosen profession. It was painful to encounter some of the horror we discovered as we listened to patient complaints, and as we read, occasionally with tears in our eyes, the embarrassing details of misconduct committed by "so called" colleagues.

We acted as swiftly as our resources allowed us, but with careful respect to the lengthy due process guaranteed to all by our great Constitution. Our decisions were not always popular. We had to walk the thin line separating protecting the public and disciplining the guilty health care provider. We made the best decisions we could, given the information we were provided, and we did it in clear conscience and in an effort to honor the very mandate to which we were sworn when we were appointed.

The nature of the task and its visibility invited attention from the media and a variety of consumer and other member advocate groups. This added further stress to an already stressful mission, and occasionally brought attempts by various political entities to influence some of our decisions. I was startled to discover the impact of politics on decisions that should be exclusively determined by the need for public protection, and at times there seemed to be an inclination by some members to yield to political pressure coming from high above. It was painful to watch as some tried to manipulate fellow board members to make decisions that satisfied political concerns, and occasionally followed personal agendas, at the expense of what was best for the board and the public. But as carefully crafted and orchestrated as some of those schemes were, I was proud to see the board make the right decisions in the end, and not give in to coercion and manipulation.

As political appointees, board members who accept appointments and take their oath of office, should never allow themselves to be torn by a conflict between political influence and responsibility to the public. The choice should be easy. Public protection must always be placed ahead of self promotion or appeasement of outside political pressures.

THE DISPARITY IN STATE-BASED QUALITY OF CARE DISCIPLINARY STANDARDS

Judith Dickinson, *Public Member, New Hampshire Board of Medicine*

ABSTRACT

This article explores the fact that current state-based physician disciplinary statutes display a great lack of uniformity between states regarding the threshold standards used to determine when a physician can be disciplined for substandard patient care. Many states use a gross negligence standard to make the determination; others use a lower, ordinary negligence standard; and other states use both standards in the same statute. Among gross negligence states, there are many different statutory and case law definitions of "gross negligence" in use, adding to the lack of harmony. The lack of uniformity in state-based regulatory laws and standards is an issue in the national debate over the efficacy of state-based physician regulation. The true dimension of this multiplicity of disciplinary standards and definitions cannot accurately be assessed without a detailed study of how state medical boards actually interpret and apply these terms, and whether there is a resulting observable impact on how many physicians are disciplined from state to state for quality of care mistakes. However, even the appearance and perception that some states treat patient care more strictly than others may create regulatory issues that might require resolution through an effort to bring disciplinary negligence standards between the states into conformity with one another.

INTRODUCTION

State-based disciplinary systems are still the primary method for regulating physician conduct and competency in the United States today. Although regulatory control remains local, state medical boards are constantly faced with the challenge of evaluating whether their locally shaped disciplinary statutes and regulations should be revised to become more consistent with the regulatory structures of other states. One area of physician regulation that has not been placed squarely under the uniformity microscope is the discipline of physicians who have provided substandard care to their patients. A study of 51 jurisdictions in the United States, conducted specifically for this article, reveals that there are no consistent statutory structures from state to state for defining when a state medical licensing board may take disciplinary action against a physician for medical negligence.[1] This article will explore the nature and scope of this disharmony and examine some of the implications of a state-based regulatory system in which the disciplinary framework in quality of care cases is different in virtually every jurisdiction.

The need for uniformity and consistency across state lines in physician licensing laws has been the subject of several initiatives in recent years. In a 1998 policy document, *Maintaining State-based Medical Licensure and Discipline: A Blueprint for Uniform and Effective Regulation of the Medical Profession*, the Federation of State Medical Boards (FSMB) issued a clearly articulated call to the state medical boards to engage in an ongoing process of statutory revisions that would help the states attain uniform standards and procedures between the states.[2] This *Blueprint* policy adopted the recommendations of the Special Committee on Uniform Standards and Procedures, a committee commissioned with a "profound sense of urgency," in response to the concern that the viability of a state-based system of physician licensure and discipline might depend in part on improving medical board consistency and promoting uniform standards for the effective regulation of the medical profession. This call to arms has been supported by other FSMB initiatives, such as the policy document *A Guide to the Essentials of a Modern Medical Practice Act, 10th Edition*,[3] policy statements on the evaluation of quality of care and maintenance of competence[4] and the role of ethics in quality of care decisions,[5] as well as current efforts to perfect license portability.

The *Blueprint* includes recommendations for upgrading medical board disciplinary regulations, focusing attention on

the need for uniformly recognized standards in due process procedures, investigatory procedures, reciprocal disciplinary actions, board order formats and conflict of interest policies. The prefatory remarks to the *Blueprint* acknowledge that comprehensive, effective regulation of the medical profession would include, among other features, recognition between various jurisdictions of standard definitions for their most-used terms and commonly accepted definitions of substandard or inappropriate physician behavior.

Most medical boards in the United States have striven to meet the call. Current statutes and administrative codes all reflect that serious efforts have been made to update physician licensing and disciplinary provisions, especially in the areas of physician incompetence and remediation, physician misconduct for sexual boundary violations, deceptive practices, advertising and other ethical issues. Statutory due process structures have become more uniform as well. This movement towards uniformity between the states is not reflected from state to state, however, in the disciplinary laws that delineate the threshold for imposition of discipline upon physicians for substandard patient care.

QUALITY OF CARE DISCIPLINARY THRESHOLDS: "ORDINARY" NEGLIGENCE VERSUS "GROSS" NEGLIGENCE

Quality of care discipline may appear in several different formats in any given physician licensing and disciplinary statute. Most states have an investigatory process that requires the screening of civil medical malpractice suits and settlements in addition to quality of care complaints made directly to the licensing board. Many state statutes have "multiple occurrence" scrutiny in place, where investigatory review for repeated negligence is automatically triggered for physicians who are reported to have had multiple complaints or suits within a small period of time, such as three events during a five-year period. A few states have additionally made civil medical malpractice findings into independent grounds for discipline.[6] Many states even have some standards of care built right into the disciplinary statute, usually in practice areas of heightened concern such as drug prescription practices.

While the above-described types of statutory provisions may help generate some of the quality of care issues that may become the subject of physician discipline, the true threshold in almost every state regulatory scheme is the provision that defines what standard of medical negligence will subject a physician to discipline.[7] There are fissures between different state definitions of negligence, however, that separate the states into three basic categories of quality of care regulation: 1) those states in which a physician may be disciplined only for "gross negligence"; 2) those states where physicians may be disciplined for "ordinary negligence"; and 3) those states which maintain statutes containing both gross negligence and ordinary negligence concurrently as standards for the imposition of discipline. These interstate inconsistencies are exacerbated by the fact that among the states using a gross negligence standard, there is no uniform definition of "gross negligence" in use and, in fact, there are quite a few state medical boards that do not have any statutory definitions whatsoever for "gross negligence."[8] Even the courts have not achieved uniform results in the few reported cases in which the definition of gross negligence has been directly addressed.[9] When all of these factors are taken into consideration, it is fair to say there may not be two states expressly regulating quality of care discipline for physicians in the same way.

THE "ORDINARY NEGLIGENCE" STATES

At least 13 states[10] use an ordinary negligence standard as the sole threshold test for defining culpable conduct warranting discipline for quality of care mistakes. This is the threshold recommended by the FSMB, which, in the *Essentials* model medical practice act, recommends two methods by which a physician licensing board should be authorized to take disciplinary action for substandard care: 1) for "negligence in the practice of medicine as determined by the Board"; and 2) for "any adverse judgment, award or settlement against the licensee resulting from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section …."[11] This category of quality of care disciplinary culpability will be referred to here as "ordinary negligence," although in disciplinary statutes the term usually appears as "negligence" or "malpractice." The ordinary negligence standard is distinguished from the gross negligence standard by the fact that an ordinary negligence finding does not require proof of the severity of the negligence, but only a determination that the medical practice in question failed to meet the established standard of care.[12]

THE "DUAL STANDARD" STATES

Another 13 states[13] have disciplinary statutes containing both an "ordinary" negligence and a "gross" negligence standard. The significance of the dual standard in these states is not especially clear because many of these states do not have statutory provisions explaining when the ordi-

nary negligence standard is to be used, and when gross negligence would control.[14] Theoretically, an ordinary negligence standard would be broad enough to cover any case where gross negligence had occurred, and would be less complicated to prove than gross negligence, so the need for maintaining both standards simultaneously is not immediately obvious. Vermont has recently added an ordinary negligence standard without eliminating the pre-existing gross negligence standard, so it may be some of the other dual standards have evolved in this way.[15] The medical boards in some of these dual standard states undoubtedly have internal understandings for determining when to use ordinary negligence and when to use gross negligence, but the role each standard plays in determining which physicians will be disciplined and which will not is not transparent through statute or code.

DEFINITIONAL INCONSISTENCIES IN STATES USING "ORDINARY NEGLIGENCE

Although gross negligence standards show the greatest divergence, as will be discussed below, even the ordinary negligence states show variations between the definitions currently in use. Some ordinary negligence states require express proof that injury was caused by the negligence.[16] Another variation occurs around the scope of the standard of care to be used, some states explicitly requiring that the standard of care used be limited to that which is acceptable in the locality in which the physician practices, while other states are silent on this issue.[17]

THE "GROSS NEGLIGENCE" STATES

Seventeen[18] states use a gross negligence standard as the sole threshold provision for defining when discipline and sanctions will be imposed for quality of care violations. Another 14 states,[19] as described in the preceding section, are dual standard states that use a gross negligence standard in conjunction with an ordinary negligence standard. The definitions of "gross negligence" appear for some states in the statutes and administrative codes applicable to the medical board, and in other states, most notably New York and California, the definition has been developed through case law.[20] Although nearly all of these 31 jurisdictions has a differently worded definition for the meaning of "gross negligence," there are some general definitional groupings that are helpful for examining whether the lack of uniformity is significant. The groupings, which will be informally described in this article as the "degree of deviation definitions," the "mental state" definitions, and the "pejorative" definitions, are distinguished by the type of proof that is required in each definition for a medical board to make the finding that the physician's conduct was indeed "gross."

1) The "degree of deviation" definitions

This definition de-emphasizes, if not eliminates, the necessity of proving the physician's awareness of his or her conduct as the physician acted or failed to act, otherwise known as the physician's "mental state." This definition instead requires an assessment of the degree to which the flawed medical practice fell below the standard of care. The California definition of "gross negligence" for medical discipline purposes, developed in the case of *Gore v. Board of Medical Quality Assurance*, is a good example: "the want of even scant care or an extreme departure from the ordinary standard of conduct," which is further explained as "the want of even slight care, but not necessarily involving wanton or willful misconduct; in other words, an extreme departure from the ordinary standard of care," "very great negligence" and "more than ordinary inadvertence or inattention, but less than conscious indifference to consequences …."[21] This definition, read for plain meaning, seems to place the medical board's focus on the medical procedures themselves and to require an objective analysis of how greatly the care actually provided differed from what should have happened for the patient.

2) The "mental state" definitions

The many gross negligence definitions falling into this category all seem to require a finding of "gross" must be founded on proof sufficient to allow an inference to be drawn about the mental state of the offending physician, in addition to the analysis of whether the standard of care was breached. Under this standard, the negligence in question would rise to the level of "gross" if the nature of the deficiencies in care that occurred would allow the medical board to conclude that the physician was acting recklessly, or with conscious indifference or entire disregard to the welfare of the patient. This was explained well in one of the earliest cases to articulate a standard for medical gross negligence, as "that entire want of care which would raise a presumption of conscious indifference to consequences; an entire want of care, or such a slight degree of care as to raise the presumption of entire disregard for, the indifference to, the safety and welfare of others; the want of even slight care of diligence."[22] Arkansas case law describes gross negligence as "the failure to observe even slight care; it is carelessness or recklessness to a degree that shows utter indifference to the consequences that may result. . . ."[23]

Illinois medical board administrative code and case law define gross negligence as "an act or omission which is evidence of recklessness or carelessness toward, or disregard for, the safety or well-being of the patient and which results in injury to the patient."[24] Missouri case law requires "an act or course of conduct which demonstrates a conscious indifference to a professional duty."[25] Some states even go as far as requiring "willful" conduct, which implies an actual awareness that harm may result, such as in Oregon case law: "gross negligence," as the term is generally used, connotes an act beyond mere inadvertence or error in judgment; it must be error 'of such magnitude or recurrence' that a willful indifference to the consequences of the act may be inferred."[26]

3) The "pejorative" definitions

Another set of "gross negligence" definitions are clustered around the use of somewhat pejorative adjectives intended to be attributed to the nature of the physician's conduct as a way of describing "gross." Pennsylvania case law has recognized that gross negligence would exist where "the facts support substantially more than ordinary carelessness, inadvertence, laxity or indifference. The behavior of the defendant must be flagrant, grossly deviating from the ordinary standard of care …. Gross negligence is merely the same thing as ordinary negligence, with the addition of … a vituperative epithet."[27] Nebraska, for instance, recognizes that gross negligence is achieved when the conduct is found to be "flagrant, shameful, not to be excused."[28] Under Massachusetts case law, the conduct described must be "flagrant and extreme,"[29] and New York and New Jersey both require a finding that the deviation from the standard of care be "egregious."[30]

DISTINCTIONS WITHOUT A DIFFERENCE?

The gross negligence standard clearly has been allowed to inconsistently infiltrate disciplinary statutes and case law. Without a detailed comparative study of board decisions containing findings and rulings applying these various gross negligence definitions, it is hard to say whether all these apparent dissimilarities actually matter. Any medical board facing these definitions as written would be justified in finding that different types of proof might be required. Further, medical boards will not find any guidance for determining whether evidence that appears to be sufficient to support a finding of "extreme deviation from the standard of care" would also be sufficient to support a finding of "flagrant and shameful" conduct or "conscious disregard for patient safety." Although there is some case law outlining the various gross negligence definitions, the cases are not finely tuned enough to compare the different definitions as they are applied to actual factual situations. A review of available case law would show that, while there are certainly recognizable factual scenarios upon which gross negligence findings have been upheld, the results so far seem to be the same regardless of which particular gross negligence definition was applied during the analysis.[31]

The best evidence to help in deciding whether this plurality of gross negligence standards and definitions is fostering inconsistent and unfair results for licensees and the public is buried within the relatively inaccessible written adjudicatory decisions of medical boards across the United States. It is in these decisions that the board decision-makers must align findings of fact and applicable law and determine whether culpability has been proven. An organized dissemination and examination of these decisions must be done before any final conclusions are drawn about the apparently inconsistent standards that can currently be found in disciplinary laws governing quality of care discipline.

IMPLICATIONS OF THE LACK OF UNIFORMITY IN QUALITY OF CARE DISCIPLINARY STANDARDS

There is no question there exists a fundamental difference between the ordinary negligence standards used in many states, and the gross negligence standard used in a minority of states. Ordinary negligence is a lower threshold, and therefore creates an environment where physicians can be punished for substandard care that would not be subject to sanction in a gross negligence state. The multiplicity of gross negligence definitions in use raises the concern the gross negligence threshold may not be uniformly administered either among states already authorized to screen out ordinary negligence quality of care complaints. There are several issues to consider in deciding whether these disparities make the negligence disciplinary threshold a candidate for uniformity reforms. In essence, the appearance of unfairness and inconsistency may not be the reality, or the most important consideration when local control issues are at stake.

The Arguments for Uniformity

Basic fairness to physician licensees is a major consideration in considering whether the states should be strongly encouraged to adopt the same quality of care threshold standard. Board discipline is one of the triggers for report-

ing physicians to the National Practitioners Data Bank. Also at stake are insurance consequences, license portability and reputation. It is not fair to maintain a system where some physicians may suffer serious consequences for conduct that would go undisciplined and maybe even undisclosed for another physician, based simply upon the state in which the physician practices.

The lack of uniformity is also a barrier to effective enforcement of the license reciprocity provisions that kick in when a medical board learns that a current licensee or license applicant has been disciplined in another state. These provisions usually require the medical board to determine whether the discipline in the other state was for conduct that would qualify for discipline in the new state. This analysis is complicated and burdensome when the new board is forced to determine whether what was judged discipline under another state's ordinary negligence standard would qualify for gross negligence in the state being petitioned. Such significant variations create divisions between states instead of promoting mutual respect and coordination, and impede the ability to give full faith and credit to another state's physician discipline.

