MEDICAL BOARD OF CALIFORNIA
Executive Office

EDUCATION COMMITTEE

MEMBERS OF THE COMMITTEE

Barbara Yaroslavsky, Chair
Hedy Chang
Mary Lynn Moran, M.D.
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D.

July 29, 2010

Medical Board of California
Hearing Room
2005 Evergreen Street
Sacramento, CA 95815
(916) 263-2389

Action may be taken on any item listed on the agenda.

AGENDA

1:30 p.m. – 2:45 p.m.
(or until the conclusion of business)

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE.
If a quorum of the Board is present, members of the Board who are not members of the Committee may attend only as observers.

1. Call to Order
2. Public Comment on Items Not on the Agenda
3. Approval of the Minutes of the Committee's Meeting on July 23, 2009
4. Opening Remarks – Ms. Yaroslavsky
5. Presentations About the Education of Physicians Regarding Hepatitis
   - Gail Bolan, M.D – Chief, STD Control Branch, Department of Public Health
   - Eddie Cheung, M.D. – Director, Hepatology, VA Northern California Health Care System
   - Samuel So, M.D. – Director, Stanford Liver Cancer Program
   - Diana Sylvestre, M.D. – Executive Director, O.A.S.I.S. Clinic
6. Consideration of Committee's Next Steps
7. Agenda Items for Future Discussion
8. Adjournment

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act, and to promote access to quality medical care through the Board's licensing and regulatory functions.
Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Public Meetings Act. The audience will be given appropriate opportunities to comment on any issue before the Board, but the Chair may apportion available time among those who wish to speak. For additional information call (916) 263-2389.
NOTICE: The meeting is accessible to the physically disabled. A person who needs disability-related accommodations or modifications in order to participate in the meeting shall make a request to the Board no later than five working days before the meeting by contacting Cheryl Thompson at (916) 263-2389 or sending a written request to Ms. Thompson at the Medical Board of California, 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815. Requests for further information should be directed to the same address and telephone number.

MEDICAL BOARD OF CALIFORNIA
Executive Office

Education Committee Meeting
Medical Board of California
Hearing Room
2005 Evergreen Street
Sacramento, CA 95815

July 23, 2009

MINUTES

Agenda Item 1 Call to Order

The Education Committee of the Medical Board of California was called to order by Chair Barbara Yaroslavsky at 1:03 p.m. A quorum was present, and due notice had been mailed to all interested parties.

Members of the Committee Present:

Barbara Yaroslavsky, Chair
Hedy Chang
Mary Lynn Moran, M.D.
Janet Salomonson, M.D.

Board Members, Staff and Guests Present:

Robert McKim Bell, J.D., Office of the Attorney General
Fayne Boyd, Licensing Program
Kathi Burns, Manager, Enforcement Program
Susan Cady, Manager, Enforcement Program
Yvonne Choong, California Medical Association
Candis Cohen, Public Information Officer
Janie Cordray, Research Specialist
Zennie Coughlin, Kaiser Permanente
Julie D'Angelo Fellmeth, Center for Public Interest Law
Shelton Duruisseau, Ph.D., Board Member
Sean Eichelkraut, Information Systems Branch
Abbie French, Telemedicine Manager
Jeffrey Gray
Laurie Gregg, M.D., Member, Wellness Committee
Teri Hunley, Business Services Office
Diane Ingram, Manager, Information Systems Branch
Scott Johnson, Information Systems Branch
Barb Johnston, Executive Director
Kim Kirchmeyer, Deputy Director

Arlene Krysinski, Enforcement Program
Ross Locke, Business Services Office
Armando Melendez, Business Services Office
Jimmy Miranda, Administrative Services
Kelly Nelson, Legislative Analyst
William Norcross, M.D., PACE
Deborah Pellegrini, Chief of Licensing
Regina Rao, Business Services Office
Paulette Romero, Associate Analyst
Kevin Schunke, Regulation Coordinator
Cheryl Thompson, Executive Assistant
Anita Scuri, Senior Staff Counsel, DCA
Chris Searles, M.D., PACE
Kathryn Taylor, Manager, Enforcement Program
Cheryl Thompson, Executive Assistant
Renee Threadgill, Chief of Enforcement
Linda Whitney, Chief of Legislation
Peter Yellowlees, M.D., U.C. Davis

Agenda Item 2 Approval of the May 7, 2009 Minutes

It was M/S/C to approve the minutes of the May 7, 2009 meeting.

