

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**STATE MEDICAL BOARDS AND
QUALITY-OF-CARE CASES:
PROMISING APPROACHES**



FEBRUARY 1993

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FEBRUARY 1993 OEI-01-92-00050



EXECUTIVE SUMMARY

PURPOSE

The purpose of this inspection is to help States address cases involving physicians who provide poor-quality medical care. It describes promising approaches to such cases that have been taken or being considered by medical boards.

BACKGROUND

Quality-of-care (QC) cases are among the most difficult types of cases for State medical boards to address. In the course of our ongoing inquiry into the work of State medical boards, it has become clear to us that many are beginning to devote greater attention to QC cases. In this report, we focus on that experience with the intent of identifying specific approaches that appear to be worthy of further attention by boards.

In determining what to characterize as a promising approach, we depended on (a) the judgments of the State officials with whom we conversed; (b) a review of their experiences in dealing with these approaches; (c) a focus group discussion with the executive directors of eight medical boards; and, drawing on our own years of experience in reviewing medical and other health care boards, (d) our judgment of whether an approach is sufficiently different and important to warrant the attention of those in other States.

Our research consisted of field visits to nine States, telephone calls with agency officials in nine States, informal discussions with knowledgeable parties, and a review of available literature.

We organize the promising approaches according to the four phases of pursuing QC cases: identification, investigation, negotiation/prosecution, and intervention. We also include a section on the prevention of quality problems. The following briefly describes all of the promising approaches included in the report.

IDENTIFICATION

How can State medical boards get complete and timely disclosure of quality-of-care problems, particularly from reliable sources such as peers and government agencies?
(page 4)

- *Enforce practitioner reporting requirements*
- *Increase awareness of reporting requirements*
- *Improve reporting from Peer Review Organizations (PROs) and Medicaid agencies*
- *Randomly audit pharmacy records*
- *Get referrals from survey agencies*
- *Require reporting from medical schools and residency programs.*

How can State medical boards that receive a large number of complaints distinguish significant, actionable quality problems from minor or nonmeritorious issues? (page 6)

- *Establish formal prioritization scoring*
- *Use contract physicians or staff nurses to set priorities among complaints*
- *Recruit local physicians to serve on advisory committees by offering them CME credits*
- *Gather a board panel to screen complaints*
- *Prioritize investigation of malpractice claims*

INVESTIGATION

How can State medical boards gather sufficient and credible evidence, particularly to demonstrate multiple problems or incompetence? (page 8)

- *Conduct practice reviews in response to complaints*
- *Review a large number of patient records*
- *Use information from hospitals*
- *Get patient names from Medicaid*
- *Have physicians take competency exams*
- *Request information from PROs*
- *Measure competence directly*

How can State medical boards involve medically trained people in investigations? (page 10)

- *Have physicians on staff*
- *Use committees from the medical society to conduct investigations*
- *Use nurses and physician assistants as investigators*
- *Conduct intensive medical training for investigators*
- *Pay consultants the going rate*
- *Make an intensive recruiting effort to get medical experts*
- *Involve PROs in investigations*

How can State medical boards assure that the investigative process is timely? (page 12)

- *Require physicians to respond to requests in a timely manner*
- *Establish legislative requirements for turnaround of investigations*
- *Use paraprofessional staff to gather medical records*

How can State medical boards assure that they are neither prosecuting cases that have no merit nor dismissing important cases? (page 13)

- *Have cases screened by two medical reviewers prior to deciding to pursue cases further*

- *Gather review panels with medical, legal, and investigative expertise to dispose of cases*
- *Prepare a handbook to guide peer reviewers*

NEGOTIATION/PROSECUTION

How can State medical boards get regular access to prosecuting attorneys and hearing officers who have the knowledge and skills necessary to handle quality-of-care cases? (page 14)

- *Have attorneys and hearing officers on staff*
- *Have attorneys dedicated to medical board cases*
- *Train hearing officers to hear medical board cases*

How can State medical boards encourage and facilitate fair and effective consent agreements? (page 15)

- *Settle minor cases before full investigation*
- *Get board members, especially physicians, involved in settlement negotiations*
- *Draw up consent agreements before meeting with respondents*
- *Require mediated settlement conferences for certain cases*
- *Establish the facts in advance of negotiating a sanction*
- *Write detailed consent agreements and make them public*

What can State medical boards do to ensure that their expert witnesses provide clear, credible testimony at hearings? (page 17)

- *Get testimony from two physicians with different perspectives*
- *Provide clear instructions for expert reviewers*
- *Emphasize the potential duty to testify when soliciting expert opinions*
- *Recruit highly respected experts by paying them well*

How can State medical board prosecutors establish prevailing standards of care in addition to providing expert witness testimony? (page 18)

- *Have a practitioner in the respondent's specialty on the hearing panel*
- *Refer to written practice parameters as they become available*

How can State medical boards ensure timeliness in hearings and decisions? (page 19)

- *Limit the number of board members required for hearings*
- *Provide hearing committee members with advance background information*
- *Impose time limits on hearings and judgments*
- *Raise objections to irrelevant arguments brought up by defense attorneys*
- *Conduct pre-hearing conferences and adhere to timeframes*

INTERVENTION

What can State medical boards do to express their concern about the quality of care provided other than pursuing formal sanctions? (page 21)

- *Hold an off-the-record discussion between the physician and one or more board members, physician staff members, or expert consultants*
- *Write an educational letter to the physician explaining the board's concern*

How can State medical boards address educational interventions and monitoring programs for physicians whom they have disciplined? (page 22)

- *Refer physicians to individually-tailored educational programs*
- *Grant immunity to probation monitors*
- *Use community hospitals as retraining sites*

PREVENTION

What can State medical boards do to make physicians aware of boundaries of acceptable care in certain areas of widespread or egregious problems? (page 23)

- *Publish detailed, anonymous descriptions of important cases*
- *Conduct educational programs*
- *Use newsletters to licensees to discuss important issues*

How can State medical boards identify and address quality-of-care problems when physicians are isolated from the medical community or when they have undetected deficiencies in their performance? (page 24)

- *Conduct periodic reexamination of physicians*
- *Audit the practices of isolated physicians*

CONCLUSION

In closing, we must note that there are two factors that in all States are indispensable to successful pursuit of QC cases. One is adequate funding. If boards are to handle QC cases effectively, it is widely recognized that they must have access to a wide range of medical, legal, and investigatory expertise and to computer and other resources. The other factor, which may be the most important of all, is having sufficient will to make a serious, ongoing commitment to QC cases. State legislators, executives, and board members must recognize that a more activist board posture in addressing QC cases will generate some controversy and some pressures to pull back. At such times, they must provide boards with the support necessary to persevere in carrying out their responsibilities to the public.