Continuing to allow different standards for disciplining substandard patient care to flourish from state to state may also be unwise because such state-to-state variances without any visible justification may undermine public confidence in the ability of a state-based regulatory system to protect patients. The disparity creates a perception that patient safety and quality of care is arbitrary, and some states are safer for patients than others. There could be understandable public consternation engendered by the realization that, as a matter of official policy, a physician in a "gross negligence" state could continue to commit lower level non-similar malpractice on multiple occasions that would be stopped through disciplinary intervention in an "ordinary negligence" state.

Finally, lack of uniformity prevents different state boards from being truly helpful to each other. Presently, the medical boards across the nation do not speak the same language on the type of case that those boards spend most of their time evaluating. This weakness is especially acute given so many of the nation's medical board decision-makers are volunteer medical specialists and public members working in inadequately resourced environments. Medical boards need resource support to do their jobs well, and boards cannot build on each other's collective wisdom when they do not use the same standards and speak the same language. This dissonance also makes the job of evaluating board performance much more complicated.

The Argument for Local Control and Maintenance of Diverse Standards

The very state-based health care regulatory system that permits such a large legal divide to exist between the states is also the most important guarantor that each state can design a regulatory system tailored to the needs of it citizens, the quality of its health care community and the resources available to support responsible regulatory action by medical licensing boards.[32] Quality of care complaints and collateral review of civil malpractice events constitute the largest percentage of any state medical board's investigatory caseload. A state legislature that lowers the disciplinary threshold to ordinary negligence and/or makes civil malpractice results into grounds for discipline in a previously "gross negligence-only" state must assume the disciplinary caseload may increase significantly. The conversion to "ordinary negligence" cannot be performed to improve public confidence without a concomitant commitment to increase funding and staffing to handle the increased investigation, prosecution and adjudicatory burdens that will follow. To do any less will be to set up the medical board for failure and loss of the very public confidence that the change of standard was intended to inspire.

Real study should also be conducted before concluding the gross negligence/ordinary negligence dichotomy must be eliminated in favor of a national, uniformly defined ordinary negligence standard for all quality of care complaints against physicians. State board decisions should be studied and reliable data collated to determine whether in fact the ordinary negligence standard already being used produces more physician disciplinary results than gross negligence has. All board members know that the fact that a case qualifies for discipline does not mean that discipline is automatically imposed. State medical boards are usually granted varying degrees of decision-making discretion and the power to make nonpublic, non-disciplinary settlements in appropriate cases. Efforts should be made to determine whether the use of this discretion affects at all the actual number of physicians disciplined and sanctioned for delivery of substandard care in ordinary negligence states. Ordinary negligence may not automatically mean more discipline and sanctions.

Finally, in favor of caution is concern for fairness and due

process. If state boards with statutory mandates to prosecute ordinary negligence cannot fulfill that mandate due to inadequate resources, those boards may be forced to use discretionary powers to settle or dismiss cases at a non-disciplinary level in order to control the more expensive disciplinary caseload. If the state boards engage in this method of caseload control without any articulated or publicized standards for doing so, there is a risk of creating the perception, if not the reality, of arbitrary use of power and consequential loss of confidence from the public and the licensee community as well. It could be better from a board performance perspective to have a more selective, but visible and administratively affordable threshold such as gross negligence that can be consistently enforced and that promises known disciplinary results when invoked.

CONCLUSION

Significant disparities exist among state medical boards as to the standards currently being used for imposing discipline upon physicians against whom quality of care complaints have been filed. A full third of the states still use gross negligence as the sole threshold for deciding disciplinary culpability, and the remainder of the states use a more inclusive "ordinary negligence" standard, or some combination of ordinary and gross negligence, and several states use neither. Fragmentation further exists among states using a gross negligence standard, because multiple definitions of gross negligence requiring different elements of proof are in use among the gross negligence states. Concern exists for the impact of this lack of uniformity on the reliability of and public confidence in the current state-based regulatory system, but the need for a movement toward uniformity is not clear until further comparative study determines whether the observed disparities produce actual disparate and unfair results. Such study should be done in order to either quell any unease that comes from the knowledge that physicians can be disciplined differently from state to state for delivery of substandard patient care or to point the way toward the disciplinary standard that can best serve the regulatory goals of public safety and fairness to licensee physicians.

REFERENCES

1. This study was conducted by the author during Dec. 2004-Jan. 2005, and consists of an independent review of state statutes, administrative codes and selected case law relating to physician regulatory discipline. Disciplinary laws relating to osteopathic doctors and physician assistants were not specifically examined, although in many states, these professions are regulated by the same statutes as, or statutes identical to, those for physicians.
2. The Federation of State Medical Boards of the United States, Inc. *Maintaining State-based Medical Licensure and Discipline: A Blueprint for Uniform and Effective Regulation of the Medical Profession*. 1998.
3. The Federation of State Medical Boards of the United States, Inc. *A Guide to the Essentials of a Modern Medical Practice Act, 10th Edition*. 2003.
4. The Federation of State Medical Boards of the United States, Inc. *The Special Committee on Evaluation of Quality of Care and Maintenance of Competence*. 1998.
5. The Federation of State Medical Boards of the United States, Inc. *Ethics and Quality of Care: Report of the American Medical Association and the Federation of State Medical Boards*. 1995.
6. Montana, Nevada, Rhode Island and Texas are some of the states in which discipline may be imposed for civil malpractice results.
7. The following are some of the states which have physician discipline statutes that do not have a quality of care discipline standard explicitly grounded on either "ordinary" or "gross" negligence standards: Maine, Maryland, Mississippi, South Carolina and South Dakota.
8. Some state statutes and administrative codes using a statutorily undefined "gross negligence" standard can be found in Alaska, Delaware, District of Columbia, Hawaii ("hazardous negligence"), Iowa, Massachusetts, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oklahoma, Oregon, Tennessee and Utah. A few of these state boards have judicially fashioned definitions of "gross negligence" to guide their decision-making. It is permissible, and of course necessary, for a disciplinary board in a definition-challenged state to fashion a definition appropriate to that state. The board could look first to sources within the home state to determine whether gross negligence has been defined for some other legal purpose in the state statutes or case law. Examples of potential sources of definition guidance might be other statutes enacted by that state's legislature, such as emergency personnel or volunteer "Good Samaritan" statutes. There may be case law from the courts defining common law "gross negligence," or gross negligence under institutional or governmental tort immunity, or criminal law concerning intervening circumstances which excuse criminal liability, which

can sometimes include intervening medical gross negligence. If no adequate intrastate guidance can be found, the board could reach out to licensing case law in other jurisdictions and choose a definition that seems appropriate to the board's understanding of its particular licensing and disciplinary mandate, or seems consistent with the unrelated gross negligence precedent found within the home state.

9. For a sampling of the case law defining "gross negligence" in the physician discipline setting, see the following cases: *Gore v. Board of Med. Qual. Assur.*, 167 Cal.Rptr. 881 (Cal. 1980); *Rho v. Ambach*, NYS2d 1005 (1989); *Enu v. Sobol*, 617 NYS.2d 960 (1994); *In the Matter of Jascalevich*, 442 A.2d 635 (NJ 1982) ; *Langvardt v. Nebraska*, 581 NW2d 60 (Neb. 1998); *Hellman v. Board*, 537 NE2d 150 (Ma. 1989); *Poole v. Iowa Board of Medical Examiners*, 2000 WL 193612 (Iowa 2000)(unpublished opinion); *Paulsen v. Illinois Dept.*, 739 NE2d 536 (Ill. 2000); *Bloom v. Dubois Reg. Med. Ctr.*, 597 A.2d 671 (Pa. 1991); *Bever v. State Board*, 2001 WL 68307 (MoAppWD 2001); *Britton v. Board*, 632 P.2d 1273 (Ore. 1981); *Livingston v. Arkansas Board*, 701 SW2d 361 (Ark. 1986); *Woodard v. Brown*, 770 P.2d 1373 (Colo.App. 1989); *Yoshizawa v. Hewitt*, 52 F.2d 411 (Haw. 1931).
10. The "ordinary negligence" as sole threshold states are Colorado, Georgia, Louisiana, Idaho, Minnesota, Montana, Nevada, North Carolina, Ohio, Texas, Virginia ("intentional or negligent conduct"), Washington and Wisconsin.
11. *Essentials*, *supra* note 3.
12. The Alabama statute, 545-X-3-.01(1)(l), has helpful definitions of the two standards: "Malpractice as used in these rules shall mean negligence. Gross malpractice shall mean gross negligence. Negligence shall mean the failure to do that which a reasonably prudent physician would have done under the same or similar circumstances, or the doing of that which a reasonably prudent physician would not have done under the same or similar circumstances. Gross negligence is the conscious doing of an act or the omission of some duty to act with a conscious disregard of known conditions of danger or with careless and reckless indifference to the consequences of such act or omission ...."
13. The "dual standard" states are: Arizona, District of Columbia, Florida, Illinois, Kentucky, Massachusetts, Nebraska, Oregon, Pennsylvania, Rhode Island, Vermont, West Virginia and Wyoming.
14. The dual standard states of Alabama, Arizona and North Carolina are exceptions, because they do provide some statutory guidance for how the ordinary and gross standards are meant to work together. In Arizona, for example, the threshold for discipline is ordinary negligence, but cases with a gross negligence finding qualify for imposition of enhanced sanctions.
15. See Vermont statute 26 V.S.A. sec. 1354 (a)(22) & (31)(b).
16. Illinois, Virginia, and Washington are among the states that require either proof of injury or proof of likelihood or unreasonable risk of injury to the patient as part of the negligence standard.
17. Some of the states in which it is required under the disciplinary negligence standard that the physician's conduct be assessed according to a local standard of care are Arizona, Idaho, Nebraska, Oregon, Pennsylvania and West Virginia.
18. The states using a gross negligence standard as the sole threshold for imposition of discipline in quality of care cases are: Alabama, Alaska, Arkansas, California, Delaware, Hawaii ("hazardous negligence"), Iowa, Kansas, Missouri, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oklahoma, Tennessee and Utah.
19. The dual standard states are listed in note 13, *supra*.
20. The leading cases from these states are *Gore v. Board of Med. Qual. Assur.*, 167 Cal.Rptr. 881 (Cal. 1980) and *Rho v. Ambach*, NYS2d 1005 (1989).
21. *Gore v. Board*, 167 Cal.Rptr. at 887-888. Another example with different language can be seen in the West Virginia board rules sec.11-1A-12.2.c: "a serious act, or series of acts ...."
22. *Yoshizawa v. Hewitt*, 52 F.2d at 412. It should be noted that Hawaii's current statute requires a finding of "hazardous negligence."
23. *Livingston v. Arkansas State Medical Board*, 701 SW.2d at 363.
24. *Paulsen v. Illinois Department*, 739 NE.2d at 541, citing Ill. Code 1285.240(c).
25. *Bever v. State Board*, 2001 WL 68307 (Mo AppWD 2001). See also, Arizona board policy statement (available on Arizona Medical Board website): "Gross Negligence: Is an extreme departure from the standard of care; or conduct the physician knows or should know involves a high degree of probability that substantial harm will result; or is the product of reckless indifference to the result of an act," and the Alabama statute, *supra* at note 12.
26. *Britton v. Board of Podiatry Examiners*, 632 P.2d at 1279-1280.
27. *Bloom v. Dubois Reg. Med. Center*, 597 A.2d at 677-

680 (citing, in part, Prosser and Keeton on Torts, 5th ed. 1984).

28. *Langvardt v. Nebraska*, 581 NW.2d at 70-71.
29. *Hellman v. Board*, 537 NE.2d at 152-153.
30. *Rho v. Ambach*, 74 NY2d at 1007; *Enu v. Sobol*, 576 NYS2d at 381 ("Gross negligence [in the New York physician statute] refers 'to an event of some duration occurring at a particular time or place, during which either a single act of negligence of egregious proportions or multiple acts of negligence that cumulatively amount of egregious conduct could constitute gross negligence.'" See also, *In the Matter of Jascalevich*, 442 A.2d at 642-643 ("gross neglect" and "gross malpractice" suggest conduct beyond such wrongful action ... substantial and medically unjustifiable departure form the physician's duty to the patient ...").
31. Before generalizing based upon case law, it is important to note that the cases that are appealed and decided through the court system are not necessarily a representative sample of the full range of cases being adjudicated in the state medical board system. Judicially decided cases are also sometimes of limited utility for study because many appeal cases focus on other issues and the gross negligence determination receives perfunctory treatment. Nevertheless, case law is helpful. Gross negligence findings have most often been found in the following categories:

    Failure to diagnose or conduct diagnostic tests or appropriate follow-up: *Wahba v. NYS Dept.*, 716 NYS2d 443 (2002); *People v. Brown*, 770 P.2d 1373 (1989); *Gore v. Board*, 167 Cal.Rptr. 881 (Cal. 1980); *Lajevic v. Dept.* 645 A.2d 348 (Pa. 1994)(dentist); *Gandianco v. Sobol*, 567 NYS2d 909 (NY 1991); *Britton v. Board*, 632 P.2d 1273 (Ore. 1981); *Gabaldoni v. Board*, 785 A.2d 771 (Md. 2001); *Kobrin v. Gastfriend*, 2002 WL 32156924 (Ma. 2002); *Parrish v. Kentucky Board*, 145 SW.3d 401 (Ky. 2004); *Vance v. Fordham*, 671 P.2d 124 (Utah 1983); *Camas v. Delaware Board*, 1995 WL 717272 (Del.Super.1995); *State v. Sanderson*, 550 SW.2d 236 (Tenn.1977); *Langvardt v. Nebraska*, 581 NW2d 60 (Neb. 1998); *Bloom v. Dubois Reg. Med. Ctr.*, 597 A.2d 671 (Pa. 1991); *In the Matter of Jascalevich*, 442 A.2d 635 (NJ 1982); *Woodard v. Brown*, 770 P.2d 1373 (Colo. App. 1989).

    Failure to take appropriate emergency action: *Rosi v. Board*, 665 P.2d 28 (Alaska 1983); *Wahba v. NYS Dept.*, 716 NYS2d 443 (2002); *Schwalben v. Comm'r Health NY*, 696 NYS2d (NY 1999).

    Wrong act or decision: *Pearl v. NYS Board*, 744 NYS2d 64 (NY 2002); *Kaphan v. DeBuono*, 702 NYS2d 438 (NY 2002); *Weisenthal v. NYS Board*, 671 NYS2d 568 (1998); *Poulard v. Comm'r Health NY*, 608 NYS2d (NY 1994); *Franz v. Board*, 642 P.2d 792 (1982); *Livingston v. Arkansas Board*, 701 SW2d 361 (Ark. 1986); *Gupta v. DeBuono*, 654 NYS2d 426 (1997); *Braun v. Board*, 702 A.2d 124 (Vt. 1997)(dental); *Fitzgerald v. Board*, 506 NE2d 712 (1987)(vet); *Enu v. Sobol*, 617 NYS2d 960 (1994); *Oliver v. Kentucky Board*, 898 SW2d 531 (Ky. 1995); *Taylor v. Dept. Commerce*, 952 P.2d 1090 (1998)(vet); *Escobar v. Board of Medicine*, 560 So.2d 1355 (Fl. 1990); *Lopez v. N. Mexico Board*, 754 P.2d 522 (NM 1988); *Enu v. Sobol*, 617 NYS.2d 960 (1994); *Glover v. Board*, 231 Cal.App.3d 203 (C.A.Cal AD1 D.5 1991); *Britton v. Board*, 632 P.2d 1273 (C.A. Ore. 1981).
32. The importance of local control for state medical boards has been recognized by the FSMB in the *Blueprint* policy: "The Federation strongly believes that the state-based system retains a flexibility and sensitivity to local concerns that would inevitably be lost in a national system, and allows for the evolution and testing of a range of new approaches to improve the regulation of the medical profession in a number of jurisdictions at once." The *Blueprint* policy, *supra* at note 2, "Introduction and Charge."