Agenda Item 3 Opening Remarks by the Chair – Ms. Yaroslavsky

Committee Chair Barbara Yaroslavsky explained why the Committee was meeting on the topic of sexual misconduct. Several recent news clips emailed to Board members by staff dealt with stories involving sexual misconduct by physicians against patients. Although the Board is used to seeing such cases, several members of the Committee were concerned because the cases were so close in time, and interested in exploring what the Committee might do to address the issue, since such conduct, while rare, is willful and at least some of it is preventable. The goal at this meeting is to see if the Committee might be able to decrease this particular misconduct by educating both physicians and the public. She stated it was time to remind physicians of the laws prohibiting sexual relations with patients, and to educate the public, as well.

Ms. Yaroslavsky added that the Board in 1996 issued a policy statement denouncing sexual misconduct by physicians, included in our newsletter and posted on our Web site, as are two other, related articles, one published in 2004 and one in 2006. Additionally, since 2002 sexual misconduct is a legislative mandated enforcement priority of the Board's, so continuing educational efforts by this Committee would be consistent with that directive.

Agenda Item 4 Discussion of education of the public and the medical profession regarding sexual misconduct, its avoidance, and the physician-patient relationship

Chris Searles, M.D., of UCSD and the Physician Assessment and Clinical Education (PACE) Program, designed and implements the professional boundaries program for PACE. He noted that touch is not taught well in medical school, so physicians are in "uncharted waters." Some physicians will touch inappropriately, no

matter who does what, and that is very rare. Patients should be empowered with knowledge without being scared. Ultimately, knowledgeable patients and physicians who communicate well and encourage patients to tell them when they are uncomfortable should be our goals. Physicians and patients must learn both appropriate personal and professional boundaries. Culture is also a factor in touch, which physicians must take into account.

Communication and touch should be taught better in medical school. Physicians need to be aware of touch protocols, including: pre-touch: Is this necessary? Why am I doing this? Is it clinically necessary? Should a colleague be doing this? For whose benefit is this touch? Am I communicating well with the patient? Is the patient comfortable? Minimize the touch and make it the same for each patient. Talk to the patient about the touch and thank them for their trust. Give patients the opportunity to ask questions. Then self-evaluate: how did I do? Was I respectful? Review the patient's response to touch, and change course, if necessary.

Dr. Searles also recommended empowering the patient as much as possible, including putting a sign in exam rooms asking patients to inform physicians if they are uncomfortable, and assuring them their comfort is the physician's highest priority. Giving an evaluation form to patients can help physicians learn a lot. In turn, doctors should teach patients as much as possible, as patients will feel more empowered by the knowledge and with context comes more safety for both patient and physician.

Robert McKim Bell, supervising deputy attorney general, Health Quality Enforcement Section, said the law is clear on the matter of sexual touching and involvements with patients, and it is available on the Medical Board's Web site, so he wished to provide instead some suggestions about how to help get the available information to those who need it. The materials on our Web site are harder to access than they need to be, so Mr. Bell worked with the Board's Information Systems Branch staff to come up with ideas to guide the traffic better. The Board has about 35,000 first-time users every week, and the dominant interest is in the physician profile section of our Web site. The Board's newsletter also attracts much interest.

Mr. Bell proposed putting a portal to the Board's articles on sexual misconduct on its home page, as those articles presently receive very few "hits." Once clicked on, the "landing page" currently has three articles listed, each from previous Board newsletters. The Web site also has the Board of Psychology's booklet, "Professional Therapy Never Includes Sex," which he believes should be added to the list, as could a list of frequently asked questions. Links might also be provided to others' sites, such as the Board of Psychology, the California Medical Association, the American and California Psychiatric Associations, and other valuable resources. More text on a page creates a greater likelihood of being found by search engines such as "Google." Links also create a higher ranking in the search universe. These technical steps will draw vastly more visitors to our site regarding sexual misconduct, and this information will be quantifiable by the Board's technical staff.