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INTRODUCTION

PURPOSE

The purpose of this inspection is to help States address cases involving poor-quality medical care. It describes promising approaches to such cases that have been taken or are being considered by medical boards.

BACKGROUND

State medical boards provide a vital front line of protection for the millions of people who receive medical care including those in the Medicare and Medicaid programs. They determine whether or not a physician meets the minimum necessary qualifications to practice medicine. And through their enforcement of State medical practice acts, they identify and take action against physicians responsible for poor-quality care, unprofessional behavior, and other violations of these acts.

Because of the boards' significance to quality medical care, we have since 1986 issued many reports addressing their performance (see appendix A). In these reports, we have made it quite clear that quality-of-care (QC) cases are among the most difficult types of cases for boards to address. They tend to be complex, time-consuming, expensive, and controversial. Accordingly, boards are often inclined to avoid or downplay such cases.¹

Many others who have reviewed the performance of boards have reached similar conclusions. Illustratively, at a 1991 conference sponsored by the Agency for Health Care Policy and Research in the Department of Health and Human Services, an expert panel found boards to be severely lacking in how they address QC cases.² They offered several suggestions, but made it clear that much remains to be learned in this area.

In the course of our ongoing inquiry into the work of State medical boards, it has become clear to us that many are beginning to devote greater attention to QC cases. Their efforts are sometimes tentative and invariably incremental; no one board that we are aware of serves as a comprehensive model for how to address QC cases from beginning to end. Yet the boards, it seems to us, are gaining some valuable

¹Mark R. Yessian, "State Medical Boards and Quality Assurance," *Federation Bulletin*, September 1992, pp. 126-135.

²Heather Palmer, "Professional Review Sanctions," in Agency for Health Care Policy and Research, *Issues in Medical Liability: A Working Conference (Summary Report)*, Washington: Government Printing Office, 1991, pp. 51-56.

experience which can be of enormous significance in learning how to approach these cases more efficiently and effectively.

In this report, we focus on that experience with the intent of identifying specific approaches that appear to be worthy of further attention by State boards. We cannot be sure that all of the approaches we describe have in fact been successful, as objective evaluation criteria and hard data are almost always lacking. Indeed, some of the approaches we describe have never been tested in any States. Furthermore, we recognize that what appears to work in one State will not necessarily work in another, given the great variations among the States.

Even with these limitations, however, we expect that a compendium of approaches that we deem promising will be helpful to State legislators, executives, board officials, and others as they consider ways in which they might improve a State's capacity to address QC cases. Our aim is to stimulate ideas and exploration, not to present a blueprint for action.

We list many approaches, each in a succinct manner. State officials are likely to find them to be most helpful if they consider them in the context of their own State's overall system for addressing QC cases.

To facilitate such consideration we organize the promising approaches by five major sections and in each include statements of pertinent issues and questions. The first four sections are sequential phases associated with the pursuit of QC cases:

- *Identification* -- learning about physicians who might be responsible for poor-quality medical care and deciding which complaints merit further study.
- *Investigation* -- obtaining the pertinent facts and deciding whether to pursue discipline or other actions.
- *Negotiation/Prosecution* -- using evidence and testimony, in either a formal or informal setting, to establish that one or more violations of State law occurred.
- *Intervention* -- imposing an appropriate remedy in response to proven or admitted violations.

The final section focuses on the prevention of quality problems and includes efforts to educate and otherwise avert or minimize QC problems.

METHODOLOGY

In determining what to characterize as a promising approach, we depended on (a) the judgments of the State officials with whom we conversed; (b) a review of their experiences in dealing with these approaches; (c) a focus group discussion with the executive directors of eight medical boards; and, drawing on our own years of experience in reviewing medical and other health care boards, (d) our judgment of whether an approach is sufficiently different and important to warrant the attention of

those in other States. These are certainly qualitative criteria. Their effectiveness will depend on the reactions of those reading this report.

In selecting the States from which we identified promising approaches, we drew again on our own experience, on a review of available literature, on information obtained from many national conferences concerning health care quality assurance, and on word of mouth. We did not seek to establish that these States were the "best" in handling QC cases. We sought States having some specific procedures, laws, or styles that might be instructive to a wider audience and that reflect some balance in terms of size and geography. Given that orientation, we conducted the bulk of our research during site visits to nine States: California, Maryland, Minnesota, New York, Ohio, Rhode Island, Texas, Vermont, and Wisconsin. We also talked by telephone to agency officials in the following nine States: Arizona, Arkansas, Florida, Massachusetts, Michigan, Nevada, North Carolina, Oregon, and South Carolina (see appendix B for a list of the boards' telephone numbers and addresses).

During our site visits, we typically spoke with executive, investigative, medical, and legal staff involved with QC cases. In some States, we spoke with board members and State attorneys as well. We also examined laws, documents, and individual case records. In each State, we sought a thorough understanding of the board's procedures for handling QC cases.

We conducted this study in accordance with the *Interim Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

IDENTIFICATION

ISSUE: State medical boards need to receive good information about quality-of-care problems. The bulk of complaints to boards come from consumers, but reports from medical professionals may be more likely to indicate violations of medical practice acts.

QUESTION: *How can State medical boards get complete and timely disclosure of quality-of-care problems, particularly from reliable sources such as peers and government agencies?*

PROMISING APPROACHES:

- **ENFORCE PRACTITIONER REPORTING REQUIREMENTS:** Minnesota, like many other States, has a law that requires health care practitioners who have personal knowledge of violations of the medical practice act to report these incidents to the board. Unlike most other States, Minnesota has shown a willingness to enforce this law (see box). Since 1987, according to the board, reporting from licensed health care professionals has increased significantly.

ENFORCING A "SNITCH LAW"

In January 1987, the Minnesota Board of Medical Examiners disciplined three physicians for failing to report to the board a colleague who was "habituated to a drug or intoxicant." The discipline included reprimands and fines up to \$7,500.
- **INCREASE AWARENESS OF REPORTING REQUIREMENTS:** Staff from the Ohio medical board attend county medical society meetings, conferences, and courses and make presentations to try to facilitate referrals. These presentations include information about anonymity, immunity, and the amount of documentation and narrative required for reports. Ohio officials are hoping that this new program, by improving understanding of the law, will increase reporting from physicians.
- **IMPROVE REPORTING FROM PEER REVIEW ORGANIZATIONS AND MEDICAID AGENCIES:** In both New York and Ohio, when the Peer Review Organization (PRO) determines that a physician's mismanagement has caused significant adverse effects to a patient, the PRO refers that case to the medical board.³ In 1991, the New York PRO referred 100 cases to the board. Thirty-

³Our draft report entitled "The Peer Review Organizations and State Medical Boards: A Vital Link" (OEI-01-92-00530) recommends that all peer review organizations submit this level of information to medical boards. Most PROs currently do not because they are concerned about confidentiality.

four of these spurred investigations. In Ohio, approximately 2 percent of the 1,654 complaints received in 1990 were from the PRO. In addition, these States' Medicaid agencies release to the boards information on overprescribing, presumed overutilization, and excessive use of invasive testing and procedures.