EMERGING TRENDS IN THE U.S. PHYSICIAN WORKFORCE: IMPLICATIONS FOR LICENSURE AND PROFESSIONAL STANDARDS

Robert M. Galbraith, M.D., M.B.A., *Executive Director, Center for Innovation, National Board of Medical Examiners*

Stephen G. Clyman, M.D., *Executive Director, Center for Innovation, National Board of Medical Examiners*

ABSTRACT

During the past quarter century, demand for physicians has dramatically increased, yet the supply of trained allopathic United States medical graduates (USMG) has become fixed. Expansion of funded residency positions has allowed large-scale absorption of international medical graduates (IMG), but there is now growing competition for IMG from other Anglophone countries with developing shortages. Substantive expansion of allopathic USMG enrollment will have to overcome hard fiscal and political realities and an uncertain pool of additional qualified applicants. Although the numbers of osteopathic physicians and non-physician clinicians (NPC) have increased briskly over the last decade, particularly in primary care, their ability to address shortages of specialists appears limited. This conjunction of events could result in serious shortages of physicians, particularly of specialists and in areas that are traditionally victims of maldistribution. Although many corrective actions are theoretically possible, most are impractical, and increasing enrollment of allopathic USMG may be the most feasible immediate approach. There could also be important ripple effects on professional standards, procedures for licensure and the introduction of several important new initiatives in assessment relevant to licensure and certification.

BACKGROUND AND INTRODUCTION

Determining the appropriate number of physicians for the United States is a difficult and imprecise enterprise. Reports in the 1980s and 1990s projected large surpluses of physicians (150,000 or more) and particularly of specialists, whereas more recent analyses have projected a major shortage of (200,000 or more) and notably of specialists.[1-3] The appropriate size of the workforce continues to be debated by organizations in the House of Medicine (e.g., American Association of Medical Colleges, the American Medical Association, the Council of Graduate Medical Education), but indications are official positions are shifting towards contingency planning for a major physician shortage. Demand appears to be growing rapidly, while supply appears to be lagging behind. Absent any change, there is a growing belief that shortages are inevitable and could be severe in some areas, with some unpalatable consequences. Together with the increasing number of patients with insufficient health coverage, this could lead to further restriction of access and suboptimal care. It could also breed further deterioration in professional satisfaction, with large numbers of baby boomers reducing hours or retiring early and a negative recruitment image for any expanded enrollment of students. For organizations involved in education and professional regulation, these changes will likely exert pressure on the high standards traditionally followed. The view of licensure, certification and accreditation could turn rapidly from providing protection of the public to impeding the supply of physicians and access thereto. One example of this is the recent movement to introduce legislation in California that would allow Mexican physicians to achieve licensure without passage of the United States Medical Licensing Examination (USMLE) in order to increase the number of Spanish-speaking physicians in that state. The chief factors driving physician workforce service capacity during the past 50 years (1950-2000) are briefly summarized on the following pages.

DEMAND FOR PHYSICIANS IS GROWING RAPIDLY

Demographic Factors

The United States population has grown rapidly from 152 to 282 million (1950 to 2000), with a further increase of up to 40 million anticipated by 2010.[4] This reflects several components. Although the fertility rate in the United States declined from the mid-1950s to the mid-1980s, it

has subsequently remained higher than in many other developed countries. Second, infant mortality and average life expectancy at birth have continued to improve. Third, the United States continues to take in large numbers of legal immigrants and a substantial additional number probably entered without documentation. The foreign-born United States population has risen correspondingly, resulting not only in increased numbers but also a major expansion of cultural and linguistic diversity of patients. The number of elderly has expanded dramatically. This segment of the population is the most prone to chronic disease, and typically has both health coverage (e.g., Medicare) and free time to seek medical care. They are therefore positioned for robust consumption of health care resources.[5]

Economic Affluence

Economic growth appears to be a powerful driver of health care expenditures.[3,6] Growth allows the investment of resources in research and development necessary for advances in treatment and care. However, economic prosperity also enables obesity, inactivity and other lifestyle consequences, with substantial morbidity. Increasing consumption of sensitive diagnostics and of medical services for non-urgent conditions or cosmetic procedures carry risks of false positives and complications requiring the attention of more physicians. The costs of defensive medicine also continue to rise inexorably. In the United States, health care expenditures have grown rapidly to a projected $1.7 trillion or 15 percent of GDP in 2003.[7] Despite the best efforts of the managed care industry to decelerate the rate of growth in health care expenditures during the 1990s,[8] this upward trend currently shows no evidence of abatement.

Changing Scope of Practice

During the 20th century, Western medicine scored notable successes with much acute disease, and the health burden has tilted dramatically towards chronic disease and palliation, particularly as populations have aged. A slow shift from cure to prevention may also be underway, with prediction of serious disorders and primary prevention through lifestyle changes, medication and eventually by genetic interventions facilitated by new knowledge of the Human Genome. Consequent increases in demand might be blunted by involvement of patients in self-management activities, by savings from disease prevented and not treated, and by expanded use of non-physician clinicians (NPC). Nevertheless, these thrusts will involve new attention to healthy people not otherwise consuming medical services, and will lead to more genetic counseling, dealing with false positives and almost certainly more involvement of physicians.

Growth of New Technologies

New technologies are often introduced into medical practice in the absence of prima facie evidence for use. Doubtless, technological innovations can turn out to enable effective care for previously incurable or fatal disorders – to wit the $15 billion Medicare end-stage renal disease program. Safer or less invasive new procedures can also free physicians to do other work. The downside is the potential for a medical-industrial complex with a technology spiral that involves: availability of new services; effective advertising; increased demand for services; new procedural opportunities for physicians; expanded provision of services; more investment in technology; availability of new services; and so on. Physicians then spend additional time answering patients' questions about the new technologies, providing follow-up and fixing complications. The end result is that supply of technology may directly create demand, testing the economic axiom that demand drives supply. Equally important, such a technology spiral can still churn even when economic times are hard.

The Growing Population of Patients with Partial Coverage

Approximately 75 million Americans under the age of 65 were uninsured at some point in 2001 and 2002, and 49 million for at least six months.[9] Such patients do use some medical services, and may contribute to over-utilization of emergency room visits and of hospitalizations for acute care. However, equity and societal issues aside, this group provides a real hindrance to accurate workforce projections, since the advent of any effective coverage would presumably add substantial demand for medical services.

Summary of Demand Issues

The conjunction of factors summarized above constitutes a gathering storm of demand, and potential moderating forces do not currently appear equal to the task of containment.

THE SUPPLY OF PHYSICIANS MAY BE LIMITED

The traditional view of the United States physician workforce is of allopathic male USMG who work without interruption until age 65 or later. However, the reality is clearly changing, and fast. Practicing physicians are increasingly drawn from sources beyond allopathic schools in the United States, women now form a majority of the appli-

cants to allopathic schools, and average weekly work hours and years in practice appear to be declining.

Availability of Allopathic USMG

From 1950 to the mid-1970s, first year enrollees in and graduates of medical school more than doubled. For the past 25 years numbers have been essentially constant – around 16,900 for first-year enrollees and 15,800 for graduates. These changes parallel the number of medical schools which increased in number from 75 in 1960 to 126 around 1980, but thereafter have remained more or less unchanged in number.[10] Similar numbers are apparent for graduates completing residency training.[11] In sum, the overall number of trained USMG available to enter practice – around 15,000 annually – has been static for almost a quarter of a century.

Availability of Osteopathic USMG

The historical pattern for enrollees in osteopathic medical schools is the obverse of that for allopathic USMG. The number of trainees remained stable from 1960-1990, and then grew substantially throughout the 1990s. Four new schools were opened in the 1990s, bringing the total to 20; annual enrollment increased by 50 percent from 1,951 to 2,927, and the number of graduates annually increased by 70 percent from 1,534 to 2,598.[12]

Availability of IMG

The growth of IMG enrolling in residencies has been impressive and IMG constituted a full third of physicians entering the United States workforce during the 1990s.[13] Some countries produce more graduates than can find satisfactory employment, while others are subject to unstable political or economic conditions. The number of IMG with English skills may also be increasing, mirroring the dominance of English in electronic communications and medical literature. English has also been adopted for medical students in most of the Arabic-speaking countries in the Middle East; there are also English language tracks available in Israel and former Soviet republics and in state medical schools in China. There is also a progressive seepage of English into medical education in non-Anglophone countries in the European Union. Increased global migration of physicians also parallels that of the general public; in 2000 an estimated 175 million people were living outside their country of birth, as compared to 100 million in 1995.[14] Equally important, the numbers of United States citizens graduating from international schools (designated USIMG) and matching to United States residency programs increased rapidly during the 1990s.

Several barriers to entry of IMG into the United States may also have been lower during the 1990s. These include changes in J-1 visa waiver rules, and the continued availability of more funded residency slots than available USMG. In addition, the United States was previously alone among Anglophone countries in requiring IMG to pass a licensing exam and an English test, but parallel exams are now required for IMG entering Canada, the United Kingdom, Australia and New Zealand. In this regard, it is notable that the addition of a clinical skills component to the USMLE in 1998 was followed by a >50 percent drop in the number of IMG applying to take USMLE.[15]

Reservations have been raised about the quality of IMG education, since this lies outside the formal accrediting and monitoring systems of the United States. Differences may also be perceived in relation to citizenship and cultural experience (i.e., United States versus non-U.S. origin) and facility with English. Despite this, the net result has been the percentage of the physician workforce constituted by IMG has increased, from 20.9 percent in 1980 to 24.2 percent in 2000. In a very real sense, the United States has "outsourced" the undergraduate education of between one-quarter and one-third of physicians joining the workforce. Further, the lack of growth in trained USMG during a period of robust increase in demand appears to have resulted in functional dependence on IMG to make up the shortfall.

Work Output of Physicians

The assumption that all physicians will work full time until 65 or older is no longer tenable. There are anecdotal but clear indications of declining physician work hours. Increasing attention is being paid to lifestyle issues. Practitioners, and especially younger physicians, are increasingly rejecting the long work hours accepted as a matter of course by their predecessors, and controllability of lifestyle is an increasing influence upon career choice. Generational differences in balancing work and play, and the growing number of women physicians, may also be relevant. The growth of managed care has meant many physicians have moved from self-employed to full-time employee status on relatively fixed salaries. In parallel, pressures exist for restricting work hours. In the EU, new government regulations restricting the work week to 48 hours for all physicians are in the process of being implemented.[16] In the United States, maximal weekly work hours for residents have recently been limited to 80. It is too soon to know the effect of these changes on the hours

worked by physicians or the quality of patient care, but overall work output of physicians seems destined to fall.

Physicians also appear to be increasingly leaving active practice altogether. This involves a mix of issues: costs of practice; threats to autonomy; professional dissatisfaction; declining incomes; malpractice costs; intrusive regulation and litigation and lifestyle concerns. The 1990s bull market facilitated the exit of many physicians with sufficient financial reserves. Large numbers of baby boomers are now of an age to ponder early retirement, assuming favorable economic conditions. More physicians may be gravitating to non-clinical work in government, administration, insurance, pharmaceuticals, education or in regulatory and professional organizations. Moreover, the physicians leaving the clinical workforce are often in their professional prime.

Summary of Supply Issues

In essence, the domestic supply of allopathic physicians is currently fixed. Although supplies of osteopathic physicians and IMG increased rapidly over the last decade or two, it is unclear for how long this rate of growth can be sustained.

WHERE ARE WE NOW? DEMAND AND SUPPLY

Demand for medical services during the 1990s increased at a rapid pace, but growth of physician supply (30 percent) was also strong and substantially stronger than growth of the general population (12 percent). Ignoring the serious issue of maldistribution of physicians, overall the workforce expanded from 2.4 physicians per 1,000 population in 1990 to 2.8 in 2000.[6] As to whether supply and demand are in balance, there is very little agreement. The increase in physicians/1,000 population is viewed by some as evidence of a burgeoning physician surplus, with full employment maintained through marketing and inflated demand for unproven procedural services. Others project an impending and serious deficit, driven by runaway demand and the escalating complexity of modern medical care, with deteriorating access to specialists and an army of around 50 million underinsured. The middle ground holds that the large increase in physician workforce of the 1980s and 1990s was market-driven and occurred more or less in balance with strong growth in demand.

Although there are major caveats in such comparisons, physician:population ratios are currently higher in the United States than in the five other Anglophone countries (see Table 1).[6] It is also noteworthy the mean physician:population ratio in Anglophone countries is lower in the United States than in the 19 other non-Anglophone European countries. Indeed, only three of the latter have ratios lower than in the United States. Interestingly, with the notable exception of the U.S., the other Anglophone countries have initiated planning and policy changes designed to ramp up medical school building and enrollment (especially in the United Kingdom), or to deliberately attract qualified IMG, or both.

Table 1.

Number of Physicians per 1000 Population by Country (1990 and 2000)			
	1990	2000	% Increase 1990-2000
Australia	2.3	2.5	9
Canada	2.1	2.1	0
Ireland	1.6	2.3	44
New Zealand	1.9	2.2	16
United Kingdom	1.4	1.8	29
United States	2.4	2.8	17
Mean Anglophone Countries	2.0	2.3	16
Mean Non-Anglophone European Countries*	2.8	3.2	17
Mean All Countries	2.4	3.1	17

*Non-Anglophone European countries include Austria, Belgium, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Italy, Luxembourg, Netherlands, Norway, Poland, Portugal, Spain, Sweden and Switzerland.

WHERE ARE WE GOING?

Given the above, it is hard to escape concern that demand for physician services is steadily outstripping supply.

Managing Demand

Controlling demand was a major impetus for managed care. Despite some successes, the industry has been bruised by adverse public opinion, a steady trickle of legislative and legal reverses, and revelations of corporate malfeasance. Annual premium increases remain above cost-of-living. It is unclear if demand can be reined in

with political and fiscal levers. Medicare and other large payors have muscle to influence utilization through major changes in payment mechanisms. However, concerted action that smacks of explicit rationing at a time when politicians are scrambling to expand health care benefits (e.g., prescription coverage for the elderly) seems implausible. State governments could also curtail utilization by reducing eligibility for Medicaid, but their ability to do this is limited. Many forces driving demand seem simply to be realities that are here to stay. Managing demand also requires willing and active participation by physicians, who are hardly disinterested. In short, this option does not look like an especially plausible solution absent major reform in payment mechanisms.

Managing Supply

Theoretically, expanding supply ought to be possible — the number of allopathic physicians has been static for 25 years. However, achieving real increases rapidly will be problematic. No clear consensus has yet emerged to fuel a concerted drive to increase enrollment. Both federal and state governments are confronting ballooning deficits, medical schools have suffered large dents in their endowments, and academic health centers are on the fiscal sick list. Another issue is the minimum of seven years or more in lag time in training before additional physicians can be added to the workforce. Accreditation of any new schools may constitute another speed bump. Experience during the past decade has indicated that osteopathic enrollment may be more amenable to expansion, in that the political environment is more favorable and educational costs are generally lower. However, the proportional contribution of any additional graduates is numerically small.

There are also likely to be unintended consequences in expanding medical school enrollment. It is not certain there are sufficient additional qualified United States applicants, at least without lowering entry standards.[17] During the past 25 years, national ratios of applicants:matriculants have ranged from around 1.5:1 to 3:1; some individual locations have experienced lower applicant ratios. Moreover, current pervasive dissatisfaction with health care as a career does not project a positive image of the profession of medicine to potential applicants. Another complicating factor is that any expansion could simply allow more enrollments of IMG, and particularly USIMG into Liaison Committee on Medical Education-approved schools within the United States. This would be beneficial in that trainees would be exposed to the undergraduate quality framework experienced by USMG. However, a net workforce gain would only occur if such physicians are not already coming here.

The supply of physicians could also be increased by attracting additional IMG, for example by further expanding available residency slots. In essence, this amounts to more outsourcing of undergraduate medical student training, and the desirability of this will be debated. Concerns over the quality of undergraduate IMG training also remain. Increased absorption of IMG may provoke criticism from several source countries, particularly if enrollment of USMG is not expanded in parallel. More to the point, Anglophone countries with emerging physician shortages are now actively competing with the United States for IMG. In Canada, IMG have "favored status" as immigrants, and Britain has already launched an aggressive physician-recruiting campaign in several countries. The United States may no longer have its pick of the IMG pool.

