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BUPRENORPHINE OFFERS NEW OPTIONS FOR TREATMENT OF OPIOID DEPENDENCY

*By Susan McCall, M.D.
Medical Director,
BME Health Professionals Program (HPP)*

The federal Drug Addiction Treatment Act of 2000 established a waiver allowing qualified physicians (as defined below) to use Schedule III, IV and V medications in their offices to treat opioid-dependent patients. Medications must be approved for this purpose by the U.S. Food and Drug Administration (FDA).

On October 8, 2002 the FDA announced the approval of buprenorphine for the treatment of opioid addiction. Buprenorphine, a Schedule III medication, is the first medication to be available for use in detoxification or maintenance of opioid dependent patients in office-based practice.

The use of medication to treat opioid dependence has traditionally been restricted to a limited number of physicians working in federally-regulated opioid treatment programs. In contrast, office-based opioid treatment (OBOT) is a new model that allows qualified physicians to treat opioid dependence in their practices. OBOT provides a major new treatment modality for many opioid-dependent patients who have been unable or unwilling to access methadone treatment. OBOT

places the treatment of opioid dependence in the context of standard medical care, under the regulation of state medical boards.

Buprenorphine is a partial opiate agonist eliciting a maximal response, which cannot be exceeded with increasing doses. This characteristic provides an improved safety profile over full agonists such as methadone, and makes buprenorphine more appropriate for use with less restriction.

Buprenorphine is formulated as sublingual tablets with naloxone, marketed as Suboxone, and without naloxone, marketed as Subutex. Naloxone has minimal oral bioavailability and is used to prevent the tablet being dissolved for intravenous use. The formulation, Subutex without naloxone is available for initiation of treatment and in cases where naloxone use is contraindicated such as during pregnancy.

The partial agonist quality of buprenorphine may precipitate withdrawal symptoms in patients with an established high requirement for opiates. Caution in initiating treatment of patients with an unusually high tolerance to opiates is advised, and the initial dose buprenorphine may need to be delayed until withdrawal symptoms are significant in these patients.

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2002 In Review *(continued from page 2)*

Physician Assistants

Members of the Board, its Physician Assistant (PA) Committee and staff completed a comprehensive new Practice Description form for PAs in 2002. Included is a list of “core competencies,” those procedures which it is assumed PAs are capable of performing. Our hats are off to members of the work group that spent more than a year carefully selecting the core competencies and crafting the form.

PA roles in assuring stable, quality health care in Oregon’s rural or isolated communities was a key topic as well. The 2001 Legislature passed laws allowing physicians in “medically underserved” locales to supervise more than four PAs, and to supervise PAs by direct electronic communication, if approved by the Board.

Technology Helps Us Work

During 2002, the BME added several new features to its Web site, in an effort to better serve both the professions and the public. In March, the BME added its Licensing Action Report to the Web site. Through this report, Web users may obtain a listing of all licensees currently under Board orders, and brief descriptions of the actions.

The BME also teamed up with Google, one of the Internet’s top search engines, to afford the public expanded search capabilities on the ‘Net. Physicians and citizens wishing specific information may type in words or phrases, and be guided to their on-line destinations in a swift, accurate fashion.

The BME Web address is www.bme.state.or.us.

New People Join In The Effort

The Board and its committees welcomed several new members during 2002. John Stiger, D.O. joined the Board in April, succeeding Barbara Gilbertson, D.O., Klamath Falls. Dr. Stiger is owner-physician at the Oak Grove Family Medical Clinic in Milwaukie, and is active in civic and church activities in his community.

Dr. Stiger was named Board liaison to the Acupuncture Advisory Committee, which also welcomed Debra Mulrooney, L.Ac., Portland, as a new member. Ms. Mulrooney is affiliated with the Portland Alternative Health Center, and brings to the Committee a wide range of experience as a practitioner and teacher of acupuncture.

Joel Rice, M.D. is the newest member of the Health Professionals Program (HPP) Supervisory Council. Dr. Rice is a psychiatrist and former HPP supervising physician. He is chief of staff at Grande Ronde Hospital in La Grande.

Harry “Randy” Randolph, P.A. joined the Physician Assistant (PA) Committee in July. Mr. Randolph practices in Columbia and Washington counties, and is affiliated with the School of Physician Assistant Studies at Pacific University in Forest Grove.

