D.C. Board of Medicine

INFORMATION FOR THE MEDICAL COMMUNITY AND THE PUBLIC FROM THE D.C. BOARD OF MEDICINE

Government of the District of Columbia
Vincent C. Gray, Mayor

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BOARD MEETING SCHEDULE

Upcoming Meetings

January 26, 2011
February 23, 2011
March 30, 2011
April 27, 2011
May 25, 2011

The Board of Medicine (full board) meets on the **LAST WEDNESDAY** *of every month.*

Open Session is 10:30 am - 12 noon.

MISSION STATEMENT: *"To protect and enhance the health, safety, and well-being of District of Columbia residents by promoting evidence-based best practices in health regulation, high standards of quality care and implementing policies that prevent adverse events."*

LETTER FROM THE CHAIR

By the time this article goes to press and you read these words, the New Year will be underway with all of the excitement of new opportunities and a chance to commit to "resolutions". I would like to thank you all for the hard work and devotion that you've shown to your patients over this past year. I know many of you will have spent some or all of the holidays tending to your patients as you do throughout the year. We thank you for this continual commitment to quality and the best medical care.

The idea of resolutions to better oneself or achieve a goal is a perfect segue into a new process the Board of Medicine has undertaken this past year. The new process is associated with the resolution of complaints received at the Board of Medicine. The Board of Medicine decided to make a change in the process because, in reviews of complaints from the public, we often find ourselves in a similar situation of finding the medical care adequate but the patient experience less than expected. Often the individual filing the complaint has a legitimate concern regarding their care, or a loved one's care with a concern about communication, rudeness or inappropriate medical care. We thoroughly review the complaint, asking for details about the physician the time of the complaint, the nature of the complaint, and others who may have been party to the complaint. We then ask the physician to respond.

Often the medical details are technically correct and demonstrate that "the standard of medical care" for the patient was met; however, we find ourselves aware that the doctor's care fell short of the patient's understanding and expectations of the situation. Often times it's a lack of clear communication, a staff member's assurance that the doctor will complete a task that the physician is unaware that a promise was made, or a lack of help in understanding instructions or billing. In other situations, we find that the patient's concerns were not listened to or were brushed aside. We also see situations where there were not clear expectations set for the care situation. In essence, the "care" in their healthcare was not present.

Now, why does this happen? A busy office, a harried doctor or an inefficiently run office or

Janis M. Orlowski, MD, MACP
Chair, DC Board of Medicine

clinic can lead to concerns. Any of these issues can lead to concerns raised by patients which are serious but do not cross the line of standard of care. Few of our patient's concerns are raised to the level of the Board of Medicine, but when they are, we need to review the situation in light of what's best—not only for medicine but what is best for the public in general.

The Board of Medicine has adopted a new ruling with requirements for action in these very situations. That is a complaint were the finding of standard of care was met but the patients experience or outcome was less than optimal.

(continued on page 6)

From Where I Sit

By Jacqueline A. Watson, DO, MBA
Executive Director, DC Board of Medicine

HAPPY NEW YEAR!

We're off and running. Our new year—FY2011—began on October 1, 2010, and our priority focus during the first quarter was renewing licenses for the over 10,000 healthcare professionals under our purview. I hope that your renewal experience was a pleasant one. I would like to take this opportunity to say a special thank you to all of the staff who worked diligently throughout the renewal cycle, and the holidays, to address all concerns. If you would like to share any comments with us about your renewal experience, please send an email to **dcdocsspeak@dc.gov**. Also, I would like to especially thank all the licensees who voluntarily completed our first ever physician and physician assistant Healthcare Workforce Survey. The response was astounding with more than 80% of licensees participating in the survey. Over the next few months we will review and analyze the data and share the findings with you in a special report to be published later this year.

As an organization, we continue to focus our attention on constructing our best-practices framework and achieving operational excellence, despite increasing budgetary constraints. **T.E.A.—Transparency; Efficiency; Accountability—**remain the motivating forces that drive our activities and approach in protecting the safety of the public and providing quality services to you. We have been diligently and methodically laying our best-practice building blocks and have a few noteworthy mentions to share with you since our last issue.