We should not overlook other supply-side interventions that do not directly involve expanding the physician workforce. It is conjectural to what extent the trend for physicians to reduce the intensity of practice could or should be reversed by carefully crafted incentives and measures that might arrest the slide in professional satisfaction. However, health care delivery ought to be amenable to improvement such that the existing physician workforce could do more with less, for example by reducing unnecessary visits; minimizing physician time devoted to administration; and increasing the efficiency of information management and communication. Another complementary option would be to shift more physician responsibilities to NPC. The difficulty with the latter approach is while physician assistants and nurse practitioners are increasingly viewed as an important addition to the primary care workforce, it is unclear they can replace all specialists.[3] To this should be added the serious and deepening shortage of nurses. In comparison with expanding IMG or medical enrollment, these options currently seem even more daunting.

SOME IMPLICATIONS FOR ASSESSMENT AND PROFESSIONAL STANDARDS

The occurrence, or the perception, of a developing physician shortage will highlight several questions for organizations engaged in professional regulation. Three of the more important questions are considered below.

Why Not Lower Professional Standards for Licensure and Certification?

National standards control entry into and passage through training, and could quickly become viewed as an unwelcome constriction in the physician supply pipeline and an irresistible target for relaxation, either at entry into medical school (e.g., MCAT, SAT), graduation (e.g., USMLE) or postgraduate training (e.g., USMLE, specialty board certification). Relaxing standards is simply a bad idea, for several reasons. The organizations involved invest substantial effort and gather broad input to establish consensus professional standards consistent with good practice. In addition, public pressure is in the direction of raising existing standards, related for example to consumer activism and better access to medical information, revelations about patient safety, concern over impaired physicians, and a steady drip of ethical, professional and communications issues. Plus, the effectiveness of relaxing standards to expand the physician workforce remains to be seen. The number of willing USMG who fail to enter the workforce is already miniscule, with the eventual USMLE failure rate at around one percent and medical school attrition rates at historic lows.[18] Liberalizing standards in USMLE could only really affect IMG, and the use of a lower cut point for a selected class in a single licensure pathway is untenable.

Is Summative Assessment Actually Predictive of Future Performance?

Theoretically this appears to be an eminently reasonable proposition, but there is scant evidence linking scores in licensing and certifying examinations with actual competence throughout a lifetime of practice. Demonstrating predictive validity over the long haul is not a trivial undertaking, but it is not helped in the United States by a lack of appropriate longitudinal data sets. Since continuous measures (e.g., maintenance of certification and/or maintenance of licensure) are still on the drawing board, measurement of competence in practicing physicians continues to rely upon initial licensure with or without certification, followed by episodic measures of potential performance (e.g., examinations of cognitive knowledge and management skills). In addition, such data as does exist is fragmented across a patchwork of organizations in the House of Medicine, and usually unavailable for viewing across the continuum. The longitudinal educational data set collected over the past decades at Thomas Jefferson University, and more broadly across the six allopathic and two osteopathic medical schools in Pennsylvania since 1982, are important initiatives in this regard.[18] In addition, some evidence of predictive validity may be extracted from studies of longitudinal data collections in Canada.[19] Questions about the predictive validity of current assessment approach seem likely to be magnified in the event of any serious shortage of physicians. Some may go so far as to argue that current high stakes, summative, national examinations typical of licensure and certification should be discontinued in those who have completed their training in properly accredited schools and programs (e.g., USMG). However, the fact is this approach does provide some assurance about physicians at the time of examination. The paucity of predictive validity data argues less for de-emphasizing existing episodic summative testing than for adding newer approaches involving continuous assessment (see below).

Why are We Adding More Assessment Initiatives?

A series of new physician assessments is under development across the entire training:practice continuum. Such broadening of the base of individual assessment includes addition in 2004 of Step 2 CS to the USMLE to test clinical skills. Other initiatives are more formative and lower stakes in nature.[20] They are particularly important because they represent the first real steps towards assessment of competence and quality of care longitudinally, and possible use for professional self-regulation. However, additional measurement activities, and especially pay for performance (e.g., large payors), will inevitably raise legitimate concerns amongst physicians around added accuracy, cost, time and inconvenience. They may also reduce the numbers of physicians who are adjudged fit to enter the workforce, or increase the number who leave or are required to undergo remediation. Additional measurements could also have a chilling effect on the number of those entering or traversing the training pipeline. Even though the public is clamoring for this type of assessment, it is not hard to envisage concerted opposition from the medical profession to addition of new assessment.

In summary, although rigorous summative assessment of individual trainees and evaluations of training programs and organizations are generally believed to be major contributors to the high quality of physicians in the United States, professional standards may be seriously scrutinized and at risk in the event of workforce shortages.

We are grateful to Meredith P. Post for her diligence in research. We also thank Dr. Ruth B. Hoppe, Dr. William T. Williams and Dr. Donald E. Melnick for their helpful suggestions. The opinions contained in this article do not necessarily reflect those of the National Board of Medical Examiners.

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THE UNITED STATES MEDICAL LICENSING EXAMINATION: PART ONE

David Johnson, M.A., *Director, USMLE Step 3 Services, Federation of State Medical Boards*

ABSTRACT

The United States Medical Licensing Examination (USMLE), co-sponsored and co-owned by the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME), was implemented in 1992-94 as the successor of the NBME certifying examinations (Parts I, II and III) and the Federation Licensing Examination (FLEX). It is a three-step examination for medical licensure in the United States. The USMLE assesses a physician's ability to apply knowledge, concepts and principles, and to demonstrate fundamental patient-centered skills important in health and disease and constitute the basis of safe and effective patient care. Results of the USMLE are reported to medical licensing authorities in the United States for their use in granting the initial license to practice medicine.

This article is the first in a series focusing on the USMLE program. The following article provides a broad overview of the USMLE program along with a brief description of the USMLE content, characteristics of test administration, and information on the scoring of the exam. Subsequent articles will focus on development of examination content, quality assurance mechanisms, standard setting and such administrative issues as test accommodations and irregular behavior. The intent of this series is to provide the reader with short, topical articles that collectively provide a better understanding of the nature, role and function of the USMLE in assisting medical licensing authorities in the United States.

HISTORY

In 1988, the Educational Commission for Foreign Medical Graduates (ECFMG), the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME) sponsored a task force charged with studying the feasibility and benefits of a single examination for medical licensure in the United States. The task force included representatives from a broad array of organizations and entities engaged in academic medicine and the licensing community.[1]

At that time the landscape of medical licensure included multiple examinations serving different, yet often complementary, purposes and audiences. Some were explicitly designed as licensing exams (e.g., FLEX and the three-part examination of the National Board of Osteopathic Medical Examiners); others were intended solely for use as certifying examinations (e.g., the Foreign Medical Graduates Examination of Medical Sciences which fulfilled one of the prerequisites for ECFMG certification). Still others were certifying examinations that had become recognized in many jurisdictions as a licensing examination (e.g., the National Board of Medical Examiners Parts examination leading to certification as a diplomate of the NBME).

The task force viewed the existence of these multiple examinations as counterproductive to a greater goal: the establishment of a single, high-quality examination fostering a national standard for the assessment of physician candidates for initial medical licensure. Their efforts culminated in a major recommendation — *A Proposal for A Single Examination for Medical Licensure* — that set the stage for one of the more significant changes in the field of medical regulation in the late 20th century: the creation of the United States Medical Licensing Examination (USMLE) as the first step toward a single examination written by all physician candidates for initial medical licensure in the United States.

The first USMLE Step 1 and Step 2 examinations were

administered in 1992, followed by Step 3 in 1994. Since its inception in 1992, the USMLE has been the predominant choice of medical licensing authorities for an objective examination to meet their statutory requirement for demonstration of competence prior to issuance of an initial medical license.

Today, the program administers approximately 100,000 Step examinations annually. Most students at LCME-accredited medical schools take Step 1 at the end of their second year and the two components of Step 2 prior to graduation.[2] The majority of physicians take the Step 3 during their residency training, in most cases approximately six to 36 months into residency. Although taken at three different points in the prospective physician's career, the USMLE is considered a single examination. Each of the USMLE Steps complements the others; no Step stands alone in the assessment of readiness for medical licensure.

GOVERNANCE

The USMLE is jointly sponsored by the FSMB and the NBME. Program policies and content integrity for the USMLE are established through an appointive governing body (the Composite Committee) comprised of representatives from the two parent organizations, the ECFMG and the American public. Membership on the committee is drawn from the medical licensing, academic and practice communities; five members of the current membership served previously on their state's medical licensing board. The committee meets biannually with additional quarterly meetings scheduled on an as needed basis.

EXAMINATION CONTENT

Collectively the three Steps of the USMLE provide a broad assessment of physician knowledge and skills appropriate for the unsupervised practice of medicine. Each Step has its own examination blueprint outlining test content.

The Step 1 assesses whether individuals understand and can apply the important concepts of the basic medical sciences; further, that one has a mastery of scientific principles required for maintenance of competence through lifelong learning. Examinees are commonly required to interpret graphic and tabular material; identify gross and microscopic pathologic and normal specimens; and to apply basic science knowledge to clinical problems. The Step 1 consists of approximately 350 multiple-choice items.

The Step 2 contains two components: Clinical Knowledge (CK) and Clinical Skills (CS). The Step 2 CK is a broadly based, integrative 370 item multiple-choice examination appropriate to individuals providing patient care under supervision. Examinees are asked to provide diagnosis, prognosis, indicate underlying mechanisms of disease and/or the next step in medical care.

The Step 2 CS ensures examinees can demonstrate the fundamental clinical and communication skills essential for safe and effective patient care under supervision, e.g., taking a relevant medical history, performing a focused physical examination, communicating effectively with a patient, clearly and accurately documenting findings and diagnostic hypotheses. Examinees interact with "standardized" patients as they move through a series of patient encounters.

The Step 3 contains approximately 480 multiple-choice items, nine computer-case simulations and is organized along two principal dimensions: clinical encounters and physician tasks. The clinical encounters are structured to include emergency, initial and continuing care, and the test content focuses on knowledge related to history taking, physical examination, formulating diagnoses/prognoses and patient management.

A complete outline of the examination content for all three Steps is available on the USMLE website at http://www.usmle.org.

USE OF USMLE SCORES

The USMLE is an objective, high-quality, standardized examination used by state medical boards in their decision-making process when granting initial medical license. The USMLE provides state medical boards with a common standard for assessing physician licensure candidates.

While medical licensing authorities are the primary intended users of the USMLE, it is recognized that other audiences commonly utilize the examination as well – specifically, medical schools and residency training programs. The latter have commonly used individual performance on Step 1 and Step 2 CK as one factor in screening and evaluating applicants for their residency programs. Thus, the numeric Step scores reported on a USMLE transcript and forwarded to program directors as part of the annual residency match become important criteria in the evaluation of residency applicants.

Medical schools are even more specific in their incorporation of the USMLE as part of their ongoing evaluation of student progress. For example, in 2002, 84 percent of all U.S. medical schools required its students take and pass the Step 1 either for advancement to the third year or graduation; over half required their students to take and pass both Step 1 and Step 2 for graduation.[3] This percentage is hardly surprising. The USMLE offers an objective, national standard against which all schools can gauge their students' progress and evaluate the educational effectiveness of their curricula.

ADMINISTRATION OF THE USMLE

At its April 1995 Annual Meeting, the FSMB House of Delegates approved a Strategic Plan for Enhancement of the USMLE. This plan contained several key objectives: transitioning all Steps to a computer-based administration; including an assessment of patient management skills using computer-based case simulations in Step 3; and incorporating a clinical skills assessment into the USMLE.

The first two objectives were completed as part of the initial phase of implementation in 1999 when the USMLE program moved the exam from paper-pencil administration to computer-based administration. Whereas previously all Steps were administered twice annually at a relatively limited number of domestic and international sites, today the USMLE is administered throughout the year to examinees at more than 500 Thomson Prometric testing centers in the United States and around the world. The transition to computer-based testing has provided examinees with the benefits of more flexibility in scheduling and greater uniformity in the testing environment. Examinees can schedule and sit a USMLE Step at virtually any time throughout the year and have an even greater number of testing sites from which to choose.

Examinees, however, were not the only ones to benefit from the move to a computer-based administration. When the USMLE program assumed the responsibility of test administration for all Steps in 1999, medical licensing authorities were able to forego the substantial costs associated with administering the Step 3, such as renting a test site(s), hiring test proctors and secure handling of test materials.

Other significant advantages rendered by computer-based testing involve enhanced testing capabilities and increased exam security. The Primum case simulation portion of Step 3 is the most obvious example of the former. Administering examinations by computer has also made possible improved graphics and pictorials for use in all three Steps. Complementing these enhanced testing capabilities are improvements in the area of exam security — e.g., videotaping of test sessions, digital images of examinees; delivery of test materials via encrypted electronic files.

Under a computer-based administration of the exam, USMLE Step 1 and Step 2 CK are available in the United States and internationally; Step 2 CS and Step 3 are administered only in the United States and its territories. All three Steps are offered routinely Monday through Friday and, in some instances, on weekends, throughout the year. Step 1, Step 2 CK and Step 2 CS are single day examinations; Step 3 covers two days of testing.

Thousands of test items and multiple test forms exist for each USMLE Step. Test forms are assigned randomly to individuals taking a Step for the first time. Standard procedures ensure that individuals repeating a Step are not assigned the same test form from a prior administration.

The USMLE program complies with the Americans with Disabilities Act (ADA) by administering the exam with appropriate accommodations to individuals who have documented disabilities covered under the ADA. In 2004, approximately 300 Step examinations were administered to students and/or physicians requiring testing accommodations under the ADA.

STEP 2 CLINICAL SKILLS

The USMLE program achieved the final objective of its strategic plan with the implementation of the Step 2 Clinical Skills (CS) component in June 2004. Drawing upon years of NBME research and the experiences of the ECFMG and the Medical Council of Canada in administering large-scale, high stakes clinical skills assessments, the USMLE program's Step 2 CS represents the first assessment of clinical and communication skills in a medical licensing examination in the United States since the demise of the clinical bedside encounter from the NBME Parts exam 40 years ago.

The Step 2 CS typically involves 12 standardized patients (SPs) portraying a spectrum of cases reflecting common and important symptoms one would expect to encounter in a clinic, office, emergency room and/or hospital setting. Prior to each encounter with an SP the examinee

receives a brief set of information on the SP (i.e., pertinent biographic information and vital signs). A 15-minute patient encounter is followed by an opportunity for the examinee to record pertinent medical history and physical findings, render initial differential diagnoses, and describe an initial diagnostic workup.

The Step 2 CS is a pass/fail examination with scoring performed around three subcomponents: Integrated Clinical Encounter, Communication and Interpersonal Skills, and Spoken English Proficiency. All three subcomponents must be passed in order to receive an overall passing performance on Step 2 CS.

Like all other portions of the USMLE, the Step 2 CS is administered throughout the year. Regional testing sites for administering Step 2 CS are located in Atlanta, Chicago, Houston, Los Angeles and Philadelphia.

SCORING THE USMLE

The standard (i.e., minimum passing score) for each USMLE Step is reviewed by the Step Committees approximately every three years. As part of that review process, data are gathered from constituent surveys and from independent reviews of examination content.[4] Medical licensing authorities are routinely involved in this process, and representatives from a number of state medical boards participated in standard-setting exercises for the USMLE program during the last round of standard review. Standard setting for any USMLE Step involves a close review of examinee performance data, the results of standard-setting exercises conducted with physician panels, and survey data from key constituencies (e.g., medical schools deans, residency program directors, chairpersons from medical licensing authorities). Despite changes to the standard over time, the performance of United States/Canadian students and graduates taking any Step for the first time remains remarkably high – at or above a 90 percent pass rate.

The USMLE program's quality control procedures utilize independent scoring software to supplement the software used to score each examination. All score records are monitored for any unusual patterns (e.g., zero scores or missing sections) that might indicate a technical problem. Scoring takes approximately four weeks for Step 1 and Step 2 CK, approximately eight weeks for Step 2 CS and approximately four to six weeks for Step 3. Individuals who fail a Step can retake that examination no sooner than 60 days after the previously failed attempt. For reasons of examination security, the USMLE program limits individuals to three attempts at a given Step within a 12-month period.

The USMLE program reports the Step 1, 2 CK and 3 scores on a two- and three-digit scale. Scores are computed in such a way that a two-digit score of 75 always represents the minimum passing score for each Step. One common misconception among examinees is that the two-digit scaled score on a Step exam represents the percent of items answered correctly by the examinees. In fact, examinees must typically answer 60 to 70 percent of items correctly to achieve a passing score on any USMLE Step.

