



# THE EXAMINER

The Newsletter of the Colorado Board of Medical Examiners  
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State of Colorado *Bill Owens, Governor*  
Department of Regulatory Agencies *Tambor Williams, Executive Director*  
Division of Registrations *Rosemary McCool, Director*

## DID YOU KNOW...

...that there are state laws regarding public health reporting of certain diseases and conditions? See [Required Disease Reporting in Colorado](#).

...that the Division of Registrations is conducting annual audits of its licensing database against criminal databases, and that failure to disclose criminal conduct could constitute grounds for denial or discipline of a license? See [Be Honest with the Board](#).

...that between 44,000 and 98,000 people die in hospitals each year as a result of medical errors? See [Whether 30 Safe Practices or the National Patient Safety Goals: It's About the System](#).

...that the Board has adopted new rules regarding Distinguished Foreign Teaching Physicians? See [Distinguished Foreign Teaching Physician](#).

...that the Board has a new program director and several new Board members? See [New Program Director and Board Members](#).

...that two public members of the Board have volunteered to serve as mentors to members of other boards? See [The Role of a Public Member](#).

...that you can renew your license, changes your mailing address, or check the status of a pending application online? See [Registrations Online Services](#).

...that the address you provide to the Board is a matter of public record and is available to the public? See [Your Address is Public Information](#).

...that the Board maintains a list of Board actions on its website? See [Board Actions](#).

## Required Disease Reporting in Colorado

During the 2006 state legislative session, a bill was introduced that called new attention to the state laws regarding public health reporting of "certain diseases and conditions." Colorado Revised Statutes (CRS) 25-1-122 states that the Colorado Board of Health "has the authority to require reporting, without patient consent, of those diseases and conditions by any person having knowledge of such to the state and local health departments, within their respective jurisdictions." The Board of Health (BOH) regulations translate "any person" to require reporting by physicians, hospitals, and in-state laboratories, and the BOH has broad authority to add or delete diseases and conditions that must be reported. This required reporting is specifically exempted from HIPAA requirements by federal law.

The ultimate intent and value of public health reporting is to facilitate disease control efforts at the public health level. For example, prompt reporting is essential for the timely distribution of prophylaxis for bacterial meningitis and pertussis. More recently, reporting of E. coli O157:H7 infections has been important in the investigation of a multi-state outbreak linked to contaminated spinach. A complete list of required reportable conditions for physician use is available on the Internet at [www.cdphe.state.co.us/dc/medlist.pdf](http://www.cdphe.state.co.us/dc/medlist.pdf).

Despite the requirements of law and the importance of disease reporting, most licensed physicians in Colorado do not comply with public health reporting. The Colorado Department of Public Health and Environment (CDPHE) does not aggressively pursue enforcement of this law, but instead relies primarily on reporting by in-state laboratories and hospitals for disease control. CDPHE feels that the current process usually provides adequate information for disease control efforts in many instances. However, licensed physicians need to be aware of this law and should make efforts to comply, as earlier notification of these diseases improves the timeliness and quality of disease control interventions and will be critical to public health emergency response.

The bill mentioned above would have required physicians and laboratories to notify patients of public health reporting prior to a test being ordered, and to notify patients of what was reported to public health agencies after results were available. The public interest cited in proposing this bill was that individuals have the right to know with whom their personal health information is shared. Ultimately, the bill did not go forward due to concerns about the potential negative impact that this requirement could have on clinical practice and decisions about test ordering.

Regardless, CDPHE supports the recommendation that patients should be aware that certain diseases and conditions are reported to public health (if not by the physician, than by the laboratory) and that these reports include personal health information. Physicians are free to choose whether and how to implement this recommendation in their own practices. One suggested approach that emerged from the bill hearings is to post the list of reportable conditions in physician offices. On October 16, 2006, CDPHE will post a list oriented towards patients on the Internet at [www.cdphe.state.co.us/dc/medlistpatients.pdf](http://www.cdphe.state.co.us/dc/medlistpatients.pdf). CDPHE recommends printing out and posting this list in waiting and/or exam rooms where it could be reviewed by interested patients. Finally, physicians and patients should know that state law and CDPHE policy and practice keeps this public health information strictly confidential.

