

The Abell Report

What we think about, and what we'd like you to think about

Published as a community service by The Abell Foundation

Progress Underway in Efforts to Protect Marylanders From Dangerous Doctors: *Doubts Remain About Effectiveness of Focus on Punishment*

ABELL SALUTES: “Living Classrooms,” Playworks, and Principal Marc Martin, for using physical education in sup- port of academic achieve- ment at Commodore John Rodgers Elementary

Dakari: “Boom Chicka Boom, I said
Boom Chicka Boom.”

Children: “Boom Chicka Boom Chicka
Boom.”

Dakari: “Chicka Boom!”

This is Playworks’ coach Dakari Taylor-Watson, leading 42 children, ages 6 to 13, in a pep yell in the gym of the Commodore John Rodgers Elementary School at Fayette and Chester streets. The school was designated in 2009 as one of the lowest-performing schools in Baltimore City. It is 11 o’clock in the morning.

Dakari leads the pep yell; the children respond robustly. Their voices ricochet against the bare walls of the gym:

Children: “Boom Chicka Boom Chicka Boom!”

In moments, they will break off into groups of 10 or so; some will play soccer or basketball, others will play dodge ball or hula-hoop. This is playtime at the Playworks’ program, for one hour every Monday, Tuesday, Wednesday, and Thursday—36 weeks of the year.

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By Joann Ellison Rodgers, M.S.

“The mission of the Board of Physicians is to assure quality health care...through the efficient licensure and effective discipline of health providers...by protecting and educating clients/customers and stakeholders and enforcing the Maryland Medical Practices Act.”

The intentions of the Maryland Board of Physicians (MBP), and the Maryland Medical Practices Act it enforces, appear straightforward. But it is when people get hurt, and attempts are made to uncover causes and solutions, that the extraordinary complexities and frustrations inherent in preventing physician misconduct and malpractice, and ensuring patient safety, raise public anxiety.

Consider the case of obstetrician/gynecologist Nikita Levy, who took his own life after charges by a co-worker in 2012 that over a long period of time he illegally and secretly videotaped his female patients at a Johns Hopkins community clinic. Given the MBP’s 21 volunteer peer overseers, investigatory powers, paid staff of 68, and \$9 million annual budget, as well as the activities of a second state agency called the Office of Health Care Quality, it undoubtedly surprised many Marylanders to learn that neither body had any authority to proactively oversee Levy’s practice, or the outpatient clinic where he worked.

At the time the charges were made against Levy, the MBP’s website (<http://www.mbp.state.md.us>), which publishes details of allegations made against physicians for “moral turpitude,” drug abuse, and malpractice, showed no active complaints, actions, or investigations. But it turns out that kind of information—for any of the state’s 20,000

licensed (14,000 of them practicing) physicians—would not be public anyway in the absence of a formal complaint. If not for the whistleblower, the allegations would likely never have come to light.

Experience suggests that even draconian law or regulation rarely prevents the nastiest violations of any code of conduct. That’s in part because whistleblowing is a bumpy process and because attempts to oversee behavior, particularly of highly educated professionals, must strike a balance between protecting public health and respecting the due process rights and privacy of practitioners.

But over the past decade or so, patients, consumer watchdogs, legislators, state health officials, and safety experts seem to have become less patient with excuses for what many see as an erosion of patient protection.

There is evidence that patient protections have indeed eroded, owing in part to the growing intricacy and diffusion of care, decreased reimbursement levels for practitioners, persistently poor regulatory performance, state agency budget cuts, and bureaucratic blunders.

In addition, the MBP, together with its six allied health advisory committees, has an “up front” licensing and credentialing authority (nurses excluded) that is somewhat dependent on a questionable self-reporting honor system, and on routine checks with the National Physicians Data Bank (NPDB). That organization gathers data on malpractice, criminal activities, and licensing actions, but it too depends on how fully information is reported. And although reforms have strengthened the MBP’s post-licensing role, that process still depends almost entirely on formal complaints to trigger investigations and

disciplinary action by a panel comprised mostly of other physicians.

Ultimately, though, patience appears to have run out because the small percentage of bad actors often escape detection or consequences for long periods of time, and do a lot of harm despite multiple legislative and administrative efforts at reforming and improving the identification and discipline of errant physicians.

That diagnosis seems to especially fit the situation in Maryland. In testimony before the state senate's Education, Health, and Environmental Affairs Committee in November 2011, State Health Secretary Joshua Sharfstein, M.D., noted that a legislative evaluation as far back as 2005 "found a series of problems, including a lack of sanctioning guidelines and an inability to resolve cases quickly."