ACTIVITIES

- **CBC-Criminal Background Checks:** Effective January 3, 2011, all new applicants requesting a license to practice their profession in the District will be required to undergo a CBC through the Metropolitan Police Department. See page 4 for the details.
- **LATE RENEWALS:** Please submit your renewal application, and complete the workforce survey, as soon as possible. An $85 late fee will be required to process your application. Applicants for renewal after February 28, 2011, will have to apply for reinstatement.
- **CE Audits:** Now that the renewal season is officially over we will begin our random audits for CE requirements. You may be contacted to submit proof of your documented CEs.
- **BoMed New License Application:** New licensees will now complete a new and improved application form when applying for their license in the District. Screening questions have been updated and additional demographic information has been included.
- **Road Trip:** In November I had the opportunity to visit the North Carolina Medical Board (NCMB), considered the best-practice board of the south. My southern colleagues rolled out the welcome mat and were extremely gracious hosts. I was allowed to observe hearings, participate in committee meetings, have in-depth conversations with key members of their management staff, and I was able to bring back invaluable information they shared on a host of relevant matters—in particular, guidance on developing a policy on physician reentry and managing anonymous complaints.
- **Anonymous Complaints:** In the past, anonymous complaints were not reviewed by the Board. Recently the Board voted to review each anonymous complaint on a case by case basis. If the complaint illicits enough concern from the Board and staff, the licensee will be issued an Order to Answer (OTA), giving them an opportunity to respond. Depending on the circumstances, the Board may launch an investigation, to gather further information, or close the matter.
- **Letters of Concern (LOC):** In her letter to you in this issue, Dr. Orlowski, the board chair, has taken the time to outline some of the reasons why the Board issues LOCs. More information about LOCs can be found on page 6. We have selected a case where a licensee received a LOC from the Board, based on his malpractice suit history, and the licensees exemplary response with the corrective action plan (CAP).
- **MOU and Physician Health Program:** After much discussion, the Board and the Medical Society of DC (MSDC) are poised to sign an MOU during this quarter. The purpose of the MOU is to allow the Board to more effectively manage the oversight of impaired practitioners under an order with the Board and protect the safety of the public.
- **Outreach:** As part of our outreach efforts, we will carry out two important activities during this fiscal year. 1. Launch the **Professionalism in Medicine** pilot program. This program is being designed for third and fourth year medical students to inform them on issues related to professionalism, ethics, medical licensure, and regulation. I have met with the deans of the three medical schools to discuss our intentions and to solicit their feedback. All have agreed to work collaboratively with BoMed as we develop the details and roll out the program this summer. 2. **BoMed Symposium**. The Board is planning to host a symposium this year to increase awareness and educate licensees, and the public, about the role of the medical board and the capacity of the healthcare workforce in the District. The symposium is tentatively set for the month of September.
- **Board Vacancies:** The Board of Medicine, and Advisory Committees to the Board, have a few vacancies that need to be filled. If you are interested in being a member of the full board, or serving on one of the board advisory committees, please read more on page 3 and visit the Mayor's Office of Boards and Commissions website at www.obc.dc.gov to submit an application.
- **Taskforces.** The Board will establish 2 taskforces/workgroups this year in an effort to develop regulations around two rapidly growing areas of medicine—**cosmetic/spa medicine and telemedicine**. If you are interested in getting involved with any of these taskforces, see page 3.

We will be busy throughout the year and we have some interesting challenges and exciting opportunities ahead of us. On the local level, we have a newly elected mayor, new leadership and changed roles on the city council, and a new Director of the Department of Health. I would like to pause here to personally thank Dr. Pierre Vigilance for his service to the Department, and his work with the Board of Medicine and the community, and wish him success as he moves forward.

On the national level, healthcare reform will again take center stage and, with more people slated to have access to healthcare, it will naturally increase the demand for healthcare providers and services. According to a recent American Association of Medical Colleges (AAMC) Report, it is predicted that, by 2020, Americans will need an estimated 45,000 primary care physicians and 46,000 surgeons and medical specialists. Meeting those demands will be critical to maintain the health, safety and well-being of our citizens and will require us all working together to figure out how to be more efficient in the way we deliver care, and redefining which professionals will deliver the care.

I look forward to working with all newly elected officials to ensure that our Board and organization continue on the trajectory of becoming a best practice board in the country.

Our next issue will be published in May. Until then, Be Well!

WE WANT YOU!

LOOKING FOR A FEW GOOD DOCTORS

and Consumers to fill vacancies on the Board and Advisory Committees to the Board. Applicants must be DC residents and Physician Members must be practicing for a minimum of 3 years and be in good standing with the Board.

VACANCIES ON THE BOARD OF MEDICINE

- 1 Physician

Preferred Specialties: Emergency Medicine, Psychiatry, Pediatrics, Family Medicine, OB/GYN

- 1 Consumer

PHYSICIAN VACANCIES ON BOARD ADVISORY COMMITTEES

ACUPUNCTURISTS :	• 1 Physician with acupuncture experience
NATUROPATHIC PHYSICIANS:	• 1 Physician with naturopathic medicine experience
PHYSICIAN ASSISTANTS:	• 1 Physician with experience working with Physician Assistants
POLYSOMNOGRAPHERS:	• 2 Physicians certified by national accrediting body as sleep specialists
SURGICAL ASSISTANTS:	• 1 Surgeon with experience working with Surgical Assistants
	• 3 Licensed Surgical Assistants

TO APPLY, GO ONLINE AT WWW.OBC.DC.GOV AND DOWNLOAD AN APPLICATION, OR CALL THE OFFICE OF BOARDS AND COMMISSIONS AT (202) 727-1372.

THANK YOU CHERYL R. WILLIAMS, MD

During the last Board meeting of FY2010, BoMed Chair, Dr. Janis Orlowski (right), took a moment to present a gift to DR. CHERYL R. WILLIAMS on behalf of the entire Board. Members and Board Executive Director Dr. Jacqueline Watson praised Dr. Williams for her many years of dedicated service on the Board and working to protect the safety of the public in the District.

BoMed TASKFORCES

The Board of Medicine will establish two taskforces/work groups in this quarter:

- **Telemedicine**
- **Cosmetic/MediSpa Medicine**

If you are interested in serving on either of these taskforces/work groups, please send the Board an email at DCDOCSSPEAK@DC.GOV.

Please place the word TASKFORCE in the subject line.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARMENT OF HEALTH
Health Regulation and Licensing Administration

Criminal Background Check Unit

IMPORTANT NOTICE
Requirement for a Criminal Background Check

Effective January 3, 2011, each **new applicant** for license, registration or certification shall obtain a criminal background check. This criminal background check requirement is mandated for all health care professionals by the District's "Criminal Background Check Amendment Act of 2006".

An applicant for **initial licensure**, registration, or certification shall not be issued a license, registration or certification until the background check has been completed by the District's Metropolitan Police Department. A criminal background check shall be conducted in accordance with Metropolitan Police Department's (MPD) and Federal Bureau of Investigation's (FBI) policies and procedures and in a FBI-approved environment, by means of fingerprint and National Criminal Information Center checks and procedures.