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## Be Honest with the Board

*Cheryl Hara, Program Director, Colorado Board of Medical Examiners*

The mission of the Division of Registrations is “public protection through effective licensure and enforcement.” One way the division, including the Board of Medical Examiners, safeguards the public is by issuing licenses to fully qualified, competent and ethical applicants.

During the initial licensing, reinstatement, or reactivation process, the Board will ask you to provide information regarding any criminal history you may have. Specifically, the Board will ask you whether you have ever been charged, indicted, convicted, received a deferred prosecution, received a deferred judgment and sentence, entered a plea of guilty, entered a plea of nolo contendere, or been placed on adult diversion for any violation of any law. During the renewal process, the Board will ask you to update information regarding criminal charges since you last renewed your license. Specifically, the Board will ask you whether you have had any felony or misdemeanor charges of any kind or any traffic citations involving drugs or alcohol brought against you.

A “yes” response regarding your criminal history is not an automatic disqualification from licensure. Instead, the Board will look at the facts surrounding the criminal conduct in assessing whether to grant, renew, reinstate or reactivate a license.

It is important to be completely honest in providing your answers. Failure to fully disclose could constitute grounds for denial of an application or discipline of a license.

Please be aware that explanations such as the following are not substitutes for disclosure of criminal events:

My attorney told me I didn't have to disclose the criminal conduct.

I didn't think the prior conduct had anything to do with the profession.

I didn't think the arrest, charges, or conviction was still on my record.

I didn't think it was subject to disclosure because I received a deferred sentence/judgment.

The division is now conducting annual audits of its licensing database against several criminal databases. In this way, the division verifies the accuracy of applications and tracks subsequent criminal conduct after initial licensure.

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## Whether 30 Safe Practices or The National Patient Safety Goals: It's About the System!

*Jandel T. Allen-Davis, MD, Board Member*

*Remove the rock from your shoe rather than learn to limp comfortably.  
- Stephen C. Paul*

Dr. Stephen Paul, a psychotherapist and author, wrote this quote in his book [Inneractions](#).<sup>1</sup> I heard it recently in my work as Director of Patient Safety for the Kaiser Permanente Colorado Region. In a discussion with my boss and friend, Dr. Michael Raggio, I was lamenting how difficult cultural change can be, how medicine's systems frequently seem to be defensive instead of offensive, and how limiting this approach to improvement is. He pointed out that we spend a great deal of time designing systems from a reactive perspective, instead of a proactive one; that is, we learn to live with the rocks. How different would health care look and feel if we worked proactively in changing our health care system by always looking for and addressing the risks that impede safety? What if we removed the rocks from our shoes?

According to the Institute of Medicine (IOM) report, To Err is Human: Building a Safer Health Care System, 44,000 to 98,000 people die in hospitals each year as the result of medical errors. If we follow this logic, medical errors are the eighth leading cause of death in this country—higher than motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516). About 7,000 people per year are estimated to die from medication errors alone—about 16 percent more deaths than the number attributable to work-related injuries. Additionally, medical errors are expensive. It is estimated that the cost of medical errors in the United States is 37.6 billion dollars annually and about half of that is due to preventable errors.<sup>2,3</sup>

That same report makes very specific recommendations regarding performance standards and expectations. It explicitly focuses on accrediting organizations, licensing bodies, and professional societies. In short, the report recommends a radically different approach to reviewing ourselves. It is in that spirit that this article is written. Physicians must take a bold and proactive approach to the design and development of safe systems of health care at the national, regional, local, and organizational level. We must do this in part because we are integral to the safe (and unsafe) delivery of care, and because we have implicit and explicit knowledge about how our systems work. We also must do this or else, to turn a phrase, “somebody else will.”