Records show that, in some cases, patients continued to be harmed by physicians under investigation by the MBP for up to seven years before action was taken to revoke or suspend licenses, and in a third of some kinds of cases, it took two years or more.

In his testimony, Sharfstein said that in 2011's follow-up audit by the General Assembly's Department of Legislative Services (DLS), reviewers again found "serious problems," including "worsening delays in case resolution, inadequate progress on sanctioning guidelines, inconsistency, and a range of other administrative and oversight problems."

The persistent and serious disciplinary logjam, with "pending" cases often numbering in the hundreds, prompted the 2011 General Assembly and Sharfstein to propose a buffet of serious legal and regulatory reforms. A torrent of publicity was seemingly designed to embarrass administrators into speeding up implementation of reforms that in some cases had been promised as early as 2003. Indeed the DLS audit proposed to "sunset" the MBP unless all or most of a list of 46 recommended reforms

were promptly made.

The 2013 session of the General Assembly, which ended in April, finally codified many of these reforms, and capped a two-year flurry of sunset audit-driven activity that included wholesale changes in leadership of the MBP and its operations, some tough love by legislative auditors, and review by an independent blue ribbon panel commissioned by Sharfstein to augment the legislative audit, and that generated 18 additional or overlapping recommendations.

The major targets of the reform effort have been MBP efficiency and consistency of sanctions, based on the conviction that swifter investigation and discipline would take dangerous physicians out of practice more quickly.

In that regard, statistics gathered by the MBP's new executive director and chair show that reforms are indeed having an impact. More of that later in this report.

But whether, in fact, Maryland patients are or will be safer as a result is not at all clear. The supposition is that if physicians who behave badly, or whose standards of care are deficient, are put out of business or disciplined or rehabilitated, then people will be protected. But larger questions remain about *prevention* of harm in the first place. At best, it is uncertain if the threat of sanctions is an effective way to improve care, and many wonder why there is so little oversight of medical personnel once they are licensed in the state, especially solo, independent practitioners who provide most of the care in the community.

"We can't punish our way to patient safety," insists Peter Pronovost, M.D., senior vice president for Patient Safety and Quality, and director of the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine. An internationally recognized authority on efforts to prevent patient harm, Pronovost says "evidence is clear that to make patients safer, the *culture* in which physicians are licensed and practice must be reformed in ways that make prevention of harm the goal." Discipline is a critical part

of licensing and regulation, he adds, "but study after study demonstrates that lifetime learning, positive peer feedback on physicians already in practice, and other factors are critical in making patients safer."

Every state has an entity comparable to the MBP. But nationwide, proactive reviews of physician behavior and quality are rare outside of hospital settings, and quality improvement is left largely to other organizations that offer continuing medical education offerings required for re-credentialing and maintenance of specialty board certifications.

Consequently, it's unclear whether current reforms, or those proposed for implementation before the next scheduled legislative audit in 2016, are sufficient, sustainable, or likely to falter as they have in the past. The hope is that they will result in a more transparent and accountable medical workforce, and reduced malpractice or inappropriate physician behavior; and that the MBP is poised to become a force for improving practice and *preventing* harm rather than only reacting to it.

This Abell Report summarizes the MBP's challenges; the details and impact of reform efforts to date; some of the debates about the scope of the MBP's role in keeping Marylanders safe; and recommendations by health officials, watchdogs, MBP members, and patient safety experts for additional reforms.

A Nationwide Problem

Maryland is not alone in its worry over whether the MBP can reform its own operations well enough to meet modern demands.

A national watchdog organization, Public Citizen, whose Health Research Group (HRG) publishes reports on the activities of state boards, stated in a recent article that 55 percent of U.S. physicians censured by *hospital* peer review systems for negligence, substance abuse, malpractice, sexual abuse, fraud, or other bad behaviors have avoided or escaped any licensing action by state boards.

Sidney Wolfe, M.D., director of HRG, says this is but one indicator of the long-standing need for serious state board reforms and greater attention to the activity of such boards by the federal Office of the Inspector General.

Information gleaned by Wolfe from the NPDB shows that since 1990, when it began keeping records, 5.1 percent of the doctors in the U.S. account for 54.2 percent of the number of malpractice payouts. Moreover, these are the doctors against whom two or more payouts have been made.

