



Your Records: Your Friends

Inside:

"Hot Tubs and You:" Boundary Issues

New Board member, officers

Board Website update

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By Philip F. Parshley, M.D.
BME Medical Director

With the startling revelation by the Institute of Medicine in *To Err Is Human* that 44,000 to 98,000 deaths from medical errors occur in this country every year, emphasis has been placed on developing systems to prevent these errors rather than assigning blame to individuals. Every Board of Medical Examiners (BME) licensee can contribute to this process by reassessing the systems that lead to the development of medical records in his or her office. In addition, the medical record can be a healthcare provider's most valuable friend, when that provider is challenged by a malpractice suit, a hospital medical staff organization, the BME or other regulatory organizations.

The standard of care requires a very complete documentation of every aspect of the medical care physicians provide their office patients. There are certain specific components that the BME expects to find in the medical record.

First, it must be in the record and legible – or it didn't happen! Two pieces of pertinent information that frequently fail to make the medical records are progress notes you forgot to write or dictate, and telephone communications with the patients, consultants, former treating physicians, and the patient's family. Those who share call with you and your staff need readable information from your chart in order to assist you in providing quality care for your patients.

The SOAP (Subjective, Objective, Assessment, Plan) format is considered the

standard of care with a separate set of entries for each major issue. The Subjective part is expected to contain a detailed history of the presenting issues, including identifying previous providers who have dealt with the present problems and what those providers did for the patient, a record of past illnesses, procedures, current medications, allergies, and a review of systems. The review of systems may be facilitated by a printed questionnaire which the patient completes. If you review the patient's responses on that form with the patient, perhaps with expansion of issues in your handwriting followed by your initials, date and time, you will demonstrate that you have reviewed the information.

The Objective part is a detailed complete physical examination that may vary based on the specialty of the examiner. This would also include laboratory and imaging results.

Your Assessment should include your reasoning for your diagnosis, as well as alternative diagnoses, if pertinent.

The Plan should have an explanation for your choice of action, especially if there are alternatives, and indicate the alternatives that were discussed with the patient. It is always a good idea to note that the patient was asked if he/she had any questions, and their answer. Note the expected date of revisit.

Physicians are currently being overwhelmed by more and more paperwork, but written protocols are very worthwhile to make certain that the professional providers and the office staff understand what is expected of them in all aspects of the practice. For example nothing is to be

(continued on page 4)



From the Executive Director

Hot Tubs and You

By Kathleen Haley, J.D.

When I came to the Board office eight years ago, I was surprised at the nature and number of sexual misconduct complaints that the Board received.

Surprised but undaunted – I felt certain the Board could remedy that state of affairs, and reduce the number of complaints down to practically nothing by making clear its expectations of licensees, and the consequences of inappropriate behavior with patients, (via notices in *BME Reports*, etc).

However, I learned quickly that thanks to basic human nature, that was a very unrealistic expectation on my part. So I wanted to take a moment to outline some of the issues and circumstances leading to physician sexual misconduct, as I've observed them.

Patient Scheduling – There are two possible warning signs from this area of patient management: “When” and “Where.”

Scheduling a particular patient for appointments late in the day is often a warning sign. When a physician notices that this is the case, or staff brings this circumstance to a physician's attention, it is probably a good time to re-examine that particular doctor-patient relationship for the potential of any undue intimacy.

Meeting with a patient outside the office is another potentially risky practice. Physicians may feel that it is quite an innocent practice, to stop and have a cup of coffee with a patient. And in some circumstances – in small communities and/or rural areas – this is often the case. In many cultures and circumstances, such informality is normal and is usually not harmful to the patient, or to the doctor-patient relationship.

However, in some circumstances, meeting a patient outside of a clinical setting can often be misread by the patient as the first step toward greater intimacy – regardless of which party makes the first such overture. The physician should take responsibility by assessing his or her relationship with a patient, any personal feelings regarding the patient, and any perception of the patients' possible feelings toward him or her, before arranging or entering any such meetings.