The good news is that this is happening in systems all over this country and in this state. The bad news is that people are still injured at our hands every day that we let pass without attending to our systems. In Spear’s article *Fixing Healthcare from the Inside, Today*, physicians “tend to work around problems, meeting patients’ immediate needs while not resolving the (system’s) ambiguities themselves. As a result, people confront the same problem every day for years... regularly manifested as inefficiencies and irritations, and occasionally as catastrophes.”<sup>4</sup>

It has been said, “Our system is broken.” When one considers the cost of health care in America, especially in view of our health status, coupled with the health insurance crisis, removing just this level of waste would go a long way toward reducing costs. Instead we limp along, trying to accommodate and work around and within a flawed system, rather than focusing on solutions. The outcomes of these flaws play out in many arenas, including complaints to the Board of Medical Examiners.

We have a pivotal role to play in shaping a new reality of medicine. Most of us do not awake in the morning and say, “I want to go to work today and harm someone,” and yet this frequently happens. We are surprised when the system responds in ways we did not predict, i.e., when patients get surgical site infections, when the wrong limb or organ is removed, or when medication errors leave patients incapacitated at the hands of well-meaning providers. We have been trained to believe that bad outcomes are “the cost of doing business,” or that someone screwed up, that we screwed up. We are smart people and yet we don’t examine our systems with a critical eye. If we did, we would recognize that, given the relative lack of true coordination within health care, many *good* outcomes happen by chance as well!

The patient safety movement seeks to look at our work in the context of a system; patient safety is concerned with the continuum of care. Patients and providers navigate an extremely complex, interwoven, interdependent web that is fraught with risk. As physicians, we are but one part of a complex adaptive system that can behave in an unpredictable fashion, *unless we deliberately focus on its parts and work to improve them*. As long as we continue to believe that the key to making care safe is “to work harder next time,” we will continue to falter. Said another way, it is less often about the individual and is more often about the system.

Health care can be compared to other inherently risky industries such as nuclear submarines, commercial aviation, and nuclear power plants. In each of these industries accidents are virtually unheard of, due to careful coordination of systems and a fierce attention to and correction of risk. They are characterized by a high degree of reliability. In this context, reliability implies that the system behaves in a predictable fashion most of the time. Imagine how much safer health care could be if our system began to function like a high reliability organization. Karl Weick and Kathleen Sutcliffe, in their book Managing the Unexpected, describe the tenets of a high reliability organization.<sup>5</sup> Such organizations:

- Have a preoccupation with failure, and are always on the lookout for system malfunctions and seek to correct them;
- Are reluctant to simplify interpretations of events, rather they seek to expand the list of possible explanations for unexpected outcomes;
- Are highly sensitive to operations, and are always looking for loopholes in the system’s defenses (James Reason’s so-called “latent failures or conditions”<sup>6</sup>);
- Are committed to being resilient in the face of failures by quickly bouncing back from them and innovating when there is no clear answer; and
- Defer to expertise, by seeking answers and solutions from those who do the work rather than working within rigid hierarchies.

Getting to a level of high reliability takes work and some “good enough” road maps. The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) has established a set of National Patient Safety Goals.<sup>7</sup> The National Quality Forum (NQF), which includes 260 consumer, purchaser, and provider organizations, has issued a list of 30 Safe Practices and has urged universal adoption of these practices in health care settings across the United States.<sup>8</sup> In reviewing the newest set of patient safety goals from JCAHO, in comparison to the 30 safe practices from NQF, there are a number of themes that provide a “good enough” road map.