Put another way, Wolfe claims, most offenders are repeat offenders who keep practicing. He points out that only 7.6 percent of those disciplined in the last 12 years, and only 13.3 percent with five or more malpractice payouts (1,192 doctors), have been disciplined. The Federation of State Medical Boards seems to agree, noting that Public Citizen's report was a "reminder of the collaboration required by many parties to better protect the public," and that under-reporting the extent of the problem to the Boards is likely a problem.

Attempts at physician licensure and discipline date back to 1789 in Maryland, and major organized attempts to protect the public from medical charlatans and snake oil salesmen began in 1799 with the establishment of the Medical and Chirurgical Faculty of the State of Maryland, (MedChi), a society of physicians who took on the role of policing their own. "We were the only official group doing that until the 19th century, when the state of Maryland took a role," notes Gene Ransom, executive director of MedChi. (Today, MedChi is more commonly known as The Maryland State Medical Society.)

Worried that the foxes were guarding the henhouse, in 1988, Maryland lawmakers established what is now the MBP, giving it regulatory responsibility for licensure and discipline of physicians and allied health practitioners (such as laboratory technicians). The MBP now reports to the state health secretary, but operates more or less autonomously.

In response in part to several high-profile cases involving dangerous physicians—including reports in 2002 of an obstetrician



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who had been sued 18 times in 20 years, successfully in nine of them, and had never been disciplined by the MBP—the state's legislature that same year documented a large backlog of pending complaints before the MBP. In 2003, the legislature amended laws regulating physician behavior and practice; expanded the working members of the MBP from 15 to 21; added five nonphysician members; changed the MBP's leadership; and lowered the standard of proof required to discipline physicians from "clear and convincing" evidence of malfeasance or malpractice to "preponderance of evidence," the latter already the standard in most states at the time.

Despite heavy lobbying from MedChi and some MBP members against the changes, the legislature, in 2003, also eliminated MedChi's substantial role in the investigative and disciplinary process. Lawmakers clearly believed that the low rate of discipline was in part due to a peer-review process that many felt resembled a

benevolent and protective society, and that drawn-out peer physician reviews showed evidence of reluctance to come down hard on fellow practitioners.

Moving forward, the MBP would no longer be required to refer every case in which a Maryland doctor was accused of violating "standard of care" to MedChi for a peer review by two of the nonprofit lobbying organization's members. Under the old law, if the two reviewers disagreed, the case was generally abandoned and the complaint kept secret. And the referrals often meant long delays in case resolution.

In 2004, HRG issued a report titled "Dangerous Maryland Doctors," concluding that 3 percent of doctors—about 576 practitioners—were responsible for half the medical malpractice payouts. Moreover, the MBP, or its predecessor Maryland Board of Physician Quality Assurance, had disciplined only 20.6 percent of 180 Maryland doctors who made three or more malpractice payouts between 1990 and 2004. The report further noted that in 2002, Maryland ranked 46th among all states and the District of Columbia for the frequency of its serious disciplinary actions involving "incompetence, inappropriate prescription of drugs, sexual misconduct, criminal convictions, ethical lapses, or other offenses," levying serious sanctions against only 39 of its 21,833 doctors. Putting it bluntly, HRG said, "there is no effective means for removing dangerous doctors from practice in Maryland." By 2003, things weren't much better, HRG reported. Compared to the national average of 3.55 serious actions per 1,000 doctors, Maryland had a rate of two per 1,000, ranking it 42nd among all states and the District of Columbia. Kentucky and Wyoming disciplined at least 11 out of 1,000. "Sometime in the 1990s, Maryland really began to slip," according to Wolfe, who, along with his staff, compiles the annual reports.

Wolfe has weathered criticism from MedChi and MBP officials for years over the statistical methods used to calculate the rankings, criticism that insists Public Citizen "over counts" the denominator of practicing physicians because many of the state's licensed doctors are researchers who don't practice. The executive director of the MBP at the time, Irving Pinder, M.D.,

argued that the Free State's low rate of disciplinary action was also due to effective means of denying licenses to unqualified doctors, and to the high quality of doctors trained at its two top-rated medical schools, Johns Hopkins and the University of Maryland.

Snapped Pinder at the time, "if you need a doctor and have a serious ailment, would you want to go to Kentucky, Wyoming, or Maryland?"

Wolfe calls such arguments "ridiculous," and strongly defends the methodology, noting that decades of data collecting and analysis by Public Citizen show that patients are more likely to be harmed in states with low rates of discipline than in states with higher rates. "You can't look at a 10-fold difference in rates of serious discipline and explain it by saying 'we have better doctors here,'" Wolfe said in an interview. "All states say that but it makes no sense, because when legislatures and boards have acted to improve their disciplinary rates, they go up dramatically and that can't be attributable to some sudden huge change in the quality of doctors practicing in one state or the other."

