

MEDICAL LICENSURE AND DISCIPLINE:

AN OVERVIEW

JUNE 1986

CONTROL NUMBER:
P-01-86-00064

Region I
Boston, Massachusetts

Office of Analysis and Inspections
Office of Inspector General
Department of Health and Human Services

Office of the Inspector General

The mission of the Office of the Inspector General (OIG) is to promote the efficiency, effectiveness and integrity of programs in the United States Department of Health and Human Services (HHS). It does this by developing methods to detect and prevent fraud, waste and abuse. Created by statute in 1976, the Inspector General keeps both the Secretary and the Congress fully and currently informed about programs or management problems and recommends corrective action. The OIG performs its mission by conducting audits, investigations and inspections with approximately 1,200 staff strategically located around the country.

Office of Analysis and Inspections

This report is produced by the Office of Analysis and Inspections (OAI), one of the three major offices within the OIG. The other two are the Office of Audit and the Office of Investigations. OAI conducts inspections which are typically short-term studies designed to determine program effectiveness, efficiency and vulnerability to fraud or abuse.

This Report

The report is entitled "Medical Licensure and Discipline: An Overview." It was prepared following a review conducted to help the U.S. Department of Health and Human Services and other interested parties gain a broadly based and up-to-date overview of State medical licensure and discipline. Specifically, the report addresses pressures being exerted on licensure and discipline processes, the changes taking place, and the effects being achieved.

The study was prepared by the Regional Inspector General, Office of Analysis and Inspections, Boston Region. Participating in the project were the following people:

Boston Region

Mark R. Yessian, Ph.D. (Project Leader)
Theodore Wall
Barry McCoy
Jane Wentworth
Eleanor Ellis

Kansas City Region

Raymond Balandron

Headquarters Office

Elisabeth A. Handley

TABLE OF CONTENTS

MAJOR FINDINGS	i
MAJOR RECOMMENDATIONS.	ii
MEDICAL BOARDS IN PROFILE.	1
LICENSURE.	2
FMGS IN PERSPECTIVE	4
THE STATE RESPONSE.	5
OVERALL IMPACT.	8
REMAINING VULNERABILITIES	8
THE BIGGER PICTURE.	10
DISCIPLINING	12
INCIDENCE OF DISCIPLINARY ACTIONS	12
TYPE OF VIOLATION	13
SOURCE OF DISCIPLINARY ACTIONS.	15
THE ADMINISTRATIVE PROCESS.	16
INFORMATION SHARING	16
A FINAL NOTE	17
RECOMMENDATIONS.	18
APPENDIX I, BACKGROUND AND METHODOLOGY	21
APPENDIX II, BEST PRACTICES.	24

MAJOR FINDINGS

LICENSURE

- o Since 1982-1983, the licensing of foreign medical graduates (FMGs) has been the major policy concern of most boards. This concern relates to the authenticity of the credentials and the medical education of FMGs.
- o In response to the FMG problem, States have taken a number of actions. All have agreed to use a new and more clinically oriented licensure exam. Nearly all have tightened up their credentials verification procedures. About one-half have extended the minimum period of FMG residency training. Many have passed laws concerning medical education standards and have been reviewing and even disapproving foreign medical schools. Some have established rules governing clinical clerkships offered to FMGs in their States.
- o These actions have made it more difficult for FMGs to be licensed, and increased the likelihood that those who do become licensed will have valid credentials and be adequately trained.
- o However, two major vulnerabilities remain:
 - Most boards cannot adequately assess the education offered by the foreign schools. Boards tend to lack the necessary resources and expertise. And, they find that the standards used in accrediting U.S. medical schools are too general to serve as an effective reference point for evaluating foreign schools.
 - Residency training programs, although a major gateway to medical licensure, tend to be insufficiently attentive to this reality. They often have inadequate credential screening processes, a failing that is especially serious in the many States not requiring residency training permits. And, they often do not share information on residents' performance or behavior with State boards, a practice that can lead to some undeserving individuals being licensed.

DISCIPLINE

- o During recent years the investigatory and disciplinary authority of most boards has been increased. However, since budgetary, personnel, and productivity increases haven't kept pace with expanding workloads, large backlogs and extensive caseloads have become commonplace.
- o The rate of disciplinary actions taken by boards has been increasing. The most substantial increases have been in the actions that involve reprimands or voluntary stipulations, which are often agreed to in informal proceedings.

- In most States, violations involving drugs or alcohol seem to account for three-fourths or more of all disciplinary actions. Most of these concern the inappropriate writing of prescriptions. An increasing proportion involve the self abuse of drugs or alcohol.
- Strikingly few disciplinary actions are imposed on the basis of medical malpractice or incompetence. Boards find such cases to be enormously difficult ones to pursue because of the many legal intricacies and the variations that often exist in defining acceptable medical practice. Yet, this minimal response in the midst of escalating public expectations for action is placing boards in an increasingly untenable position.
- Consumers and law enforcement agencies are the two most active sources of alerting boards of possible violations. Professional review organizations (PROs), medical societies, hospitals, and individual physicians have been relatively poor sources, even in States having mandatory reporting laws.

MAJOR RECOMMENDATIONS

- Peer Review Organization (PRO) regulations and Medicare carrier instructions should be amended to require more extensive and timely reporting of case information to State medical boards.
- Financial assistance by the U.S. Department of Education and the Veterans Administration for medical education should follow the same limitations set forth in the various health professional educational assistance grants programs of the Public Health Service, in that it should be limited to students attending U.S. and Canadian schools.
- Medicare funding for the direct medical education costs for FMGs should be limited to graduates of schools accredited by HHS or by a private body designated by HHS.
- The Accreditation Council for Graduate Medical Education (ACGME) standards should be amended to require that hospitals (1) conduct thorough credential screening of residents and (2) inform State medical boards of resident performance and conduct.
- HCFA should consider examining the effect on indirect medical education costs of FMGs being subsidized who are ineligible to practice medicine in the U.S. or participate in Medicare upon completion of residency.
- Renewal fees charged to practicing physicians should be increased sufficiently to support expansion and improvement of the enforcement activities of State medical boards.