And at year’s end, Lisa Cornelius, D.P.M. prepared to join the Advisory Council on Podiatry, effective January 1. Dr. Cornelius is a partner in Specialty Physicians and Surgeons, Corvallis. ■

LIABILITY CAP REGISTRATION RENEWAL AVAILABLE

Licensees who provide health care services without compensation are reminded that they may register with the Board of Medical Examiners (BME) to claim liability limitation, as provided by state law.

A 1999 law limits the liability of Oregon-licensed physicians, physician assistants, and

certain other health professionals for injury, death, or other loss that may arise from services they provide without compensation. These health professionals are liable only when such loss results from gross negligence on their part, provided they have met the following prior conditions:

- The physician or physician assistant must be registered with the BME as a provider of health care services without compensation and who wishes to claim the liability limitation provided by law.
- The patient, or a person who has authority under law to make

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BME Investigative and Disciplinary Statistics – 2000 through 2002

COMPLAINTS AND INVESTIGATIONS, 2000 - 2002						
Complaints Received			2000	2001	2002	
Total Phone Calls	4,253	3,759	4,051			
Total Complaint Calls	1,150	1,545	1,618			
Total E-Mail Inquiries	213	262	180			
Total Written Complaints	721	662	637			
Open/Closed Complaints			2000	2001	2002	
Complaints Opened	452	420	328			
Average Complaints Open	206	229	229			
Complaints Closed	424	383	380			
Investigative Committee Interviews Held			2000	2001	2002	
	68	75	59			
Contested Case Hearings Held			2000	2001	2002	
	8	2	1			
Sources of Complaints			2000	2001	2002	
Insurance Company	2	13	2			
Patient or Associate	287	277	190			
Pharmacy	10	9	8			
Other Providers	35	19	32			
Other	25	31	29			
Self	3	3	3			
Hospital or Institution	18	11	15			
Other Board	4	3	1			
Malpractice Review	46	41	42			
Compliance	n/a	n/a	1			
Board of Medical Examiners	33	38	27			
Categories of Complaints			2000	2001	2002	
Inappropriate Care/Incompetence	272	274	210			
Inappropriate Prescribing	51	56	31			
Personal Substance Abuse	15	12	6			
Unprofessional Conduct	87	58	66			
Mental Illness/Impaired	9	6	8			
Violation of State/Federal Statutes	11	12	9			
Violation of Probation	1	2	3			
Other/Miscellaneous	38	29	22			
Sexual Misconduct	14	9	9			
Compliance	n/a	n/a	1			
FINAL DISPOSITIONS OF CLOSED CASES						
			2000	2001	2002	
No Violation	No apparent violation of Medical Practice Act		93	38	10	
	No apparent violation/preliminary investigation		20	13	21	
	No Violation/Prior to Committee Appearance		179	192	235	
	No Violation/Post Committee Appearance		16	16	8	
	Letter of Concern/Prior to Committee Appearance		51	62	47	
	Letter of Concern/Post Committee Appearance		19	11	9	
Public Order	Corrective Action Order		4	16	10	
	Stipulated Order **		27	23	37	
	Voluntary Limitation **		1	1	1	
	Final Order **		13	11	1	
Totals	TOTAL CASES CLOSED		423	383	379	
	CASES CLOSED WITH PUBLIC ORDERS		45	51	49	
	(Nat'l Database) TOTAL REPORTABLE ORDERS		41	35	39	
	PERCENTAGE REPORTABLE BOARD ACTIONS		9.7	9.1	10	
TERMS OF PUBLIC ORDERS						
			2000	2001	2002	
Refer to Remedial Program			9	13	22	
Revocation			7	4	0	
Revocation with Stay			2	9	3	
Surrender License			0	2	0	
Retire/Surrender Under Investigation			11	6	5	
Probation			10	13	15	
Suspension			2	1	7	
Reprimand			13	12	17	
Denial of License			2	1	2	
Assessment of Fine			5	9	10	
Assessment of Costs			2	1	0	
Accept Retirement			0	0	0	
State Court of Appeals			1	0	0	

*** Public orders reportable to the National Database

Board Actions – August 2, 2002 to November 20, 2002

BERSELLI, Robert A., MD07894, Portland, Ore.