For applicants residing in the District of Columbia:

1. Refer to the Criminal Background Check Unit link on the Board website, or http://hpla.doh.dc.gov/hpla/cwp/view,a,1194,q,501826.asp
2. Download the Live-Scan Fingerprint Appointment Request Form to schedule your appointment with the DC Metropolitan Police Department.
3. The fee to conduct a criminal background check through the MPD is $50.00. (not included in licensure fee) The appointment request form and criminal background check fee shall be submitted with your licensure application.
4. The Criminal Background Check Unit will mail you an appointment confirmation and LIVE-SCAN request documents to take to the DC MPD.

Applicants who do not reside in the District of Columbia

If you reside outside of the District of Columbia, you can undergo a criminal background check in two ways:

1. You may come to District of Columbia and undergo a criminal background check with the District of Columbia Police Department. (refer to the process defined above)
2. You may go to any law enforcement agency in the state where you reside
   a. Ask to be printed on a FBI Applicant Fingerprint card (FD-258)
   b. Mail the Fingerprint card (FD-258) to the FBI. In the "Reason Fingerprinted" block of the card write in "License, certification or registration, Health Regulation and Licensing Administration, Department of Health, 717 14th Street, NW, 6th Floor, Washington, DC 20005."
   c. The FBI will mail the results of the background check to you, the applicant.
   d. Forward/mail the results of your background check in a sealed envelope to our office at the following address:

      Criminal Background Check Unit
      Health Regulation and Licensing Administration
      717 14th Street, 6th Floor
      Washington, DC 20005

Please note that the applicant is responsible in making sure that the criminal background check results are delivered to the Criminal Background Check Unit at the above address.

For more information regarding criminal background check from the FBI, please visit the FBI website: http://www.fbi.gov/about-us/cjis/background-checks.

Applications will not be processed without criminal background check

717 14th Street, NW, 6th Floor, Washington, DC 20005 doh.cbcu@dc.gov phone (202) 727 9855 Fax (202) 727 8471

Rev. 12/28/2010

COUNSEL'S COLUMN

THE DUTY TO REPORT

By Eugene E. Irvin, Esq.
Senior Assistant Attorney General & Board Legal Advisor

Recent participation in the Board of Medicine's application renewal process has probably highlighted for many of you the Board's interest in obtaining several forms of documentation that impact an applicant's ability to practice medicine in the District of Columbia.

Part of the Board's interest is influenced by rules and regulations; by law, each health care professional is required to keep the Board current on aspects of their professional life that might factor into the licensing decision. This means that applicants are obligated by law to keep the Board apprised of any disciplinary actions, malpractice lawsuits, or other change in identifying information at all times, not just when it is time for an applicant to renew their license.

By law, each health care professional is required to keep the Board current on aspects of their professional life that might factor in to the licensing decision. This article will provide each Board of Medicine health professsional with a practical guide covering the responsibilities each has in this regard.

The Health Occupations Revision Act or as it is commonly referred to "the HORA", in Section 3-1205.13(a)(4) sets out some general guidelines for reporting to the Board. Under the terms of that provision each health care professional licensed, registered or certified by the Board is obligated to inform the Board within 30 days of any change in residence, place of business, place of employment, or legal name. The notice submitted must be in writing. Thus, a marriage, a divorce, the purchase of a new home or a relocation to a new facility provides the basis for written notice to the Board apprising it of the event. Additionally, Section 3-1205.13(a)(4) further mandates that the termination, revocation, suspension, or voluntary surrender of health care facility privileges by reason of "incompetence or improper professional conduct" obligates the affected health care professional to inform the Board by certified mail, return receipt, within 10 days of the occurrence. The statute does not allow for an extension of time, a waiver or excusable delay. It simply mandates a time period for compliance which is enforceable through the imposition by the Board of penalties for failure to act within the time allowed. So it is important to be mindful of these obligations and to make certain that the required notice is timely delivered.

Licensed physicians are also subject to the reporting requirements outlined in Section 3-1205.13(a) of the HORA. Under that statutory provision, the affected physician must report to the Board:

(1) any notice of judgment in a malpractice lawsuit,

(2) any notice of confidential settlement in a malpractice action whether to be paid by the physician, an insurer or other entity, or

(3) any disciplinary action by a health care licensing authority of another state. The notice must be provided within 60 days of the occurrence or the physician may be the subject of a Board review.

Under that same statute, a health care provider who employs a DC licensed physician is required to report to the Board any disciplinary action taken against the physician within 10 days of the discipline imposed. Also, the resignation of a licensed physician during the course of an investigation of the physician obligates the employing health care provider to report that fact to the Board within 10 days. A health care provider's failure to comply with either requirement can subject the provider to the imposition by the Board of a fine of $2,500.00.

In a somewhat similar vein, DC Official Code Section 44-508 imposes a reporting requirement on medical facilities whenever a health care professional's

(1) clinical privileges are reduced, suspended, revoked, or not renewed or

(2) employment or staff membership is involuntarily ended or restricted while involuntary action is being considered.

If the basis for that result is due to professional incompetence, mental or physical impairment, or professional or unethical conduct, the facility is obligated to provide a full written account that details the facts of the case to the Board. This reporting requirement does not apply to temporary actions or restrictions where the health care professional successfully completes a program of education or rehabilitation before having the limitations removed from their privileges.

"By law, each health care professional is required to keep the Board current on aspects of their professional life that might factor in to the licensing decision."

Those health care professionals required to submit supervised practice letters should also be aware that certain changes in circumstances give rise to the obligation to provide notice to the Board. Events such as a reassignment, a relocation, a new supervisor, a change in responsibilities or a new physician in charge could provide the basis for the submission to the Board of a new letter.

Enrollees in the Postgraduate Physicians Training program have a responsibility to report in writing or to allow their institution to do so whenever the participant ends his or her clinical training earlier than the scheduled conclusion of the program. The report must specify whether the departure was the result of academic or non-academic reasons.