MEDICAL BOARDS IN PROFILE

In the mid-1960s, as the Medicare and Medicaid programs were starting up, State medical boards were little noticed instrumentalities of State government, dominated almost completely by physicians. Most were autonomous bodies, having little operational interaction with other occupational licensing boards or even with medical boards in other States. While their responsibilities typically covered both licensure and discipline, they tended to focus on the former and in particular on the development and administration of their own licensure exams. They would discipline physicians, but only rarely, as their authority and inclination to do so were quite limited.

A decade later, these boards were caught up in the stirrings of change. The nationwide effort to address the physician shortage resulted in a sharp rise in the number of medical licenses being issued (from 9,147 initial licenses in 1965 to 16,859 in 1975) and in the proportion of initial licenses being granted to FMGs (from 16.7 percent in 1965 to 35.4 percent in 1975). This growth added to the complexity of the licensure job, and, as concerns began to shift from a shortage to a surplus of physicians, it began to intensify public pressure on boards to discipline physicians engaging in unprofessional conduct.

Simultaneously, there were a number of other developments jarring the once tranquil environment of State medical boards. A sharp rise in malpractice actions led many States to expand the grounds upon which disciplinary action could be taken and to increase the investigatory resources and authorities of the boards. The consumer movement, raising concerns about public accountability, contributed to an increasing number of boards (1) being under the aegis of a central agency, (2) having non-physician members, and (3) facing sunset reviews. (The first sunset legislation, heralded as a device for assessing the overall usefulness and effectiveness of agencies, was passed in Colorado in 1976.) And, the widespread adoption by the States of the Federation Licensing Exam (FLEX), developed in 1968 by the Federation of State Medical Boards, reduced boards' preoccupation with examination issues while fostering inter-State uniformity and reciprocity.

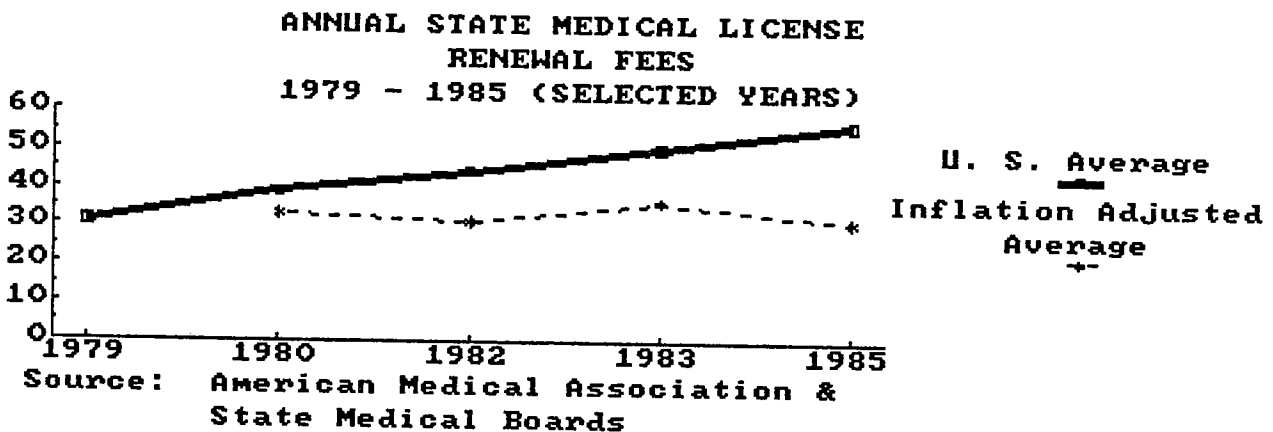
By the mid-1980s, these developments were accompanied by others that caused medical boards to undergo the most intense period of change they have experienced during the past century. These developments include the publication of newspaper exposes berating boards for not adequately protecting the public; the establishment in the Caribbean basin of proprietary medical schools geared to U.S. citizens; the conviction of individuals responsible for the widespread distribution of fraudulent medical credentials involving two of these schools; the discovery of cheating scandals involving the FLEX and the examinations given by the Educational Commission for Foreign Medical Graduates; the growth of allied health professions; and a second generation of medical malpractice crises.

In the process, most boards have undergone major transformation. At least thirty-one of them are now under a central agency, compared with sixteen in 1969. Nearly all have at least one or two non-physician members, whereas one-half had no such members in 1965. Most still have responsibility for osteopaths, but also for a larger number of other occupational groups, such as podiatrists, physician assistants, nurse midwives, physical therapists, and emergency medical technicians. Most have more board members, who find it

necessary to devote considerably more time to the role than did their predecessors. Paid an average per diem of about \$50, these members are typically appointed by the Governor for terms of three to six years and, at least in the more populous States, tend to spend at least thirty days a year on board business.

In nearly all States, medical board revenues derive entirely from fees imposed on physicians. Usually about two-thirds of this fee income comes from renewal fees paid by licensed physicians; the remainder comes from examination fees or fees charged to those seeking licensure on the basis of a license already held in another State or of endorsement of a certificate received from the National Board of Medical Examiners. (This is the usual route to licensure for graduates of U.S. medical schools.) Boards are typically part of the State budget process and subject to the same budgetary and personnel controls as other State agencies.

In response to their expanded responsibilities and workloads, nearly all boards have raised their fees in recent years. Renewal fees, which usually cover two or three years, have increased from an annual level of about \$31 in 1979 to \$51 in 1985. (This covers a range from no current renewal fee in Pennsylvania to \$160 in Connecticut.) Yet, if one takes inflation into account, (using the Consumer Price Index), there is hardly any net increase. This, added to the fact that boards aren't necessarily allowed to spend all the money they collect from fees, has left many of them in an extremely vulnerable position, with investigatory and administrative resources well below the level necessary to handle the job before them. Thus, even though medical licensure and discipline have grown to become an almost \$50 million a year enterprise, many board officials feel as though they are swimming upstream.



LICENSURE

Over time, State boards have come to judge applicants on the basis of four general requirements: (1) acceptable personal attributes (usually defined in law as "sound moral character"); (2) graduation from a medical school; (3) passage of a medical licensing exam; and (4) completion of a specified period of graduate medical education.