Providing Personal Counseling – Since Hippocrates' day, this has been an important part of the primary-care physician's scope of practice. Such counseling is often essential in treating the whole human being.

Generally, these sessions start out with the best of intentions on the physician's part. But it is possible for personal counseling sessions to lead to more intimacies between the physician and the patient – first emotional, then physical.

The Board does not suggest that physicians do not take the time or effort to hear and understand their patients' concerns. Even in our more clinical and cynical society, the physician is still regarded by many as not only a practitioner of medical science but also as a kind and wise counselor. But as with out-of-office meetings, it is only prudent that physicians take special care in monitoring any possible personal physician-patient (or vice versa) feelings that may emerge during such counseling.

Controlled Substances – The practice of medicine and the physician-patient relationship contain many gray areas. But there remains at least one black-and-white truism: Writing a prescription for a patient equals establishing a

physician/patient relationship.

Physicians who prescribe narcotics to patients are encouraged to be doubly vigilant and scrupulous in their relationships with those patients, particularly where there is danger of emotional and/or physical vulnerability on the part of either party. The problem may be compounded by a romantic and/or sexual relationship between physician and patient.

It is surprising, but these have become “textbook cases” for the Board. Each agenda contains cases in which physicians gradually became more personally intimate with patients. Some patients had psychological or drug/alcohol problems, yet physicians continued to write inappropriate prescriptions or provide alcohol, while engaging in sexual misconduct.

Within clinical settings, physicians should avoid offering patients anything stronger than coffee or cola drinks for other than medicinal reasons. In this case, “clinical settings” includes those out-of-office meetings with patients to discuss health-related issues.

When physicians and patients are together in purely social settings – again, this often occurs in certain communities – the physicians should assume responsibility for their judgment and actions regarding the use and sharing of alcohol with patients.

Hot Water: For Birthing, Not Bathing! – When a patient tells you that her sister is going to be out of town for the weekend and that she has a great hot tub, the screaming answer in your brain needs to be “No, thank you!”

The Board has seen more than one case involving physician sexual misconduct in which the hot tub has been the first, inviting way-station on the road to ruin, *vis-à-vis* a doctor's professional life.

In the case of sexual misconduct, as you may have noted in previous editions of this newsletter, the Board frequently places the physician on probation with many terms of compliance. In some cases, a suspension is imposed. Such Board orders are recorded in the National Practitioner Database, with serious consequences for the physicians involved. Often,

(continued on next page)

STIGER APPOINTED TO BOARD OF MEDICAL EXAMINERS

John Stiger, D.O., Milwaukie family practitioner, is the newest member of the Oregon Board of Medical Examiners (BME).

Gov. John Kitzhaber appointed Dr. Stiger to serve on the BME until Feb. 28, 2005, at which time Dr. Stiger may be reappointed to a second and final three-year term. The state Senate confirmed his appointment to the medical board earlier this spring.

Dr. Stiger is owner-physician of Oak Grove Family Medical Clinic, where he has practiced since 1974. He is affiliated with Eastmoreland Hospital, Portland. Dr. Stiger also practiced at Dwyer Memorial (now Providence Milwaukie) Hospital as an emergency room physician from 1975 to 1989.

He is a veteran member of the Medicare Advisory Board, and also is a



John Stiger, DO

member of the Medical Advisory Board of Northwest Physicians Mutual Insurance Company. Dr. Stiger also is an active member of Rolling Hills Community Church, Tualatin.

Dr. Stiger earned his Doctorate of Osteopathy (D.O.) from the Chicago College of Osteopathic Medicine. He holds a bachelor's degree in pre-medicine, with a minor in zoology, from the University of Washington. Dr. Stiger also served four years as a medical corpsman in the U.S. Air Force.

He and his wife, Meredith, live in Oak Grove. They have three children and one grandchild. ■

Hot Tubs and You (continued from page 2)

they may have a very difficult time getting or remaining on insurance panels.

The question frequently arises: "What is an appropriate amount of time to lapse, before a physician engages in a romantic and/or sexual relationship with a former patient?" This question represents another gray area for physicians and patients, in which good judgment must be exercised.