A Stipulated Order was entered into on November 12, 2002. Licensee will not conduct surgery as primary surgeon. He may, however, serve as assistant surgeon.

CALHOUN, James M., MD17171, Portland, Ore.

An Interim Stipulated Order was entered into on November 12, 2002. Licensee agreed to withdraw from practice pending conclusion of the Board's investigation.

DENKER, John T., MD12668, Portland, Ore.

A Corrective Action Order was entered into on October 17, 2002. Licensee will participate and complete the Board's Appropriate Prescribing Workshop (APW) and the Physicians Evaluation Education Renewal (PEER) program.

ELLISON, John H., MD06289, Portland, Ore.

A Corrective Action Order was entered into on September 5, 2002, granting reactivation of his Oregon license under the following conditions: Participation in the Health Professionals Program (HPP or "Diversion"); abstention from the use of ethanol and any mood altering or potentially addictive substances; affiliation with a mentor who will monitor and review Licensee's practice.

ELMORE, Susan E., MD19811, Portland, Ore.

An Interim Stipulated Order was entered into on October 17, 2002. Licensee agreed to voluntarily withdraw from practice pending the conclusion of the Board's investigation.

FARRIS, Cathleen L., MD19029, Camas, Wash.

An Interim Stipulated Order was entered into on October 17, 2002, terminating an Order of Emergency Suspension dated April 18, 2002, pending

the conclusion of the Board's investigation. Licensee will abstain from alcohol, will not self-prescribe medications, and will remain under the care of a primary care physician who will manage all medications.

GOMBART, Augustin K., MD08874, Roseburg, Ore.

A Corrective Action Order was entered into on November 12, 2002. Licensee will complete the Physicians Evaluation Education and Renewal (PEER) program within two years.

HAHN John E., DPM, DP00015, Bend, Ore.

A Stipulated Order was entered into on November 12, 2002. Terms of the order include: Reprimand; fine; no intravenous chelation therapy (EDTA or micronutrient) for patients under his podiatric license; licensed physician or naturopathic physician must be at his clinic anytime a patient is receiving chelation therapy; documentation of communications with primary care providers and specialists; "Subjective, Objective, Assessment, Plan" (SOAP) format chart entries: documented patient examination, assessments and treatment plans; practice monitor who will review at least 20 charts of podiatric patients per quarter with quarterly written reports to the Board's Medical Director.

PEARL, Janice M., MD09392, Bothell, Wash.

A Corrective Action Order was entered into on September 5, 2002. Licensee was granted a license under the following conditions: She must have a practice monitor at each of her Oregon practice sites. The monitor shall review 10 percent of Licensee's charts and provide quarterly reports to the Board regarding Licensee's performance. ■

LIABILITY CAP REGISTRATION RENEWAL AVAILABLE *(continued from page 3)*

decisions for the patient, must sign a statement notifying the patient that the health care services are provided without compensation and that the practitioner is liable only to the extent provided by the new law. This statement must be signed prior to receiving the services.

- The practitioner must receive the informed consent of the patient or the person who has

authority under law to make health care decisions for the patient prior to providing the health care services.

- The practitioner must provide health care services without compensation, except for reimbursement for laboratory fees, testing services, and other out-of-pocket expenses.

The BME does not charge for registration in this program,

which must be renewed annually. However, to keep expenses down, the BME does not send renewal notices. Participating physicians and physician assistants are responsible for updating their own registration each year.

To receive a registration packet or get more information, call the BME at (503) 229-5770. ■

BUPRENORPHINE OFFERS NEW OPTIONS FOR TREATMENT OF OPIOID DEPENDENCY

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Comprehensive information about buprenorphine is available on the FDA Website, http://www.fda.gov/cder/drug/infopage/subutex_suboxone/default.htm.

Minimal training requirements have been established to ensure that physicians authorized to use this new treatment option have adequate training in the diagnosis and treatment of opioid dependence. Qualified physicians are defined as those with certification in addiction medicine by the American Society of Addiction Medicine (ASAM) or the American Osteopathic Association (AOA). Other possible qualifiers include a Certificate of Additional Qualifications in Addiction Psychiatry, or completion of eight (8) hours of training in the treatment of opioid dependent patients. Such training may be sponsored by ASAM, the AOA, The American Academy of Addiction Psychiatry (AAAP) or the American Medical Association (AMA).