- ***RANDOMLY AUDIT PHARMACY RECORDS:*** North Carolina conducts frequent random audits of pharmacy records. Pharmacies with computerized systems are able to print out records, by physician, of prescriptions filled. Although designed to detect illegal drug diversion and other misuse of controlled substances, these audits can also indicate quality problems with physicians. Because the audits need not be spurred by distinct complaints, they represent a proactive and timely source of referrals.
- ***GET REFERRALS FROM SURVEY AGENCIES:*** In New York, the medical board is in the same division of the Department of Health as the hospital and nursing home survey agencies. These agencies occasionally become aware of quality-of-care problems for physicians. Because the agencies are in the same division, the board receives referrals for these problems quickly and can follow up on them easily. In California, a proposed initiative would make it easier for the State's long term care ombudsmen throughout the State to report quality-of-care problems to the medical board.
- ***REQUIRE REPORTING FROM MEDICAL SCHOOLS AND RESIDENCY PROGRAMS:*** The Nevada medical board, which requires medical residents to have licenses, mandates that medical schools and residency programs report disciplinary actions taken on students and residents. In one case, the board revoked the license of a resident who had been placed on probation by a program.

ISSUE: In order to respond quickly and effectively to important complaints and to not waste resources on groundless or unimportant cases, State medical boards need to make wise decisions about which cases to pursue.

QUESTION: *How can State medical boards that receive a large number of complaints distinguish significant, actionable quality problems from minor or nonmeritorious issues?*

PROMISING APPROACHES:

- **ESTABLISH FORMAL PRIORITIZATION SCORING:** Wisconsin is testing a formal priority evaluation system for complaints. Each complaint is screened by a staff attorney. The attorney decides if the board has jurisdiction over the case. If it does and the complaint falls into one of a number of specific categories, such as sexual misconduct, discipline by another licensing authority, or suspension of hospital privileges, the complaint will be investigated. If the complaint does not fall into one of the categories, the complaint is reviewed by three board members and the Department of Regulation and Licensing Secretary to determine if it should be investigated. All complaints that will be investigated are then given priority scores (see box). Complaints with high scores are investigated sooner than lower-scored complaints.

- **USE CONTRACT PHYSICIANS OR STAFF NURSES TO SET PRIORITIES AMONG COMPLAINTS:**

California hires contract physicians to screen quality-of-care cases after staff members gather the medical records associated with the complaint. The contract physicians write reports on the cases and recommend whether to dismiss or investigate the cases. In Ohio, staff nurses review quality-of-care complaints to provide safeguards against the premature closing of cases. New York has staff

PRIORITIZATION SYSTEM

Wisconsin's draft prioritization system assigns points as follows:

- *The conduct could result in:*
 - Death or permanent impairment limiting major life activity -- 30*
 - Temporary impairment limiting major life activity -- 20*
 - Temporary impairment not limiting major life activity -- 10*
 - Minor impairment -- 5*
- *Complaint involved:*
 - Death of patient -- 20*
 - Permanent impairment limiting major life activity -- 10*
 - Temporary impairment limiting major life activity -- 5*
- *Misrepresentation or fraud:*
 - If pattern or over \$1,000 -- 20*
 - If no pattern and less than \$1,000, but significant -- 10*
 - Relatively minor -- 5*
- *Violation of a specific prohibition in the medical practice act such as divulging privileged matters -- 10 each*
- *More than 3 previous complaints -- 10*
- *One to three previous complaints -- 5*
- *More than one patient affected -- 10*
- *Alcohol or drug abuse, physical or mental impairment -- 5*

nurses who review all incoming complaints. The nurses, with advice from staff physicians if necessary, identify which complaints involve legitimate quality concerns.

- **RECRUIT LOCAL PHYSICIANS TO SERVE ON ADVISORY COMMITTEES BY OFFERING THEM CME CREDITS:** In Florida, the board and the Department of Professional Regulation recruit local physicians to serve on a medical advisory committee (MAC). The committee meets over weekends to evaluate complaints and make

recommendations about whether to investigate or drop them. The physicians serving on this committee get continuing medical education credits in return for their efforts. The board has found this an effective and low cost way to get medical input prior to investigating a case (see box).

PRESCREENING SAVINGS

Florida's Medical Advisory Committee saves money by closing meritless cases before they are reviewed by expert consultants. The average cost of a MAC review is \$49, compared with \$305 for an expert review.

- **GATHER A BOARD PANEL TO SCREEN COMPLAINTS:** Maryland convenes weekly a review panel composed of medical board members and staff to screen pending complaints. By combining medical, legal, and investigative expertise, the panel makes immediate decisions about whether to investigate the complaints.
- **PRIORITIZE INVESTIGATION OF MALPRACTICE CLAIMS:** States that receive reports of all malpractice claims generally do not launch full investigations of those reports. Rather than discarding all such reports, the Texas board uses a scoring system much like Wisconsin's (see page 6). Points are awarded to each report based on the number of recent claims against the physician involved, amounts of payments, physician specialty, and practice setting (urban vs. rural). The point total determines whether a full investigation is launched and the priority given to any such investigation.

INVESTIGATION

ISSUE: When investigating QC cases, boards often need to gather evidence that demonstrates multiple acts of negligence or incompetence. Obstacles include difficulty selecting records of patients other than the complainant, reluctance by physicians to cooperate in investigations, and the limitations of relying solely on medical records to determine competence.

QUESTION: *How can State medical boards gather sufficient and credible evidence, particularly to demonstrate multiple problems or incompetence?*

PROMISING APPROACHES:

- **CONDUCT REVIEWS OF ENTIRE PRACTICE IN RESPONSE TO COMPLAINTS:** Investigations of single complaints in Maryland may lead to reviews of physicians' entire practices. Peer review committees visit respondent physicians' offices, examine samples of medical records, review procedures and safeguards in the offices, and test the respondents' medical knowledge and judgment.
- **REVIEW A LARGE NUMBER OF PATIENT RECORDS:** Success in quality-of-care cases often depends on broadening the scope of investigation beyond the original complaint. New York board staff have the explicit legislative authority to conduct reviews of physicians' records (see box). Boards in Oregon and Minnesota can issue subpoenas for patient records without naming the patients in advance. Investigators can request that physicians turn over any number of cases that meet certain criteria.
- **USE INFORMATION FROM HOSPITALS:** The New York board identifies patients for record reviews by using the Statewide hospital discharge database (SPARCS). This database contains clinical and financial information for each hospital stay in the State and identifies the hospital, patient, and physician involved. From this database, the investigative staff can get preliminary information about all of the respondent physician's cases that are similar (in terms of diagnosis or procedure) to the complaint. The State can then gather and examine specific patient records from a sample of these discharges. Also,

SUBPOENA AUTHORITY

Key statutory language in New York allows the State to conduct record reviews:

•Section 230.10(iv) of the Public Health Law specifies: "The director, in addition to the authority set forth in this section, shall be authorized to conduct a comprehensive review of patient records of the licensee and such office records of the licensee as are related to said determination."

the State mandates reporting of all incidents in hospitals which result in unexpected death or injury. Because many incidents do not involve substandard care, these reports are not often used to start investigations. However, they frequently provide evidence that supports the complaint.