Wolfe also points out that in the mid-1990s, Maryland had about the same ratio of practicing to nonpracticing licensed physicians, but a higher rate of disciplinary activity comparable to other high-ranking states like Kentucky. Clearly something went wrong, Wolfe says. "In 1995, Maryland's ranking was 23rd."

As if to underscore that point, Public Citizen's 2008-2010 report, reflecting some reforms, ranked Maryland 38th, with 2.55 disciplinary actions per 1,000 physicians at a time when the national rate was nearly three per 1,000. And today, Wolfe says, with even more reforms in place, Maryland ranks between 27th and 28th.

Sunset Review and Perman Audit

By November 2011, the persistent pile of negative data, notably the case backlog, led to the DLS audit known as the "sunset evaluation." Legislators complained that Marylanders had waited years for the MBP to clear the case logjam, upgrade sanctioning guidelines, improve its public reporting, and make its operations more accountable.

In its call for immediate implementation of major reforms, the legislature levied the threat of eliminating funding, essentially "sunsetting" or decommissioning the agency unless things got better fast.

The subtext of the sunset report—and Secretary Sharfstein's response to it—was a call for a "cultural adjustment," at the MBP, said one MBP member. "Historically," said Sharfstein in an interview, "the Board members felt their job was essentially to decide cases and issue or revoke licenses, but since the sunset review, they know it's to improve the process and look at the big picture...to influence medical practice, not just process complaints."

Then-chairman of the MBP, Paul Elder, M.D., an Anne Arundel County physician, argued that improvements were underway, and pointed to the revocation of the license of Mark Midei, a Towson cardiologist charged with overuse of coronary stents; and the suspension of the license of Mark Geier, a Rockville doctor charged with providing unproven treatments to children with autism.

During FY 2011, however, the MBP charted some 740 cases rolled over from 2010, and would close out the year with 800 still unresolved.

Sharfstein, who says his goal is to make the MBP "a national model," responded forcefully to the sunset review, commissioning an outside review led by Jay Perman, M.D., a physician and president of the University of Maryland, Baltimore. Perman's committee was charged with creating its own list of recommendations.

The General Assembly agreed to delay further sunset action, and consider the Perman review in the 2013 legislative session. The Perman report—issued in July 2012 by a group that included Donald Swikert, M.D., a long-time member of Public Citizen's highly ranked Kentucky Board of Medical Licensure—ultimately made 18 specific recommendations that held a great deal of sway in the development of the reform bill that passed in the 2013 session. (Other members of the Perman Commission were lawyer Dianne Hoffmann, professor of law and director of the Law and Health Care Program at the University of Maryland; and Barbara Klein, chief government and community affairs

officer at the University of Maryland.)

Perman, who served for six years on the Kentucky Board, said in an interview that the MBP's "hard working" members were "overwhelmed" by doing the detailed work before them. "It's a catch 22," he said. "If you spend every waking moment on discipline, you never get to the other responsibilities likely to make practice safer in the first place and discipline less necessary."



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The Perman group prescribed a form of "divide and conquer," divvying up the board members into two equal groups that would meet separately, by adding one slot to make the panels even with 11 members each. Each panel would be fully authorized to take on complaints and decide whether or not to pursue further investigation. If pursued, a case would then go to the other panel as well as for full board review.

The goal was to avoid an "unduly formal and lengthy" process of resolution of every case by a "committee of the whole," which was worse than "herding cats," according to one MBP member.

Other key recommendations intended to streamline operations included the following:

- Wider use where appropriate of "informal" processes such as mediation and "consent agreements;"
- Additional access to lawyers within the Office of the Attorney General (OAG);
- Use of firm deadlines for action based on case complexity and whether "summary suspension" of a license was likely;
- Use of only one outside peer reviewer

- in standard-of-care cases;
- Rapid completion and implementation of consistent sanctioning guidelines;
- Expert evaluation of “fraud and self-referral cases;”
- Development of standardized investigatory “templates” to make sure prosecutors have all the evidence needed to develop charging documents;
- General Assembly action to make the powers and activities of the MBP clearer and to establish MBP committees to improve oversight of its operations;
- Proactive steps by the MBP to increase educational outreach and transparency; and
- Additional training for administrative law judges to expedite cases.