Physicians utilizing OBOT must have the capacity to refer patients for counseling and appropriate ancillary services. Regulations specifically prohibit physicians from delegating the prescribing of opioids for detoxification/maintenance to non-physicians. Each physician or practice is allowed to treat a maximum of 30 OBOT patients simultaneously.

To obtain a waiver to utilize buprenorphine for OBOT, qualified physicians must notify the Substance Abuse Mental Health Administration, Center for Substance Abuse Treatment (SAMHSA/CSAT) of their intent to provide office-based opioid treatment (OBOT) and certify their qualifications. CSAT has 45 days to act on waiver applications.

If a physician finds it necessary to begin OBOT for an individual patient in an emergency, prior to approval of the waiver application, he or she must notify CSAT and the U.S. Drug Enforcement Administration (DEA) of such intent. The waiver application is available on CSAT's web site, www.buprenorphine.samhsa.gov and may be completed and submitted on line.

Physicians considering OBOT have many resources available for detailed information. CSAT's web site, www.buprenorphine.samhsa.gov

is a user-friendly site packed with all the pertinent information. It also provides information on, and links for, Web-based and on-site training programs. Information on training opportunities may also be found on specialty society web sites: www.asam.org, www.aaap.org, www.psych.org.

The BME encourages Oregon physicians to become knowledgeable about OBOT and to utilize this modality appropriately in accord with the law and sound clinical practice.

The efficacy and safety of OBOT will be under more intense scrutiny than other medical treatments. It is subject to being discontinued with 60 days' notice, at any time it is determined to be unsafe or ineffective. The ability to retain this powerful treatment option will depend on appropriate patient selection and the use of sound medical judgment in the prescribing of buprenorphine by well-trained physicians. The Federation of State Medical Boards (FSMB) has published *Model Guidelines for Opioid Addiction Treatment in the Medical Office*. The *Guidelines* are available at www.fsmb.org under "Policy Documents." ■



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.

PHYSICIAN SUICIDE CAN BE PREVENTED

By Henry Grass, M.D.

Chair, Oregon Psychiatric Association Members Assistance Committee

Tragedically, one or two physicians take their lives in Oregon every year. In the entire country, we lose the equivalent of one medical school class per year.

Depending upon how you study the demographics, this is approximately three times the average of the general population, as well as other professions. These numbers are probably low, since suicide by physicians is underreported, or often disguised as some other form of death, for a variety of reasons.

In 1978, there was an epidemic of physician suicide in Oregon, with eight doctors taking their own lives. It was this statistic that led to a pilot study, and eventually to a joint study by the American Medical Association (AMA) and American Psychiatric Association (APA).

The AMA and APA studied 200 physician suicides and reported the results in several journals during the early 1980s. And though there have been frequent articles written on the subject both in the United States and abroad, as well as theories and speculation regarding causes of physician suicide, the incidence rate has not changed.

During recent years, the Board of Medical Examiners (BME) and Oregon Psychiatric Association (OPA) have worked together in an attempt to better address the mental health needs of the state's physicians. The BME has a formal Statement of Philosophy regarding physicians with mental illness, which balances the need to assist and restore physicians needing help, with the need to protect the public.

In addition, hospitals are now required to provide Employee Assistance Programs (EAP), including screening and referral services, to meet the emotional needs of physicians and their families.

What are the emotional or mental health problems physicians face, and how do those problems compare to those of the general population? And what problems do physicians face in recognizing and getting help for these problems?

Cases of physician depression seem to have increased in number. It is unlikely that a person with schizophrenia would be able to get through medical training, but most of other emotional or mental disorders seem to occur among physicians

with the same frequency as that of non-physicians, according to the study.

Studies of physician personality profiles have shown that, generally, we seem to be an intelligent, compulsive, perfectionist, overachieving group of individuals with needs to please others and avoid conflict. These traits are often influenced by our family-of-origin backgrounds. Medical schools tend to select for these traits, which often are reinforced in residency training. We are also taught to think and make decisions independently. Finally, most of us minimize emotional problems to ourselves or others, and choose indirect means of trying to cope with such issues.

Most of us have seen the recent evolution of medicine bring more regulations, managed-care pressures, and increasing malpractice litigation with subsequent insurance costs. Many will acknowledge that medicine is not as enjoyable or rewarding as it once was.