The American Psychiatric Association (APA) recommends "Once a patient, never a lover" as its guideline for psychiatrists. The American Medical Association (AMA) does not issue such a blanket recommendation, but in its official *Code of Medical Ethics* appears to discourage such relationships. The AMA in opinion 8.14 of the *Code* opines that "(a)t a minimum," a physician should terminate the professional relationship before entering into the personal one.

Authors of the *Code* also noted that such relationships might be "unduly influenced" by the previous, professional relationship, and that such relationships are unethical if the

physician "uses or exploits trust, knowledge, emotions or influence" obtained from that relationship.

So what is a proper interval for a transition from patient to partner? Two years has been suggested as an appropriate hiatus, but in some cases, this may be an extreme length of time.

At the other end of the scale, a physician thought he had formally terminated a particular patient relationship late in the afternoon on the same day he had written his soon-to-be-lover a long-term prescription for narcotics. The physician and his "former" patient engaged in sexual relations that evening. Obviously, the state medical board deemed that to be unacceptable behavior, and the physician was denied a license.

Again, it is best for physicians and other health care providers to determine on a case-by-case basis whether romantic/sexual relationships between physicians and former patients are appropriate, as well as the hiatus between the physician-patient partnership and something much more intimate.

Staying aware of sexual boundaries is easier said than done, in many instances. Physicians having difficulties maintaining these boundaries are encouraged, before it is too late, to seek help. There are a number of resources open to physicians, through The Foundation for Medical Excellence, the AMA or the Oregon Medical Association.

Other professional associations have practitioner resources as well: the Oregon Psychiatric Association, Oregon Society of Physician Assistants, Osteopathic Physicians and Surgeons of Oregon, Oregon Podiatry Association and the Oregon Acupuncture Association. For more information, contact the BME.

We've already discussed hot water in passing. Literally staying out of it if one's bathing partner is a patient, is but one way to stay out of hot water in the figurative sense, when conducting physician-patient relationships. Maintaining professional boundaries is vital to patient health and public safety, as well as preserving the integrity of the health care professions. ■

Your Records: Your Friends *(continued from page 1)*

filed and buried somewhere in the chart without the pertinent physician's readable signature or initials. This includes everything from chart notes, to diagnostic studies, to copies of portions of the hospital records forwarded to the office, to consultant reports and virtually anything else that goes into the medical record in the office.

Your office should have protocols to see that preventive measures such as immunizations, screening procedures and counseling about tobacco, alcohol and drugs will be addressed in a timely manner. Protocols to track failed and canceled appointments, as well as failure to report for diagnostic studies or consultations, should be developed. If you are referred a patient for consultation and he or she fails to keep the appointment, notify the referring health care provider. You might consider a protocol to track followup procedures on previous problems.

Some other protocols that are strongly urged are policies on staff placing date, time and signature on any entries they make in the chart, handling telephone calls to the practitioners, phoning prescriptions, emergencies both in the office and those phoned to the office, threatening behavior toward staff or practitioner, and triage guidelines for staff giving response time according to category. These written protocols are important even in small medical offices with only one employee. Since there is inevitable turnover of staff, these written protocols will make orientation of new employees and additional practitioners much easier and more reliable.

The presence of a problem list and particularly a medication list, or even better, a medication flow sheet, has become the standard of care for any primary care provider or any provider who has patients receiving multiple medications or even a single medication on a regular basis. The medication flow sheet is considered critical if chronic pain is an issue as is a Material Risk Notice; the latter

being required by law (Oregon Revised Statutes [ORS] 677.485 and Oregon Administrative Rules [OAR] 847-010-0030).

Electronic records will and are making records better, but there are drawbacks. Using voice-recognition computer software for medical records is risky unless you are willing to carefully edit and correct the final result. There should be some mechanism to prevent changes in the electronic record once the author has signed off on the content. If you dictate or use an electronic record, be sure you edit what comes back for errors and date the final result.

Hospital medical records usually document a much faster pace of events than those in the office environment. Under these circumstances, it is absolutely critical that the progress notes, orders and any acknowledgment of laboratory and imaging studies be dated and timed. The more critical is the patient, the more important the time record. Documentation of the note by time as well as date may save your bacon many times over.