It is incumbent upon every health care professional to have a working understanding of the reporting requirements as they apply to their particular circumstance. Yet each should feel free to look to the Board of Medicine staff for assistance in helping them sort out their responsibilities if uncertainty arises.

LETTER FROM THE CHAIR (continued from page 1)

In these situations the ruling of the Board will be to issue a **"letter of concern"**. The expectation of the letter of concern is that the physician will review the case and develop a corrective action plan or performance improvement plan. So if the complaint is that a patient did not have their call returned but they received the information in another way, we would ask the physician to develop a corrective action plan to see that all calls are returned. This corrective action plan or resolution to improve should help the efficiency of the office and dramatically improve the perception and care provided to the patient. Another letter of concern example is the situation of a rare complication not understood or diagnosed by the physician. In this particular case *[see pages 6 and 7 of this newsletter]* the finding of the Board of Medicine was that the physician met the standard of care and that the majority of physicians would have acted in a similar matter, however, the doctor was so moved by the poor outcome and the letter of concern from the Board of Medicine that he completely studied the rare outcome, developed a mechanism to identify it early and shared the finding of his performance improvement plan with his medical group.

A letter of concern is not a negative finding by the Board of Medicine and does not lead to disciplinary action, but the expectation of the Board is that the physician will review the concerns, the situation which led to the concern and develop a plan to improve care. These performance improvement opportunities are actually a mirror of the requirements of most Board recertification programs, that is, to review the patient's view of their care, take to heart any complaints or concerns raised by the patients and use these opportunities to develop a mechanism to improve care to all patients.

The Board of Medicine remains committed to the highest quality of care and oversight of the practice of Medicine in the District.

Best regards,

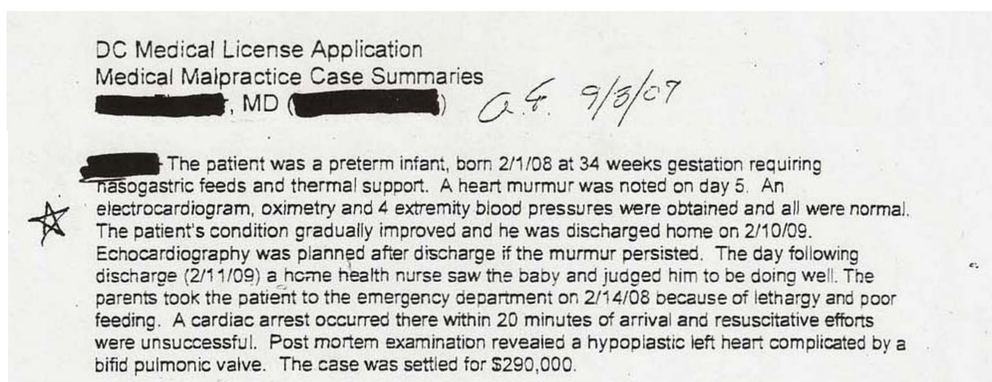
Janis M. Orlowski, MD MACP
Chairperson
DC Board of Medicine

MORE ABOUT LETTERS OF CONCERN (LOCs)

Throughout the year and during the renewal period, in particular, we receive supporting documentation from applicants associated with their malpractice suits. Depending on the case and circumstances, for example:

a. the physician's specialty
b. time in practice
c. malpractice history
d. disciplinary history
e. National Practitioner Data Bank (NPDB) report
f. patient outcomes
g. payout history

The Board may 1) request more information, 2) invite you for an interview, or 3) send you a Letter of Concern requesting a Corrective Action Plan (CAP). We are often asked by licensees how best to respond to an LOC from the Board. What follows is an example of correspondence sent to a licensee, and his response (see page 7) after the Board received his history of 3 malpractice suits. The doctor reported 3 malpractice suits and the Board sent him an LOC to address malpractice cast #3 (below). The doctor's response demonstrates an exemplary response.



DC Medical License Application
Medical Malpractice Case Summaries
[redacted], MD ([redacted]) a.f. 9/3/07

[redacted] The patient was a preterm infant, born 2/1/08 at 34 weeks gestation requiring nasogastric feeds and thermal support. A heart murmur was noted on day 5. An electrocardiogram, oximetry and 4 extremity blood pressures were obtained and all were normal. The patient's condition gradually improved and he was discharged home on 2/10/09. Echocardiography was planned after discharge if the murmur persisted. The day following discharge (2/11/09) a home health nurse saw the baby and judged him to be doing well. The parents took the patient to the emergency department on 2/14/08 because of lethargy and poor feeding. A cardiac arrest occurred there within 20 minutes of arrival and resuscitative efforts were unsuccessful. Post mortem examination revealed a hypoplastic left heart complicated by a bifid pulmonic valve. The case was settled for $290,000.

Below, is the Board's Letter of Concern sent to the physician. At right, is a letter of reply from the physician; it is an exemplary example of how a physician should reply to a Letter of Concern.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
★ ★ ★
HEALTH PROFESSIONAL LICENSING ADMINISTRATION

BOARD OF MEDICINE

September 2, 2010

Re.: Letter of Concern and Request for Corrective Action Plan

Dear Dr.

The District of Columbia Board of Medicine ("Board") has completed its review of **your application for licensure**, and has already licensed you.

However, the Board has some concerns regarding **the third malpractice suit you reported, related to an infant death,** and would like to know what steps you have taken to prevent a recurrence of this type of situation in the future. Therefore, the Board is requesting that you submit a corrective action plan, which should include, but not be limited to, the following:

- A statement of your perspective on this case;
- Identification of the deficiency or the root cause that led to the matter at issue;
- Efforts undertaken to improve or correct the problem, including any additional training or changes you may have made to your practice protocols to minimize the chance of future occurrences.