- *Establish a culture of safety.* Safety in this context includes freedom from harm as well as psychological safety. Psychological safety implies that it is safe for individuals, regardless of “rank,” to speak up when they have safety concerns, indeed, to “stop the line.” Errors are discussed and reported in a blame-free way, according to processes established at the institution. The institutional leadership directs patient safety initiatives and problems are addressed. Successes are celebrated and those with the courage to speak up about safety concerns are rewarded.
- *Be relentless in the quest to communicate critical information to all caregivers in an effective manner.* This includes the use of correct patient identifiers, the communication of verbal orders, the performance of handoffs, and clear documentation in the medical record (i.e., legibility, use of clear language in the orders sections of the chart, and adopting the “Do Not Use” list of abbreviations from JCAHO). Given the volume of information that every caregiver must consume, and the limited amount of time in which to do this, it is critical that our communications be effective, complete and clear.
- *Reduce the number of medication errors across the continuum of care.* This includes work to prevent the “look-alike” “sound-alike” drug interactions, avoiding unapproved abbreviations, proper labeling of all medications in sterile fields, and performing medication reconciliation at times of all transfers (including admission and discharge). One additional area of concern among physician-led organizations and others is Internet prescribing.
- *Reduce nosocomial infection by washing your hands before and after every patient contact.*
- *If your institution is not participating, encourage your hospital administration and your medical staff to get involved in the Institute for Healthcare Improvement’s (IHI) 100,000 lives campaign.* Since the call to action in 2004 by Dr. Don Berwick, the IHI’s President and CEO, it is estimated that more than 122,000 lives have been saved.<sup>9</sup>
- *Make sure you have a reminder system in your office to assure that ordered critical and non-critical lab tests are performed, results are received, and that the information is communicated to patients.*
- *Probably most important, include your patient in all discussions and assure that they know that they have a crucial role to play in the provision of safe care.* Patients should be directed to ask questions when we are unclear. They should make sure their physicians know all medications that they are taking and question any and all medications that are given to them in the inpatient and outpatient setting, including the indications. They should make sure they have family members who can advocate for them when they are unable to do this for themselves, and they should never allow anything to be done to them that they don’t fully understand.<sup>10</sup>

In the [September 2005 online version](#) of *The Examiner*, the article “Anatomy of a Complaint – Complaints and Physician-Patient Communication: Many Parts of the Same Elephant” outlined several common themes present in any given month in the complaints that we read at the Board.<sup>11</sup> These complaints are rife with systems issues that are in need of systems fixes. If we are to make care safe for the citizens of Colorado, physicians must lead this charge. Otherwise, we cast ourselves in the role of victim, limping along and through a broken system that continues to behave in unpredictable ways. Among the system’s victims are countless well-intentioned, hardworking caregivers who must stop long enough to remove those rocks!

Engineering reliability into our system is key. This is neither simple nor work for the faint of heart. It requires courage, tenacity, humility, and tremendous patience. The patient safety movement envisions a time when health care will be safe and reliable. On a personal level, we owe it to ourselves to examine our systems and remove the rocks, so as to avoid more unnecessary harm and its outcomes, including our own sense of shame and isolation, let alone lawsuits and complaints to the Board of Medical Examiners.

When I am at my most visionary place, I imagine a day when the patient safety movement will significantly reduce the amount of work of peer review committees, quality improvement departments and state medical boards. I think Dr. Berwick said it best when he said, in reference to the 100,000 Lives Campaign,

*“The names of the patients whose lives we save can never be known. Our contribution will be what did not happen to them. And, though they are unknown, we will know that mothers and fathers are at graduations and weddings they would have missed, and that grandchildren will know grandparents they might never have known, and holidays will be taken, and work completed, and books read, and symphonies heard, and gardens tended that, without our work, would never have been.”<sup>9</sup>*

Now **that** is a comfortable pair of shoes!

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## Distinguished Foreign Teaching Physician

The Colorado Legislature recently revised section 12-36-107(3), CRS allowing a physician of noteworthy and recognized professional attainment – who is a graduate of a foreign medical school and who is licensed in a foreign jurisdiction – to be granted a distinguished foreign teaching physician license to practice medicine as a member of the academic staff of a Colorado medical school or one of its affiliated hospitals. As a result of this statutory change, the Board adopted [Rule 140](#), Licensure And Supervision Of Distinguished Foreign Teaching Physicians. This rule specifies standards related to the qualification and supervision of distinguished foreign teaching physicians.

Further information regarding this and all other Board Statutes, Rules and Policies may be found on the following web page:  
[www.dora.state.co.us/medical/statutesrulespolicies.htm](http://www.dora.state.co.us/medical/statutesrulespolicies.htm)

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## New Program Director and Board Members

The Colorado Board of Medical Examiners wishes to welcome Ms. Cheryl Hara to the staff in the position of Program Director, effective July 1, 2006. Cheryl replaces Susan Miller who, after many years of exemplary service to the Board, was appointed to the position of the Director of the Healthcare Section of the Division of Registrations, Department of Regulatory Agencies.