Legislative Action

The complexity of regulating, controlling, and disciplining licensed Maryland physicians and other health-care workers is reflected in the hundreds of pages of laws and rules covering these activities. Bills introduced in the 2013 Maryland General Assembly ran to 74 pages of verbal/legal thicket. The grounds for and range of sanctions alone include more than 40 categories and dozens of subcategories, with minimum and maximum sanctions ranging from reprimands to license revocation, and minimum and maximum fines running between \$1,000 and \$100,000.

Beyond establishing the parallel MBP panels, the new legislation, passed in April, also accomplishes the following:

- Requires the board to apply for a search warrant when someone is suspected of practicing without a license;
- Gives the board more authority to regulate and fine so-called “alternative health systems” in ways that align with how it regulates hospitals;
- Requires courts to report to the MBP, in a timely manner, information about convictions or “no contest” pleas related to moral crimes by physicians;
- Requires a summary of formal charges filed against a physician to be posted

- prominently on the MBP website within 10 days, along with a disclaimer that the charging document does not indicate a final finding of guilt;
- Reaffirms that peer groups are best qualified to regulate and discipline physicians; and
- Emphasizes that the MBP, in addition to its licensing powers, “develop and implement methods to ensure the ongoing competence of physicians,” to report all disciplinary actions; to “make recommendations that benefit the health, welfare, and safety of the public;” and to “provide ongoing education and training to board members.”

Finally, the legislature voted to repeal the MBP’s authority to directly provide rehabilitation services for licensees in need of treatment for alcoholism; chemical dependency; and other physical, emotional, or mental health conditions.

The Impact of Reforms

Today, the MBP has new leadership in place with executive director Carole Catalfo, a former government attorney with experience in regulatory compliance and professional oversight; and chair Andrea Mathias, M.D., a family practitioner with extensive experience in private practice management, hospital care, and public health safety regulation. Mathias is the first chair not appointed by the MBP itself, but instead by Governor Martin O’Malley, in a bid to confer more oversight of board operations.

In a wide-ranging joint interview, Catalfo and Mathias say they fully support what Sharfstein characterized as “getting bread and butter issues right,” and focusing on the biggest known areas of bad practice, such as misuse of controlled and dangerous substances by physicians personally and in their patient care, poor pain management, sexual abuse, poor record keeping, the overuse of technology and diagnostic tests, and financial conflicts of interest in billing practices.

Recently, Public Citizen’s Wolfe lauded Sharfstein and the legislature for the no-holds-barred audits and demands for measurable reforms. “After a long history of poor performance, there is a welcome uptick in the Maryland board’s performance,”

Wolfe says.

For example, for FY 2012, the last full year for which data are available, the MBP reported its backlog of pending complaints was down by 100, to about 739, and that it was carrying over only 244 into FY 2013.

In that same time period, 214 cases were closed with formal disciplinary action compared to 170 the year before.

Board disciplinary referrals for formal prosecution rose 150 percent between 1999 and 2009, and by another 100 percent from 2009 to 2012, and summary suspensions more than doubled from six to 15.

Similarly encouraging, Catalfo and Mathias note, are the data on the cases and complaints that were before the MBP for more than 18 months. In FY 2011, the number was 85; in FY 2012, the number dropped to 70. As of mid-January 2013, there were 92 current cases in process for more than 18 months, and there were 167 in process for less than 18 months.

MBP leaders are especially happy with the growing number and percent of cases resolved at Case Resolution Conferences. From August to December of 2011, 66 percent were resolved; for the same period a year later, that figure rose to 90 percent. “This is one way to rationally achieve goals of safe practice and offer licensees the chance to learn where their peers or patients have a concern without a full-blown, excruciating, years-long process,” says Mathias, adding “the goal is to strike a balance between the rights of licensees and making remediation and education work to stop a problem.”

In a Sunset Report Update presented in January 2013, Mathias and Catalfo also pointed to improvements in the MBP’s operations, transparency, budget planning, and board training. As of December 2012, 33 of the 46 sunset recommendations had been completed, seven were underway, and six were under discussion or headed to the General Assembly. Of the Perman recommendations, seven were complete and six were underway—notably including plans for the two-panel system designed to expedite board reviews of complaints.

In addition, Mathias and Catalfo reported that the MBP had achieved the following:

- Revised its hearing regulations and physician sanctioning guidelines;
- Standardized its investigation templates;
- Developed a long-term fiscal plan that included an analysis of its fee structures;
- Established plans for greater public disclosures and more timely ones, and revised guidelines for reopening sexual misconduct cases;
- Reduced a “false” backlog of cases due to data errors and duplicate case files; and
- Instituted a backlog review team, and reached out to improve communications with the OAG, a move vital to the MBP’s timely resolution of cases.