- **GET PATIENT NAMES FROM MEDICAID:** In California, investigators cannot subpoena records without having patient names. They can, however, use Medicaid patient records to generate a sample of cases that might demonstrate a pattern of poor quality care. The State has legal access to medical records of Medicaid patients without getting their consent through incorporation in the State Medicaid agency's quality assurance plan.
- **DISCIPLINE LICENSEES IF THEY DO NOT COMPLY WITH BOARD ORDERS:** In Oregon, the board has disciplined licensees for not complying with board orders to take competency exams, to be interviewed, or to submit medical records (see box). By virtue of the fact it enforced the rule, it is getting much more frequent and rapid compliance with requests and orders.
- **REQUEST INFORMATION FROM PROs:** In South Carolina, board staff regularly request information on physicians the board is investigating for QC problems. The PRO, after a 30-day waiting period, must respond to the board's request and provide whatever material they have on that physician.
- **HAVE PHYSICIANS TAKE COMPETENCY EXAMS:** California regularly asks or demands physicians to take competency exams, particularly when the board feels a physician's competence is lacking but does not have enough evidence to support such an accusation. The exams and scoring criteria are written by a panel of physicians who are familiar with the complaints and investigation on the respondent physician. This panel then conducts the exam orally and grades it. If the physician passes the exam, the board must drop the case. If the physician fails the exam, the board has a valuable piece of evidence in its case or can take immediate action to reeducate the physician. Oregon also frequently requires competency exams.

COMPLIANCE WITH BOARD ORDERS

Oregon statute requires licensees to comply with board orders and requests:

•Section 677.190 of the Oregon Regulatory Statute specifies: "The Board of Medical Examiners for the State of Oregon may refuse to grant, or may suspend or revoke a license to practice issued under this chapter for any of the following reasons: . . . (18) Willfully violating any provision of this chapter or any rule adopted by the board, board order, or failing to comply with a board request pursuant to ORS 677.320. . . . (23) Refusing an invitation for an informal interview with the board requested under ORS 677.415. . . ."

ISSUE: States need access to medical expertise in the investigation process in order to conduct complete and informed inquiries on quality-of-care cases.

QUESTION: *How can State medical boards involve medically trained people in investigations?*

PROMISING APPROACHES:

- **HAVE PHYSICIANS ON STAFF:** Both California and New York use medical consultants in their investigative offices. They are full-time, permanent employees of the State. These medical consultants often conduct interviews with the respondent and other physicians, assist in directing the course of the investigations, and help recruit medical experts to conduct intensive reviews of cases.
- **USE COMMITTEES FROM THE MEDICAL SOCIETY TO CONDUCT INVESTIGATIONS:** Maryland is required to refer all quality-of-care cases to the medical society (MedChi) for investigation. The board staff collects basic medical records, then sends the complaint and the records to MedChi. MedChi, in turn, refers complaints to peer review committees organized by county or specialty societies throughout the State. The committees recruit volunteers to review either single cases or entire practices (see p. 8). When a review is complete, MedChi must deliver to the board a comprehensive report evaluating the case and must make recommendations as to what action (if any) the board should take. Although the Maryland experience suggests that a State medical society can be a promising source of medical expertise, a recent review of that experience raised significant reservations about the board's statutory obligation to refer all QC cases to MedChi.⁴
- **USE NURSES AND PHYSICIAN ASSISTANTS AS INVESTIGATORS:** The Texas board has special classifications for its investigative staff which allow it to recruit nurses and physician assistants as investigators. These investigators are able to dig deep into medical matters.
- **CONDUCT INTENSIVE MEDICAL TRAINING FOR INVESTIGATORS:** California has its own two week training academy for investigators which it

⁴See "Sunset Review: State Board of Physician Quality Assurance: An Evaluation Report Prepared Pursuant to the Maryland Program Evaluation Act," Department of Fiscal Services, State of Maryland, October 1991. According to this report, the delegation of investigative authority has limited the board's flexibility and control over cases. Furthermore, the report notes that required medical society control has raised public concerns that investigations are overly protective or biased to the point where the board's credibility has been affected.

conducts twice a year. The State brings in its own medical consultants and instructors from the Attorney General's office to conduct training on the handling of medical cases.

- ***MAKE AN INTENSIVE RECRUITING EFFORT TO GET MEDICAL EXPERTS:*** In Massachusetts in the late 1980's, the board actively recruited medical experts by sending information to and meeting with leaders of medical schools, the medical society, medical specialty associations, and hospitals. Because of this effort, the board has been able to maintain a list of medical experts (50 -75) in a wide variety of specialties. South Carolina recently mailed every licensee a newsletter that included questions and answers about serving as a medical expert and a reply coupon. Seven percent of all licensees responded.
- ***INVOLVE PROs IN INVESTIGATIONS:*** When the Arkansas medical board needs a peer review in a quality-of-care case, it obtains the medical records and refers the case to the State's PRO. The PRO, in turn, engages two or three physicians in the respondent's specialty to review the case and prepare a summary for the board. The board pays the reviewers approximately \$60 per hour for their services (reviews for Medicaid or Medicare patient records are free to the board). Key to the success of this program is the board's good working relationship with the PRO.

ISSUE: State medical board investigations must be timely to protect both the safety of the public and the rights of the respondent.

QUESTION: *How can State medical boards assure that the investigative process is timely?*

PROMISING APPROACHES:

- **REQUIRE PHYSICIANS TO RESPOND TO REQUESTS IN A TIMELY MANNER:** One of the stumbling blocks in executing timely investigations is the length of time it takes physicians to respond to requests for patient records. Arizona's statute allows the board to discipline physicians who fail to or refuse to furnish information in a timely manner (see box).

RESPONSE TO REQUESTS

The Arizona board's policy requires physicians to respond to a notification of complaint within 20 days. Physicians' responses must include copies of patient records and a written response to the complaint. If the physician does not respond within 20 days, the staff notifies the board (who can initiate disciplinary action) and subpoenas the information from the physician. The physician has 10 days to respond to the subpoena before further legal action is taken.