Resist the urge to write in blank forms for lab results in a "progress notes," with plans to return and fill them in later in the day. This is a formula for disaster. A great deal can transpire between the writing of the progress note and the time when the laboratory reports are received by that physician. This could easily make the accompanying plan of action in that progress note inappropriate, negligent, and/or below the standard of care.

Do not in any way change the medical record. This is the kiss of death! If you are caught, you might as well ask how many pounds of flesh the plaintiff, the BME, or the medical staff committee would like you to sacrifice. If you find errors later, make a dated and timed note of the changes without erasing the original. Better still, make a late entry in the current part of the record indicating the error and what you feel the correct entry should

have been.

Promptly correcting errors on transcription of your dictation is acceptable. Even then, to be safe you should initial and date the corrected copy. In this day and age, more patients have access to their records and may become incensed by what they read. It is not uncommon to receive a "demand" that the record be changed to reflect what the patient believes to be correct. Unless you find that an error has been made you do not have to change your record. If an error has been made, you may change it as outlined above. If no error has been made you may acknowledge the concern of the patient in the record, but the original entry may remain unchanged.

Specific procedures in the art of medical recordkeeping have changed with the passage of time, but not the need for such records, nor the importance of their accuracy and legibility. The difference between top-notch records and less-than-desirable records can mean the difference between a career saved and a career lost – not to mention a limb, or a life! ■



Statement of Purpose

The *BME Report* is published to help promote medical excellence by providing current information about laws and issues affecting medical licensure and practice in Oregon.

Board Actions – January 19, 2002 to August 1, 2002

Following is a summary of the actions taken by the Oregon Board of Medical Examiners between January 19, 2002 and August 1, 2002. To find a glossary of the terms used in this article, go to the Board's Web site, www.bme.state.or.us, click on **Board Actions**, and click on **glossary of terms**.

ANAYA, DOMINIC J., DO, LL10785, Portland, Ore.

A Stipulated Order was entered into on June 6, 2002. Licensee surrendered his license to practice medicine in lieu of further Board investigation.

BEEHLER, GARY A., DO18233, Seattle, Wash.

A Stipulated Order was entered into on July 11, 2002. The Board terminated the licensee's January 15, 1999 Stipulated Order, under the condition that he surrender his Oregon license.

BEGGS, TIFFANY L., DO22817, Albany, Ore.

An Interim Stipulated Order was entered into on June 6, 2002. Licensee agreed to withdraw from practice, pending the conclusion of the Board's investigation.

BOGARD, PETER S., DO18557, Grants Pass, Ore.

A Stipulated Order was entered into on July 11, 2002. The terms of this Order include: reprimand, probation, \$1,000 fine, quarterly Board reporting, psychotherapy, no self medicating or prescribing, no personal use of controlled substances or medications containing steroids unless prescribed, and random urinalysis.

BORLAND, DUNCAN, DO23780, Portland, Ore.

A Corrective Action Order was entered into on April 18, 2002. Licensee was granted a license under the following conditions: Complete 50 hours of continuing medical education (CME) in neurology; obtain regular consultation and review by Board-certified neurologist; maintain a physician/patient relationship with a primary-care physician.

ELMORE, SUSAN E., MD19811, Portland, Ore.

A Corrective Action Order was entered into on February 6, 2002, returning licensee back to practice under these conditions: Participation in the Health Professional Program (HPP); limitation on work hours; practice in a group setting; practice limited to psychiatric and medical assessments and medication management; maintain a physician/patient relationship with a primary-care physician.

FAHEY, KAREN J., MD19600, Grants Pass, Ore.

An Interim Stipulated Order was entered into on March 7, 2002. Licensee agreed to withdraw from practice pending the conclusion of the Board's investigation.

FARRIS, CATHLEEN L., MD19029, Camas, Wash.

On February 6, 2002, an order for evaluation was imposed. An emergency suspension was imposed on April 18, 2002.