A "performance profile" relating feedback to examinees accompanies each USMLE score report. The performance profile provides examinees with a self-assessment tool that identifies their areas of relative strength and weakness for that administration of the Step.

Aggregate performance data for all USMLE Steps since the program's inception in 1992 are available at www.usmle.org. Aggregate performance data on Steps 1 and 2 are provided annually to all LCME- and AOA-accredited medical schools. Additionally, the Federation provides an annual report to each medical board on the aggregate Step 3 performance of that board's Step 3 registrants.

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2. The USMLE is open to students and graduates of both LCME- and AOA-accredited medical schools. Most osteopathic students and graduates take the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA).
3. Data derived from the 2001-2002 LCME Medical School Questionnaire conducted by the American Association of Medical Colleges.

4. At its April 2003 meeting, the Step 2 Committee approved a motion to increase its standard from a three-digit scaled score of 174 to 182; the Step 3 Committee raised its standard from 182 to 184 in March 2004. In 2003, the Step 1 Committee voted to maintain its current standard.

ALBERTA, CANADA
RESTRICTED ACTIVITIES UNDER THE HEALTH PROTECTION ACT

1. The following, carried out in relation to or as part of providing a health service, are restricted activities:
   (a) to cut a body tissue, to administer anything by an invasive procedure on body tissue or to perform surgical or other invasive procedures on body tissue:
      (i) below the dermis or the mucous membrane or in or below the surface of the cornea;
      (ii) in or below the surface of teeth, including scaling of teeth;
   (b) to insert or remove instruments, devices, fingers or hands:
      (i) beyond the cartilaginous portion of the ear canal,
      (ii) beyond the point in the nasal passages where they normally narrow,
      (iii) beyond the pharynx,
      (iv) beyond the opening of the urethra,
      (v) beyond the labia majora,
      (vi) beyond the anal verge, or
      (vii) into an artificial opening into the body;
   (b.1) to insert into the ear canal:
      (i) under pressure, liquid, air or gas;
      (ii) a substance that subsequently solidifies;
   (c) to set or reset a fracture of a bone;
   (d) to reduce a dislocation of joint except for a partial dislocation of the joints of the fingers and toes;
   (e) to use a deliberate, brief, fast thrust to move the joints of the spine beyond the normal range but within the anatomical range of motion, which generally results in an audible click or pop;
   (f) to prescribe a Schedule 1 drug within the meaning of the Pharmaceutical Profession Act;
   (g) to dispense, compound, provide for selling or sell a Schedule 1 drug or Schedule 2 drug within the meaning of the Pharmaceutical Profession Act;
   (h) to prescribe, dispense, compound or administer a vaccine or parenteral nutrition;
   (i) to prescribe, compound or administer blood or blood products;
   (j) to prescribe or administer diagnostic imaging contrast agents;
   (k) to prescribe or administer anesthetic gases, including nitrous oxide, for the purposes of anesthesia or sedation;
   (l) to prescribe or administer radiopharmaceuticals, radiolabelled substances, radioactive gases or radioaerosols;
   (m) to order or apply any form of ionizing radiation in:
      (i) medical radiography,
      (ii) nuclear medicine, or
      (iii) radiation therapy;
   (n) to order or apply non-ionizing radiation in:
      (i) lithotripsy,
      (ii) magnetic resonance imaging, or
      (iii) ultrasound imaging, including any application of ultrasound to a fetus;
   (o) to prescribe or fit:
      (i) an orthodontic or periodontal appliance,
      (ii) a fixed or removable partial or complete denture, or
      (iii) an implant supported prosthesis;
   (p) to perform a psychosocial intervention with an expectation of treating a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs:
      (i) judgment,
      (ii) behavior,
      (iii) capacity to recognize reality, or
      (iv) ability to meet the ordinary demands of life;
   (q) to manage labor or deliver a baby;
   (r) to prescribe or dispense corrective lenses.

2. Despite subsection (1), the following are not restricted activities:

   (a) activities of daily living, whether performed by the individual or by a surrogate on the individual's behalf,
   (b) giving information and providing advice with the intent of enhancing personal development, providing emotional support or promoting spiritual growth of individuals, couples, families and groups;
   (c) drawing venous blood.

The Act also requires each profession to regulate how its members supervise other people in the performance of a

restricted activity unless the other person is a regulated health professional entitled in their own regulation to perform the activity. Other people can include the physician's office employees, other health care workers and hospital and health authority personnel. Medical students and residents will also be recognized in the regulations. We already know that some physicians delegate drug and vaccine injection to nurses and imaging procedures to medical radiation technologists. We want to learn other restricted activities that physicians currently delegate to non-physicians in their offices. This information will help us write the regulations for the medical profession.

Please write to us and provide the following:

1. the name or description of the medical procedure delegated to a non-physician in your office, and
2. the qualifications of the person to whom the procedure is delegated.

Reprinted from issue 112 and 113 of *The Messenger*, published by the College of Physicians and Surgeons of Alberta.

BRITISH COLUMBIA, CANADA
FROM THE ETHICAL STANDARDS AND CONDUCT REVIEW COMMITTEE

Judging by the number of telephone calls to the Ethics Department of the College from patients wanting their records transferred to a new doctor, there is an increasing problem out there. The problem is two-fold.

First, the doctor who retires or leaves a practice without making arrangements for storage and distribution of patient files, or notifying the College of their whereabouts, creates problems for patients and physicians who take over their care. In doing so, the physician is also in violation of Rule 14(a) of the Rules made under the Medical Practitioners Act. Similarly, as happened with three physicians this year, sudden death can leave a distraught spouse with the problem and no direction or resources to handle it.

It should be part of your office management plan to have an arrangement for the care of your patient files if or when you are no longer around to look after them yourself.

Second, the College receives many calls from patients who are angry because they have to pay a fee to have their records transferred to a new doctor, particularly if that transfer is not of their own volition, but rather because the physician has retired or has left the practice. Patients do not like to receive bills in what they believe is a free publicly funded system. They do not know which services are uninsured. It does prevent upset if information about record transfer and the associated fees is posted in your office and printed in patient practice information leaflets.

Reprinted from the Fall 2004 issue of *College Quarterly*, published by the College of Physicians and Surgeons of British Columbia.

ONTARIO, CANADA
MAINTAINING BOUNDARIES WITH PATIENTS

Do you think a lot about a particular patient? Do you share your personal problems with your patients? Be careful. You may be allowing your professional boundaries to become blurred.

A recently qualified family physician moves to a new town and sets up a practice. One of her patients, a middle-aged man, has a long history of panic attacks and depression following the death of his wife. At several appointments, the patient talked at great length about the loss of his wife. The patient sent the physician some flowers with a note thanking her for taking the time and being sensitive. The physician thought this was a nice gesture and didn't really think anything of it. More flowers came and then small gifts. At this point, the physician had an uneasy feeling but decided that if she ignored it, the patient would get the message and stop. A short time later, the patient called to ask some questions about medications – this conversation rapidly turned to his asking questions about her hobbies, relationships and where she lived. The physician was working one night, when the patient called requesting a home visit. He described feeling breathless, sweaty and nauseous. She was concerned that he might be faking a panic attack to get her alone, so she told him that a house call would not be necessary and suggested that he use some of the anxiety reduction techniques they had talked about. The patient eventually staggered to a neighbor's house and an ambulance was called immediately. He was having a myocardial infarction and later made a complaint about the physician.

This example illustrates what can occur when physicians allow the boundaries with patients to become blurred. Medical care can be compromised because objectivity

diminishes to the same degree that feelings – both positive and negative – develop between a patient and a doctor.

To help doctors in this regard, the College of Physicians and Surgeons of Ontario (College) has developed a self-assessment tool physicians can use to assess their awareness of boundaries and identify the early warning signs of boundary crossings and violations. The tool focuses on those areas most vulnerable to boundary blurring, i.e., gift giving, physician's self disclosure, physical contact and dual relationships.

Dr. John Lamont, chair of the Patient Relations Committee — the College committee that developed the self-assessment tool — says the tool was designed to be informative and educational for physicians, with the hope that it will sensitize doctors to the issue of boundaries.

"We don't want people to perceive this tool as a test or as the College making a judgment," says Dr. Lamont. "This is simply a tool intended for a physician's private use so that he or she can reflect on these issues and be alert to identifying them when they arise in practice."

According to Dr. Lamont, it is a given that boundary crossings will arise. "They are unavoidable," says Dr. Lamont. "They happen to all doctors. Patients will cross boundaries, whether on purpose or by mistake. It happens. Physicians need to know when they are happening, so they can protect both themselves and their patients."

Some may argue that in the example used earlier, the patient was inappropriate and that the physician was just trying to be polite. However, the nature of the physician-patient relationship is such that the physician must take the responsibility for maintaining boundaries. Within this fiduciary relationship, there is an inherent power imbalance. Since a patient believes the physician knows more about the matter in question than he or she does, the patient tends to defer to the physician's judgment. It is this tendency that puts the professional in a "one up" power position relative to the patient.

Examples of Possible Boundary Crossings:

- Attend/frequent the same places
- Sharing mutual friends or people in common
- Self-disclosure
- Establishing dual relationships (professional/social relationships)
- Hugs/touching

Examples of Boundary Violations

- Giving or receiving inappropriate gifts*
- Ignoring established conventions by making exceptions for certain patients: for example, providing care in social rather than professional settings, not charging for services rendered where you would usually do so, scheduling treatments outside office hours, providing or using alcohol during treatment
- Assuming a patient's values are the same as your own
- Excessive self-disclosure or self-disclosure that is not for the purpose of helping the patient
- Intruding verbally on your patient's personal space. This may include breaching patient confidentiality, making value judgments about your client's body or lifestyle, probing for inappropriate personal information, using intimate words (such as dear or darling) or allowing their use by your patient
- Inappropriate touching

In understanding boundaries, it is important to differentiate a boundary crossing from a violation. A boundary can be crossed without necessarily being violated, Dr. Lamont explains. In fact, many crossings are quite benign. "For example, you may get a box of cookies from a sweet old lady whom you have been taking care of for years. This is how she expresses her gratitude. You don't need to reject the gift, but you need to be aware and alert to the fact that it is a crossing," he said.

If a physician is made uneasy in being given, for example, a box of chocolates by a particular patient, he or she can defuse the situation by keeping the gift in the clinic and treating it as if it were intended for the whole staff, said Dr. Lamont. If the gift giving continues, the physician will need to document the crossings in the patient's chart and let the patient know that it is inappropriate for physicians to be accepting presents for providing medical services.

There is good reason not to take a crossing too lightly. A pattern of crossings could be the first step in the slippery slope toward boundary violations. And, violations should be of concern to physicians, in that most cases of sexual abuse of patients by health professionals are preceded by boundary violations. Between January 1998 and July 2002, the College referred 84 cases with allegations of sexual misconduct or related allegations to the Discipline Committee. Allegations were proven in the majority of cases and the penalty applied in 30 out of the 49 cases was revocation of the physician's certificate of registration. The prevention of sexual contact starts with the careful atten-

tion to boundary crossings that may escalate into sexualized behavior.

Dr. Lamont acknowledges the situation becomes more complicated for rural and geographically isolated physicians who may have no choice but to develop friendships and socialize with people who also happen to be their patients. "The way rural or isolated physicians differ is that they have to accept the fact there will be more boundary crossings in their environment. There should not, however, be more boundary violations. Going curling with your patient is no excuse for boundary violations."

What should you do if you are concerned that you may be at risk?

- Document any inappropriate behavior on the part of the patient.
- Focus objectively on the patient's needs and best interests.
- Establish and maintain appropriate boundaries; look at the relationship from three perspectives – the physician's, the patient's and the neutral observer's:
  - The physician's: Be clear about your own needs and experiences in the relationship.
  - The patient's: Try to understand how the patient is experiencing your behavior. Empathize with what she or he is experiencing.
  - The neutral observer's: Step outside the relationship. Try to understand what an outsider would see when observing your relationship. Strive for objectivity and fair solutions to problems in the patient's best interests.
- Treat all patients equally. Function compassionately and free of preferences for some patients.
- Encourage patients to take responsibility for their own health. Don't impose your knowledge and authority.
- Do not accept inappropriate gifts from patients. Patients who offer gifts of great value should receive a sensitive explanation as to why the gift cannot be accepted. The frequency of gifts given by the patient, regardless of their value, should also be considered.
- Do not imply that patients are obligated in some way. Do not expect patients to return kindnesses or to be thankful.
- Ask yourself why you are acting in a particular way, i.e., stress, burnout, failed relationship, depression, etc.
- Discuss the situation with a colleague (of course, adhering to patient confidentiality) and document the discussion in the patient's chart.

If you have concerns and wish confidential advice, please call (416) 967-2600, extension 629, to speak to the intake coordinator or when more information is needed, call the Physician Advisory Service at extension 606. For your information, the College offers a course on boundary issues called "Understanding Boundary Issues and Managing the Risks Inherent in the Doctor-Patient Relationship." Information on the course can be obtained by calling (416) 967-2600, extension 346.

*"While small gifts such as cookies ... may represent benign boundary crossings rather than serious violations ... more significant and expensive gifts may be problematic from two standpoints. First, gift giving may be a conscious or unconscious bribe by the patient ... Second, there is often a secret or even explicit expectation of some reward or acknowledgment involved in performing services or bestowing a gift. The same can apply to the doctor who gives patients gifts or refrains from charging a fee for a particular patient." From "Boundaries in the Doctor-Patient Relationship," *Theoretical Medicine and Bioethics*, 2002;23(3): 191-201. C. Nadelson; M. Notman.

Reprinted from the online version of *Members' Dialogue*, published on the College of Physicians and Surgeons of Ontario website.

LONDON, ENGLAND
STRIKING A BALANCE IN HEALTH CARE DEBATE

Patient and public involvement in regulation will be a major theme for the General Medical Council (GMC) in 2005. According to Sir Graeme Catto, GMC president, getting public involvement is crucial to the success of independent regulation. "I do not believe in self-regulating professions," he says, "but I do believe very strongly in professionally led regulation. Regulation that protects patients by fostering professionalism in doctors and by involving patients and the public."

Sir Graeme argues that at the heart of such regulation is the setting of standards, which should be determined independently of government, the National Health Service (NHS) or any of the other health care providers and employers. "Of course, there needs to be substantial public involvement in the development of those standards, but ownership of the standards by doctors is absolutely essential. The model that can best achieve that aim is 'professionally led' or 'independent' regulation in

partnership with the public," says Sir Graeme.

Sir Graeme makes these points in a new report published by the Social Market Foundation. The GMC wants to stimulate a public debate on what constitutes best practices in health care regulation. Ultimately it would like to see a greater degree of patient-centeredness across health care regulation as a whole. In the GMC we have already done much to ensure the public plays a crucial role, for example:

- 40 percent of Council members are lay people.
- A patient and public reference group scrutinizes the GMC's work and has made important contributions to its revalidation plans.
- The GMC consults widely with the public and the profession on all major policy decisions, such as revalidation and its complaints procedures.

But, as Sir Graeme says, there is more the GMC and other organizations within the health sector could do. The GMC has already begun talking to people with expertise in this area, including colleagues at the Departments of Health and patient groups, and is keen to hear from others about what else it could be doing. Public involvement will be a major theme for the GMC in 2005. All persons who would like to contribute to the debate should e-mail their views to patient.involvement@gmc-uk.org.

GETTING INVOLVED IN PATIENT SAFETY

Patient and public involvement in the National Health Service (NHS) has gotten a bad name during the past few years, mainly because of the government's disastrous and illogical insistence on abolishing Community Health Councils (CHCs) in England — no matter what patients and the public, or anyone else for that matter, had to say about it.

The problem has been compounded even more, recently, by the decision to abolish the Commission for Patient and Public Involvement in Health, just a year after it got going (again without any consultation) and the watering down and fragmentation of the role of patients' forums. These had been key components of the new system to replace CHCs, which had been secured only due to the huge controversy over the abolition of CHCs in the first place. It is easy to see why anyone might be a little cynical about the genuineness of government-led initiatives on patient and public involvement now. However, the need to involve patients in the planning and monitoring of health care is not about political fads. It is about bringing new perspectives, challenging the peceived wisdom of health professionals and institutions, and providing a dose of common sense from a consumer perspective. Fortunately, there is a lot of good work going on in this field, in spite of the mess left in the wake of CHCs. One area where Action against Medical Accidents (AvMA) hopes to make a significant contribution is in developing patient and public involvement in patient safety/clinical governance work. Preventing the same thing from happening to someone else is usually high on the list of priorities of people who contact us, having been affected by a medical accident. Opportunities to get involved, however, have been limited and largely uncoordinated up to now. Working with others, we hope to develop a program of induction training and support for people who want to make a contribution to the local work of clinical governance committees, for instance, or national programs, in conjunction with bodies such as the National Patient Safety Agency.