Catalfo and Mathias also noted procedures aimed at preventing harm by closer scrutiny of prospective licensees. For example, the MBP uses so-called “continuous inquiry” to check up on physicians’ backgrounds with the NDBP over time, a significant factor in preventing harm, according to Public Citizen’s Wolfe. The idea is not to depend on physicians’ own reports of their problems, or to wait for complaints to arise, but to use the database on a proactive, rolling basis to check to identify disciplinary actions whenever physician licenses are sought or renewed.

Mathias and Catalfo say a licensee’s complaint history is now reviewed every time a complaint of sexual misconduct is received, and the MBP has implemented a special tracking system for these complaints that reopen such cases whenever information indicates a pattern of misconduct.

In April 2012, the MBP website underwent what Catalfo called a “sweeping overhaul,” taking it from a “long list of blinking disciplinary alerts” to a site that is easier for the public and physicians to navigate. The MBP is also preparing to post allied health profiles similar to those posted for physicians, with a goal of including information for the past 10 years. (The MBP licenses and regulates numerous health-care technicians and practitioners other than physicians.)

Continuing Challenges

Those interviewed for this report suggest that even if the current round of reforms is perfectly implemented, efforts to monitor and improve physician practice and behavior will still face challenges. Among these are the uncertain impact of providing access to care for tens of thousands more Marylanders owing to the Affordable Care Act, and the lack of consistency among the 50 states in terms of what is reported about malpractice and other violations to the NPDB.

The cultural divide between community-based physicians and academic physicians is also likely to remain a barrier to quality improvement. MedChi constituents are largely in solo or small group community practices, and they share a sense that hospital-based specialists and large groups are insensitive to the time and economic pressures community physicians face.

“MedChi thinks the board is just out to get doctors,” says one member of the MBP, “but it’s important to understand that MedChi does not represent most physicians in Maryland.”

MedChi’s Gene Ransom says its members are generally supportive of reform efforts, but consider the disciplinary process “still too byzantine and too long for doctors and patients,” particularly if a physician is innocent. Records are not expunged timely, he says, and other states require a “significantly shorter time to get licensed.” He says his organization wants the MBP to focus on clearing the backlog of cases, and perhaps then it can “play a bigger role in efforts to prevent complaints.”

“The big issues for the solo doctors are complex and different,” Ransom adds, noting that MedChi has 7,500 members among the 14,000 practitioners. However, not a single member of the National Institutes of Health, which employs hundreds of physicians, is a member. Rubbing elbows with research and academic physicians could enhance physician practices, he says, and hopes Johns Hopkins and the University of Maryland will increase their memberships.

Issues related to sanctions also remain a source of concern. Comments during the hearings at the 2013 General Assembly session made clear that some would prefer tougher and more consistently applied

sanctions. MBP officials argue they need considerable flexibility to allow for mitigating or aggravating factors, and to break with precedent in the interest of fairness.

Additionally, while the MBP has established an “operational” unit to further streamline its processes, much still needs to be done to systematize the identification of “hot topics” that form clear patterns of physician malpractice or bad behavior, and to target preventive education to them via continuing medical education courses, websites, newsletters, and other educational outreach.

Inherent in many of these challenges is what Mathias calls the battle for the overall “soul” of the MBP. Currently, she says, “the board is complaint driven, so our prevention and outreach efforts must be directed at advising our licensees on how the board is observing practice trends recognized as bad. By implication we are not then looking for quality improvement outside of these complaints, but we should be doing more in this regard.”

Catalfo agrees that to improve physician practices, carrots as well as sticks are necessary, a strategy that may require labor-intensive partnerships to advance continuous lifetime learning. Currently, MedChi is a primary source of continuous medical education for community-based practitioners. But academic medical centers that employ large numbers of physicians and other health-care workers, and usually have robust peer-review operations, also are a source of substantial efforts in continuing medical education, patient safety, and quality improvement—efforts largely untapped for the benefit of community physicians. Says Catalfo, “We are moving in this direction, but this is all new ground and will take time.” Adds Mathias: “Our relationships with MedChi and a whole host of other professional groups need to be formalized.”