In this process, the boards, as early at the 1930s, began to express concern about the licensing of FMGs. However, it was not until the early- to mid-1980s

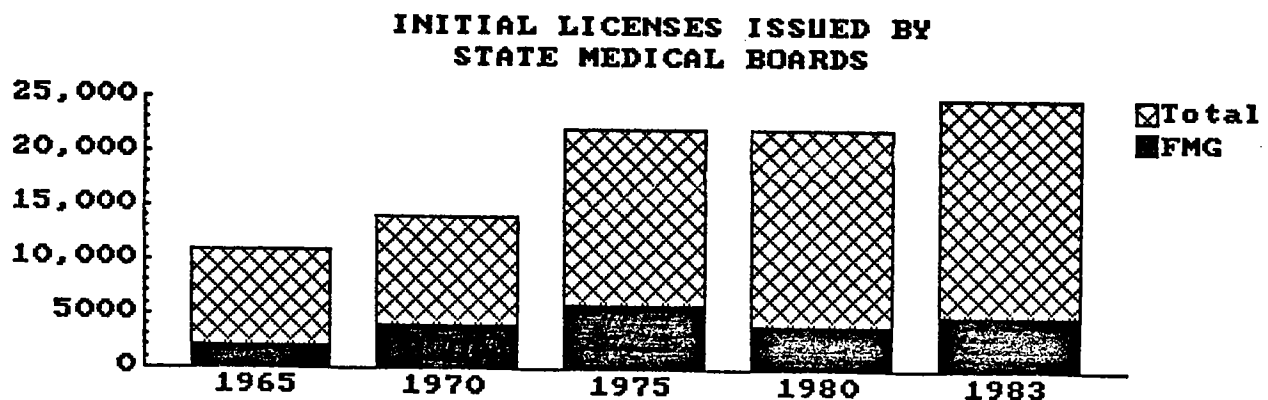
that the concern became a major one, receiving nationwide attention. The precipitating event was the disclosure by the U.S. Postal Service of a network responsible for the distribution of several thousand fake medical degrees from schools in the Caribbean area. Alarmed by this development, most boards set out to tighten their application and verification procedures. In the process, they became concerned about the adequacy as well as the authenticity of the education of many FMGs.

Widely endorsed is the view of one State board executive director, who said: "The quality of the education being received by FMGs is a much bigger issue than the phony credential one. It is an issue that is less within our control. And one that is not confined to the Caribbean schools."

While they noted that there are a number of excellent foreign schools, board officials stressed that most of the schools, especially the newer ones, are far inferior to U. S. medical schools. They expressed particular concern about inadequate clinical training and minimal admission requirements. Currently U.S. and Canadian schools are accredited by the Liaison Committee on Medical Education (LCME), a body compiled of representatives of the American Medical Association and the American Association of Medical Colleges (AAMC). The LCME, however, does not accredit schools outside of the U.S. or Canada. No U.S. entity does this at present.

In the early 1980s, these concerns were also gaining force in the broader medical community. A November 1980 GAO report provided some of the fuel. On the basis of on-site reviews of six foreign schools, three in the Caribbean region, it documented numerous deficiencies, particularly with respect to clinical training. Soon thereafter, in June 1982, the AMA House of Delegates passed a resolution urging State medical boards to require that FMGs, in order to get licensed, be graduates of medical schools meeting standards equivalent to those set forth by the LCME, the official accrediting body for U.S. medical schools. Only two and one-half years earlier, in December 1979, the final report issued by the AMA's committee on FMG affairs focused not on the quality of education received, but on ways to facilitate the licensure and involvement of FMGs in the American medical system.

As the concern about FMGs was rising, so too was the number of FMGs receiving initial State licenses, from 3,131 in 1981 to 4,753 in 1983 (see chart). This represented an increase from 16.6 percent to 23.1 percent of all those receiving initial licenses. Although this level was still well below the peak year of 1973, when 7,419 FMGs (44.5 percent of the total) were granted initial licenses, the resumption of the growth contributed to the unease being felt by many State board officials.



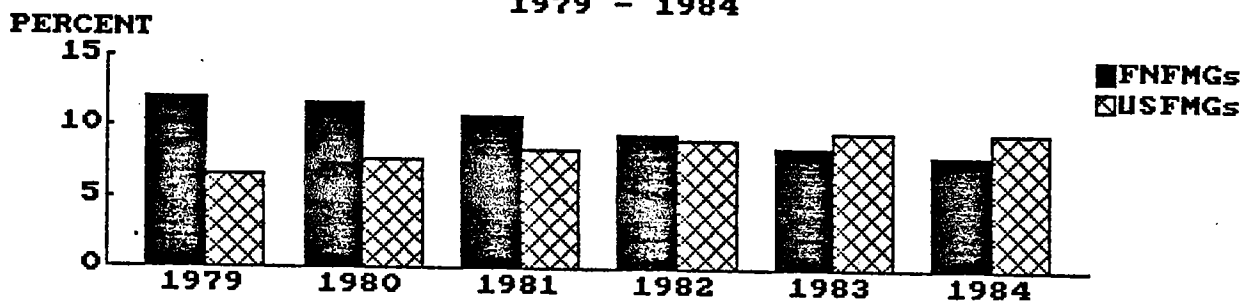
Source: American Medical Association

By 1983-1984, in the States accounting for the great majority of practicing physicians in the U.S., the licensing of FMGs had become the premier policy issue facing the State medical boards. Discipline, which typically accounts for two to three times greater expenditures than licensing, remained a vital area of concern, posing many important policy issues. However, the urgency and vulnerability posed by the FMG problem tended to bring it to the forefront.

FMGS IN PERSPECTIVE

In the early 1970s, when foreign national FMGs (FNFMGs) were actively being sought to help fill the U.S. physicians shortage, FNFMGs accounted for the great majority of FMGs seeking licensure in this country. By the late 1970s, however, this situation had begun to change, both because of the tightening of U.S. immigration laws and the emergence of the Caribbean schools geared to U.S. citizens. This is reflected by the relative proportion of USFMGs and FNFMGs participating in accredited U.S. residency programs. Whereas in 1979 FNFMGs accounted for 12.1 percent of the total compared with 6.5 percent for USFMGs, by 1984 they slipped to 8.0 percent while USFMGs rose to 9.8 percent (see chart).