Dr. Moran asked how long after termination of therapy by non-psychotherapists is it appropriate to engage in a romantic relationship with a patient. Mr. Bell said case law holds that it depends on the intensity and the dependency of the relationship. There is no bright line. Dr. Searles said he defers to the law because there is no answer to the "timing test," but there are factors to be considered, such as the depth and nature of the relationship. At its onset, the relationship is not equal because of the power differential. Any personal relationship with a patient involves some risk, to be judged by one's peers.

Ms. Yaroslavsky asked for a motion to have staff come up with a plan to make it easier for consumers and physicians to find information about sexual misconduct in the physician-patient relationship, and to enhance the

Board's Web site along the lines suggested by Mr. Bell. Ms. Chang so moved, which was seconded. Ms. Yaroslavsky asked for the involvement of the California Medical Association, since it has an excellent publication on relevant topics. The motion passed unanimously. Ms. Yaroslavsky expressed concern about the dearth of information given to medical students. Dr. Searles said ACGME should be contacted by the Board,

since they "set the rules of the road for medical training." Dr. Moran moved to ask staff to evaluate existing materials for education on sexual boundaries in medical schools. Dr. Searles offered to share a curriculum on that topic. Ms. Chang seconded the motion. The motion passed unanimously. There was no public comment.

Agenda Item 5 Public Comment on Items not on the Agenda

None was offered.

Agenda Item 6 Agenda Items for Future Discussion

Dr. Moran wanted a similar meeting on education on medi-spas. Dr. Chang asked about a discussion of physicians' responsibility in prescribing. Dr. Solomonson asked for follow-up on the day's topic at the next Board meeting, including input from mental health care professionals since the laws are different with respect to their personal involvement with patients. Ms. Yaroslavsky asked for a report back from staff to the Committee.

There being no further comment, Ms. Yaroslavsky asked for a motion to adjourn. A motion was M/S/C.

Agenda Item 7 Adjournment

The meeting was adjourned at 2:14 p.m.

Speakers: Medical Board of California, Education Committee
July 29, 2010

Gail Bolan, M.D.
Chief, STD Control Branch, California Department of Public Health

Dr. Bolan is the chief of the STD Control Branch of the California Department of Public Health and has served as co-chair of the California Chlamydia Action Coalition. Dr. Bolan also has directed the nationally funded California STD/HIV Prevention Training Center for the past 20 years.

Dr. Bolan served as the director of the San Francisco City and County STD Prevention and Control Program and as medical director of City Clinic, the San Francisco STD Clinic, from 1987 to 1997. Currently, she serves on the Board of the American Social Health Association and the CDC CID Board of Scientific Counselors. Previously, Dr. Bolan served as chair of the National Coalition of STD Directors (NCSD) and served on the CDC HIV/STD Prevention Advisory Committee and the American STD Association (ASTDA) Executive Committee as well as on numerous regional and local committees. Dr. Bolan has published extensively in the field of STD epidemiology, prevention, and control.

Dr. Bolan earned her medical degree from the Dartmouth Medical School in Hanover, New Hampshire. She completed her training in internal medicine at the University of Virginia, Charlottesville, and subspecialty training in infectious diseases at the Tufts New England Medical Center in Boston and the Stanford Medical Center. She trained in medical epidemiology as an Epidemic Intelligence Service (EIS) officer at the Centers for Disease Control and Prevention (CDC) in the Respiratory and Special Pathogens Branch.

Eddie C. Cheung, M.D., F.A.C.G.
Director-Hepatology, VA Northern California Health Care System, Oakland

Dr. Cheung is a clinical professor of internal medicine and gastroenterology/hepatology at the UC Davis School of Medicine, and member of the clinical faculty at the Stanford University School of Medicine. He has been involved in clinical practice, research, and teaching for 30 years and is active on the national and international levels in a number of efforts in the fight against hepatitis. Dr. Cheung is chairman of the American Liver Foundation's National Asian Leadership Advisory Council. He is also president of the Chinese American Physicians Society, where he chairs the hepatitis committee.

Dr. Cheung received his medical degree from Taipei Medical University in Taiwan, received medical training in Tri-service General Hospital and Central Clinic in Taipei as well as at Catholic Medical Center in New York, and served as a fellow in digestive diseases and nutrition at the University of Louisville.