You are requested to submit the corrective action plan to the Board **within fifteen (15) days of receipt of this letter.** Your prompt attention to this matter is appreciated. Should you have any questions or concerns regarding this letter you may contact Lisa Robinson at (202) 724-8802.

Sincerely,

DC Board of Medicine

Enclosures

SC-10-198

717 14th Street, NW, 10th Flr, Washington, D.C. 20005 Phone: (202) 724-8800 Fax: (202) 724-8677

ANONYMOUS COMPLAINTS

The DC Board of Medicine will now begin to evaluate anonymous complaints on a case-by-case basis.

If the allegations in the complaint raise enough concern with the Board, the licensee will be issued an Order to Answer (OTA) and must respond.

EXEMPLARY RESPONSE FROM PHYSICIAN

DC Board of Medicine
717 14th St., NW, 10th Floor
Washington, DC 20005

Re:

Dear

I am writing in response to your letter dated September 2, 2010 requesting further information on the medical malpractice case. I am a Board Certified Neonatologist and was one of the clinicians who participated in care at the

was a 34-week preterm infant born on February 1, 2008 and although he was stable from a cardiopulmonary standpoint, he required nasogastric feeds and thermal support in an incubator. On the fifth day one of my partners noted that had a heart murmur. A chest x-ray, electrocardiogram and four extremity blood pressures were obtained. The studies were interpreted as normal. The radiologist who reviewed the chest x-ray interpreted the heart size as normal. The cardiologist who reviewed the EKG interpreted it as normal. I saw from the fifth to eighth day of the hospitalization. I reviewed his chest x-ray, electrocardiogram and blood pressures and agreed that they were normal. The character and radiation of the murmur was compatible with the diagnosis of peripheral pulmonic stenosis which I documented in the medical record. Peripheral pulmonic stenosis is benign, does not require echocardiography and can be followed on an outpatient basis. If a patient developed symptoms or the quality of the murmur changed an echocardiogram would be obtained at a later time. pattern of feedings improved and weight gain was established. His temperature stabilized in an open crib. I discharged home on the ninth day of life (February 10, 2008) with a scheduled home nursing visit and a follow-up appointment with a Pediatrician at the When I dictated the discharge summary, I probably misspoke saying the baby had an echocardiogram rather than an electrocardiogram. When I authenticated the transcription I did not catch that documentation error.

There was no clear indication to order an echocardiogram. Our standard practice at is that all infants with heart murmurs are screened for congenital heart disease with a chest x-ray, electrocardiogram, 4 limb blood pressures and a check of their pulse oximetry. All tests were interpreted as normal by myself and a second board certified neonatologist who had originally ordered the tests. had eight days of continuous pulse oximetry in the NICU and his clinical course was one of progressive improvement to the point where standard discharge criteria were met. initial symptoms were all attributable to the preterm birth. He did not have symptoms of hypoxia, tachypnea, lethargy, or persistent poor feeding, all of which are associated with hypoplastic left heart. After nine days of observation in the NICU I felt that the chances of presenting with an obstructive cardiac lesion like hypoplastic left heart were extremely small.

The medial record reflects that was seen by a Home Health Nurse on February 11, 2008. The nurse noted that "baby looked fine, examined fine, eating well, good suck breast feeding." parents did not keep the Pediatric follow-up appointment which I had scheduled for them on February 13. However, they brought to the emergency department at the on February 14, 2008, four days after hospital discharge with a complaint of several hours of lethargy and poor feeding. Shortly after arrival, suffered a cardiopulmonary arrest and expired.

Postmortem examination revealed a hypoplastic left heart and an abnormal bifid pulmonic valve. This finding is significant because it explains why I confused murmur with benign peripheral pulmonic stenosis.

I have enclosed a paper published in Pediatrics (2008;121;751-757) entitled Epidemiologic Features of the Presentation of Critical Congenital Heart Disease: Implications for Screening. It makes several points germane to this case.

1. The incidence of potentially preventable significant physiologic compromise as a result of congenital heart disease in the general population is estimated to be 1 per 15,000 to 1 per 26,000 live births. This child would fit into this group.
2. The vast majority of these infants present in the first 3 days of life. This is documented in Figure 2 on page 755 of the paper. It is notable that *all* of infants with Class IV congenital heart disease, which includes hypoplastic left heart, presented in the first 5 days of life. Despite having that type of heart disease had a highly atypical late presentation.
3. In the discussion section of the paper it is noted that there is no broadly accepted standard for screening a population of infants for congenital heart disease. It is a challenging problem in light of the fact that 50%-75% of all newborns have an audible murmur. The vast majority of these murmurs are benign.

Based on the data presented in this paper it is apparent that I was confronted with an infant who had a rare delayed presentation of an uncommon cardiac condition. The case was investigated by both the Department of Health Services and the Medical Board. Both agencies closed their cases without issuing a sanction, reprimand or a demand for corrective action.

Although I feel that my treatment of was conscientious, I was frustrated that I was unable to diagnose his congenital heart disease prior to discharge. The above article makes it clear that it is not uncommon to miss the diagnosis of this type of heart disease in the immediate newborn period. In 2009 I undertook a project in my role as the Regional Director of Neonatal Services for I organized a review of the literature pertaining to the screening of populations of newborn infants for unsuspected congenital heart disease. Based upon the work of Meberg, et. al. (J. Pediatr 2008;152:761-5) and other related literature, I worked with the Pediatric Cardiology group to implement a pilot program for oximetry screening of all newborn infants at the Attached to this letter are both the Meberg article and the cardiac disease screening algorithm I developed. Screening began in January 2010. Over 2000 babies have been screen to date, and 2 cases of heart disease have been identified. Based on the encouraging results at the pilot site, (good sensitivity and low rate of false positive studies), I am now moving forward with implementation of this screening program at 13 additional hospitals where I am responsible for the neonatal care. When fully implemented in 2011, I anticipate that 33,000 newborns per year will be screened for congenital heart disease. No disease screening program is 100% effective, but I believe that the work I have lead will significantly reduce the likelihood that a newborn baby will be discharged from one of our hospitals with undiagnosed congenital heart disease.