PERCENT DISTRIBUTION OF FMGS IN ACCREDITED
RESIDENCY PROGRAMS, USFMGs & FNFMGs
1979 - 1984



Source: American Medical Association

Since 1984, the proportion of USFMGs seeking licensure has increased. The immigration controls restricting FNFMGs have remained as the number of U.S. citizens graduating from foreign schools has continued to rise. The 1985 GAO report cited an estimate that there are 13,000 to 19,000 U.S. citizens now studying medicine abroad, compared to 10,000 to 11,000 estimated in the 1980-GAO report. Other observers argue that the latest estimate is a considerable exaggeration and that for the past year or two the number of U.S. citizens enrolling in foreign medical schools has been dropping significantly.

Of the newly arriving USFMGs, it appears that the great majority have attended school in the Dominican Republic or Mexico. This is suggested by the fact that of the 5,026 Americans who took the 1984 ECFMG qualifying exam, 2,079 (41.4 percent) went to school in the former and 1,277 (25.4 percent) in the latter. Among FNFMGs, India and the Phillipines appear to account for the major concentrations.

Finally, while the FMG issue is a pervasive one across the country, it is more pressing in some States than others. In 1983, the latest year for which the data are available, 56 percent of FMGs granted initial licenses were in just six States: NY (12.5); NJ (12.3); MA (9.4); GA (7.6); MD (6.9); and CA (6.8). Perhaps of even more relevance are the rankings of FMGs in terms of the

proportion of all initial licensees they account for in a State. Here, using the 1983 data, NJ ranks highest (72.6 percent), followed by ME (68.0); FL (54.4); MD(53.3); GA (47.8); IA (45.4); NM (44.7); MA (43.0); and SD (41.6). Viewed in this manner, it is apparent that a number of the less populous States also have a significant stake in the licensure of FMGs.

THE STATE RESPONSE

States have taken many initiatives in response to the FMG problem. There are six major components to this State response, each of which is addressed below.

Medical Education

While State laws have required that applicants for a medical license be graduates of a medical school, they typically have offered few if any specifics concerning the substance of that education. However, as the concerns about the educational experience of FMGs have grown, many States have amended these laws along the line of the AMA resolution cited earlier. During the past four years, at least eight States have enacted requirements that all applicants be graduates of schools that meet or are "substantially equivalent" to the standards set by the LCME. Some other States have made similar changes that were not tied to the LCME standards, but that made clear the board's authority to approve or disapprove a foreign medical school.

The State that has established the most exacting requirements is California. Concerned that the LCME standards did not provide a sufficiently explicit frame of reference for assessing foreign schools, the California board in 1983 issued guidelines that set forth more detailed specifications and that, for equal protection reasons, applied to U.S. as well as foreign graduates. These specifications, which were enacted into State law in late 1985, call for applicants to have completed thirty-two months of medical instruction covering a number of identified subjects. The instruction must encompass 4,000 hours of actual course work over four years and a minimum of seventy-two weeks of clinical instruction, at least fifty-four weeks of which must be in a hospital. A number of additional specifications concern the affiliation and supervisory apparatus of the hospital.

In assessing whether foreign schools meet their standards, California and at least two other States (NY and NJ) have visited a number of the schools, mainly in the Caribbean area. Other States have relied on material sent by the schools. Aware of the limitations of this approach, all fifty-four licensing jurisdictions that are part of the Federation agreed at the 1984 annual meeting to empower the Federation to collect information on their behalf. In response, it established a Commission on Foreign Medical Education which, in turn, developed a comprehensive assessment questionnaire that it will send to foreign schools identified by State boards. The Commission will review the information, conduct follow-up site visits as it feels necessary, and then pass the information on to the States. At this time, this process is just getting underway.

Thus far, a number of States have disapproved individual foreign schools, thereby denying their graduates licensure. These actions, not unexpectedly, have led to legal challenges. Defending the suits has been a costly and time

consuming process for some States. It has resulted in a few set-backs, one recently in North Carolina. Yet in California, which has the most stringent standards, the suits have been successfully defended.

Clinical Instruction

Because the clinical training of U.S. students attending Caribbean schools is often obtained in U.S. hospitals and because of concerns about the extent of the supervision these students receive, a few of the more populous States have taken action to control the clinical instruction offered to foreign students in their States.

The most forceful action has been by Pennsylvania; it has precluded foreign students from taking clinical clerkships in the State. Others (NY, NJ, CA, and IL) have allowed it but only if the parent foreign school has been approved by the State. In this regard, New Jersey has developed the most explicit set of standards. Among other things, they call for the director of the clinical program to be acceptable to the State and for each student to successfully complete training by the equivalent to the fifth and sixth semester of U.S. medical school. Also, New Jersey as well as California and New York require students to pass a written medical science exam before they begin clinical training.

Texas, taking a somewhat different approach, instituted in 1984 a regulation concerning the supervision provided to students of foreign schools who are taking their clinical clerkship in the State. It mandates that supervising physicians register with the board and in so doing certify to a number of specific conditions governing their role as supervisor.

Residency Requirements

Many have come to regard graduate medical education as a means of quality assurance, as a way of assuring the development of a certain minimum level of clinical competence. Thus, an increasing number of States have amended their licensure laws to require more extensive residency training for FMGs than for graduates of U.S. medical schools.

With Massachusetts' imposition of a one year residency requirement in 1985, all States now require at least that minimal amount of graduate medical education in an accredited program in order to be eligible for licensure. But in response to the FMG problem, at least twenty-three States require FMGs to have two or more years of residency training and at least fifteen mandate three years of such training. At least four States also require U.S. graduates to have two or more years of graduate training.

Verification Procedures

The U. S. Postal Inspectors' disclosures on phony credentials prompted State boards to take a close look at their verification procedures. As a result, nearly all have made changes in these procedures.

At their core, the changes involve a more thorough and lengthy process for reviewing applications. It is reflected by the development of more detailed application forms calling for, among other things, a full chronological listing of all training and employment experiences; by requirements to present original educational credentials and certified translations; by verification efforts involving fiber content analysis of documents, finger printing of applicants,

and background checks by criminal justice agencies; by a greater use of the disciplinary action reports that incorporate all the formal actions taken by State boards and that are distributed on a monthly basis by the Federation; and by a careful review of physician profile information made available by the AMA. As a further check, some States also require some or, in a few cases, all applicants to appear for a personal interview.

