directed to an on-line summary report, while a detailed report is available for US$12. Other states provide full details online. Some also post disciplinary sanctions from hospitals, the federal government, and civil or criminal courts. "One of them even tells you if they take MasterCard," says Swankin. "It's just chock full of information."

10 operated under a mandate. Some 18 of 20 top-scoring states provided information about malpractice settlements, while 15 included information about criminal convictions and 13 provided hospital discipline information. The survey urged state lawmakers to adopt steps to make disciplinary information more comprehensible and searchable.

The system is far from perfect, but has been significantly bolstered by legislative requirements.

Information on malpractice claims and settlements are handled carefully, if at all. Some have a financial threshold above which settlements are reported. Others provide no settlement figures. Some remove malpractice information after 5 or 10 years; others leave it up permanently. "It's a tough sell to put up malpractice information," says Swankin. "Physicians and medical societies don't like to see it. They say it's totally deceptive."

Massachusetts is the model, Swankin says. Recognizing that physicians in some specialties are more likely to be sued than others, the state's board compares doctors only to others in their speciality, and offers guidance before providing details about malpractice suits. With studies showing no correlation between malpractice history and a doctor's competence, the site states: "you could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history." Information about the malpractice history of the physician's speciality is then provided, along with the individual physician's history of malpractice payments, expressed as "below average," "average," or "above average."

A 2006 survey of doctor disciplinary information on state board websites by Washington, DC–based Public Citizen found that New Jersey, Virginia and Massachusetts ranked highest, with North Dakota scoring lowest. The top 10 states were all required by legislation to display profiles. Only 1 of the bottom

Until the public site was launched in 2001, Federation disciplinary information was only available to hospitals, insurance companies and state medical boards. Now, if disciplinary action has been taken, the physician profile — which costs US$9.95 per physician — specifies the state medical board involved, the date and type of action, and the reasons for it. But information on malpractice claims or settlements isn't included.

Loopholes that previously allowed physicians with revoked licenses in 1 state to practise in other states have been closed. Since 2002, the Federation's Disciplinary Alert Service has notified boards by e-mail within 48 hours when a licensed physician has been disciplined in another state. Before issuing new licenses, state boards can query the database. They can also search the National Practitioner Data Bank, an electronic repository of information on disciplinary actions, hospital privilege restrictions and medical malpractice payments, which is not open to the public. Many states have also changed confidentiality laws to allow medical boards to share information about investigations. Thus a doctor under investigation in one state loses any window of opportunity to obtain a license in another state before disciplinary action is taken.

Even in the litigious United States, boards are seen to serve an important role in protecting the public, with their power to set and enforce minimal standards of expected practice, and to impose sanctions for actions that don't rise to the level of malpractice. "They [boards] can look at things you just can't sue over," Miller says. "For example, violation of privacy. It's very difficult to sue over violation of privacy, but you can get disciplined for it very easily."

The number of complaints received and rectified each year by state boards, Miller notes, greatly outnumbers the number of malpractice suits. In 2006, state boards reported 5574 disciplinary actions. Yet only a fraction of injured patients advance their case to lawsuit stage: roughly 2%–10%, according to several studies. A US Bureau of Justice report that looked at malpractice insurance claims in 7 states between 2000 and 2004 found that most malpractice suits ended without a settlement. — Janet Rae Brooks, Salt Lake City, Utah

DOI:10.1503/cmaj.080209

## More bang for the taxpayer's buck

Consider it a milestone for public access to the findings of publicly funded research. Commencing this April, researchers funded by the US National Institutes of Health will be required to send copies of their final manuscripts to the National Library of Medicine's PubMed Central database, where they will be made available to the general public 1 year after publication in peer-reviewed journals.

A National Institutes of Health directive issued Jan. 11, 2008, mandated that researchers comply with the federal agency's public-access policy, which was initially implemented as a voluntary measure in 2005. But a provision of a $940-billion spending bill signed into law by President George W. Bush in December 2007 moved the bar from requesting to requiring.

Researchers, libraries, citizens and patient advocacy groups pushed lawmakers for the change after less than 5% of researchers voluntarily submitted copies of their manuscripts to PubMed Central.

Proponents say the change will speed medical progress, improve hu-

man health, help libraries cope with rising subscription costs and offer taxpayers access to research for which they annually cough up about US$100 apiece to cover the National Institute of Health's US$29-billion budget.

"Technology has enabled this policy," says Heather Joseph, executive director of the Scholarly Publishing and Academic Resources Coalition, a consortium of academic libraries. "It was definitely a polarizing issue, but the reality is that it gives us a tremendous new resource to do things we haven't even thought of yet."

About 70 000 more manuscripts will be available annually to researchers and the public, Joseph added.

Several journal publishers opposed the change, fearing that making articles free would reduce their advertising and subscription revenue. They also claimed the policy undermines their copyright.

But commencing May 25, 2008, researchers will be required to include the PubMed Central or National Institutes of Health submission number for all articles cited in their future grant applications and progress reports. Failure to do so would jeopardize future funding. — Janet Rae Brooks, Salt Lake City, Utah

DOI:10.1503/cmaj.080211

## Dispatch from the medical front

### Soup truck

The pickup truck, loaded with buckets full of banku balls and groundnut soup, stops on the red earth courtyard of Tamale's residential mental health centre, where the windows are boarded up, the staff and funding long gone.

For a moment, there is no one — mangos ripen high on a tree, a goat investigates litter.

Then, as if on cue, a woman, her face expressionless, wearing tattered clothing and a cardinal tuque in 40 degree Ugandan heat, turns a corner and walks with firm certainty towards us to receive her meal. Other former in-patients soon appear from their makeshift shelters, still living on the grounds of this closed facility, also anticipating the daily visit.

We go to the next stop.

The driver explains to me that many people with mental illness in his city are banned from their families, and few have access to treatment. They become the homeless on the streets, feared by the public and without any means of support.

To address this issue, his clinic developed a free food program, and in 17 years has not missed a single meal.

Since then, the public has seen an improvement in those on the streets, and many gossip that the clinic secretly puts medication in the food.

Of course there's no medication, he laughs.

Having a full stomach helps their symptoms, and so does having others who care about them, arriving predictably each day.

Daren Lin

The food truck on a road in Tamale, with one of the cooks, Mary (right), and the driver, Somebody (left). Somebody got his moniker because the clinic needed "somebody" to do odd jobs and he stepped up to the plate.

Seeing their safe interactions with the clinic, the public stigma is now also gradually subsiding.

Our truck approaches some roadside market stalls, where people gather to stare at the nearby traffic circle.

There a man jumps up and down, dangerously close to honking scarlet tro-tro taxis whirling about him.

He is nearly naked under the blazing sun, screaming pressured speech.

Stepping from the truck, I approach him.

There is calm in his eyes as he takes my parcel of banku and groundnut.

Gently, he sits down to eat.

It is an amazing sight: compassion achieving the same short-term effect as an antipsychotic, often pierced violently into an uncooperative patient's straining muscles back home. — Daren Lin MD, Hamilton, Ont.

DOI:10.1503/cmaj.080212

*CMAJ* invites contributions to Dispatches from the medical front, in which physicians and other health care providers offer eyewitness glimpses of medical frontiers, whether defined by location or intervention. The frequency of the section will be conditional on submissions, which must run a maximum 350 words or be subject to our ruthless editorial pencils. Forward submissions to: wayne.kondro@cma.ca