The views expressed in this article are those of the author and are not necessarily shared by the GMC.

DEVOLUTION PLEDGE

Devolution will see the U.K. countries take a diverse approach to health care and the General Medical Council (GMC) will respond accordingly, said GMC president Sir Graeme Catto at a dinner he hosted on the evening before the Northern Ireland conference. The conference on Nov. 9, 2004, in the Hilton Templepatrick Hotel near Antrim, gave the GMC an ideal opportunity to communicate some key messages about its reforms to the wider Northern Ireland community. Some 90 delegates – including Professor Rod Hay and GMC president Sir Graeme Catto, as well as doctors and patient and interest group representatives — attended the conference, which had the theme "Moving Forward." Dr. Joan Martin, the lay member of Council for Northern Ireland, chaired the conference. The GMC outlined the development of its Registration and Fitness to Practice reforms, as well as current GMC thinking on medical education and CPD. Other speakers included Dr. John Jenkins, the medical member for Northern Ireland, who set out his role leading the current review of *Good Medical Practice*, and Dr. Henrietta Campbell, chief medical officer for Northern Ireland. Delia van der Lenden, a former member of the

GMC's patient and public reference group, also gave a presentation. Dr. Henrietta Campbell said: "The GMC has a pivotal place in protecting, promoting and maintaining the health and safety of the public. The Reform Program, outlined by the GMC on November 9, will modernize professional regulation and promote high standards of care for patients."

THE MEMBERS' COLUMN

There are many opportunities for the General Medical Council (GMC) to engage with the medical profession, but we must get better at engaging with the public and patients. It is not that little happens at present. We have a strong lay membership, an active public and patient reference group and take every opportunity to work with a range of patient interest and consumer groups. But there are three areas where we can make significant improvements. These are:

- **Helping the public when things go wrong.** There is no doubt that when a patient is dissatisfied with their care, the current systems that come into operation are not centered on the patient. The Healthcare Commission is tackling this issue, but it is vital the GMC continues to clarify the options open to patients and explain its own role in the process.
- **Leading the debate on health and ethical issues.** The GMC needs to facilitate broad debate on key medical issues and stimulate the wider population into developing views on these important topics. The advent of new technology should allow people to participate in ways that have never been seen before.
- **Shaping the doctor-patient relationship.** We need to take what patients see as a good relationship our starting point and continue to update that relationship in line with societal changes. The GMC's Education Committee has launched a series of actions to help it build a picture of what will be required of doctors in the future, which involve everything from research projects through to essay competitions for schoolchildren.

Whatever improvements the GMC makes, it is vital we form our policies by consulting with specific patient interest and consumer groups, and with the public at large. It is also important we build a picture of an effective doctor that is driven not only by things that have gone wrong, but also by what is regarded by patients as the very best of what the profession can offer.

Reprinted from the December 2004 issue of *GMC News*, published by the General Medical Council of England.

LET US HEAR FROM YOU

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

CALIFORNIA

INVESTIGATING PHYSICIANS SUSPECTED OF SUFFERING FROM DISABLING MENTAL AND PHYSICAL CONDITIONS

Business and Professions Code section 821.5 became law on Jan. 1, 1997. The law addresses concerns regarding timeliness of hospital medical staffs completing investigations and corrective action regarding physicians with potential impairment affecting competency, thus putting patients at risk. Medical staff can initiate a "formal investigation" of a physician when there are concerns the physician may be suffering from a disabling mental or physical condition that threatens patient care. The law still allows medical staff to investigate physicians with suspected impairment without automatically referring the case to the board, as long as the physician cooperates with the investigation and the investigation is completed in a timely fashion.

Under 821.5, such formal investigations require completing the steps of the investigation in accordance with specified timelines. California Code of Regulations, Title 16, sections 1362-1362.1, contains the time for investigations and the contents of the required report. Within 15 days of initiating a formal investigation, a "peer review body," as defined in B&P Code section 805, must report the action to the board's diversion program administrator.

The medical staff must gather facts within 30 days. Within 45 days, the medical staff must evaluate and dispose of the matter. (For an outside evaluation, 75 days are allowed.) A final report must be rendered to the diversion program administrator within 15 days of disposition of the matter. Disposition of the case can involve the following determinations and actions:

- No problem exists.
- List problems and indicate mental or physical disorder diagnosis, if applicable.
- If a mental or physical disorder exists, is there a threat to patient care? If yes, explain.
- Indicate implementation of applicable "action plan" options:

1) Treatment for the disorder.
2) Monitoring of the physician and description of the monitoring plan.
3) Practice restrictions or conditions that have been summarily imposed.
4) Practice restrictions or conditions have been recommended and the physician has been offered a hearing under B&P Code section 809.1.
5) An 805 report has been filed.
6) Other.

The board has developed peer review body forms for the initial report and for the final report. These forms are available and will be presented in a frequently asked questions format in the next issue of the board newsletter *Action Report* in January 2005.

CALIFORNIA MANDATES UNIVERSAL SCREENING OF THE HUMAN IMMUNODEFICIENCY VIRUS (HIV) FOR PREGNANT WOMEN

Women, particularly women of color, are the fastest growing population with AIDS both in the United States and in California.* Even more alarming, the percentage of annually reported female AIDS cases in California has risen every year since 1983. As such, in October 2003, former Governor Gray Davis signed Assembly Bill 1676 into law (Health and Safety (H&S) Code sections 125085, 125090, 125107 and 125092).

The H&S Code requires routine incorporation of HIV testing into the standard battery of prenatal tests as a strategy to ensure that all women have the opportunity to be prenatally tested for HIV, when interventions to prevent transmission to the unborn baby are most effective. The Centers for Disease Control and Prevention (CDC) has recommended offering prenatal HIV testing for all pregnant women since 1995. Routine testing is a strategy to help ensure pregnant women are tested for HIV, particularly women who do not know they are at risk of contracting HIV. This strategy should reduce treatment costs through the earlier identification of infected mothers and the prevention of HIV transmission to their infants.

H&S Code sections 125085, 125090, 125107 and 125092 require medical care providers to screen every pregnant woman in the state for HIV as part of the standard prenatal test panel. Additionally, providers are required to explain the purpose of the HIV test and to ensure the right of the woman to refuse the test. The statute also requires laboratories to report a positive HIV test result to their local health office and requires the provider who ordered the test to inform the woman of the test results.

Under H&S Code sections 125085, 125090, 125107 and 125092, HIV testing would not be required if the pregnant woman has been previously determined to be infected with HIV.

By Jan. 1, 2005, HIV informational material and a consent form can be downloaded via the Internet by accessing PDF files in English, Spanish, Armenian, Cambodian, Farsi, Korean, Lao, Chinese, Hmong, Russian and Vietnamese at DHS/OA's website at http://www.dhs.ca.gov/AIDS.

More information on the state statute described above is accessible through the Internet on the official California legislative information website at www.leginfo.ca.gov. HIV care and treatment information for health care providers is available through the Warmline at (800) 933-3413.

HIV referral and consultation resources for patients, including experts of prenatal HIV treatment, are available through the California HIV/AIDS Hotline at (800) 367-2437 (AIDS).

*Centers for Disease Control and Prevention. *HIV/AIDS Among U.S. Women: Minority and Young Women at Continuing Risk.* http://www.cdc.gov/hiv/pubs/facts/women.htm.

LEGISLATIVE UPDATE

The following legislation, which may impact physicians licensed in California, has been chaptered into law and took effect Jan. 1, 2005 (bills with an urgency clause take effect upon enactment). For additional information on all of these bills, please contact the website maintained by the Legislative Counsel of California at www.leginfo.ca.gov (click on "Bill Information").

Medical Care, Licensing and Enforcement

AB 30 (Richman, Chapter 573) Permits licensed health care facilities to print prescription forms by computerized prescription generation systems and exempts these forms from specified recordkeeping requirements. Provides that these computer-generated forms may contain the prescriber's name, category of professional licensure, license number, federal controlled substance registration number, and the date of the prescription. Deletes the inclusion of a pharmacy prescription number, license number, and federal controlled substance registration number from the prescriber's duty to keep a record of Schedule II and, as of Jan. 1, 2005, Schedule II and Schedule III prescriptions dispensed by the prescriber. Contains an urgency provision and went into effect on Sept. 18, 2004.

AB 691 (Daucher, Chapter 36) Requires specified nursing facilities to offer immunizations for influenza and pneumococcal disease to residents 65 years or older. Residents must first have their eligibility for the immunization determined by their physician or the medical director. Requires the facilities to obtain informed consent from residents prior to the administration of the immunizations.

AB 1403 (Nunez, Chapter 367) Renames the California Physician Corps Loan Repayment Program of 2002 to the Steve M. Thompson Physician Corps Loan Repayment Program.

AB 1629 (Frommer, Chapter 875) Requires skilled nursing facilities to include in a resident's care assessment, the resident's projected length of stay, and discharge potential. Requires the attending physician to indicate in the assessment the needed care to assist the resident in achieving his or her preference of a return to the community. Requires the Department of Health Services to develop and implement a facility-specific rate-setting system subject to federal approval. Contains an urgency provision and went into effect on Sept. 29, 2004.

AB 1975 (Bermudez, Chapter 756) Clarifies provisions of last year's AB 236, Bermudez (Chapter 348, Statutes of 2003). Requires the board to revoke the license of any person subject to the requirement to register with the police as a sex offender on or after Jan. 1, 1947. Contains provisions authorizing a one-time petition to the Superior Court for reinstatement of a license, if revoked after Jan. 1, 1947 and prior to Jan.1, 2005. Provides an exemption for a physician who is required to register as a sex offender solely because of a misdemeanor conviction under Penal Code section 314 or whose duty to register has been formally terminated under California law.

AB 2049 (Nakanishi, Chapter 78) Requires a person or facility that offers fetal ultrasound, for entertainment or keepsake purposes, to make the following specified written disclosure to the client prior to performing the ultrasound: "The federal Food and Drug Administration has determined that the use of medical ultrasound equipment for other than medical purposes, or without a physician's prescription, is an unapproved use." The disclosure must state that the use of ultrasound equipment without a physician's prescription is unapproved by the federal Food and Drug Administration (FDA).

AB 2185 (Frommer, Chapter 711) Requires health care service plans to provide coverage for equipment used in the treatment of pediatric asthma.

AB 2626 (Plescia, Chapter 452) Eliminates the requirement for a supervising physician to countersign a patient chart when a Schedule III, IV, or V drug order is administered by a physician assistant. The supervising physician still is required to review and countersign the chart when the physician assistant is issuing a Schedule II drug.

AB 2835 (Plescia, Chapter 452) Provides that it is a cause for revocation or suspension of a health care license or certificate for a health care professional to solicit, accept, or refer any person to a health care practitioner with the knowledge that, or with reckless disregard for whether, the individual intends to commit insurance or workers compensation fraud.

AB 3023 (Matthews, Chapter 351) Requires the board, along with other healing arts practitioner boards, to report within 10 working days to the Department of Health Services, the name and license number of a person whose license has been revoked, suspended, surrendered, made inactive by the licensee, or placed in another category that prohibits the licensee from practicing his or her profession.

AB 3044 (Yee, Chapter 770) Requires, with specified exceptions, sonographers who perform prenatal ultrasounds to screen for congenital heart disease to substantiate that they meet specified training and experience levels. Requires a sonographer, screening for congenital heart disease, to perform ultrasounds under the supervision of a physician. Becomes effective on July 1, 2006.

SB 136 (Figueroa, Chapter 909) Corrects an unintended consequence from the board-sponsored licensing status change from last year's SB 1077 (Chapter 607, Statutes of 2003). Due to this change, some physicians were required to change their licensing status from retired to active to continue practicing in the same manner they had practiced prior to the status change. The law still requires that the licensing status change take place, but requires payment of fees, as a result of these changes, only when the change in status coincides with the physician's renewal date. Requires the board to refund the money it already has collected from physicians who were forced to change their licensing status outside of their normal two-year renewal cycle. The time period set forth for this change to occur to receive this benefit was Jan. 1, 2004, through Dec. 31, 2004. Extends the due date of the enforcement monitor's initial report to the Legislature from Sept. 1, 2004, to Nov. 1, 2004, and extends the due date of the final report from Sept. 1, 2005, to Nov. 1, 2005. Clarifies that it does not constitute a waiver of any exemption from disclosure or discovery or of any confidentiality protection or privilege otherwise provided by law when the board provides confidential data, information, or case files to the enforcement monitor.

SB 1159 (Vasconcellos, Chapter 608) Establishes the Disease Prevention Demonstration Project (DPDP) to evaluate the long-term desirability of allowing licensed pharmacists to furnish or sell nonprescription hypodermic needles or syringes to prevent the spread of blood-borne pathogens. Permits a physician or pharmacist, without a prescription or permit, to furnish hypodermic needles or syringes for human use if the person is known to the furnisher and the furnisher has previously been provided a prescription or other proof of a legitimate medical need requiring a hypodermic needle or syringe to administer a medicine or treatment. Permits, between Jan. 1, 2005, and Dec. 31, 2010, a pharmacist to furnish or sell 10 or fewer hypodermic needles or syringes to a person 18 years of age or older, if the pharmacist works for a pharmacy that is registered for the DPDP. Permits the legal possession of 10 or fewer hypodermic needles or syringes if acquired through an authorized source from Jan. 1, 2005, to Dec. 31, 2010.

SB 1691 (Vasconcellos, Chapter 742) Excludes a physician from being subject to disciplinary action for certain aspects of unprofessional conduct solely on the basis that the treatment or advice he or she rendered to a patient is alternative or complementary medicine, if the treatment meets all of the following requirements:

- It is provided after informed consent and a good faith

prior examination of the patient.
- It is provided after the physician has given the patient information concerning conventional treatment and described the physician's qualifications related to alternative or complementary medicine.
- It does not cause a delay in, or discourage, the traditional diagnosis of a condition of the patient.
- It does not cause death or serious bodily injury to the patient.

SB 1725 (Knight, Chapter 404) Updates and makes clarifying and conforming changes to the provisions relating to parking placards and license plates for the disabled. Requires the physician, chiropractor, or optometrist who signs a certificate for a placard to retain information sufficient to substantiate that certificate. (Language also found in AB 1138 Frommer, Chapter 363)

SB 1782 (Aanestad, Chapter 864) States the intent of the Legislature that the California District Attorneys Association (CDAA), on or before Jan. 1, 2006, collaborate with interested parties, including the Medical Board, to develop protocols for the development and implementation of interagency investigations in connection with a physician's prescription of medication to patients. The protocols shall be designed to facilitate a timely return of all seized medical records.

SB 1794 (Perata, Chapter 486) Establishes standards for administering antipsychotic medication to persons found incompetent to stand trial (IST). Requires psychiatrists or psychologists appointed to examine potential IST defendants to also evaluate whether medication is medically appropriate and likely to restore mental competence.

SB 1913 (Business and Professions Committee, Chapter 695) Allows a retired physician to continue to use the title "Doctor" or the designation "M.D." Provides the specified liability protection to a medical expert who reports to any part of the medical board. Allows student midwives the same opportunities afforded other health professionals by permitting matriculating students the opportunity to provide clinical services.

Other Health Professionals

AB 932 (Koretz, Chapter 88) Clarifies the scope of practice for doctors of podiatric medicine, clearly authorizing them to perform limited amputations and to treat ulcers or wounds of the lower leg that are related to a condition of the foot or ankle. Clarifies that amputations cannot be of the entire foot. Requires the Board of Podiatric Medicine, in consultation with the Office of Examination Resources of the Department of Consumer Affairs, to ensure that Part III of podiatric examination adequately evaluates the full scope of practice for podiatric medicine. Changes "podiatrist" to "doctor of podiatric medicine."