Overseeing and reducing financial misconduct among medical professionals is yet another area of challenge. Some observers would like the MBP to tackle this area; others note that this area goes beyond the expertise and mandate of the MBP. “The rules around Medicare and Medicaid coding and fraud are extraordinarily complicated and easy to unintentionally break, so we are very sensitive to the difference between losing track of a rule and deliberately gaming the

system,” says Mathias. Although the MBP does investigate complaints of billing fraud, she doubts that the MBP will ever be able to track trends or implement sensible practice standards, noting that other professional groups that offer practice management programs may be better positioned to do so.

Beyond such practicalities, some ongoing challenges to improved physician quality and patient safety fit into that “cultural” category.

For instance, Mathias says she is aware of a “sense of fear” among licensees about asking the MBP for guidance or advice, and a concern among patients who worry that making complaints will create problems for them, and that their care will suffer.

Mathias says both physicians and the public need to understand that the MBP’s purpose is not to “go after people,” but to solve problems and improve medical practices.

Current and even some former members of the MBP, and others familiar with its challenges, were generally unwilling to speak on the record, but they agree that Mathias has diagnosed a big problem for the MBP. What is missing, they said, is a commitment to taking advantage of what one called the “tremendous opportunity to get involved in the prevention of harm.”

“There are too many Lone Rangers out there practicing medicine, physicians who have little opportunity for lifetime learning, rigorous peer review,” said another. “The CME courses they take are not especially rigorous and many practitioners don’t get the kind of scrutiny that is available in academic medical centers or from specialty boards. Even if you streamline the disciplinary aspect of oversight, it leaves a whole world of how to prevent malpractice mostly untouched. Real culture change is needed and it’s hard to say if this will happen.”

“There is an opportunity for a strong focus on quality improvement and patient safety,” said one physician intimately acquainted with the work of the MBP, “but what’s needed is a lot more whistleblowing. Patients and office staff need to be empowered to report bad practices and to be vigilant.”

Perman agrees. “I would be happy if I knew that the board spent half its time doing discipline and the rest making sure doctors practice better medicine. It can be

done. Maybe it’s the pediatrician in me, but we need to spend more time on prevention. It would be totally appropriate for the Board of Physicians to focus on ways to enhance the safe practice of medicine, but there is not sufficient expertise on the board yet to do this. The composition of the board needs more academic input.”

Peter Pronovost, the patient safety expert who also is an anesthesiologist and critical care specialist, circles back to the primary charge to the MBP under Maryland law: to protect people, to improve safety and practice, and to enhance professionalism. “Most of the impact on safety,” he says, “will continue to come through intrinsic motivation, professional norms and values, culture if you will. If one broadens the lens of the notion of protecting patients, then social norms of teamwork, and collaboration, empowerment of subordinates to speak out about troubling practices, humility and respect could have enormous impacts on safety and patient experience. The vast majority of physicians want to do good, not harm patients. But they need to work more broadly to create a culture where harm is preventable and not inevitable.”

Conclusions and Recommendations

For this report, those most intimately involved with the MBP and its goals were asked what would be on their “wish list” for an organization that is likely to see special scrutiny for years to come. Here are the highlights.

- Develop an intense public education campaign to encourage awareness among patients, physicians, and ancillary health-care workers of MBP’s role.
- Make it easier and less fearful for physicians to seek guidance and for patients to express concerns.
- Make it easier for patients and medical office workers to lodge complaints without a thicket of bureaucratic barriers.
- Beef up the information provided in physician profiles on the MBP website. A new information technology system is needed and is being planned for, Catalfo says, to improve transparency and efficiency, including conversion to a paperless licensure application system

and to an easier system for filing complaints.

- Improve background checks of physicians throughout their careers by accessing not only the NPDB, but also other regulatory and law enforcement databases.
- Gather and analyze information about trends in inappropriate behavior more intensely, and develop more targeted prevention and remedial programs. Then alert the public to them as well.
- Put resources and effort into partnerships with academic medical centers, specialty societies, and MedChi to upgrade CME and develop and implement programs that promote a “culture of safety.”
- Advocate for stable funding so that the work of the MBP is not interrupted.
- Use data on trends in violations to set priorities for investigations.
- Commission or champion efforts to take a fresh look at the overall scope of responsibility of the MBP and what resources may be needed in the future as medical care becomes even more complex.
- Partner with business schools, MedChi, and other organizations to provide practice management/financial management training for community-based physicians.
- Partner with organizations such as Public Citizen to conduct research on factors that predict better MBP performance. Encourage and help implement a system of peer-to-peer reviews in which physicians pay visits to practitioners on a regular basis to observe and offer guidance. Feedback would be confidential but ruthlessly authentic.
- Measure the impact of such interventions. Research suggests that people can’t improve what isn’t measured.