Residency Training Permits

Entry to a residency training program is a gateway to medical licensure. In recognition of that about one-half of all the States, for some time, have required that residents obtain a residency training permit or license. This enables a board, if it has sufficient staff resources, to do a background check on them and to track their progression in a residency program.

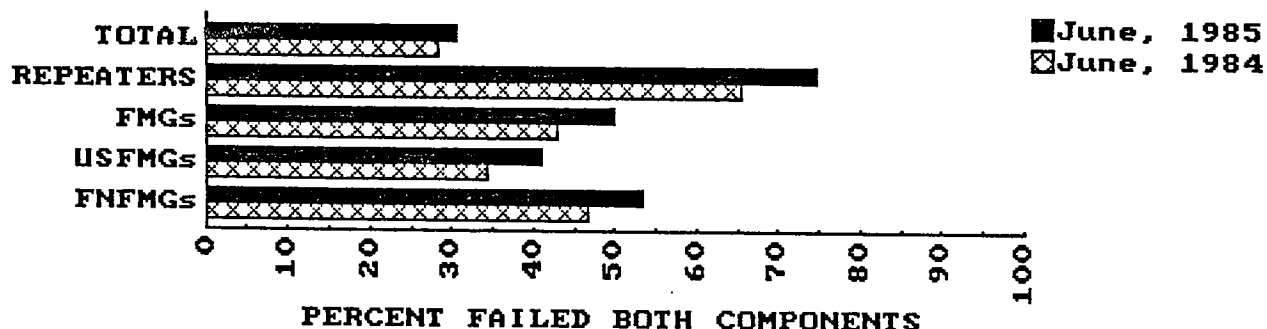
Among the States that have not established such a requirement are many of the more heavily populated ones. This is because of the administrative burden involved, the short time frame available for conducting background checks between the time a physician is accepted in a residency program and then begins the training, and the opposition of medical schools and hospitals responsible for residency training.

However, their inquiries concerning fraudulent credentials have led some of these States to become more aware of the vulnerabilities that exist at this vital point of entry. This has been most obviously the case in New York, which accounts for almost one-third of the FMGs in accredited residency training positions in the U.S. There, a task force appointed by the governor to examine the phony credential issue found that the credential screening process for admission to residency programs in the State was extremely limited and inadequate. That finding and an associated recommendation led to an October 1984 issuance by the State Department of Health that set forth detailed verification requirements for health care facilities. They were followed by workshops to help these facilities develop and improve techniques in this area.

Tests

In 1985, the States, via the Federation, instituted a new and more competency/practice oriented FLEX, the exam that all FMGs must pass prior to licensure. The first administration of the new exam was in June 1985. The overall performance on the test was about the same as in the previous year. However, 75 percent of the repeaters taking the test failed, compared with 65 percent in 1984, and 50 percent of all FMGs taking it failed, compared with 43 percent in 1984 (see chart).

FLEX RESULTS



Source: Federation of State Medical Boards

States have differing policies involving the administration of the FLEX -- concerning, for instance, when it can be taken, whether the two parts can be taken simultaneously, or how many times one can take it without passing. However, during the past few years, a number of States have required that applicants who do not pass the exam after a certain number of attempts (usually three), will have to take some additional training before being allowed to take it again.

Finally, it should be noted that in addition to the FLEX, a few States administer an oral exam as part of the licensure process. Board officials in these States regard it as a useful additional check of an applicants' knowledge base as well as their capacity to communicate in English.

OVERALL IMPACT

In many States, the FMG problem served to transform the entire licensure process, for graduates of U.S. medical schools as well as for FMGs. A director of State licensing, in one of the more populous States in the nation, observed:

"Licensing here used to be nothing more than a stamping process. If you passed the exam, you were all set. This changed in 1982, with the FLEX cheating scam and then the fraudulent credentials scandal. Now, with all the reforms we've made, our staff is swamped. We have many thousands of applications on file and take much longer to process even the routine ones."

In most States, the transformation has been less dramatic. In general, however, the greater scrutiny of applications from FMGs has led to more thorough reviews of those from U.S. graduates as well. And, because staff increases and computerization have not kept pace with the added burdens, processing backlogs and slowdowns have become widespread.

Somewhat less noticeable is that in the process, the reciprocity movement, which had gained some momentum, has been set back. As they have tightened up their own procedures and requirements, many State boards have become increasingly wary of automatically granting a license to a physician already having one in another State. One board executive director reflected the mind-set of many board officials when he said: "Why work hard in improving your own licensing procedures and disciplining your own doctors if you go license others by mail? If we did that we'd be much more vulnerable."

With respect to the FMG problem, the State actions described on the proceeding pages are having a substantial overall impact. They are making it more difficult for FMGs to become licensed. They are adding to the likelihood that those who do obtain a license will be adequately trained. And they are providing the public with greater assurance that individuals are not slipping through the process with fraudulent credentials.

REMAINING VULNERABILITIES

Notwithstanding the above developments, there are two major vulnerabilities that remain. One concerns foreign medical schools; the other, residency training programs.

With respect to the schools, board officials in most States still feel somewhat uneasy. They stress that they do not have the resources or expertise to obtain sufficient information about the schools. They are hopeful about the Federation's information gathering effort, but tend to feel that it will be a slow, long-term process.

But even if complete and accurate information is obtained, most boards feel they are on shaky ground in disapproving schools. A State-level statutory provision that foreign schools meet standards which are substantially equivalent to those of LCME is of some help. Yet, the LCME standards are quite general. As one board official noted: "LCME standards are not very concrete or substantive. They don't give us much to draw upon in establishing curricula standards for licensure."

Also having a bearing on State deliberations about foreign schools as well as on FMGs in general is the fact that sufficient political support for toughening-up frequently does not exist. This is especially so in States that have large concentrations of practicing FMGs and/or rely heavily on FMG residents in certain hospitals. But, there exists in all States a sensitivity to efforts that zero in on foreign graduates and a suspicion that tougher licensure laws are intended to protect the economic interest of the practicing physician more than the health and safety of the public.