FOUQUETTE, JOHN K., MD, Applicant, Junction City, Ore.

A Stipulated Order was entered into on July 11, 2002. Applicant agreed to withdraw his application for licensure in lieu of further Board investigation.

FOUTZ, STEVEN R., MD17523, Grants Pass, Ore.

A Stipulated Order was entered into on June 6, 2002. The terms of this Order include: probation, \$1,000 fine, no dispensing prescription medications, Triplicate Prescription Program for all Scheduled drugs, PEER, no self medication, CME, quarterly Board reporting.

GEORGE, DARRYL B., DO22049, McMinnville, Ore.

A Stipulated Order was entered into on August 1, 2002. The terms of this Order include: probation, reprimand, \$5,000 fine, 90-day suspension, chaperone when treating female patients, psychotherapy, quarterly polygraph, quarterly Board reporting, CME.

HALL, JAMES W. III, MD08335, Central Point, Ore.

A Voluntary Limitation was entered into on August 1, 2002. Licensee limited to Administrative Medicine and/or volunteer practice in Addiction Medicine without prescribing privileges.

HANNON, RONALD M., MD, Applicant, Columbia Falls, Mont.

A Final Order was issued on July 11, 2002. Application for licensure was denied.

HUFF, PATRICK E., DO11184, Dallas, Ore.

A Stipulated Order was entered into on February 6, 2002. Licensee was reprimanded.

ILLINGWORTH, DAVID R., MD10576, Portland, Ore.

A Stipulated Order was entered into on February 6, 2002. Licensee may not prescribe Schedule II drugs and must enroll in the Triplicate Prescription Program (TPP) for Schedule III, IV, V drugs; time-limited treatment of pain patients; complete Appropriate Prescribing Workshop (APW).

KAHN, HEATHER A., MD22858, Klamath Falls, Ore.

An Interim Stipulated Order was entered into on June 6, 2002. Licensee agreed to withdraw from practice pending the conclusion of the Board's investigation.

KNOWLTON, DAVID A., MD20529, Eugene, Ore.

A Stipulated Order was entered into on April 18, 2002. License was revoked but the revocation was stayed; reprimand; six (6) month suspension; \$5,000 fine; maintain a physician/patient relationship with a mental-health provider; complete CME related to establishing and maintaining appropriate doctor/patient boundaries; periodic chart review of patient records by a mentor.

(continued on page 6)

Board Actions *(continued from page 5)*

LEONARD, DANN K., MD17833, Salem, Ore.

A Stipulated Order was entered into on July 11, 2002. The terms of this Order include: reprimand, \$1,000 fine, CME courses related to establishing and maintaining appropriate doctor/patient boundaries.

LEVEQUE, PHILLIP E., DO10919, Molalla, Ore.

A Stipulated Order was entered into on April 19, 2002. License was revoked but the revocation was stayed. Reprimand; \$5,000 fine; 90-day suspension; may not diagnose, treat, recommend treatment, prescribe or sign an "Attending Physician Statement" without seeing patient in a face-to-face clinical meeting; shall not use a third party to perform the medical procedures unless s/he is a licensed health-care professional who possesses a current and active Oregon license; report to the Board on a quarterly basis and allow inspection of patient charts by Board Compliance Officer.

MOZENA, JOSEPH M., DP00154, Portland, Ore.

A Stipulated Order was entered into on April 18, 2002. Licensee surrendered his license to practice podiatric medicine in lieu of further investigation.

MYERS, CRAIG G., MD15139, Aloha, Ore.

A Stipulated Order was entered into on March 7, 2002. Licensee was fined \$5,000, reprimanded and placed on probation under the following terms: maintain a physician/patient relationship with a mental health provider; complete 10 hours of Continuing Medical Education courses related to establishing and maintaining appropriate doctor/patient boundaries; complete the Appropriate Prescribing Workshop; must have chaperones when examining or treating female patients 18 years or older.

MYERS, PAUL B., MD12321, Quincy, Wash.

A Stipulated Order was entered into on April 18, 2002. Licensee shall remain in full compliance with the Stipulated Order imposed by the state of Washington Medical Quality Assurance Commission (MQAC) dated May 31, 2001.