- **ESTABLISH LEGISLATIVE REQUIREMENTS FOR TURNAROUND OF INVESTIGATIONS:** The Maryland board, which refers all quality-of-care cases to the medical society for investigation, requires a complete investigation within 90 days. The medical society may request a 30-day extension in writing. The State legislature in Michigan has proposed a new requirement that the Department of Licensing and Regulation complete its investigations within 45 days (with the possibility of a 30-day extension upon request to the board).
- **USE PARAPROFESSIONAL STAFF TO GATHER MEDICAL RECORDS:** In California, consumer service representatives, who are not trained as investigators, gather basic medical records early in the investigation process. Investigators then do not have to spend large amounts of time tracking down medical records and have more time to do intensive investigation work.

ISSUE: State medical boards' decisions about whether to dismiss or pursue cases further after investigation are crucial to their credibility and success in prosecuting cases.

QUESTION: *How can State medical boards assure that they are neither prosecuting cases that have no merit nor dismissing important cases?*

PROMISING APPROACHES:

- **HAVE CASES SCREENED BY TWO MEDICAL REVIEWERS PRIOR TO DECIDING TO PURSUE CASES FURTHER:** In California, the district offices recruit two physicians -- an academic physician who is an expert in the respondent's specialty and a local physician with a practice similar to the respondent's -- to review each case and make recommendations on its disposition. By getting two perspectives that are often very different, the offices can double-check facts and confirm or question conclusions.
- **GATHER REVIEW PANELS WITH MEDICAL, LEGAL, AND INVESTIGATIVE EXPERTISE TO DISPOSE OF CASES:** Maryland convenes weekly review panels consisting of board members, investigative staff, and lawyers from the Attorney General's office to review investigative reports from the medical society and decide how and whether to pursue the case. Oregon has a similar committee which meets monthly. These multidisciplinary panels allow the boards to make decisions based on medical and legal merits of cases and allow investigators to provide valuable input and explanation. They also assure that medical records that will be used as evidence are in order and are legible.
- **PREPARE A HANDBOOK TO GUIDE PEER REVIEWERS:** By providing explicit instructions to peer reviewers, Maryland and New York assure that there is greater consistency in reviews and that all important information is covered. Topics covered in New York's peer review handbook include immunity, confidentiality, investigations and hearings, stages of expert review, the opinion, and reimbursement. Maryland's covers similar topics and includes guidelines for practice review and sample worksheets, letters, reports, and subpoenas (see box).

SAMPLE PRACTICE REVIEW REPORT

Maryland, in its peer review handbook, includes a sample practice review report. This sample is an example of what the State expects its peer reviewers to complete and includes sections on information gathered, reasons for referral, biographical information, background information, quarterly review notes, discussion and conclusions, recommendations, and case by case descriptions.

NEGOTIATION/PROSECUTION

ISSUE: To represent cases effectively against respondents' attorneys who are often very experienced malpractice litigators, States need prosecutors who are familiar with medical practice and terminology to handle QC cases. They also need hearing officers who can follow the arguments of both sides and make fair rulings.

QUESTION: *How can State medical boards get regular access to prosecuting attorneys and hearing officers who have the knowledge and skills necessary to handle quality-of-care cases?*

PROMISING APPROACHES:

- **HAVE ATTORNEYS AND HEARING OFFICERS ON STAFF:** Texas has prosecuting attorneys on staff to the board. These lawyers are available full-time and acquire substantial expertise in medical competency cases. It is also important for boards to have hearing officers who are knowledgeable about and experienced in the law of medical discipline and readily available. In Ohio, hearing officers are hired by the board. In Wisconsin, they are employed by the Department of Regulation and Licensing, which includes the medical board.
- **HAVE ATTORNEYS DEDICATED TO MEDICAL BOARD CASES:** If the board cannot hire attorneys on its own, it can still obtain full-time prosecutors. The New York board is located administratively within a large Department, and teams of lawyers are assigned only medical board cases. In Maryland and California, where the medical boards must rely on their Attorneys General to prosecute cases, there are Assistant Attorneys General devoted full-time to medical board affairs.
- **TRAIN HEARING OFFICERS TO HEAR MEDICAL BOARD CASES:** Attorneys in Maryland stressed the importance of holding hearings on QC cases before administrative law judges (ALJs) who are comfortable with medical issues. A senior ALJ there brought to the job her experience hearing medical cases for CHAMPUS, the military's health insurance plan. She believes that ALJs without extensive medical backgrounds can handle quality-of-care cases well, but only with proper training on terminology and the reliability of medical texts. She has compiled a manual for ALJs new to medical board cases that covers these and other topics.

ISSUE: Quality-of-care cases are time-consuming and costly to litigate. Medical boards can conserve resources if they reach desirable outcomes through consent agreements instead. Boards must not, however, allow public safety to be compromised by weak settlements.

QUESTION: *How can State medical boards encourage and facilitate fair and effective consent agreements?*

PROMISING APPROACHES:

- **SETTLE MINOR CASES BEFORE FULL INVESTIGATION:** In Wisconsin, committees of two board members (the board member who has been involved in advising the investigators and a specialist in the respondent's field) try to settle some cases before launching a full investigation. The meetings involve the committee and the respondent (whose legal counsel does not usually attend). The board pursues early settlement only when both sides agree on the facts of the case and the infraction is relatively minor. The board settles two or three cases a month this way. Commonly, the settlement results in reprimands or requirements for continuing medical education. This process is faster and less expensive than formal settlements or hearings.
- **GET BOARD MEMBERS, ESPECIALLY PHYSICIANS, INVOLVED IN SETTLEMENT NEGOTIATIONS:** Medical board staff in Maryland, Texas, and Minnesota emphasized the importance of having physician members attend settlement conferences. They say that respondents seem less threatened and more willing to cooperate in negotiations when other physicians are present. In these States, the vast majority of formal charges are resolved without a hearing.
- **DRAW UP CONSENT AGREEMENTS BEFORE MEETING WITH RESPONDENTS:** Rhode Island medical board staff prepare a draft consent order and send it to the respondent in advance of the conference. If not agreed to by the respondent, this document at least serves as a starting point for negotiations.
- **REQUIRE MEDIATED SETTLEMENT CONFERENCES FOR CERTAIN CASES:** In California, every time a hearing is slated to last at least five days, the parties have to meet for a settlement conference. An ALJ listens to both sides' arguments, presents proposed solutions, and mediates to try to get a settlement on the case. Even when this conference does not result in a settlement, the Attorney General's Office believes it often starts both sides thinking about settlements and induces them to settle at a later point prior to the hearing.
- **ESTABLISH THE FACTS IN ADVANCE OF NEGOTIATING A SANCTION:** Virtually all quality-of-care cases in Minnesota are resolved after conferences involving respondents and Complaint Review Committees (CRC), which include

two physician board members and one consumer member. Each respondent is told of the allegations against him or her a month before the conference and has the opportunity to respond. If, in conference, the respondent agrees with the State on the truth of the allegations, a stipulation can then proceed. In South Carolina, a respondent can sign a Memorandum of Agreement stipulating the facts of the case and admitting the allegation. A sanction is then worked out based on these facts.