Thus, among board officials, there is a considerable support for some national action concerning FMGs. They have reservations, because they fear that such action could lead to Federal incursions into the realm of State licensing. But, at the same time many feel that they need help. Along this line, one State board director commented: "There should be a Federal level effort. States are too close to their constituencies to do the job adequately."

The other major vulnerability, involving residency training programs, has received less public attention but may very well be the more significant of the two. One problem here, that concerning inadequate screening procedures by the residency program directors, has already been noted. While California and New York have taken important initiatives in this area, many States have not. As a result, some FMGs and perhaps even U.S. medical graduates are being admitted who for various reasons should not be admitted. An example of this sort was provided by a hospital official who upon some inquiry learned that a number of foreign national FMGs had been admitted to residency training positions even though they did not have a Visa allowing them to participate in such training.

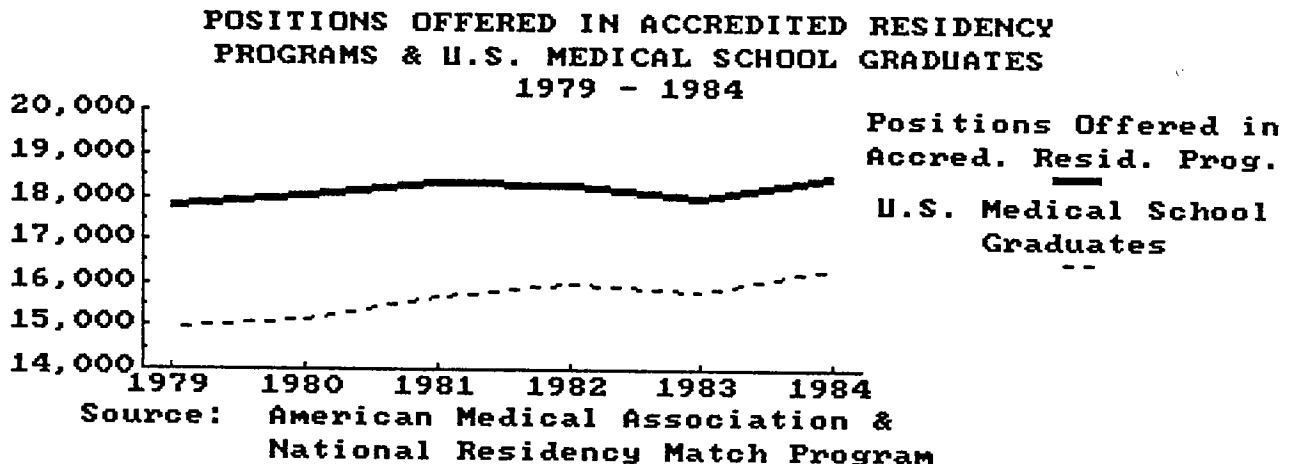
Another problem involving residency training programs is that they seldom pass on to the boards information concerning the performance and/or behavior of residents. While the Accreditation Council for Graduate Medical Education (ACGME) requires annual evaluations of residents, program directors are not inclined or accustomed to sharing those assessments with the boards, even when resident performance is unsatisfactory. Worse yet, there are indications that some hospitals, when dissatisfied with a resident's performance during the first year, will acknowledge the completion of one year of residency training but then not allow him or her to continue in the program. Yet, in nearly all the States for U.S. medical school graduates and about one-half the States for FMGs, that one year of completed training meets the minimal requirement for licensure.

Even for those completing a multi-year residency program, the lack of interaction between the program and medical board can have serious consequences. This is illustrated by a case involving a physician who left a State in which he was practicing and resettled in another State in which he also had a license and had attended residency training. Shortly after establishing his practice in the latter State, the medical board, informally, heard that he was being investigated on charges of sexual abuse in his former State. The board began its own investigation and upon obtaining his residency program records, learned that during two of the three years of his training there, he was on internal probation -- for charges of sexual abuse. The board had never been informed.

THE BIGGER PICTURE

As important as State board actions are in alleviating the FMG problem, there are other developments occurring that may prove to be even more consequential. Two of the most notable concern the availability of accredited residency positions and the performance on the ECFMG exam.

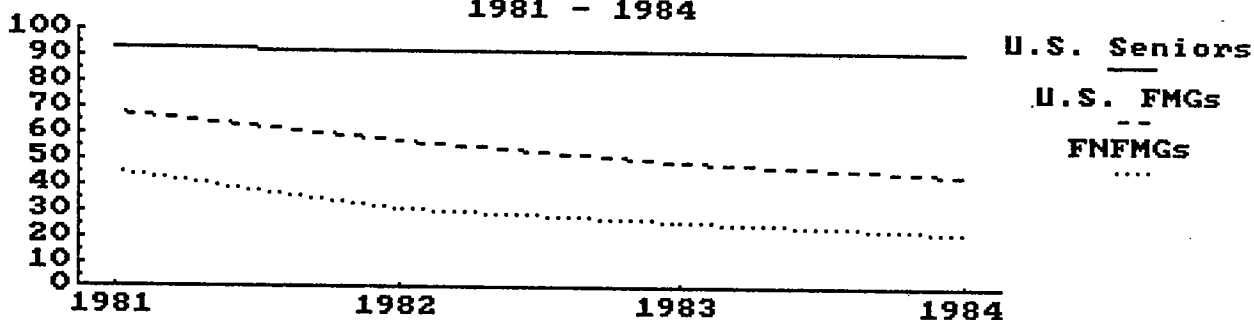
With respect to the former, FMGs are finding it increasingly difficult to gain entry to accredited residency training programs. An important indicator is the narrowing gap between the number of positions offered in accredited residency programs and the number of U.S. medical school graduates. From 1979 to 1984,



the gap has gradually been closing -- from 2,858 to 2,133 (see chart). This is especially ominous for FMGs, because as medical educators widely acknowledge, FMGs tend to be selected in those programs only when U.S. medical graduates are not available.

In assessing this occurrence, the National Residency Matching Program (NRMP), in its 1984 directory, states: "We are rapidly accumulating a sizeable pool of physicians who are not eligible for licensure." And, in the same publication, its statistical reports indicate that foreign national FMGs (FNFMGs), if they remain in the U.S., will be over-represented in this pool. Whereas the proportion of U.S. seniors successfully matched with accredited residency programs has remained at about 92 percent from 1981 to 1984, the proportion of successfully matched FNFMGs has declined from 45 to 22 percent and USFMGs from 68 to 44 percent (see chart).