As a group, we are not good at getting help for ourselves, medically or psychologically. Many don't see a physician regularly, nor would they think of seeing a psychiatrist or psychologist if they acknowledged having emotional problems. The suicidal physician often has one or more of the following difficulties: depression, hospital staff problems, office problems, malpractice difficulties, licensure concerns, marital problems, substance abuse problems or financial difficulties.

Seeking help seems to often be a threat or embarrassment to many physicians. They often worry that their problems will be reported to the BME. And often, the individual's identity as a physician is so important and central to him or her, that the perceived guilt over seeking assistance is a heavy burden to bear.

On the contrary – timely referral, psychotherapy and/or psychiatric medication can often prevent needless morbidity and mortality. Many physicians suffer needlessly every year and unfortunately, a small number lose their lives.

The BME and its Health Professionals Program, the Osteopathic Physicians and Surgeons of Oregon (OPSO), the OPA or OMA will help any physician with treatment or a referral if contacted. Hopefully, early intervention can reverse the numbers of these unnecessary losses. ■

CHILD ABUSE ISSUES MEAN REPORTING RESPONSIBILITIES FOR HEALTH CARE

By Dave La Duca
Complaint Resource Officer, BME

During the past couple of years, child abuse has been in the forefront of the news. Society has been understandably concerned about the issue of abuse, and about the need for proper reporting of abuse to the authorities.

Thus, the BME wishes to discuss reporting issues in the hope that by working together, we can prevent serious – even fatal – consequences to our precious children.

The Law

Oregon law (ORS 419B.010) requires “public or private official(s)” to report child abuse to law enforcement authorities. “Public or private official” means any physician, including any intern or resident. Emergency medical technicians (EMT), registered and licensed practical nurses, dentists, school employees and many other professionals are included in this definition.

Several categories of BME licensees – physician assistants (PA), podiatrists and acupuncturists – are not specifically included in the statutory definition of “public or private official.” However, these practitioners still have a responsibility to report child abuse to the authorities, and PAs should report it to their supervising physicians, as well.

State law makes it clear that this duty to report child abuse supercedes statutory provisions regarding confidentiality. However, psychiatrists are not required to divulge confidential communications from persons who admit to abusing a child, if such communication was made for the purpose of diagnosis or treatment of the patient’s mental or emotional condition as provided in ORS 40.230. Under that section, psychiatric patients have the privilege of refusing to disclose, and to prevent any other person from disclosing, such confidential communications.

However, ORS 40.230 (4) (a) states that such communications are not privileged if a judge orders a mental, emotional or physical examination of the patient, unless the judge orders otherwise. And subsection (4) (b) (A) denies such privilege in any proceeding in which the patient relies on an emotional or mental condition as a defense.

Failure to report constitutes a violation punishable by a fine not exceeding \$1,000. Prosecution under this subsection shall be commenced at any time within 18 months after commission of the offense.

What is abuse?

State law defines abuse as:

- Any assault, as defined in ORS Chapter 163, of a child and any physical injury to a child which has been caused by other than accidental means, including any injury which appears to be at variance with the explanation given of the injury.
 - Any mental injury to a child, which shall include only observable and substantial impairment of the child’s mental or psychological ability to function caused by cruelty to the child, with due regard to the culture of the child.
 - Rape of a child, which includes but is not limited to sodomy and unlawful sexual penetration.
 - Incest, sexual abuse, sexual exploitation and contributing to the sexual delinquency of a minor. These include but are not limited to allowing, permitting, encouraging or hiring a child to engage in prostitution.
 - Negligent treatment or maltreatment of a child.
 - Threatened harm to a child.
- The state defines a “child” as an unmarried person under the age of 18.

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CHILD ABUSE ISSUES MEAN REPORTING RESPONSIBILITIES FOR HEALTH CARE

(continued from page 8)

It is a good idea to have a nurse or medically trained person present when evaluating injuries and explanations suggesting possible child abuse. Physicians should make detailed chart entries when recording explanations of how the injuries occurred.

In reporting suspected child abuse to authorities as required by statute, the physician is free to share all information gathered in the course of examining and treating the child.

How do I make a report?