OLNEY, JOHN E., MD10049, North Bend, Ore.

A Corrective Action Order was entered into on February 6, 2002. Licensee will not diagnose, treat or prescribe medications to Patient A. In the event licensee changes his license from Emeritus to Active, he will enroll in and successfully complete APW within six months of the status change in his license.

PARENT, JEFFREY M., DO15942, Milwaukie, Ore.

On February 6, 2002, an Order for Evaluation was imposed. An emergency suspension was imposed on February 8, 2002.

PARR, TERENCE J., MD12617, Lakeview, Ore.

A Stipulated Order was entered into on August 1, 2002. The terms of this Order include: Probation, reprimand, participation in Health Professionals Program, chaperone for female patients 18 years or older, no fascial sling

surgery unless Cystoscope is used, CME related to establishing and maintaining appropriate doctor/patient relationships, and quarterly Board reporting.

QUIJANO, OSCAR M., MD10220, Salem, Ore.

A Stipulated Order was entered into on August 1, 2002. The terms of this Order include: PEER, no nerve conduction or somatosensory evoked studies on patients, and bi-annual neurological exams. Previously, the licensee and Board had entered into an Interim Stipulated Order, on May 2, 2002. At that time, the licensee voluntarily withdrew from active practice, pending the conclusion of the Board's investigation. In addition, he was ordered to undergo a comprehensive neurological examination by a neurologist.

RANDOLPH, VICTOR F., MD20197, Hermiston, Ore.

A Corrective Action Order was entered into on April 18, 2002. Licensee is to engage in and maintain a physician-patient relationship with a mental-health provider and a primary-care physician.

RODGERS, BRIAN J., DO20399, Bountiful, Utah

A Stipulated Order was entered into on April 18, 2002. Licensee was reprimanded and placed on probation under the following terms: Complete a structured, individualized education plan that addresses areas of need. If Licensee reactivates his Oregon license, he must obtain a reviewing physician who will monitor his practice. Licensee must report to the Board on a quarterly basis; inform Board if and when review of his care is conducted by any hospital or clinic, inform Board of any tort claims or patient complaints.

SHAW, JOHN C., MD09760, Beaverton, Ore.

A Stipulated Order was entered into on July 11, 2002. Licensee voluntarily retired his Oregon medical license on June 29, 2002 in lieu of further Board action.

TYSON, SANDRA J. R., DO, Applicant, Conrad, Mont.

A Stipulated Order was entered into on July 11, 2002. Applicant agreed to withdraw her application for licensure in lieu of further Board investigation.

WALKER, SHAWN M., MD11462, Salem, Ore.

A Stipulated Order was entered into on April 18, 2002. Licensee surrendered his license to practice medicine in lieu of further investigation.

WONDERLICK, EUGENE L., MD06763, Gualala, Calif.

A Stipulated Order was entered into on July 11, 2002. Licensee voluntarily withdrew from Oregon practice pending the completion of the Board investigation.

YEAGER, DEAN A., MD17697, Stayton, Ore.

A Stipulated Order was entered into on August 1, 2002. The terms of this Order include reprimand and PEER. ■

BOARD OF MEDICAL EXAMINERS SELECTS 2002-03 OFFICERS

Portland gynecologist Marcia G. Darm, M.D. is chairing the Oregon Board of Medical Examiners (BME) in 2002-03.

Dr. Darm was elected to the post by her peers on the board, which licenses and supervises Oregon's medical doctors, doctors of osteopathy and other health-care professionals.

Judith L. Rice, Portland is serving as the BME vice chair. Ms. Rice, a project management consultant, also was appointed to chair the board's Investigative Committee. She is one of two board members appointed from the general, non-medical public.

Frank J. Spokas Jr., M.D., Ontario, was appointed Board secretary. Dr. Spokas, a general surgeon, also was recently appointed to a second three-year term on the Board.

Dr. Darm has served on the BME since 1998. She headed the board's Investigative and Administrative Affairs committees before her appointment to the chair of the BME itself.