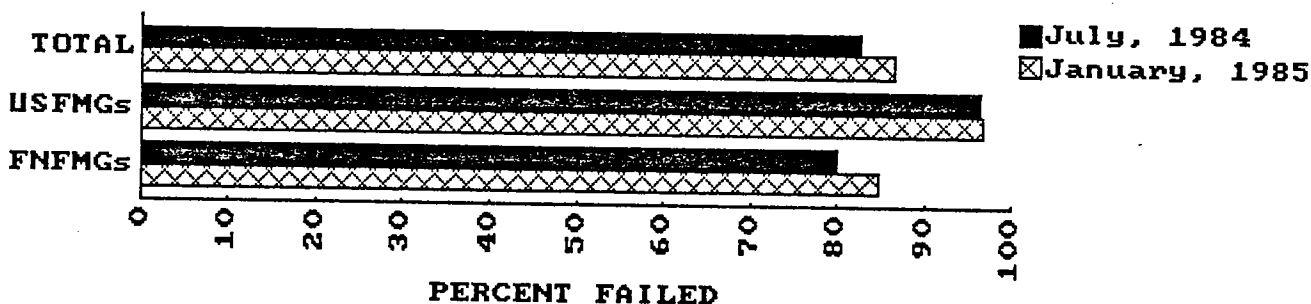
**PERCENTAGE OF NRMP APPLICANTS SUCCESSFULLY
MATCHED, U.S. SENIORS, U.S. FMGs, FNFMGs
1981 - 1984**



Source: National Residency Matching Program (NRMP)

Also of note in the private sector is the increased rigor associated with the granting of an ECFMG certificate, which is required of all FMGs entering accredited residency training programs. That rigor is reflected by more extensive and refined verification procedures and tighter security in the administration of the exams given in different parts of the world (though some board officials feel that the latter presents a continuing danger). It is also reflected by what is widely regarded as a much more difficult medical science exam. That exam, the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS), was first given in July 1984. It must be taken by all FNFMGs seeking a U.S. Visa. States require that USFMGs also take it.

ECFMG TEST RESULTS



Source: Educational Commission for Foreign Medical Graduates

The failure rate of those taking the new ECFMG test (FMGEMS) was extremely high in its first two administrations, particularly for USFMGs. Overall, about 83 percent failed in July 1984 and 85 percent in January 1985 (see chart). While the majority of those taking the test are repeaters, who typically do worse than first-time takers, the failure rate is still strikingly high. In the early 1970s, when FMGs were coming to the U.S. in greater numbers, the failure rate ranged from about 60 percent to 69 percent.

DISCIPLINING

"Balm for Errant Doctors? Critics Fault Agency" (St. Louis Post Dispatch, April 13, 1980)

"Doctor Sued 14 Times, But No State Hearing" (Chicago Tribune, May 10, 1982)

"Doctors Practice While Wheels Turn" (Detroit Free Press, April 1, 1984)

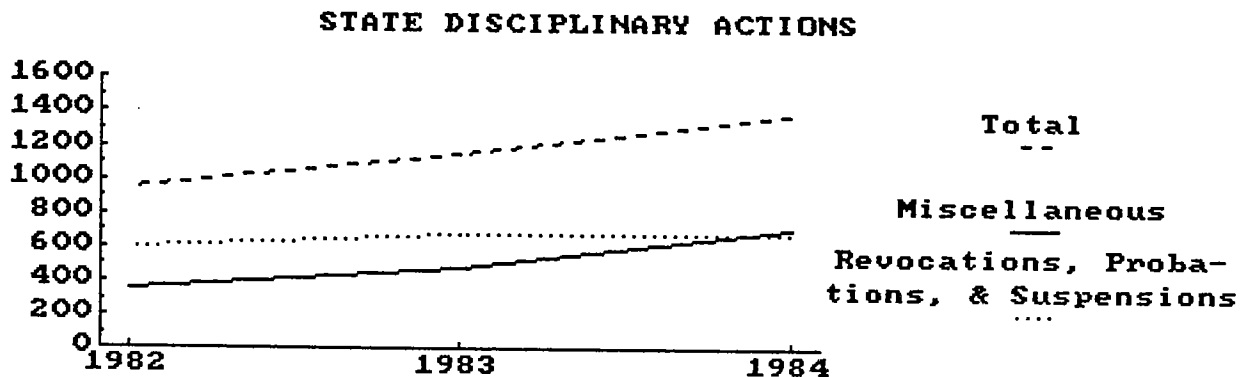
As the above newspaper headlines illustrate, State boards responsible for medical discipline have been subjected to considerable public scrutiny and criticism in the 1980s. Typically they have been viewed as being too lenient in their treatment of physicians and too slow in their handling of cases.

The exposure has had an impact. It has contributed to a strengthening of the investigatory powers of boards (for instance, the granting of subpoena powers); an expansion of their disciplinary authorities (most notably, the authorization to immediately suspend physicians posing a "clear and present danger" to the public); a widening of their access to disciplinary actions taken in other places (through mandatory reporting laws); and a broadening of the grounds upon which they can take disciplinary action. The latter development, following an earlier wave of such activity in the 1970s, has led to more detailed specifications of unprofessional conduct, covering such matters as sexual abuse, incompetence, and violations of controlled substance laws. Since 1982, at least 20 States have amended their laws to clarify and/or expand the grounds upon which physicians can be disciplined.

During this same period, the funding available to boards has increased. But, as noted earlier, the increase has been marginal, as State governments have imposed strict controls on the boards' budgets and personnel ceilings.

INCIDENCE OF DISCIPLINARY ACTIONS

Over the past few years the number of disciplinary actions taken against physicians has been increasing. National tabulations made by the Federation reveal an increase in actions (excluding simple administrative actions) from 953 in 1982 to 1,381 in 1984, an increase of 45 percent (see chart).