Samuel So, M.D.
Professor in the School of Medicine and Professor of Surgery, Stanford University

Dr. So is the Lui Hac Minh Professor in the School of Medicine and Professor of Surgery at Stanford University. He is the founder and director of the Stanford Liver Cancer Program and the non-profit Asian Liver Center. Dr. So is spearheading a multidisciplinary effort that aims to identify new strategies for eliminating hepatitis B worldwide and reducing the threat of liver cancer. In 2008, he founded APAVH (Asia and Pacific Alliance to Eliminate Viral Hepatitis), a new global initiative. His current bench research efforts focus on the discovery and evaluation of novel diagnostic markers and new therapies for liver cancer.

Dr. So is a member on the Board of Population Health and Public Health Practice of the Institute of Medicine, and a co-author of the IOM report on Hepatitis and Liver Cancer released in 2010. He chairs the National Hepatitis B Task Force. In 2009, the California API Joint Legislative Caucus presented Dr. So with the API Heritage Award for Excellence in Science. In 2010, he received the Outstanding American by Choice Award, a national recognition from the United States Citizenship and Immigration Services for making significant contributions to the U.S. and global community.

Dr. So is a graduate of the University of Hong Kong, Faculty of Medicine.

Diana L. Sylvestre, M.D.
Executive director, O.A.S.I.S. Clinic, Oakland

Dr. Sylvestre is an assistant clinical professor of medicine at the University of California, San Francisco. A specialist in addiction medicine, she is a leading medical researcher on hepatitis C treatment in addicted patients. She is the 2004 Recipient of the California Society of Addiction Medicine's Vernelle Fox Award.

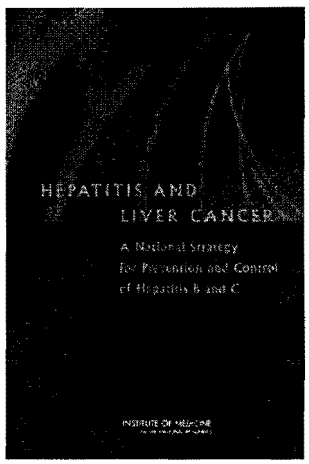
Dr. Sylvestre is a graduate of Harvard Medical School and trained at the Brigham and Women's Hospital in Boston and the Sloan Kettering Institute in New York City.

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES
Advising the nation / Improving health

For more information visit www.iom.edu/viralhepatitis

Hepatitis and Liver Cancer

Information for Health Care Providers



Hepatitis B and hepatitis C are major public health problems in the United States. Millions of people have these treatable infectious diseases, most do not know it, and about 15,000 people die each year from liver cancer or liver failure associated with these diseases. In the United States, chronic hepatitis B and C are more common, and claim more lives each year, than HIV/AIDS.

Chronic hepatitis B and C persist despite the current federal, state, and local efforts that are directed at their prevention and control. Therefore, the U.S. Centers for Disease Control and Prevention (CDC), along with several other government and private organizations, sought guidance from the Institute of Medicine (IOM) in identifying missed opportunities for addressing hepatitis B and C. The IOM report, *Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C*, offers recommendations on what health care providers, including primary care providers, can do as part of a national effort to address this epidemic.

For primary care providers in the United States, there is a good chance that patients in their practices have unrecognized chronic hepatitis B and C.

Finding and Treating Patients with Chronic Hepatitis B and C

For primary care providers in the United States, there is a good chance that patients in their practices have unrecognized chronic hepatitis B and C. These infections can be treated, and in some cases, cured, but at-risk people first must be identified so that they can receive serological testing. Therefore, new strategies are needed to find chronically infected people and get them the best possible care.

Boosting Knowledge about Chronic Viral Hepatitis

Among key steps, health care providers need to become more knowledgeable about chronic viral hepatitis. An estimated 3.5 million to 5.3 million people—roughly 1 to 2 percent of the nation's population—have chronic hepatitis B or C. About three-quarters of them are infected with hepatitis C virus (HCV); the rest with hepatitis B virus (HBV). In some people, HBV or HCV infection is noticeable in the acute phase, typically within a few months of the exposure. In many (though not all) people, the infection becomes chronic. These people frequently remain unaware of their infection for years, often until they develop symptoms of liver cirrhosis or a type of liver cancer called hepatocellular carcinoma.