Reports of child abuse may be made orally, by telephone or other means, to the local branch office of the State Office for Services to Children and Families (SCF). Reports may also be made to a law enforcement agency within the county where the person making the report is located at the time of the contact.

If you believe you have reasonable grounds to make a "good faith" report of child abuse, you have immunity from any civil or criminal liability that might arise from making such a report. The law also grants you immunity with respect to participating in any judicial proceeding resulting from such a report.

SCF telephone numbers are listed below. Toll-free numbers are indicated by "800," "866" or "877" codes:

Metro Area, Northwest Oregon

Multnomah County:

503-731-3100

Clackamas County:

800-628-7876

Washington County:

800-275-8952

Yamhill County:

800-822-3903

Clatsop County:

800-643-4606

Columbia County:

800-428-1546

Tillamook County:

877-317-9911

Willamette Valley, Central Coast

Marion County:

800-854-3508

Woodburn area:

800-358-2571

Polk County:

503-623-8118

Benton County:

541-757-4121

Lincoln County:

800-305-2850

Linn County:

800-358-2208

Lane County:

866-300-2782

Southwest Oregon

Douglas County:

800-305-2903

Coos County:

800-500-2730

Curry County:

800-510-0000

Jackson County:

541-776-6120

Josephine County:

800-930-4364

South Central Oregon

Klamath County:

541-883-5570

Lake County:

888-811-4201

North Central Oregon

Gilliam, Wheeler Co.:

541-384-4252

Hood River County:

541-386-2962

Wasco, Sherman Co.:

541-298-5136

Crook County:

541-447-6207

Deschutes County:

541-388-6161

Jefferson Co.:

541-475-2292x310

Eastern Oregon

Morrow County:

541-481-9482

Pendleton area:

800-547-3897

Hermiston area:

877-488-4939

Baker County:

800-646-5430

Union County:

541-963-8571x270

Wallowa County:

541-426-4558

Grant County:

541-575-0728

Harney County:

541-573-2086

Malheur County:

800-445-4273

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ACUPUNCTURE ADVISORY COMMITTEE NEARS 30-YEAR MARK

The Board of Medical Examiners' (BME or "Board") Acupuncture Advisory Committee was established in 1974, under the aegis of the Oregon Medical Practice Act (ORS Chapter 677).

As an advisory committee to the BME, it must maintain the same high standards of professional integrity and objectivity as the BME.

The Committee's purpose and major objective is to help ensure the availability of safe, professional acupuncture services to the people of Oregon.

The Committee makes recommendations to the Board on matters of licensing, investigations and education. The Board then contemplates final action, based upon those recommendations.

Members of the Acupuncture Advisory Committee include three licensed acupuncturists, two physicians and a member of the BME.

Current Committee members are Joel Seres, M.D., Portland, Chair; Ellen Goldsmith, LAc, LMT, Portland; Debra Mulrooney, LAc, Oregon City; Joseph Soprani, LAc, Portland; and Robert Gross, M.D., Portland. John Stiger, D.O., Milwaukie, serves as liaison between the Board of Medical Examiners and the Acupuncture Advisory Committee.

The Committee's responsibilities are to review applications and proposals, and make recommendations to the full BME, as follows:

- Applications submitted to the BME for acupuncture licensure.
- Standards of professional responsibility and practice.
- Standards of education and training for acupuncturists.
- Standards for clinical supervisors and trainees.
- Licensing examinations and temporary licenses.

The Committee is not a representative arm of any acupuncture-related professional society, organization or educational institution. Nor is it a forum for any political or personal agendas. And the Committee has no part in setting curricula for training programs.

The Committee is open to receiving input from any member of the public. In the final analysis, however, its basic charge is to follow the Medical Practice Act and the Oregon Administrative Rules pertaining to health care and acupuncture as practiced in Oregon.

Persons interested in serving on the Acupuncture Advisory Committee may apply to the BME. Oregon-licensed acupuncturists, and physicians interested in promoting the field of acupuncture, are welcome to submit applications for Committee service. ■

CHILD ABUSE ISSUES... *(continued from page 9)*

What about HIPAA?

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 contains a number of stipulations, guidelines and restrictions aimed at protecting patient privacy. However, nothing in HIPAA prevents physicians from reporting to authorities any suspected child abuse.

Religious-based refusal of health care: Is it abuse?