She is a past president of the Medical Society of Metropolitan Portland and the Oregon Health and Science University (OHSU) Alumni Council. Dr. Darm also has served on the boards of directors or trustees for the Oregon Medical Association, Interhospital Physician Association (IPA), Multnomah County Medical Society and Oregon Medical Political Action Committee. She served as vice chair and chair of the Oregon Section, American College of Obstetrics and Gynecology, from 1994 to 2000.

Dr. Darm is an OHSU honors graduate. She holds bachelor's degrees from the University of Oregon and Portland State University, and also attended the

Universite de la Sorbonne in Paris.

Ms. Rice has served on the BME since 1998. She also serves on the board's Editorial and Legislative Affairs committees. Prior to joining the BME, she served seven years as executive vice president and manager of U.S. Bancorp's human resources group.

She currently chairs the Metropolitan Exposition and Recreation Commission (MERC).

Ms. Rice attended the Institute for American Universities in Aix-en-Provence, France. She has a bachelor's degree in political science from the University of Oregon and a master's degree in business administration from Portland State University. She is a graduate of Stanford University's Executive Program.

Dr. Spokas was first appointed to the BME in 1999. He has lived in Ontario and been on active staff at Holy Rosary Medical Center since 1991. He served as Holy Rosary's chief of staff in 1998, after two years as vice chief. He also served as president of the Treasure Valley IPA from 1993 to 1995.

Dr. Spokas is licensed to practice medicine in Oregon, Idaho, Montana and Colorado. He graduated from the University of Illinois School of Medicine and took five years of general surgical training at the U.S. Veterans Administration Medical Center in Des Moines, Iowa. Dr. Spokas earned a bachelor's degree with highest honors in electrical engineering at Montana State University, and took graduate studies at MSU, before returning to his home state to earn his M.D. degree. ■

Happy Retirement, Donna!

When Donna Miles retired from the Board of Medical Examiners' licensing staff on June 28, 2002, it was estimated that she had personally licensed at least two-thirds of the physicians currently practicing in Oregon.

Ms. Miles helped license 15,636 physicians during her BME career, which began May 15, 1972. She helped set up the acupuncture and physician assistant (PA) programs, and licensed the first acupuncturists and PAs in the state. In 1979 she moved from Allied Health to Physician (MD/DO) licensing, and in 1981 began working to license podiatrists (DPM) when

they were added to the Board's purview.

Ms. Miles saw not only the number of licensees and programs grow during her 30 years with the BME, but also the number of Board staff. When she came to work for the BME there were six employees – now, there are 33.

And all 33 will miss Ms. Miles, as will Board and committee members, and the many people who relied on her to answer a licensing question, sort out a thorny problem, unravel complex issues, and be her useful helpful self. Happy retirement, Donna! ■

It's the law! You must notify the BME within 30 days of changing your practice address or mailing address. To help ensure that you receive your license renewals and other important information on time, call the BME for an address change form, or print the form from www.bme.state.or.us/forms.html.

BME Now Uses Google as its Search Engine

By Liz Lucero
BME User Support Analyst

The Board of Medical Examiners now has a search engine for its web site. The BME has teamed up with Google, one of the top search engines on the Internet, to bring the public search capabilities on the web site.

Search engines and directories help website users sift through pages to find the specific information they need. They save time by returning results that contain the word or phrase requested. Just type in a word or phrase, make sure "search www.bme.state.or.us" is selected to just search the BME website, click on the "Google Search" button or press return to begin your search. You can also search the entire World Wide Web by selecting "Search WWW."

The BME is dedicated to serving the public in the most convenient manner possible. In keeping with that principle, the web site was established in January 1999. Also that winter, the BME linked up with the Administrators In Medicine (AIM) "DocFinder" site, and added pdf forms for the convenience of downloading them from the Internet.

In October 2000, the BME added a listing of Board actions to available information via the web. The following summer, these items were added: new licensees from the quarterly board meetings, and the Physician Assistant (PA) license application (a BME pilot project). In March 2002, the Licensing Action Report was added to the website. ■