Some population groups are at higher risk of infection. For hepatitis C, high-risk groups include users of illicit drugs, especially injected drugs. The first few years of use constitute an especially risky period in which the rate of infection can hit 40 to 60 percent. As use continues, infection rates can rise to 65 to 90 percent. Other high-risk groups include people who received a blood transfusion before 1992 and people who have known exposures to HCV, such as health care workers who have been stuck with contaminated needles. There is no licensed vaccine for hepatitis C.

There are effective hepatitis B vaccines, which have helped decrease the incidence of infection, but about 43,000 people still develop acute hepatitis B each year. This total includes some 1,000 infants who are infected during birth to HBV-positive mothers. Among adults, the group at highest risk for chronic hepatitis B are people who have immigrated to the United States from regions where HBV is endemic, especially Asia, the Pacific Islands, and sub-Saharan Africa. Other high-risk groups include users of illicit injected drugs; men who have sex with men; inmates of correctional facilities who often engage in risky behaviors; people who face occupational or household exposure to HBV or HBV-infected persons; and people who travel to countries where hepatitis B is common.

Guidance on Increasing the Hepatitis B Vaccination Rate

The federal Advisory Committee on Immunization Practices (ACIP) recommends that all infants and children and all adults in high-risk groups receive the hepatitis B vaccine—typically administered in a series of three doses. But gaps in vaccine use remain across all age groups, and the IOM report offers recommendations for expanding coverage.

To help prevent infections in newborns, the ACIP recommends that infants born to infected mothers receive the first dose of vaccine within 12 hours of birth. But these first doses often are missed or delayed due to a lack of clear delivery-room policies. As a solution, the IOM report recommends that health care institutions and providers establish policies to ensure that full-term infants born to HBV-infected women receive the first dose of vaccine—in conjunction with hepatitis B immune globulin (HBIG)—in the delivery room as soon as they are stable and washed. Infants born to mothers whose status is unknown should receive the first dose within 12 hours of birth, and if further tests show a mother is infected, her infant should receive HBIG as soon as possible (no later than one week after birth). Infants born to uninfected mothers should receive the first dose of vaccine before hospital discharge.

The ACIP also calls for vaccination of all children and young adults under 19 years old. School-entry mandates have proven effective in increasing hepatitis B vaccination rates, but there is variability in coverage among states. Additionally, there are racial and ethnic disparities in vaccination rates—Asian and Pacific Islander, Hispanic, and black children have lower vaccination rates than white children. To overcome such disparities, the IOM report recommends that all states mandate that the hepatitis B vaccine series be completed or

Health care providers can help improve identification of at-risk adults by routinely seeking their patients' risk histories through direct questioning and self-assessment.

in progress as a requirement for school attendance.

Among adults, only about half of those at high-risk for HBV infection currently receive the vaccine. Health care providers can help improve identification of at-risk adults by routinely seeking their patients' risk histories through direct questioning and self-assessment. In addition, organizations that serve high-risk people should offer the hepatitis B vaccination series, and correctional institutions should offer vaccinations to all incarcerated persons.

Guidance on Screening and Testing for HBV and HCV Infections

As most chronically infected people are unaware of their infection, it will be necessary to expand screening programs to identify those who are infected and help them find medical services. Health care providers can serve as the foundation for improved screening efforts. This will require providers to be knowledgeable about chronic HBV and HCV infections and to be able to identify patients who are at risk because of their behavior or previous potential exposure to the viruses. Though generally applicable, this requirement is particularly important for providers who specifically serve at-risk populations.

People identified through screening as being at high-risk for chronic viral hepatitis should receive testing to detect a history of exposure or to ascertain whether a person has HBV or HCV infection. While the tests to determine if someone is infected with HBV and HCV are relatively straightforward, the follow-up tests to determine the stage and activity of the diseases are more complex. The IOM report provides clinicians with specific, detailed information on interpretation of test results. In some settings that serve high-risk populations, it may be appropriate to test all patients for HBV and HCV at least once and to repeat testing on those patients with continued high-risk behaviors.

Guidance on Medical Management and Treatment

Put simply, the goals of medical management of chronically infected people include decreasing their risk of developing liver cirrhosis and hepatocellular carcinoma and preventing virus transmission to others. But services for addressing viral hepatitis often are fragmented, which means the full spectrum of services is seldom easily accessible. The barriers can be physical (as when screening and testing are in a different location from medical-management services), financial, or cultural.