Some religious faiths or

spiritual disciplines teach their adherents to refuse professional health care services, in favor of faith-based healing – which in some cases may mean no treatment of any kind. This issue caused a great deal of debate at the legislative and judicial levels until 1999, when the Legislature removed the spiritual treatment defense from exceptions to mandatory reporting requirements.

Consequently, under Oregon law a parent's refusal to

authorize health care treatment for a child for religious reasons is abuse. As such, you are required to report such refusal.

In sum

Oregon's children are its most precious natural resource. It is in this spirit, and the spirit of the BME's public safety mission, that we share information on abuse reporting in the knowledge that it may save young lives. ■

CASE STUDY: PATIENT PRIVACY, MARKETING CONFLICT

By Gary Stafford
Chief Investigator, BME

In March 2002, the Board of Medical Examiners (BME or "Board") opened an investigation after receiving a complaint concerning a citizen who was a client of a Portland medical clinic.

In the complaint, it was reported that the patient received an unsolicited letter, inviting the patient to participate as a possible candidate for a study regarding erectile dysfunction. The patient also received an informed consent form to complete.

The letter also named the patient's primary care physician and stated that the physician had given the patient's name to the company conducting the study. The complaint asserted that the patient's confidentiality had been violated by the physician, in the clinic where the physician practiced.

An unofficial investigation outside any public agency verified that the author of the invitation to participate in the erectile dysfunction study was not employed by the clinic or the physician, but by the company conducting the study.

According to the complaint, the author of the letter had access to computerized medical information and clinic records revealing confidential information. The patient had not given permission for anyone but his

physician and clinic employees to see the records. A BME investigation revealed that the medical clinic had contracted with the company issuing the invitation to the study.

This company essentially acted as a conduit or "middleman" between pharmaceutical companies and medical clinics.

The "middleman" corporation contracts with pharmaceutical companies seeking to have research studies conducted for new medications, for which the manufacturers want U.S. Food and Drug Administration (FDA) approval.

The "middleman" corporation then contacts health care providers such as the subject clinic and physician, and requests the names of patients who may fit the profile from a health perspective for the drug in question. In this particular case, the subject physician and clinic allowed the "middleman" access to confidential medical records, so that the "middleman" company could profile and solicit potential candidates for pharmaceutical studies.

While the subject physician stated that the invitation to participate in the study that the patient received was (functionally) an invitation from the clinic, the initial solicitation was sent on the "middleman's" letterhead.

Thus a major issue was raised: Is functionally placing an employee of the "middleman" research company on the clinic

staff sufficient separation from his or her employer, to properly gain access to patients' confidential information housed within the clinic?

The Board decided that the facts of this case did not establish a violation of the Oregon Medical Practice Act (ORS Chapter 677). In doing so, the Board considered American Medical Association (AMA) guidelines regarding physician records and access to those records by non-treating medical staff.

The clinic that was the subject of the BME investigation subsequently revised its procedures such that patients, including potential ones, to be informed by the clinic regarding such research issues. In addition, the clinic has informed the BME of steps it has taken to further protect patient confidentiality.

The Board also considered AMA guidelines regarding clinical investigation, fee splitting, and referrals to health care facilities.

Also considered was a 1998 report by the AMA Board of Trustees, "Patient Privacy and Confidentiality in Research." ■



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.

OREGON ADMINISTRATIVE RULES ADOPTED BY THE BOARD OF MEDICAL EXAMINERS

The Board at its October 2002 meeting adopted the following Oregon Administrative Rules (OAR):

MDs / DOs

OAR 847-008-0022: Designates *Locum Tenens* as the registration status of volunteer camp physicians, who would be allowed to practice in Oregon for a maximum of 14 days per year.

OAR 847-010-0066: Clarifies that attending physicians of visiting physicians in Oregon hospitals must be actively licensed in Oregon.

OAR 847-010-0068: In the event of an emergency (as declared by the governor), physicians and physician assistants not subject to investigation in their home states would be allowed to come into Oregon to provide medical assistance, without first obtaining Oregon licenses.

Physician Assistants (PA)

OAR 847-050-0023: Clarifies that PAs holding Limited Licenses, Postgraduate will be reviewed and granted permanent licensure as soon as their files are complete.

For more information on these rules, visit the BME Website at www.bme.state.or.us.