I was saddened when I learned of demise and felt compassion for his parent's grief. Over the course of 20 years I've found the practice of neonatology both challenging and rewarding. It can also be humbling.

Sincerely yours,

OFFER THE TEST: A PLEA TO HEALTHCARE PROVIDERS TO ROUTINELY SCREEN FOR HIV INFECTION

By Lisa Fitzpatrick, MD, MPH

Healthcare providers are formidable allies in addressing the District's HIV epidemic and are uniquely positioned to assist in early identification of HIV-positive persons and their linkage to HIV care. For these reasons the DC Department of Health HIV/AIDS Administration (DOH) recently implemented a two-pronged HIV testing campaign that encourages patients to "Ask for the Test" and for providers to "Offer the Test". However, recent clinical interactions with newly diagnosed HIV-infected patients highlight an urgent need to ensure healthcare providers understand, acknowledge and act upon their power to help reduce the District's AIDS burden.

For example, just a few months ago a 66 year old woman was referred to me for newly-diagnosed HIV infection. Her CD4 count was 27. She was diabetic and had been in a healthcare provider's care for over 20 years. Years previous to her diagnosis, she requested an HIV test but her provider informed her that because she was celibate and without weight loss or other symptoms, HIV testing was not warranted. Other examples of similar missed HIV screening opportunities include a 46 year old heterosexual man with asthma, CD4 count 11 and a 38 year old gay man with hypertension, CD4 count 4! Both cases were asymptomatic and both had been in a healthcare provider's care for over 10 years. These examples of late AIDS diagnoses may seem incredible but unfortunately, they are common. Across the District, patients are not being screened for HIV infection, only to be identified years later after the disease has progressed to AIDS. These AIDS diagnoses are avoidable.

Given these missed opportunities for early identification of HIV infection, the HU LPS has utilized education and training resources to discern explanations for why providers do not or are reluctant to implement routine HIV screening. Several barriers to screening were identified, many of which can be addressed by raising awareness about District policies, standards of practice and the availability of technical support and resources. Provider-related barriers to screening include:

1. Perceptions that their patients were not at risk for infection

The demographics of the epidemic have shifted dramatically since 1980. At the onset of the epidemic, risk-based screening was endorsed by the CDC because the majority of cases were in gay men and intravenous drug users. This largely explains why many providers still assume their patients are not at-risk for HIV. As the previous cases illustrate, HIV is no longer confined to specific risk groups. In Washington, DC where the epidemic affects an estimated 3% of the general population, every primary care practice likely contains cases of unidentified HIV infection. These infections are occurring among groups traditionally not judged to be at risk, including educated professionals, heterosexuals, married persons and/or the aging. Therefore, reliance solely on risk-based screening is no longer standard of care and is not recommended.

2. Concerns about billing and reimbursement for HIV testing

HIV testing is a billable service with established coding guidelines. HIV testing-specific ICD-9 and CPT codes are available. For example, the ICD-9 code for rapid testing during a routine medical examination is V70.0 and should be accompanied by designation of one of three CPT codes. Specific information about billing codes for HIV testing can be found at www.ama-assn.org/go/cpt.

Medicare has also released Healthcare Common Procedure Coding System (HCPCS) codes specifically for HIV testing such as G0432 for a conventional HIV test and G0435 for a rapid HIV test. For specific information about Medicare reimbursement for HIV testing go to www.cms.gov/center/coverage.asp.

For patients evaluated in emergency departments, in 2009 an amendment to the DC Official Code, "Access to Emergency Medical Service Act of 1998" was added to include a provision for insurance company reimbursement for HIV screening in emergency room settings.

3. Uncertainty about the consent process

Written consent for HIV testing is not required in the District of Columbia. Both the CDC and DOH endorse verbal consent through a routine opt-out process. Opt-out language is important to facilitate patient acceptance of HIV testing. This language increases patient acceptance of HIV testing and reduces testing-related stigma because clients do not perceive they have been singled out due to risk behaviors. An effective approach for incorporating verbal consent for HIV screening is to say, "It is standard practice for us to screen every patient for treatable conditions like diabetes, HIV, heart disease or kidney disease. If you don't want to be tested for any of these conditions please let tell us." Another suggestion is to incorporate HIV testing consent into your general consent for care.

4. Feeling that HIV testing is time-intensive and not aligned with clinical responsibilities

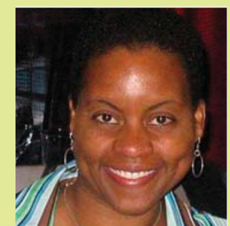
The participation and support of all healthcare providers is necessary to address the HIV epidemic in Washington, DC. HIV is chronic disease that is now treatable with medications that have favorable side effect profiles. Therefore, just as healthcare providers diagnose and refer patients for chronic diseases like diabetes and heart disease, so too can healthcare providers diagnose HIV infection. In addition, because many residents often present to a frontline provider for a specific and isolated event, this visit may be provider's only opportunity to identify HIV infection. HIV testing does not require access to rapid HIV testing technology. For practices without access to rapid testing, an HIV ELISA through traditional phlebotomy can be added to any battery of routine or follow-up laboratory testing ordered by the provider. Since HIV counseling and testing is no longer required and a separate blood draw specifically for HIV testing is unnecessary a client's visit should not be prolonged beyond the usual time.