The report identifies a number of steps that health care providers and institutions can take to improve the availability of services for people with chronic viral hepatitis. These efforts focus on providing five core services: outreach and awareness, prevention of new infections, identification of infected people, social and peer support for counseling and care, and medical management.

Committee on the Prevention and Control of Viral Hepatitis Infections

R. Palmer Beasley (Chair)
Ashbel Smith Professor and Dean Emeritus, University of Texas, School of Public Health, Houston, Texas

Harvey J. Alter
Chief, Infectious Diseases Section, Department of Transfusion Medicine, National Institutes of Health, Bethesda, Maryland

Margaret L. Brandeau
Professor, Department of Management Science and Engineering, Stanford University, Stanford, California

Daniel R. Church
Epidemiologist and Adult Viral Hepatitis Coordinator, Bureau of Infectious Disease Prevention, Response, and Services, Massachusetts Department of Health, Jamaica Plain, Massachusetts

Alison A. Evans
Assistant Professor, Department of Epidemiology and Biostatistics, Drexel University School of Public Health, Drexel Institute of Biotechnology and Viral Research, Doylestown, Pennsylvania

Holly Hagan
Senior Research Scientist, College of Nursing, New York University, New York, New York

Sandral Hullett
CEO and Medical Director, Cooper Green Hospital, Birmingham, Alabama

Stacene R. Maroushek
Staff Pediatrician, Department of Pediatrics, Hennepin County Medical Center, Minneapolis, Minnesota

Randall R. Mayer
Chief, Bureau of HIV, STD, and Hepatitis, Iowa Department of Public Health, Des Moines, Iowa

Brian J. McMahon
Medical Director, Liver Disease and Hepatitis Program, Alaska Native Tribal Health Consortium, Anchorage, Alaska

Martín Jose Sepúlveda
Vice President, Integrated Health Services, International Business Machines Corporation, Somers, New York

Samuel So
Lui Hac Minh Professor, Asian Liver Center, Stanford University School of Medicine, Stanford, California

David L. Thomas
Chief, Division of Infectious Diseases, Department of Medicine, Johns Hopkins School of Medicine, Baltimore, Maryland

Lester N. Wright
Deputy Commissioner and Chief Medical Officer, New York Department of Correctional Services, Albany, New York

Study Staff

Abigail E. Mitchell
Study Director

Heather M. Colvin
Program Officer

Kathleen M. McGraw
Senior Program Assistant

Norman Grossblatt
Senior Editor

Rose Marie Martinez
Director, Board on Population Health and Public Health Practice

Study Sponsors

The Centers for Disease Control and Prevention

The Department of Health and Human Services Office of Minority Health

The Department of Veterans Affairs

The National Viral Hepatitis Roundtable

As the nation's largest purchaser of health insurance, the federal government is positioned to lead in developing and enforcing guidelines to ensure that the people it serves have access to screening, testing for HBV and HCV, and appropriate medical management. Among specific actions, programs such as Medicare and Medicaid should incorporate guidelines for screening for hepatitis B and C as a required component of preventive care. In addition, the federal government should ensure that federally funded community health facilities and other health care settings that often serve at-risk people have adequate resources for provision of comprehensive viral hepatitis services.

Conclusion

Despite being preventable diseases, hepatitis B and C continue to be serious health problems in the United States. They can both be prevented in people at risk and successfully managed in people already chronically infected. Improved knowledge and awareness of these diseases among health care providers, including primary care providers, will lead to increased identification of infected people who can then receive appropriate medical management. Providers should build screening, testing, and vaccination strategies into their routine practices. Without concerted action, thousands more Americans will die each year from liver cancer or liver failure related to these diseases.

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES
Advising the nation / Improving health

500 Fifth Street, NW
Washington, DC 20001
TEL 202.334.2352
FAX 202.334.1412
www.iom.edu

The Institute of Medicine serves as adviser to the nation to improve health. Established in 1970 under the charter of the National Academy of Sciences, the Institute of Medicine provides independent, objective, evidence-based advice to policy makers, health professionals, the private sector, and the public.

Copyright 2010 by the National Academy of Sciences. All rights reserved.