- ***WRITE DETAILED CONSENT AGREEMENTS AND MAKE THEM PUBLIC:*** Stipulation and Orders in Minnesota contain explicit accounts of the patient case histories that justify disciplinary actions, as well as the disciplinary measures imposed. All of this information becomes a public document, and is released to the press. In this manner, the Minnesota board answers the criticism that consent agreements are vehicles for respondents to hide their behaviors from public and professional scrutiny.

A COMPREHENSIVE CONSENT ORDER

A recent Stipulation and Order in Minnesota ran for 23 pages. It included all pertinent facts, such as complete prescribing histories for six patients, and a seven-step course of remedial action. The remedy included three specific education courses, supervision by another physician, quarterly meetings with a board member, practice audits, and a \$1,500 fine.

ISSUE: Medical board members and staff generally agree that the strongest evidence at hearings is convincing and consistent testimony from a credible expert witness.

QUESTION: *What can State medical boards do to ensure that their expert witnesses provide clear, credible testimony at hearings?*

PROMISING APPROACHES:

- **GET TESTIMONY FROM TWO PHYSICIANS WITH DIFFERENT PERSPECTIVES:** Establishing the standard of care solely through the testimony of experts who practice in settings quite different from respondents may not be appropriate. For example, using physicians who practice at major teaching hospitals to comment on the care provided by community-based respondents may not adequately account for issues in community practice. In California, in every quality-of-care hearing, two physicians testify -- one whose practice is very similar to the respondent's and one who is an academic expert.
- **PROVIDE CLEAR INSTRUCTIONS FOR EXPERTS:** The strength of an expert's testimony will likely be determined to a great extent by the strength of the expert's review and written opinion. The instructions that medical boards give on conducting an expert review can help experts craft their opinions so as to be useful at hearings. New York has prepared helpful instructions (see box).
- **EMPHASIZE THE POTENTIAL DUTY TO TESTIFY WHEN SOLICITING EXPERT OPINIONS:** At one time, the Minnesota medical board found that it was investing time and money in having expert consultants review cases and form strong opinions, only to have the experts refuse to testify at hearings about those cases. It now makes clear before contracting with an expert that testimony, when necessary, is an essential part of the expert's obligation.
- **RECRUIT HIGHLY RESPECTED EXPERTS BY PAYING THEM WELL:** Reputation of experts often has great significance to the credibility of testimony, particularly in appeals. Minnesota has found that paying physicians their going rates (up to \$350 per hour) makes recruiting renowned experts easier.

EXCERPTS FROM NEW YORK'S "GUIDELINES FOR EXPERT OPINIONS"

- *Your opinion should be expressed "to a reasonable medical certainty," if possible.*
- *Make your opinion readily understandable to lay people.*
- *Avoid using vague language such as "inadequate" or "it would have been helpful if"*
- *You should not use the terms negligence or incompetence. These are legal conclusions based on specific legal definitions.*

ISSUE: Medical board prosecutors must, before arguing that a respondent provided substandard care, establish the relevant prevailing standard of care. Because hearing panels include nonphysicians or physicians unfamiliar with the specialty involved and expert witnesses representing the board and the respondent often present conflicting testimony, establishing standards is difficult.

QUESTION: *How can State medical board prosecutors establish prevailing standards of care in addition to providing expert witness testimony?*

PROMISING APPROACHES:

- **HAVE A PRACTITIONER IN THE RESPONDENT'S SPECIALTY ON THE HEARING PANEL:** Hearing panels in New York consist of two physician members and one consumer member. In quality-of-care cases, one of the physician members is usually a practitioner in the respondent's specialty. (The board's large size makes this possible.) This physician's training and experience allows him or her to probe and evaluate the testimony of experts to determine whether the conduct alleged constitutes substandard care.

- **REFER TO WRITTEN PRACTICE PARAMETERS AS THEY BECOME AVAILABLE:** Written standards have potential for alleviating the difficulties medical boards face in prosecuting quality-of-care cases. Some medical boards and medical societies are working together on practice parameters that, if followed, can constitute defenses against malpractice claims.

Specialty societies and the Federal government are also active in developing practice guidelines. Many medical board members and staff argue that written standards are not well established enough in most areas to replace expert testimony. Written standards might, however, be precise and accepted enough to be helpful in some areas including medical record keeping, prescribing of controlled substances, and anesthesia. Oregon has established strict parameters in one specific area (see box).

ADMINISTRATIVE RULES

Oregon has an administrative rule that specifies acceptable use of amphetamines for obese people. Physicians who violate this rule are subject to disciplinary action. The board has communicated clearly and very specifically to physicians what the boundaries of care are for this type of treatment. There has been a dramatic reduction in amphetamine use since the rule was established.

ISSUE: Cases that go to hearing can be a huge drain on resources and can be very difficult to schedule. Boards owe both the public and respondents timely hearings and decisions.

QUESTION: *How can State medical boards ensure timeliness in hearings and decisions?*

PROMISING APPROACHES:

- **LIMIT THE NUMBER OF BOARD MEMBERS REQUIRED FOR HEARINGS:** New York, which has 169 board members spread across the State, uses only three board members at each hearing. The full board never hears or votes on individual cases. While limiting the number of board members involved is a necessity for New York, it can be helpful in much smaller States. Vermont, which has 14 board members, recently changed its policies to allow as few as two board members to hear each case. In contrast to New York, though, cases in Vermont are ultimately voted on by larger panels. Some boards have removed board members from hearing rooms entirely. In many States, administrative law judges hear cases and render opinions, which are subject to approval by the board. The Florida medical board, which rules on cases only after all relevant facts have been agreed to or determined by a hearing officer, can issue final rulings on 40 to 50 cases in one two-day board meeting.
- **PROVIDE BOARD MEMBERS WITH ADVANCE BACKGROUND INFORMATION:** Board members in New York used to go into hearings with no knowledge of the charges involved. Now they are provided with a statement of charges and all relevant medical records a week in advance. This can speed up hearings by focusing committee members' attention on the most important issues and allowing them to prepare questions. In Florida, board staff expedite decisions by providing board members with copies of all pertinent written materials three weeks before board meetings.
- **IMPOSE TIME LIMITS ON HEARINGS AND JUDGMENTS:** Proposed legislation in Michigan would require hearing examiners to conduct a hearing within 45 days of receiving a referral. The board would then have 60 days to conduct a hearing in which they review the findings of fact and conclusions of the law that the hearing officer presented. New York and Vermont require their hearing committees to report their recommendations within 60 days of the hearings' conclusion. In California, the board must make a final decision within 90 days of receiving a proposed decision from the ALJ (they are allowed one 30-day continuance).
- **CONDUCT PRE-HEARING CONFERENCES AND ADHERE TO TIMEFRAMES:** Timeframes set in pre-hearing conferences can limit the possibility of defense attorneys dragging out the process leading to a hearing. In Wisconsin, the ALJ assigned to the case presides over a pre-hearing

conference in which all procedures of the hearing, especially timing, are worked out. The ALJ takes very seriously the timeframes set at these conferences.