Cheryl brings to the Board many years of experience that will be an asset in her new role. She is a graduate of the Physician Assistant Program at Northeastern University and worked as a PA-C from 1977 to 1983. She obtained her law degree from the University of Colorado in 1986 and gained medically related experience including medical malpractice defense and while serving as a deputy district attorney. Cheryl was an assistant attorney general representing the Board of Medical Examiners from 1997 to 2001. She also served as general counsel for the Board from 2001 to 2004.

The Board said goodbye to Board members Carmen Davila-Toro, MD, and Eugene Eby, MD this past year. Replacing the position held by Dr. Davila-Toro is Kathleen Matthews, MD, who practices forensic psychiatry. Filling the vacancy left by Dr. Eby is Michael Jobin, MD, a practicing emergency medicine physician.

We are looking forward to the experiences and vision that will be brought to the Board by these individuals.

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## The Role of a Public Member

*Karen Quinn and Susan Radcliff, Public Members, Colorado Board of Medical Examiners*

Appointment to the Board of Medical Examiners (BME) as a public member is both an honor and a significant responsibility for the four of us who serve in this role. Each panel has two public members: Carl Jennings (Panel B, Denver), Rev. Bob Leivers (Panel A, Colorado Springs), Karen Quinn (Panel A, Denver) and Susan Radcliff (Panel B, Denver). Our opportunity to participate is encouraged and supported by the physician members of the Board at both monthly inquiry panel meetings and quarterly full Board meetings. Our perspective as representatives of the public-at-large during inquiry panel meetings focuses less on the technical aspects of medical practice, such as specific techniques, procedures, knowledge or skill level, and more on how information from a complainant and the response from the physician or physician assistant appear to be logical and sufficiently complete to form an opinion about the substance of the complaint. Similarly, when we participate in rulemaking or in the creation or revision of Board policies and procedures, our input has to do with whether these regulations address the public expectations for regulating medical practice. We, along with our physician colleagues, take very seriously our commitment to serving the public trust.

Serving as a public member requires a steep learning curve, not only for those on the Medical Board but also for public members appointed to the boards of other professions regulated by the Division of Registrations. Last fall, we volunteered to pilot a Public Member Mentoring Program for new public members beginning their service on any of the professional boards within the division. Our goals are to:

- Help public members be the best representatives possible of the public trust;
- Help new members understand the confidentiality requirements and other issues critical to assuring the integrity of the regulatory process;
- Provide support for new members with respect to understanding the regulatory process;
- How discussion and communication among board members occurs;
- How to prepare for board meetings;
- How to raise issues in a board meeting in a constructive manner;
- Help public members understand their role on professional licensing boards and help each public member have his or her voice heard in a positive way; and
- Assist the division in attracting qualified public members and work with the new administration following the 2006 gubernatorial election.

As mentors, we also are charged with complying with all confidentiality and open meetings requirements. In addition, we never advise new public members about specific process or case details that may be unique to a particular licensing board. These questions are referred to the program director or legal counsel of the board in question. Our overarching philosophy is to assist new public members with general questions and help them understand their role in this important activity on behalf of the people of Colorado. We expect this program will support and enhance the collegial opportunities among the public members serving the public trust.

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## Registrations Online Services

Doing business with the Division of Registrations is easy when you use Registrations Online Services ([www.doradls.state.co.us](http://www.doradls.state.co.us))! After a simple online registration process, you can:

### **Renew your license**

- Approximately six weeks before your license expires, whether you receive a renewal notice or not;
- Use your Visa, MasterCard, Discover, or American Express card;
- Get instant payment confirmation;
- Cut the renewal processing time in half.

### **Change your mailing address**

- Update your contact information in “real time” – no more waiting for your written request to be received and processed by staff.

### **Check the status of a pending application**

- Track your application from the date we log it into our database to the date your license is printed.

...and more!