AB 2560 (Montanez, Chapter 205) Removes the restrictions on nurse practitioners as to the health care settings and areas in which they may furnish or order drugs or devices for patients in accordance with standardized procedures or protocols, developed by the nurse practitioner and the supervising physician. Permits nurse practitioners to furnish or order drugs and devices whenever it is consistent with their educational preparation or for which clinical competency has been established and maintained.

AB 2660 (Leno, Chapter 191) Reinstates a pharmacist's authority to register with the U.S. Drug Enforcement Administration (DEA) as a mid-level practitioner and therefore initiate or adjust controlled substance drug therapy under physician protocols.

SB 1485 (Burton, Chapter 117) Clarifies physical therapists' scope of practice and revises the definition of physical therapy to include "the promotion and maintenance of physical fitness to enhance the bodily movement related to the health and wellness of individuals through the use of physical therapy intervention." Eliminates the requirement for a physician referral and allows physical therapists direct access to healthy individuals.

SB 1633 (Figueroa, Chapter 861) Prohibits any business from seeking to obtain medical information directly from an individual for direct marketing purposes without clearly and conspicuously disclosing how it will use and share that information and obtaining the consumer's consent to that use and sharing. Exempts businesses that are already subject to the Confidentiality of Medical Information Act, certain telephone corporations, and insurance institutions, agents, and support organizations, as specified.

SB 1765 (Sher, Chapter 927) Requires pharmaceutical companies to adopt and update a Comprehensive Compliance Program (CCP) that is in accordance with the April 2003 publication "Compliance Program Guidance for Pharmaceutical Manufacturers," which was developed by the U.S. Department of Health and Human Services' Office of Inspector General. Requires pharmaceutical companies to establish explicitly in their

CCP an annual dollar limit on gifts, promotional materials or other items or activities, with exceptions, in accordance with existing guidelines, as specified.

Reprinted from Volume 90 of the *Action Report*, published by the Medical Board of California.

OHIO

BOARD UPDATES MASSAGE THERAPY SCOPE OF PRACTICE

After nearly six years of work, the board has officially updated the massage therapy scope of practice, rule 4731-1-05 of the Administrative Code. It is important to note the new rule is not meant in any way to expand the massage therapy scope of practice, but rather serves to clarify the long-standing components of the massage therapy scope of practice. Highlights of the changes include the following:

- Throughout the rule, references to "massage" have been updated to "massage therapy" to be consistent with previous changes in statute.
- In paragraph (A), addition of the phrase "manipulation of soft tissue" and removal of the term "passive" from "joint movements." Additional language has also been added to paragraphs (F)(3), (F)(4) and (F)(5) to clearly identify the parameters of the LMT practice, limiting joint manipulations to those consistent with LMT education and training. Paragraph (F)(3) specifically includes a reference to the prohibition on LMTs performing chiropractic, but the board did not intend by only listing chiropractic to in any way suggest or authorize massage therapists to perform physical therapy or any other profession not specifically enumerated in the rule.
- In paragraph (B), inclusion of clarification that a massage therapist may educate patients consistent with their evaluation of the patient. MTAC indicated that such advice to patients, within the scope of practice, is clinically valuable but that practitioners had been deterred because of uncertainty regarding their authority.
- New paragraph (C) explicitly protects the title and designation "Massage Therapist" and "LMT," to assist in differentiating limited branch practitioners from other purveyors of massage.
- New paragraph (E) protects the public by requiring display of the certificate to practice.

The newly amended rule became effective May 31, 2004.

COMPASSIONATE CARE TASK FORCE ISSUES REPORT

The Compassionate Care Task Force report addresses issues surrounding the care and treatment of patients suffering from terminal illness or severe chronic pain.

Recognizing the importance of addressing the profound physical, psychosocial, and economic impacts of terminal illness and severe chronic pain, the Ohio General Assembly enacted House Bill 474 in December 2002, creating the Compassionate Care Task Force. The task force met monthly from May 2003 through March 2004 for the purpose of studying and making recommendations concerning issues surrounding the treatment and care of persons with terminal illness or severe chronic pain. These recommendations are discussed in a new report from the task force, which can be found currently on the board's website under "Medical Alerts" at http://www.med.ohio.gov. The task force will continue to meet through March 2005 to address its second responsibility of monitoring and reporting on the implementation of its recommendations.

H.B. 474 delineated a variety of participants for the task force (including 18 physicians) and required the director of health or the director's designee to be the group chairperson. Task force members include board Vice President Patricia Davidson, M.D., board Executive Director Tom Dilling and board Assistant Executive Director William Schmidt. Mr. Dilling and Mr. Schmidt have also served on the Ohio Pain Advisory Committee to the director of health since its inception.

The task force activities began with identification of the many barriers interfering with appropriate care of persons with chronic pain and persons with terminal illness.

Following identification of barriers, three subcommittees worked to (1) identify current needs and resources for pain management and palliative care in Ohio, (2) identify best practices for the care of persons with chronic pain, persons with terminal illnesses, and the family members of these two groups of patients, and (3) develop strategies to improve the pain management and palliative care practices in Ohio.

Some of the barriers to quality of care of persons with chronic pain and persons with terminal illness that served as the framework and rationale for the task force recommendations included:

- Health care professionals receive insufficient education on the care of persons with pain and persons with terminal illnesses in their basic education programs; many practicing health care providers have not updated their knowledge and skills in these areas; and, there is a lack of pain and palliative care specialists throughout the state, but especially in rural areas;
- Fear and misunderstanding of the existing statutes and rules regarding prescribing of opioid medications interfere with appropriate pain and symptom management; and
- Fear of regulatory scrutiny and litigation interfere with providing appropriate care.

Education and understanding are two significant ways to conquer fear. The medical board encourages licensees to visit its website and read the report of the Ohio Compassionate Care Task Force, as well as the board's rules in Chapter 4731-21 of the Ohio Administrative Code (OAC) on prescribing for intractable pain. The hallmarks of the board's rules are that physicians who prescribe to a patient with a terminal condition are not subject to disciplinary action by the board if the treatment is provided pursuant to the requirements of Ohio Revised Code (ORC) Section 2133.11; physicians who treat intractable pain by utilizing prescription drugs, including opiates and other controlled substances, are not subject to disciplinary action by the board if the treatment is provided in accordance with ORC Section 4731.052 and the rules found in OAC Chapter 4731-21; and there is a recognition that physical dependence and tolerance are normal physiological consequences of extended opioid therapy, and do not, in the absence of other indicators of drug abuse or addiction, require reduction or cessation of opioid therapy. If you read these statutes and rules, you should understand they are based on sound principles and standards of medical practice that are essential for the safe and competent treatment of pain.

In addition, the board encourages those physicians who encounter patients with intractable pain in the usual course of their practices to complete continuing medical education related to the treatment of intractable pain, including coursework related to pharmacology, alternative methods of pain management and treatment, and addiction medicine. Accepted standards of care in medical practice require the adequate treatment of pain. The board urges you to consider assessing pain as the fifth vital sign in your own practice.

Reprinted from the Summer/Fall 2004 issue of the *Your Report*, published by the State Medical Board of Ohio.

VIRGINIA
NEW LAWS FROM THE 2004 SESSION OF THE GENERAL ASSEMBLY

The following legislation affecting the professions regulated by the board is now in effect. Included are the links to the text of each bill should you wish to read it in its entirety.

HB 211
Historically, the board had two committees to help it investigate and audit the practices of its licensees. With the advent of centralized investigations and inspections by the Enforcement Division of the Department of Health Professions and the use of expert reviewers, the committees were utilized less frequently. As part of Governor Warner's initiative to streamline government by abolishing boards, commissions, committees, etc. that added little to the mission of an agency, these two committees, the Medical Complaint Investigative Committee and the Medical Practice Audit Committee, were abolished by this legislation.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0040

HB 309
This legislation makes it unlawful to practice occupational therapy without a license. It also requires individuals who practice as occupational therapy assistants to obtain certification from a credentialing organization approved by the board. The bill provided for emergency regulations, which have been promulgated and are in effect.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0061

HB 319
This legislation provides for extensions of professional licenses for citizens of Virginia serving outside of Virginia or the United States in the armed forces or in the diplomatic corps.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0975

HB 409
This legislation authorizes podiatrists to perform amputations proximal to the metatarsal-phalangeal joints in a

hospital or ambulatory surgery center that is properly accredited.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0731

HB 577
The central feature of this legislation is the newly granted authority for the board, and other boards, to delegate some informal fact-finding proceedings to "agency subordinates." An agency subordinate could be a single board member, board staff, or other qualified individual. The board has already promulgated emergency regulations and addressed how it intends to use this newfound authority.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0064

HB 633
The Virginia Board of Nursing participates in the Nurse Licensure Compact, which allows nurses from other states that participate in the compact, to practice in Virginia without obtaining a Virginia license. This legislation clarifies the regulatory authority the Virginia Board of Nursing has over individuals who are practicing here with multistate privilege under the compact.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0049

HB 733
This legislation authorizes a patient's executor or administrator to obtain copies of the patient's health care records in pursuit of litigation. Currently only the patient, his attorney or an insurer can obtain the records.
http://leg1.state.va.us/cgi-bin/legp504.exe?ses=041&typ=bil&val=hb733

HB 851
This legislation continues collaborative agreements between pharmacists and doctors of medicine, osteopathy or podiatry.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0853

HB 855
This legislation authorizes nurse practitioners to sign a plethora of forms, essentially all those that call for the signature of a physician. Please read the entire bill for details. This bill called for emergency regulations (see below) and stated that the regulations on this matter should include that the authority for a nurse practitioner to sign forms be included in the protocol with the collaborating physician.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0855

HB 856
This legislation requires that each person licensed to practice optometry in the Commonwealth after June 30, 2004 be qualified for prescribing Therapeutic Pharmaceutical Agents. An optometrist's prescriptive authority is expanded to include Schedule III through VI controlled substances and devices. Emergency regulations to address the Schedule III through VI drugs appopos for treatment of the eye and its adnexa are under development. For information, contact the Board of Optometry.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0744

HB 875
This legislation requires upon closure, sale or relocation of a practice, current patients of the practice will be notified of the change and the option of obtaining records. For the purpose of this law, current patient means one who has had an encounter in the previous two years. Relocation is defined as moving more than 30 miles away.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0053

HB 877
This legislation raises the bar for denying a patient access to his/her records. The test will now be that there is the likelihood that release of records to the patient will endanger the life or physical safety of the patient or another individual, or that a reference to another person in the medical record might cause substantial harm if the records are released. The patient can engage a physician or clinical psychologist to review the records, and the decision regarding release by the reviewer must be followed.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0065

HB 878
This legislation brings Virginia law into compliance with HIPAA while providing access to health records and information for guardians ad litem and attorneys representing minors in juvenile and domestic proceedings, proceedings to authorize treatment for patients incapable of providing treatment, persons who are subject to petitions for involuntary commitment, and those for whom a petition seeks appointment of a guardian or conservator.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0066

HB 879
This legislation synchronizes Virginia law regarding medical records privacy and HIPAA.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0067

HB 1133
This legislation clarifies the physician or nurse midwife assuming care of a newborn infant has the responsibility for performing screening tests for inborn errors of metabolism, not the delivering physician or midwife.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0760

SB 159
Athletic trainers have been certified by the board. Pursuant to this legislation, they will be licensed.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0669

SB 160
This legislation clarifies the doctor-patient relationship created by an emergency room visit or on-call duty terminates upon discharge from the Emergency Department or the hospital unless the doctor and patient affirm they wish to continue the relationship. This termination does not relieve the physician from the duty to follow through with checking and communicating pending test results, or any other aspect of care that would be deemed integral to the standard of care for the patient and the condition.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0878

SB 224
This legislation lifts restrictions on physicians that may have prevented them from fully disclosing to patients all medical treatment options. It also prohibits health insurers from placing such limitations on physicians. Physicians who disclose such information have immunity from liability to any health insurer.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0675

SB 337
This legislation synchronizes Virginia law with HIPAA, modifies the procedure by which a patient can receive records that, in the judgment of the practitioner, should be withheld and addresses access to health records for guardians ad litem and attorneys. This bill is similar to HBs 877, 878 and 879.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP1014

SB 385
This legislation further defines the communications protected under privileged, confidential peer review processes.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0250

SB 498
As a result of this legislation, podiatrists are able to list any specialty board certification awarded by the American Board of Multiple Specialties in Podiatry. This board offers specialty certificates in primary care in podiatric medicine, podiatric surgery and prevention and treatment of diabetic foot wounds.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0703

SB 555
This legislation authorizes a physician assistant (PA) practicing under the supervision of a physician to pronounce death as long as the following circumstances are met: 1) the PA works in home health, hospice, a hospital, a nursing home, a state-operated hospital, or the Department of Corrections, 2) the PA is directly involved in the care of the patient, 3) death has occurred, 4) the patient is under the care of a physician when death occurs, 5) death is anticipated, 6) the physician is unable to be present within a reasonable time, and 7) there is a valid DNR order. The PA must inform the physician as soon as practicable and inform the chief medical examiner if the death was unexpected.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP0092

SB 573
This legislation provides for an extension to a professional license of one year after an individual's release from active military duty.
http://leg1.state.va.us/cgi-bin/legp504.exe?041+ful+CHAP1017

NEW REGULATIONS NOW IN EFFECT

§18 VAC 85-20-10 et seq All Professions
The board must perform a periodic review of its regulations every two years. Changes are usually of a minor,

cleanup nature. The reviewed and revised regulations took effect Feb. 25, 2004.

§18 VAC 85-20-22 Medicine, Osteopathic Medicine, Podiatry & Chiropractic
These regulations, effective July 14, 2004, replace emergency regulations from 2003 that raised fees pursuant to HB 1441 from the 2003 Session of the General Assembly. The renewal fee for doctors of medicine, osteopathic medicine and podiatry is now $337 and for doctors of chiropractic is $312.

§18 VAC 85-110 Licensed Acupuncture
In effect April 26, 2004, these regulations allow licensure of a graduate from a school of acupuncture who graduated while the school was in candidacy status for accreditation, as long as the school achieves accreditation from the Accreditation Commission on Acupuncture and Oriental Medicine within three years of the applicant's graduation.

18 VAC 85-80-61 Occupational Therapy
Pursuant to HB 309, the board designated the National Board of Certification in Occupational Therapy designation as an occupational therapy assistant as the credential necessary for an individual to hold himself out or advertise as an occupational therapy assistant, or use the OTA designation. These emergency regulations took effect July 27, 2004.

18 VAC 85-120-75 Athletic Training
Athletic trainers who are seeking licensure in Virginia may be allowed up to 45 days of practice prior to final licensure provided most of the documentation necessary for licensure has been submitted. As some documents take a number of weeks to obtain, athletic trainers will be able to commit to a new position in Virginia without losing it due to a delay in getting documents in to the board. These regulations went into effect Sept. 8, 2004.

18 VAC 85-120-10 et seq Athletic Training
The regulations have been changed to reflect the law that athletic trainers are now licensed, instead of certified. These became effective Aug. 25, 2004.

§18 VAC 85-15-10 et seq All Professions
In response to HB 577, these regulations define an agency subordinate as a single member of the board, board staff, or another individual deemed qualified for the fact-finding task. The regulations limit the types of cases that may be heard by an agency subordinate to profiling, continuing education, advertising, defaults on student loans, failure to provide medical records and compliance with previous orders of the board. These regulations went into effect on Aug. 31, 2004.

§18 VAC 90-30-120 Nurse Practitioners
HB 855 expanded the authority of nurse practitioners to sign numerous forms that previously required the signature of a physician. These emergency regulations specify that the written protocol between the doctor and the nurse practitioner shall include the nurse practitioner's authority for signatures, certifications, stamps, verifications and endorsements in keeping with the specialty license of the nurse practitioner and the scope of practice of the supervising physician. These regulations went into effect on Sept. 8, 2004.

§18 VAC 90-30-80 et seq Nurse Practitioners
HB 633 concerns the Nurse Licensure Compact that allows nurses to move between participating compact states without obtaining new licensure. The regulations clarify that a nurse practitioner must hold a license as a registered nurse in Virginia or in a compact state to obtain a license as a nurse practitioner. These regulations went into effect Sept. 8, 2004.