INTERVENTION

ISSUE: State medical boards sometimes receive complaints involving poor-quality care that do not compel them to pursue formal sanctions. Reasons for these decisions might include a) the evidence is not sufficient to sustain formal charges, b) the poor-quality care seems to have resulted from a single lapse in judgment or technical skill, or c) the maximum sanction would not be worth the resources necessary to secure it.

QUESTION: *What can State medical boards do to express their concern about the quality of care provided other than pursuing formal sanctions?*

PROMISING APPROACHES:

- **HOLD AN OFF-THE-RECORD DISCUSSION BETWEEN THE PHYSICIAN AND ONE OR MORE BOARD MEMBERS, PHYSICIAN STAFF MEMBERS, OR EXPERT CONSULTANTS:** Research has shown that face-to-face discussion is the most effective method of changing physicians' behavior.⁵ When a board is concerned about the care provided by a particular physician but chooses not to press formal charges, it can use the physicians at its disposal to explain its concern to the physician who provided questionable care. Vermont uses physician board members for this purpose. New York uses board members, staff medical consultants, or independent expert consultants. California uses medical quality review committees which are regionally organized groups made up of 60 percent practicing physicians and 40 percent lay people (all are nominated by the medical schools, the board, or medical societies).
- **WRITE AN EDUCATIONAL LETTER TO THE PHYSICIAN EXPLAINING THE BOARD'S CONCERN:** In conjunction with or instead of the discussions described above, boards can put their concerns in writing and send them to physicians. These letters need not become public records, although they are usually added to physicians' permanent files. New York, Maryland, and California are among the States using this approach. In California, recipients of these letters must respond to the board's concerns in writing. These letters can serve as warning signals should further complaints be lodged against the physicians involved. With identifying information removed they also could be used as a preventive measure, educating all physicians about practice patterns that the board considers questionable.

⁵Kathleen N. Lohr (ed.), *Medicare: A Strategy for Quality Assurance (Volume I)*, Washington: National Academy Press, 1990, p. 292.

ISSUE: Physicians who boards find in violation of the medical practice act may have poor knowledge and skills in their fields. They need further education if they are to continue or resume practice. But not all medical schools are equipped for or receptive to training physicians who have been identified as substandard. Traditional continuing medical education is often perceived as ineffective for these physicians.

QUESTION: *How can State medical boards address educational interventions and monitoring programs for physicians whom they have disciplined?*

PROMISING APPROACHES:

- **REFER PHYSICIANS TO INDIVIDUALLY-TAILORED EDUCATIONAL PROGRAMS:** An aspect common to educational programs that board staff find effective is individual focus. Before providing training or any other intervention to physicians who have been disciplined, these programs diagnose the physicians' practice and personal problems and design a course of action to meet their specific needs. Examples of individually-tailored programs include the Remedial Continuing Medical Education Program in Madison, Wisconsin; the Physician Prescribed Educational Program in Syracuse, New York; and a course in pharmacology taught by a professor at the University of Minnesota.
- **GRANT IMMUNITY TO PROBATION MONITORS:** In some States, physicians are hesitant to accept assignments to monitor physicians on probation, fearing lawsuits against them stemming from the actions of the probationers. The New York legislature addressed this concern (see box). The law grants immunity to monitors and requires physicians being monitored to carry a minimum of \$2,000,000 in malpractice insurance.
- **USE COMMUNITY HOSPITALS AS RETRAINING SITES:** A peer reviewer at the Maryland medical society suggested that if boards are unable to find teaching centers willing to accept physicians in need of oversight and retraining, they should establish monitoring programs at community hospitals instead. Keys to improvement in practice, this physician said, include not only formal educational interventions, but also regular interaction with and feedback from peers. Community hospitals can provide this interaction.

IMMUNITY FOR PROBATION MONITORS

"Any health care provider..., hospital..., or medical school that participates in a monitoring or remediation program [for the medical board] shall not be liable for the negligence of the monitored licensee in providing medical care pursuant to a monitoring program." (New York Public Health Law 230)

PREVENTION

ISSUE: Medical boards are in a position to notice quality-of-care problems that are common or particularly egregious. In order to improve overall quality of care, boards need to find ways to reduce these problems on a broader scale than they can by disciplining individual physicians.

QUESTION: *What can State medical boards do to make physicians aware of boundaries of acceptable care in certain areas of widespread or egregious problems?*

PROMISING APPROACHES:

- **PUBLISH DETAILED, ANONYMOUS DESCRIPTIONS OF IMPORTANT CASES:** In the Netherlands, the courts publish very detailed descriptions of important cases in medical journals (see box). If medical boards published cases in this manner, they could make clear boards' positions on certain types of problems and discourage physicians from continuing inappropriate practices. Texas uses this approach in a limited fashion. It prints short summaries of complaints in a newsletter column titled "Illustrative Disciplinary Cases."

PUBLISHED CASE DESCRIPTIONS

Included in the articles that the Netherlands' courts publish are detailed descriptions of:

- *The incident leading to a complaint of poor medical care;*
- *what the complaint was;*
- *the reasoning of the person complaining;*
- *the reasoning of the physician who is accused of poor practice;*
- *and the reasoning of the court and its final decision.*

- **CONDUCT EDUCATIONAL PROGRAMS:** In 1984, the Oregon medical board helped create an educational and research foundation. The foundation conducts programs, workshops, and courses and produces audio cassettes and reports on board-identified issues including prescribing of anti-anxiety medication and chronic pain management. In 1989, Minnesota conducted seven seminars on prescribing issues. There was a minimal registration fee for attendees and all attendees received continuing medical education credits. Attendance was very high at these sessions.
- **USE NEWSLETTERS TO LICENSEES TO DISCUSS IMPORTANT ISSUES:** Minnesota and California use periodic newsletters and other publications to communicate about key quality-of-care issues. For example, Minnesota has produced articles on controlling cancer pain and prescribing controlled substances. California has a quarterly newsletter that usually addresses important patient management topics. A recent newsletter discussed combatting breast cancer.

ISSUE: Many physicians are isolated from peer review because they do not practice in hospitals, clinics, or other situations where informal and formal peer review occur. These physicians can have quality-of-care problems that go undetected until a severe incident happens that causes a referral to the medical board or a malpractice suit. Even physicians who are subject to regular peer review may have particular deficiencies in their knowledge or ability that go undetected for long periods of time.