**REGISTRATIONS ONLINE SERVICES: Open 24 hours a day, 7 days a week**

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## Your Address is Public Information

A licensee's address for all Board correspondence shall be the mailing address as indicated on the application for initial licensure. The Board will only change a licensee's address upon receipt of a clear, explicit, and unambiguous written statement from the licensee or the licensee's agent that the address should be changed.

The licensee may also update the address of record electronically using [Registrations Online Services](#).

The mere receipt of correspondence from a licensee showing a new address shall not be considered sufficient to change an address.

The licensee's address of record with the Board must be updated within thirty (30) days of the effective date of the new address. In the event that a licensee submits a request for a change of address, but does not indicate between the business and home address where Board correspondence should be sent, the business address shall constitute the address for this purpose.

In no event will the Board accept a change of address which requests the address be changed for some, but not all, communications. Also, in no event shall the Board change the address if a licensee indicates that Board correspondence shall be marked "confidential."

Some licensees have expressed concern that their home address is available to the public. Colorado law requires that all addresses on record with the division are public record and must be provided to the public when requested. Licensees are reminded that it is permissible to provide an address of record other than a residence, such as a post office box or a practice location. A change of address may be made at any time using [Registrations Online Services](#).

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## Board Actions

On its website, the Board maintains a list of Board actions taken by the Colorado State Board of Medical Examiners from January 1, 2006 to present, as well as actions from previous years. [Click here](#) to view these actions online. Documentation of Board actions are available on [Registrations Online Documents](#) or by sending a written request to Donna Eccleston at the Medical Board address or via e-mail: [Donna.Eccleston@dora.state.co.us](mailto:Donna.Eccleston@dora.state.co.us).

### Board Action Definitions

- **Letter of Admonition (LOA):** A public reprimand issued to the physician or physician assistant in the form of an actual letter or as part of a stipulation. The letter or stipulation is a public record and may be obtained from the Board office.
- **Stipulation and Final Agency Order (Order):** An order of the Board and an agreement between the Board and the practitioner prior to a formal hearing. A stipulation resolves the case. In a stipulation, both parties agree to facts, sanctions and the terms and conditions for continued practice, if applicable. **Such orders may be disciplinary or non-disciplinary in nature.**
- **Final Board Order:** Final order issued by the Board after a formal hearing before an Administrative Law Judge (ALJ) where evidence and testimony were presented. The ALJ prepares a written report of the findings, which a Hearings Panel of the Board reviews and then makes the final ruling regarding the appropriate sanction, which may then be reviewed by the Colorado Appellate Courts.
- **Prima Facia:** Literally means "at first view" or "on its face." As used in this context, it means that the Board believes it has evidence to prove a violation of the Medical Practice Act has occurred. However, this evidence may have been rebutted or outweighed had the case gone to hearing.
- **Summary Suspension pursuant to 24-4-104(4), CRS:** An immediate, temporary withdrawal of the practitioner's license to practice medicine pending prompt commencement of formal disciplinary proceedings. This type of suspension can only be ordered when the Board finds the public health, safety, or welfare requires emergency action or that the practitioner has willfully violated the law.
- **Summary Suspension pursuant to 12-36-118(5)(g)(IV), CRS:** A suspension of a practitioner's license for failure to comply with a lawful order of the Board.
- **Summary Suspension pursuant to 12-36-118(9), CRS:** A suspension of a practitioner's license for failure to comply with a Board order for a mental or physical examination.
- **Formal Complaint:** The document filed with the Administrative Law Judge by the agency's attorney that sets forth the charges being made against the licensee by the agency and the provisions of the law the agency believes it can prove that the licensee violated.
- **CPHP:** Colorado Physician Health Program.
- **CPEP:** Center for Personalized Education for Physicians.

The list of Board actions does not represent all Board actions. Absent from this list are applicants denied initial licensure, reactivation, or reinstatement either before or after a hearing. The city listed is derived from the designated mailing address on file with the Board, and may not necessarily reflect the current city of practice.

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**Carlton R. Jennings**  
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**Susan L. Jolly, MD**  
Board Member

**Rev. Robert C. Leivers**  
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**Kathleen Matthews, MD**  
Board Member

**Karen J. Quinn**  
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**Susan Radcliff**  
Board Member

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