Moving Forward and Leading By Example

It is within our power to eliminate AIDS diagnoses in the District. However, this elimination can not be realized without the partnership, commitment and support of healthcare providers. The elimination requires a shift in provider thinking and acknowledgement of the critical role providers can play in addressing the epidemic. HIV testing must become just as routine as vital signs, diabetes screening and cholesterol evaluation. Our decision and willingness to uniformly implement this change in our collective standards of clinical practice will translate to a tremendous public health benefit for District residents. So on behalf of your patients, the community and the health of the District, help us lead the nation by example. Offer the test.

For questions, HIV-related clinical CME and training, information and technical assistance for integrating routine HIV screening into your practice or to locate a sub-specialist for co-management of HIV infection please contact the Pennsylvania Mid-Atlantic AIDS Education Training Center (PAMA AETC) Howard University LPS @ **202-806-0223** or **pamaaetc@howard.edu**.

LISA FITZPATRICK, MD, MPH



Dr. Fitzpatrick is a CDC-trained medical epidemiologist, infectious diseases clinician and the co-Principal Investigator of the Pennsylvania Mid-Atlantic AIDS Education Training Center (AETC) Howard University Local Performance Site (HU LPS).

PHYSICIAN HEALTH PROGRAMS

By Miriam A. Markowitz, MSc, Consumer Member, Board of Medicine

BOARD OF MEDICINE MISSION STATEMENT

"To protect and enhance the health, safety, and well-being of District of Columbia residents by promoting evidence-based best practices in health regulation, high standards of quality care and implementing policies that prevent adverse events."

The Board of Medicine has a broad mandate to protect and enhance the health, safety, and wellbeing of District of Columbia residents. The Board also has a responsibility to support and provide resources to our physicians and other licensed personnel as they perform critical and highly valued service to our citizens. This dual mission frequently brings Board Members and licensed physicians together to explore the challenges and needs of our provider base.

The Board of Medicine has recently increased its opportunity to meet with physicians enrolled in a physician health program. Most physicians in this situation are accessing care and formally part of a monitoring program due to chemical dependency issues, changes in cognitive conditions, or mental health issues. Physicians either self identify as needing these services or are identified through changes in work status, credentialing or malpractice reporting. By meeting with physicians enrolled in support and monitoring programs we learn about their individual progress and assess the value of alternative programs and interventions.

National data reports that 12-to-16% of physicians suffer from alcoholism, drug abuse or emotional or mental disorders. The District of Columbia's percentage of impaired physicians participating in physician health programs is less than optimal, based on the national statistics. Far from being a comfort, it is of deep concern for both the population we serve and for our physician community. How do we address this problem?

A few meetings ago, the Board met with a physician enrolled in a physician health program. The physician described his current situation and the events leading up to his decision to self-identify and seek assistance. It turns out that his best friend, a physician colleague and his own personal physician, sat him down and shared his deep concern regarding his change in behavior and increased level of alcohol consumption. This physician was still carrying on his professional clinical duties, but clearly had moved to a dangerous level of dependency and behaviors for himself and his patients. Through his physician colleague's intervention and insistence, he sought help.

Physician colleagues are a critical resource to firmly steer fellow physicians in need to programs and services for a range of clinical conditions and personal situations. The physician we interviewed cited his friend as making a critical intervention, one that he was extraordinarily grateful for—before he had caused harm to himself or one of his patients. As colleagues, friends, fellow physicians, few things can be more helpful than an honest conversation and seeking safe, confidential services for an impaired friend or colleague. Patient safety is always on our minds, and providing rehabilitative and therapeutic services for impaired physicians allows us to support our physicians and provide for safe transition to caring for their patients. Please consider this a shared responsibility for building a healthy professional community.

BoMed/MSDC MOU ON IMPAIRED PHYSICIANS

MEDICAL SOCIETY OF DC AND PHYSICIAN HEALTH PROGRAM REPRESENTATIVES MEET WITH BOARD TO DISCUSS WORKING TOGETHER UNDER A MEMORANDUM OF UNDERSTANDING (MOU) TO BETTER PROTECT THE SAFETY OF THE PUBLIC AND FACILITATE THE REHABILITATION OF IMPAIRED PHYSICIANS.

WHAT MEDICAL PROVIDERS NEED TO KNOW ABOUT LEAD REQUIREMENTS IN THE DISTRICT OF COLUMBIA

By Pierre R. Erville, JD, MS
Associate Director, District Department of the Environment Lead and Healthy Housing Division

I. LEAD SCREENING AND REPORTING REQUIREMENTS

When it comes to lead exposure, children who are residents of the District of Columbia are subject to universal screening requirements. Regardless of the family's income status and regardless of the location of the family's home, all children who live in the District of Columbia are subject to the same legal requirements when it comes to the need to be screened for exposure to lead. These rules boil down to the following key requirements:

- Children must be screened as part of a well-child visit between the age of 6 and 14 months.
- Children must be screened a second time as part of a well-child visit between the age of 22 and 26 months.
- Additional screenings are required by law whenever the physician learns that:
  - A parent has a history of occupational lead exposure;
  - There is a history of lead poisoning in siblings or playmates;
  - A child lives in, or frequently visits, deteriorated housing built before 1978;
  - A child lives in, or frequently visits, housing built before 1978, with recent, ongoing, or planned renovation or remodeling;
  - A child's siblings, housemates, or playmates have confirmed lead poisoning;
  - A child's parent, guardian, or other household members participate in occupations or hobbies that may result in exposure to lead;
  - A child lives, or has lived, near industrial facilities or operations that may release atmospheric lead;
  - A child exhibits pica, or presents frequent hand-to-mouth activity;
  - A child has unexplained seizures, neurological symptoms, abdominal pain, or other symptoms consistent with lead poisoning, including growth failure, developmental delay, attention deficit, hyperactivity, behavioral disorders, school problems, hearing loss, or anemia.
- The US Centers for Disease Control and Prevention, in an epidemiologic study released December 1, 2010, concluded that an increased risk of lead exposure in tap water exists in housing connected to a lead service line. Accordingly, providers should ask parents and guardians of children under the age of 6 years whether they live in a home connected to a lead service line. If they do, providers should recommend that they get their water tested by DC Water (formerly known as WASA), and in the meantime avoid using tap water for drinking and cooking. They should also consider conducting another lead screening.
- If a child is a new resident of the District of Columbia, or for some other reason the child has not already been screened twice by age 26 months, the child must be screened twice prior to the age of 6 years, and those two tests must ideally be performed at least 12 months apart.