For additional information about the Maryland Board of Physicians (MBP), including specifics on the services it provides, the types of complaints that result in discipline, and what happens during an investigation, log on to www.mbp.state.md.us/pages/whatis.html.

Joann Ellison Rodgers, M.S., a science journalist and author, directed Johns Hopkins Medicine's media relations and public affairs division for 25 years, and now serves as a consultant there, and as a part-time faculty member at the Johns Hopkins University's Berman Institute of Bioethics. A graduate of Boston University and the Columbia University Graduate School of Journalism, Rodgers is a past president of the National Association of Science Writers and the Council for the Advancement of Science Writing; a Fellow of the American Association for the Advancement of Science (AAAS); and a member of Sigma Xi, the Scientific Research Society. The author of seven books, her awards include a Lasker Award for medical journalism.

ABELL SALUTES

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Warming to the moment, the children are clapping their hands. They are jumping up and down, and waving their arms. They are also helping to prove a point that is the resolve of Living Classrooms and Principal Marc Martin: Physical exercise for urban children heightens their learning experience, and workouts in the gym or playground translate to higher grades in the classroom.

Starting in 2010, program administrators, working on a three-year grant of \$240,000 from The Abell Foundation, designed and implemented a plan for increasing physical education at the school, both inside the gym and outside on the playground—all toward making physical education (phys ed) a tonic to the educational experience here at Commodore John Rodgers Elementary.

* * *

Living Classrooms is a Baltimore foundation that includes within its mission “the strengthening of communities and the inspiring of young people to achieve their potential through hands-on education and job training, using urban, natural, and maritime resources.” Locally, narrowing its focus, its objective is to help people living in underserved East Baltimore neighborhoods break the cycle of poverty through education. In support of that specific goal, it funds programs on local campuses and youth training centers, and acts as operators of two public schools, Crossroads Charter and Commodore John Rodgers. The 42 children in the gym at Commodore

Rodgers are among the 510 children that make up the student body of the school and that Living Classrooms is designed to affect.

The Living Classrooms initiative at Commodore John Rodgers is based on research provided by the Robert Wood Johnson Foundation, which links physical activity to improvement in academics. The one-hour Playworks supervised recess in the gym four days a week, in support of the program, is only one piece of the more expansive physical fitness focus. The initiative also addresses severe gaps in the physical education program, including an insufficient number of phys ed teachers, very little sports equipment, no recess, and a limited number of active after-school sports programs.

In collaboration with the school, Playworks receives \$25,000 in support of its efforts, which include at least one hour of moderate to vigorous physical activity per day with a structured before-school recess and after-school programming, trained full-time coaches to supervise all physical education on the playground, social and emotional development, a junior coach program (where older youth mentor younger children), an after-school noncompetitive program in girls' basketball and co-ed volleyball, and training of school staff. While Playworks' national program is currently a pre-K to fifth-grade program, the program has expanded with Living Classrooms to include a pilot program for middle school students to be held at Commodore John Rodgers.

In addition, through the physical education initiative, Living Classrooms has hired a second phys ed teacher for the school. It has installed weight training equipment on the playground for use by the community and developed after-school programming at the two new athletic fields and the Carmelo

Anthony Youth Development Center. Also included are intramural soccer and lacrosse, and funding for bus transportation for students to and from the fields.

But for the effort, money, and energy expended in support of the Living Classrooms program at Commodore John Rodgers, what, through the one-and-a-half years, have been the results? Principal Marc Martin sums up: “Through the support of Living Classrooms and Playworks with our school fitness initiatives and goals, students are getting healthier each day. Twice the number of physical education classes are offered to students; students now receive recess each day; and students are aware of their own fitness ‘numbers,’ such as weight, endurance, and agility. This focus on fitness is making an impact. Not only is there a growing interest in our after-school athletic programs, but attendance is up, suspensions are down, and, most importantly, achievement is up. Students are improving reading levels by an average of two grade levels each year, and Commodore, for the first time in 10 years, met the state goals, by hitting 71 percent proficiency in reading and 68 percent proficiency in math. Attention on fitness does matter and will make a huge difference in years to come for the Commodore community.”

The new dean of the education school at Johns Hopkins University is working on a five-year evaluation of the project with Living Classrooms.

The Abell Foundation salutes Principal Marc Martin; Talib Horne, vice president of Living Classrooms; Commodore Rodgers physical education teacher Andrew Hiavka; and Playworks' coordinator Dakari Taylor-Watson. The Foundation salutes all, for effectively using physical education to achieve academic excellence.