PROPOSED REGULATIONS

18 VAC 85-20-10 et seq All Professions
In June 2003, the board set in motion the process for establishing standards of professional conduct for all its professions. The board made the determination that it would review the ethical standards documents for the various professions and derive its own set of regulations, rather than adopt the entirety of the documents of any profession. The results of this effort are that the board approved these proposed regulations on June 24, 2004. They are currently under Executive Branch review prior to publication for public comment.

18 VAC 90-30-10 Nurse Practitioners
These regulations governing nurse practitioners clarify that a graduate degree in nursing will henceforth be required for licensure as a nurse practitioner and that an applicant must submit evidence of professional certification consistent with the specialty area of the applicant's educational preparation by an agency accepted by the boards of Nursing and Medicine. The regulations were approved as proposed regulations by the board on April

22, 2004. They are currently in the public comment period.

Reprinted from the volume 66 issue of the *Board Briefs*, published by the Virginia Board of Medicine.

WEST VIRGINIA

HOSPITAL PREPAREDNESS IN WEST VIRGINIA

As the nation prepares for future disasters, particularly bioterrorism events, following 9/11, the West Virginia Bureau for Public Health Division of Threat Preparedness, in conjunction with the West Virginia Office of Emergency Services and the West Virginia Hospital Association, has been working to help hospitals in the state prepare for the worst. The current goal is to prepare for a surge capacity of at least 500 ill or injured patients per million population needing hospitalization as the result of a weapons of mass destruction (WMD) event, flu pandemic or other major disaster. A variety of activities are underway.

With the assistance of federal grant money from the Health Resources and Services Administration (HRSA), West Virginia hospitals are buying chemically resistant decontamination supplies, additional N95 masks, chemical and nerve agent antidotes, computers for Internet connection to the Centers for Disease Control and Prevention (CDC) and state Bureau for Public Health websites, radios and pagers for hospital security/safety personnel, etc. After committing to a three-tiered level of preparedness, the hospitals are being issued shelters and equipment for large-scale decontamination, along with training in their use.

This past year, the development of regional plans to deal with large-scale events has been a top priority. This year, training for hospital personnel will be addressed through ongoing courses in threat awareness and decontamination.

One of the biggest areas of focus will be enhancing isolation capacity so that all hospitals will be able to have either fixed or portable negative pressure isolation areas to care for patients with highly infectious diseases. The goal is for every hospital to be capable of caring for at least one highly infectious patient, and at least one hospital in each of the state's seven regions to be capable of caring for 10 or more such patients. Attention to the capabilities of hospital labs and their ability to process a potentially dangerous agent is also an area of focus.

Disease surveillance using manual reporting has been an ongoing problem, since the data often lags several days behind the patient's presentation and is sometimes incomplete.

For more timely identification and tracking of infectious diseases, the West Virginia Electronic Disease Surveillance System (WVEDSS) is being established. This will electronically connect providers and labs with the Bureau for Public Health to allow automated disease reporting.

Finally, and perhaps most challenging of all, will be the recruitment and advance credentialing of medical personnel who will volunteer to help in such a crisis. For more information, contact William D. Rose, M.D., FACEP, at wrose66@adelphia.net.

WHY DO CONSUMERS FILE COMPLAINTS AGAINST PHYSICIANS?

The most common complaint consumers have is not about fees or quality of care, but is related to the conduct of a physician – lack of attention or disinterest on the part of the physician (or even the staff), rudeness or failure to provide medical records when requested. When a beloved relative dies, apparent lack of sensitivity and communication issues often result in complaints. These are all areas where a physician's efforts to improve may result in fewer complaints being filed and less headaches for physicians.

Reprinted from the volume 8, number 3 issue of the *West Virginia Board of Medicine Quarterly Newsletter*, published by the West Virginia Board of Medicine.

LET US HEAR FROM YOU

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

EXPERT TESTIMONY

Brooks v. Roberts,
No. 2002-CA-01610-SCT (Miss. Sept. 16, 2004) - DEx 88491

The Mississippi Supreme Court ruled a trial court did not err in granting summary judgment in favor of a medical malpractice defendant due to the plaintiff's failure to comply with the trial court's order to designate an expert witness. The plaintiff argued the supreme court should excuse her delay in procuring an expert witness because the expert she attempted to retain repeatedly delayed signing affidavits, eventually rebuffing her completely. The Supreme Court rejected this argument.

The supreme court explained parties must use all good faith to comply with a trial court's order. That good faith was not present in this case, and the plaintiff failed in her duty to designate a medical expert. Litigants must understand that their cases are at risk without good faith compliance with trial courts' orders.

Lorimer v. Good Samaritan Health Sys,
No. A-03-262 (Neb. Ct. App. Sept. 28, 2004) unpublished - DEx 88695

The Nebraska Court of Appeals ruled a trial court did not err, in a medical malpractice case stemming from a patient's surgery, in inferring through other testimony and determining as a matter of law that an expert witness was not familiar with the standard for informed consent in similar communities. The appeals court noted the expert had never practiced in the community where the surgery was performed, knew no doctors there, and had not talked to doctors or physician assistants there. The expert did not provide any evidence showing familiarity with and knowledge of medical practice and informed consent for this surgical procedure in what was shown to be a community similar to the community where the surgery was performed.

Miller v. Pfizer Inc.,
356 F.3d 1326 (10th Cir. 2004), cert. denied, No. 03-1505 (U.S. Oct. 4, 2004)

The U.S. Supreme Court refused to review a Tenth U.S. Circuit Court of Appeals ruling excluding expert testimony in a wrongful death action filed by the parents of a teen who committed suicide one week after taking a drug to treat depression (see 13 *HlawWk* 158, Mar. 5, 2004). The Tenth Circuit held the trial court properly excluded the testimony of the plaintiffs' only expert witness whose theory and methodology were discredited by two independent court-appointed experts. The trial court then granted summary judgment for the drug manufacturer.

LICENSING

Chia v. Ohio Bd. of Nursing,
No. 04AP-143 (Ohio Ct. App. Sept. 7, 2004) - DEx 87697

An Ohio court of appeals ruled a trial court did not err in affirming an order of the Ohio Board of Nursing revoking a nurse's license for taking a patient's Percodan tablet for her own use. The board's decision to permanently revoke Chia's license was supported by reliable, probative and substantial evidence and was in accordance with the law.

The appeals court rejected Chia's argument that she did not receive proper notice of the board's intent to sanction her license. The court also rejected Chia's argument that the notice was ambiguous because it did not clearly explain that her license was supported and that she was entitled to a hearing on the board's proposed additional sanctions if she requested one within 30 days.

The appeals court found the notice clearly informed Chia that her license was immediately suspended. The notice also clearly notified her that the board sought to impose additional sanctions and that she was entitled to a hearing concerning those additional sanctions if she requested one within 30 days. Moreover, the appeals court noted, the notice was mailed via certified mail to Chia's address and was signed for by an individual at that address. Chia did not present sufficient evidence to overcome the presumption of valid service. Even had she been able to overcome this presumption, Chia still failed to respond within 30 days of when she admitted she received the notice.

Compton v. District of Columbia Bd. of Psychology,
No. 02-AA-1416 (D.C. Sept. 23, 2004) - DEx 88507

The District of Columbia Court of Appeals ruled the Board of Psychology improperly revoked a doctor's license to practice psychology for engaging in sexual harassment of a patient. The doctor had asked the court of appeals to decide whether evidence almost exclusively hearsay in nature constituted the critical mass of "substantial evidence" required under principles of administrative law to sustain the board's decision. After a measured examination of the record commensurate with the court's limited standard of review, it held that the particular hearsay evidence at issue in this case, which formed the core of the accusation, was too insubstantial to support the revocation order.

Ex Parte Medical Licensure Comm'n of Ala.,
No. 1022156 (Ala. Sept. 3, 2004) - DEx 87708

The Alabama Supreme Court ruled the Medical Licensure Commission of Alabama properly revoked the medical license of Dr. Oscar Almeida Jr., based upon the testimony of several of his former patients that he had engaged in sexual misconduct while he was rendering professional services. The Commission's decision was supported by substantial evidence and Almeida's due process rights were not violated.

Havsy v. State Bd. of Osteopathic Med. & Surgery,
No. 53198-1-I (Wash. Ct. App. Sept. 27, 2004) - DEx 88702

The Washington Court of Appeals ruled the state Board of Osteopathic Medicine and Surgery did not err in finding a doctor engaged in unprofessional conduct and imposing sanctions. Scott Havsy was licensed to practice osteopathic medicine in Washington. The board issued charges against him alleging that on numerous instances he had engaged in unprofessional conduct. The board's presiding officer conducted a hearing. Finding Havsy had engaged in unprofessional conduct, the presiding officer imposed sanctions. Havsy appealed. The appeals court affirmed the trial court's judgment. The record did not support a conclusion that the sanctions were arbitrary or capricious. Accordingly, the sanctions were proper.

Staschak v. State Med. Bd. of Ohio,
No. 03AP-799 (Ohio Ct. App. Sept. 2, 2004) - DEx 87844

The Ohio Court of Appeals ruled a trial court did not err in affirming an order of the State Medical Board of Ohio permanently denying a doctor's application to practice medicine and surgery in Ohio. The board's order was supported by reliable, probative and substantial evidence.

The board denied Dr. Michael Staschak's application after finding that two Pennsylvania disciplinary actions constituted a violation of Ohio Rev. Code § 4731.22(B)(22) and that Staschak failed to furnish satisfactory proof of good moral character. Staschak conceded the two Pennsylvania board orders constituted a violation of § 4731.22(B); however, he disputed the conclusion that he failed to furnish proof of good moral character. He argued the board did not use an articulable standard of good moral character when it reached its decision.

Although Ohio Rev. Code Ch. 4731 does not define good moral character, the appeals court did not agree that the board did not use articulable standard when it reached its decision. It concluded the board could find that Staschak's character lacked the elements of "simple honesty" and "respect *** for the laws of state and Nation." Therefore, Staschak lacked good moral character.

State ex rel. State Bd. of Healing Arts v. Thomas,
No. 91,403 (Kan. Ct. App. Sept. 17, 2004) - DEx 88499

The Kansas Court of Appeals ruled a trial court erred in denying an injunction sought by the Kansas State Board of Healing Arts to enjoin a dentist from attaching to his name the M.D. designation. The board sued Steven Thomas, seeking to enjoin him from attaching to his name the M.D. designation indicating that he engaged in the treatment of diagnosis of human disease, illness and injury. Although Thomas was licensed by the Kansas Dental Board as a dentist, he was not licensed by the Kansas Board of Healing Arts as a medical doctor. The trial court ruled in Thomas' favor and the board appealed.

The appeals court reversed the trial court's judgment and remanded the case. The statutory scheme of the Kansas Healing Arts Act requires the issuance of an injunction when an unlicensed individual attaches the M.D. designation to his name. The appeals court determined the trial court misapplied the law and that an injunction should have been issued in this case. Nevertheless, the appeals court found, the Act's statutory scheme as it relates to an unlicensed individual's use of the M.D. title is overbroad and should be narrowed. It found the Act's regulatory scheme may constitutionally ban only those uses of the M.D. designation that may potentially mislead the public,

patients, other health care practitioners or hospitals concerning the user's licensed or unlicensed status.

MALPRACTICE

Durham v. Vinson,
No. 25872 (S.C. Ct. App. Sept. 13, 2004) - DEx 87835

The South Carolina Court of Appeals ruled reversal was required as to a trial court's judgment regarding punitive damages in a patient's medical malpractice action against her treating physician. The court erred in admitting certain evidence during the punitive damages phase of the action.

Dr. David Vinson attempted to repair Nellie Durham's hiatal hernia by performing a laparoscopic Nissen fundoplication (LNF)—an advanced form of laparoscopic surgery. Durham initially responded well to the surgery but then began to have trouble swallowing and to vomit. An esophagram revealed food particles were dispersed throughout the esophagus and that it was not completely clearing the barium used in the esophagram.

Vinson subsequently performed an esophageal gastroduodenoscopy (EGD) on Durham the next day. During the EGD, Durham's gag reflex was suppressed. Vinson performed a repair LNF on Durham. After the repair surgery, Durham could not breathe without mechanical assistance and was transferred to the critical care unit (CCU) at Oconee Hospital.

While Durham was in CCU, her family requested that Vinson consult a pulmonologist. However, he did not do so. Durham developed adult respiratory distress syndrome and later, due to the complications stemming from her aspiration, developed pulmonary fibrosis.

Durham brought a medical malpractice action against Vinson. After the liability phase of the bifurcated trial, the jury found Vinson liable for $2.25 million in actual damages, and the jury found his conduct to be willful, wanton or in reckless disregard of Durham's rights. The jury awarded Durham $15 million in punitive damages. Vinson appealed.

The appeals court affirmed in part and reversed in part the trial court's judgment. The appeals court found the trial court committed two errors during the liability phase of trial. The trial court erred by allowing Durham's counsel to ask Vinson about his failure to fully disclose his privileging file and by giving an inappropriate standard of care charge to the jury. However, the appeals court found the errors harmless given that Vinson's liability to Durham was clearly based on the uncontradicted evidence that Vinson committed a gross breach of the standard of care in more than one instance while treating Durham.

The appeals court further found the admission of valium prescription evidence during the punitive damages phase violated S.C. Civ. R. Evid. 403. Because this error was not harmless, the appeals court reversed the trial court and remanded the case for a new punitive damages phase.

Hatcher v. Traczyk II,
No. 100038 (Okla. Civ. App. Sept. 24, 2004) - DEx 88739

The Oklahoma Court of Civil Appeals ruled a trial court erred in holding that medical malpractice plaintiffs' release of a defendant doctor's employer for any vicarious liability for the doctor's conduct also served to release the doctor of liability for his own alleged negligence. The plaintiffs' claim against the doctor was premised on the doctor's alleged individual negligence. Their claim was not based upon the doctor's vicarious liability.

STANDARD OF CARE

Jones v. LSU Health Sciences Ctr.-Shreveport,
No. 39,292W (La. Ct. App. Sept. 2, 2004)

The Louisiana Court of Appeals ruled a trial court erred in granting partial summary judgment in favor of a patient as to his medical malpractice claim against a health care provider. Issues of fact existed as to whether the provider breached the standard of care.

Prentice Jones moved for summary judgment on his malpractice claim, supported by a report from a medical review panel finding that LSU Health Sciences Center-Shreveport breached the standard of care when Jones presented at its ER and the breach caused the loss of Jones' testicle. LSU opposed the motion with an affidavit and report of a medical expert who concluded that there had been no breach in the standard of care and no malpractice. The trial court granted a partial summary judgment, ruling that LSU breached the applicable standard of care. However, it did not rule that the breach caused Jones'

injury or grant summary judgment on the issue of liability. LSU sought supervisory jurisdiction of the court of appeal, which was granted.

The court of appeal reversed the trial court's judgment. The court of appeal was presented with an opposing affidavit from a board-certified urologist stating that Jones' testis was not viable when he presented at the ER. Where such opposition is presented in a summary judgment proceeding, a trial court should not weigh or determine the credibility of the evidence. Accordingly, there remained disputed issues of material fact precluding summary judgment.

WRONGFUL DEATH

Estate of Cox v. Davis,
No. 03-2507-GTV (D. Kan. Sept. 14, 2004) - DEx 88511

The U.S. District Court for the District of Kansas ruled a doctor was not entitled to summary judgment in an estate's wrongful death action. A genuine issue existed as to whether the doctor's actions were a contributing cause to the decedent's death. The estate of Chester Cox, by and through its executrix, Jennie Lou Reemer, and Jennie Lou Reemer, heir at law of Chester Cox, deceased, brought a wrongful death action against Cody Davis, D.O. The plaintiffs alleged Davis failed to properly diagnose a fractured vertebrae that Cox suffered as a result of an automobile accident and, thus, caused or contributed to Cox's death. Davis moved for partial summary judgment.

The district court denied the motion. Davis argued the plaintiffs could not meet their burden to show that his actions proximately caused Cox's death. Specifically, Davis maintained that the plaintiffs' only medical expert, Dr. Philip Leavy, testified in his deposition that Davis did not do anything to cause Cox's death.

The district court concluded Leavy's deposition testimony was sufficient to create a genuine issue for trial as to whether Davis' actions were a contributing cause to Cox's death. Leavy testified Davis "totally missed" Cox's injury and provided him with improper medical treatment. The court determined these statements provided the degree of proof required from a medical expert to submit the case to a jury.

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