Whenever a child's blood lead test result reveals an elevated blood lead level (equal to or greater than 10 micrograms of lead per deciliter of blood), the provider must immediately inform the child's parent or guardian of the result and the measures recommended for follow-up treatment and care.

- Regardless of the blood lead test result, if a parent or guardian requests it, providers must issue a certificate of testing that includes the test date and the specific number associated with a test result under 10 micrograms per deciliter.
- Note that during the past ten years, research has demonstrated that health effects are observed at levels of lead in blood below 10 micrograms per deciliter.

II. REQUIREMENTS FOR INDIVIDUALS WHO OWN RENTAL PROPERTY

The District's lead law includes requirements that apply to owners of rental housing built prior to 1978 and located in the District of Columbia, which can be summarized as follows:

- Paint must be maintained in intact condition.
- Paint is presumed to be lead-based paint, unless documentation proves otherwise.
- Presence of non-intact paint is a violation of the lead law, unless documentation proves it is not lead-based paint.
- Owners must provide tenants with a copy of the Tenant Rights form available from the District Department of the Environment's website (green.dc.gov)
- If a new tenant household includes a child under 6 years or a pregnant woman, the new tenant must receive:
  - A Clearance Report issued by qualified personnel within the previous 12 months preceding the new tenancy, which states that the property or apartment does not contain any lead-based paint hazards; and
  - A Disclosure Form completed by the property owner, disclosing information reasonably known to the owner about the presence of any lead-based paint or any lead-based paint hazards, and about any pending actions the property is subject to under the lead law.

For more information about lead poisoning prevention and the District's lead laws, visit the District Department of the Environment's website at green.dc.gov and click on "Lead and Healthy Housing."

FILING A COMPLAINT WITH THE BOARD

To file a complaint against a licensed DC physician or other licensee under the authority of the Board, simply write a letter that describes your complaint. The letter must be signed, and you should attach copies of any pertinent documents that you may have. The letter must also include your address, so we may contact you as necessary and notify you of any findings.

Please note: You can print a complaint form from our website at www.hpla.doh.dc.gov/bomed

You should mail the complaint to:

DC Board of Medicine
717 14th Street, NW
Suite 600
Washington, DC 20005

You can also fax the complaint to the Board at (202) 724-8677.

If your complaint alleges unlicensed activity, you should address your complaint to:

Supervisory Investigator
717 14th Street, NW
Suite 1000
Washington, DC 20005

You can also fax your complaint about unlicensed activity to (202) 724-8677.

Please be advised that the Board of Medicine does not have jurisdiction over fee disputes, except for billing for services that were not provided. If you have a fee dispute with a health professional, you can seek redress through the civil courts.

UPDATE YOUR ONLINE PHYSICIAN PROFILE

REPORT CHANGES WITHIN 30 DAYS

Physicians must report changes related to:

- Change of Address
- Settlements, judgments, and convictions
- Disciplinary actions by other jurisdictions
- Final orders of any regulatory board of another jurisdiction
- Restriction or termination of privileges as a result of a peer review action
- Disciplinary action taken by a federal health institution or federal agency.

To update your profile, login to our online system at:

https://app.hpla.doh.dc.gov/mylicense/

BoMed STATS

Total Active Licenses as of January 1, 2011

MEDICINE AND SURGERY	9,802
OSTEOPATHY AND SURGERY	184
PHYSICIAN ASSISTANTS	577
ACUPUNCTURISTS	172
ANESTHESIOLOGIST ASSISTANTS	24
NATUROPATHIC PHYSICIANS	23
SURGICAL ASSISTANTS	57
POLYSOMNOGRAPHERS	0
TOTAL	**10,839**
POSTGRADUATE PHYSICIANS IN TRAINING (PPT ENROLLMENT)	1,106

HAVE A COMMENT FOR US?
SEND AN EMAIL TO DCDOCSSPEAK@DC.GOV
OUR NEW WEB ADDRESS: WWW.HPLA.DOH.DC.GOV/BoMed

BOARD ORDERS

September 1, 2010 - January 1, 2011

Fined

Garrett, Meredith (M.D.) (9/9/10) The physician was fined by consent order and ordered to complete two CME courses in Emergency Room Care, for failure to meet the standard of care. [Emergency Medicine]

Other

Hope, Shelley Ann (M.D.) (10/27/10) – The physician satisfied the terms of her prior order dated 4/28/10, which was based on a North Carolina action for practicing telemedicine. [Ob/Gyn]

Government of the District of Columbia
Vincent C. Gray, Mayor

DC BOARD OF MEDICINE

Address

Health Professional
Licensing Administration
Department of Health
717 14th Street NW
Suite 600
Washington, DC 20005

Phone numbers

(202) 724-4900
(877) 672-2174
Office Hours: 8:15 am to 4:45 pm,
Monday - Friday (except District holidays).

Fax number

(202) 724-5145

Web page

www.hpla.doh.dc.gov/bomed

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Nancy Kofie

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