QUESTION: *How can State medical boards identify and address quality-of-care problems when physicians are isolated from the medical community or when they have undetected deficiencies in their performance?*

- **CONDUCT PERIODIC REEXAMINATION OF PHYSICIANS:** The New York State Advisory Committee on Physician Recredentialing is finalizing a report that recommends legislation requiring reexamination of all licensees every nine years and reexamination of licensees 70 years old and older every three years. Although there are different issues in specialty board certification than in licensure, it is interesting to note that the American Board of Internal Medicine established a policy of periodic reexamination in 1990. This certification board requires all persons certified in 1990 or thereafter to be reexamined every 10 years.
- **AUDIT THE PRACTICES OF ISOLATED PHYSICIANS:** The Canadian provinces of the British Columbia and Ontario conduct random practice audits of physicians, focusing particular attention on elderly and isolated physicians. Physician consultants conduct detailed reviews of office procedures, facilities, and patient care and then meet with the physician to go over minor deficiencies. If the assessors find major problems, a peer assessment committee may interview the physician also. Physicians often change their practices as a result of this face-to-face interaction. Written reviews are forwarded to the medical colleges (the equivalent of our medical boards). Although the colleges regard their programs as non-punitive, physicians with QC problems are referred to retraining programs. Often deficient physicians will voluntarily retire or limit their practices after the reviews.

CONCLUSION

Quality-of-care cases present a major challenge for State medical boards. In this report we have presented a variety of approaches that boards and their State governments can take to meet this challenge. Some are minor measures conducive to quick enactment; others are far-reaching and difficult to implement. Some are aimed at helping boards operate more quickly; others at enabling them to function more effectively. Some can be carried out by boards themselves; others require State legislation. All, we believe, are worthy of consideration.

As we noted in the introduction, it is important to consider each approach we identified in the context of a State's own environment. What works well in one State may not work so well or at all in another. Yet, in closing, we must note that there are two factors that in all States are indispensable to successful pursuit of QC cases.

One is adequate funding. If boards are to handle QC cases effectively, it is widely recognized that they must have access to a wide range of medical, legal, and investigatory expertise and to computer and other resources. These are costly. State medical boards can use physician licensure and registration fees to raise the needed funds, but their State governments must be willing to allow boards to set the fees they need and to allow the revenue from the fees to be passed on to the boards. As we have noted in other reports, that is often not the case.

The other factor, which may be the most important of all, is having sufficient will to make a serious, ongoing commitment to QC cases. State legislators, executives, and board members themselves must remain firmly rooted in the conviction that the boards are responsible for protecting the interests of the public, not the physician community. They must recognize that a more activist board posture in addressing QC cases will generate some controversy and some pressures to pull back. At such times, they must provide boards with the support necessary to persevere in carrying out their responsibilities to the public.



APPENDIX A

RELATED REPORTS FROM THE OFFICE OF INSPECTOR GENERAL

- **"Medical Licensure and Discipline: An Overview," June 1986 (P-01-86-00064)**

Identified vulnerabilities associated with licensing of foreign medical graduates and significant problems and patterns in discipline.
- **"State Medical Boards and Medical Discipline," August 1990 (OEI-01-89-00560)**

Assessed disciplinary practices by, among other things, examining key changes taking place and impediments to improved performance.
- **"State Medical Boards and Medical Discipline: A State-By-State Review," August 1990 (OEI-01-89-00562)**

Profiled, State-by-State, the authorities and policies relating to discipline.
- **"Quality Assurance Activities of Medical Licensure Authorities in the United States and Canada," February 1991 (OEI-01-89-00561)**

Provided an overview of the extent and type of quality assurance activities being undertaken in the United States and Canada.
- **"Performance Indicators, Annual Reports, and State Medical Discipline: A State-By-State Review," July 1991 (OEI-01-89-00563)**

Profiled on a State-by-State basis the use and content of annual reports, focusing on performance indicators relating to discipline.
- **"The Peer Review Organizations and State Medical Boards: A Vital Link (Draft)," August 1992 (OEI-01-92-00530)**

Reviewed the status of PROs' efforts to provide boards with information about substandard medical care.
- **"National Practitioner Data Bank: Usefulness and Impact of Reports to State Licensing Boards (Draft)," October 1992 (OEI-01-90-00523)**

Assessed the utility of National Practitioner Data Bank reports to State licensing boards.



APPENDIX B

MEDICAL BOARDS MENTIONED IN THIS REPORT

Arizona State Board of Medical Examiners
2001 West Camelback Road, #300
Phoenix, Arizona 85015
(602) 255-3751

Arkansas State Medical Board
2100 Riverfront Drive, Suite 200
Little Rock, Arkansas 72202
(501) 324-9410

Medical Board of California
1426 Howe Avenue, Suite 54
Sacramento, California 95825-3236
(916) 920-6393

Florida Board of Medicine
Northwood Centre, #60
1940 North Monroe
Tallahassee, Florida 32399-0750
(904) 488-0595

Maryland Board of Physician Quality Assurance
P.O. Box 2571
Baltimore, Maryland 21215
(410) 764-4777

**Massachusetts Board of Registration in
Medicine**
Ten West Street, 3rd Floor
Boston, Massachusetts 02111
(617) 727-3086

Michigan Board of Medicine
P.O. Box 30192
Lansing, Michigan 48909
(517) 373-6650

Minnesota Board of Medical Examiners
2700 University Avenue West, Suite 106
St. Paul, Minnesota 55114-1080
(612) 642-0538

Nevada State Board of Medical Examiners
P.O. Box 7238
Reno, Nevada 89510
(702) 688-2559

**New York State Board of Professional Medical
Conduct**
Room 438, Corning Tower Building
Albany, New York 12237-0614
(518) 474-8357

North Carolina Board of Medical Examiners
P.O. Box 26808
Raleigh, North Carolina 27611-6808
(919) 828-1212

Ohio State Medical Board
77 South High Street, 17th Floor
Columbus, Ohio 43266-0315
(614) 466-3934

Oregon Board of Medical Examiners
620 Crown Plaza, 1500 SW First Avenue
Portland, Oregon 97201-5826
(503) 229-5770

**Rhode Island Board of Licensure and
Discipline**
3 Capitol Hill, Cannon Room 205
Providence, Rhode Island 02908-5097
(401) 277-3855

**South Carolina State Board of Medical
Examiners**
P.O. Box 12245
Columbia, South Carolina 29211
(803) 734-8901

Texas State Board of Medical Examiners
P.O. Box 45805
Austin, Texas 78714-9134
(512) 834-7728

Vermont Board of Medical Practice
109 State Street
Montpelier, Vermont 05609-1106
(802) 828-2673

Wisconsin Medical Examining Board
P.O. Box 8935
Madison, Wisconsin 53708
(608) 266-2811