Source: Federation of State Medical Boards

However, with a close look at the above chart, it is apparent that tier-1 actions -- the more serious actions involving revocations, probations, and suspensions -- have been increasing only slightly from 600 in 1982 to 678 in 1984. The bulk of the increase has been in the miscellaneous, or tier-2 category, which incorporates such actions as reprimands, censures, and stipulated agreements. Indeed, it is likely that the increase in this category is even greater than the Federation's summary suggests, because many stipulated agreements are made on a confidential basis, with the information not reported to the Federation.

Some observers have dismissed these second-tier actions, which are often handled in informal proceedings, as being relatively inconsequential. Yet in actuality, they are often quite significant, involving a voluntary surrender of a license for a period of time or perhaps a restriction of prescription privileges. Moreover, these actions represent a practical response by boards faced with insufficient investigatory resources and with the memory of many cases that have lingered during the hearing and judicial process for two or more years, while the physicians involved have continued to practice.

In view of the FMG problem's prominence in the realm of licensing, it is pertinent to inquire if FMGs are any more likely to be disciplined than U.S. medical school graduates. The information available is inconclusive. Of 1,166 disciplinary actions reported by the Federation between January and September 1985, our tabulations indicate that only 638 specified the medical school from which the physician graduated. Of this total, 167 or 26 percent of the physicians were FMGs. While this is somewhat higher than the 21 percent of U.S. physicians who are FMGs (according to the AMA), the spread is too thin and the number of "not available" too great to conclude that FMGs are any more likely to be disciplined than other physicians.

TYPE OF VIOLATION

The inappropriate writing of prescriptions is, by far, the most common violation upon which disciplinary actions are based, accounting for about one-half of all such actions taken by State boards. These tend to be serious matters involving not only excessive or unnecessary prescribing of drugs to patients but also unlawful distribution to addicts. They also tend to be among the easier kinds of cases for investigators to develop, especially in States with triplicate prescription laws.

The second major type of violation is the self-abuse of drugs and/or alcohol. It appears that in most States this category is expanding, in both absolute and proportionate terms, and together with over-prescribing is accounting for three-fourths or more of all disciplinary actions.

Throughout the nation, programs designed to help impaired physicians have been expanding and receiving increased attention. Typically, they are run by medical societies or other private organizations, although in California they are run by the board itself. While the exact approaches vary, they generally involve group sessions, signed agreements stipulating the terms of participation, and periodic monitoring to assure that participating physicians are adhering to the agreements. The extent and type of actual treatment offered seems to vary

considerably, with some programs, such as in Oregon, stressing inpatient care, and others focusing on outpatient treatment.

While the programs have tended to be well-received and apparently beneficial, they have met with some criticism and underlying skepticism. At the core, these involve concerns about physicians being treated too sympathetically for behavior that can be harmful to their patients. The result in some States has been a tightening of monitoring practices and/or a closer examination of the responsibilities that these programs have to report violations to the boards. The substantial number of physicians who have signed up for these programs on their own initiative, without board involvement, has made the latter issue an especially sensitive and difficult one, since these physicians often sign up with the understanding that their participation is confidential.

The remaining types of violations underlying disciplinary actions cover a wide range. Among the more prominent are cases involving the conviction for a felony or fraud. Much less prominent are cases involving incompetency or sexual abuse, which are among the most difficult kind of cases to develop.

The minimal response in the area of physician incompetence is placing boards in an increasingly untenable position as the incidence of malpractice cases and public concern about the implications of these cases increase. During the past decade the number of malpractice cases has been increasing rapidly and since 1979 the average settlement has jumped from \$5,000 to about \$330,000. At the same time, the cost of premiums for some high risk specialties has exceeded \$100,000 in some areas.

Boards, it is increasingly felt, can and should do something about this situation. Why, then, the minimal response to date? At least three major factors seem to be involved: (1) the complexity, length, and cost of cases concerning alleged incompetence, even where a malpractice judgment has been rendered; (2) the substantial burden of proof that tends to call for "clear and convincing" evidence rather than the "preponderance of evidence"; and (3) the considerable variations among physicians themselves about what constitutes acceptable practice in many facets of medicine. One board executive director summed up his frustrations in this area by noting:

"We just can't seem to do anything with malpractice. In fact, we've never had a disciplinary action based on malpractice. It's such tender legal ground, even though we have a statute. So when there is a malpractice case, we tend to look for another basis for disciplinary action."

Yet, in the course of addressing rising malpractice costs, some States are taking initiatives that could prove to be consequential. Particularly notable in this regard are two amendments that Wisconsin made in 1985 in its medical practice act. One allows for a court finding of physician negligence in patient care to serve as conclusive evidence that a physician is guilty of negligence of treatment. This frees the medical board from the need to hold a probable cause hearing in such cases. Another amendment, perhaps even more significant, provides the board with a lesser burden of proof in disciplinary proceedings, one that calls for "a preponderance of evidence" rather than "clear and convincing evidence."

Also of note are laws in California and Oregon that authorize boards to compel a physician to take a clinical competency exam if there is reasonable cause to believe that his or her skill level is inadequate. The California effort, just getting started, involves a rather intricate process that allows a physician two chances to pass an oral exam conducted by a panel of two physicians. The Oregon effort, underway for a number of years, can involve oral or written exams, but has employed the latter because it was found to offer a firmer legal basis for subsequently denying a license or imposing discipline.

SOURCE OF DISCIPLINARY ACTIONS

During the past few years, the number of consumer complaints being received by boards has been rising, often quite substantially. The greater visibility of boards and in some States the establishment of toll-free complaint lines have contributed to this development.

These consumer generated complaints together with information provided by other government agencies (mainly law enforcement agencies) and information obtained directly by board investigators tend to account for most of the disciplinary actions eventually taken by a board. Strikingly few such actions first come to a board's attention as a result of referrals by medical societies, peer review organizations (PROs), health care institutions, or individual health care professionals.

In commenting on this situation, board officials often pointed to the PROs as an especially unproductive source of information. The following comment, by the executive director of a board in a heavily populated State, would be endorsed by many of his colleagues across the country:

"We get very little from the PROs. They take care of their own problems in house until they get out of hand. We should be getting a lot more information from them."

Aware that much important information is not being passed on to boards, many States have initiated, expanded, or tightened reporting laws. At least 17 States have taken such action since 1982. Most of these laws focus on hospitals. They typically require that hospitals inform boards of any changes of a physician's staff privileges or in some States of any resignations from the staff. An increasing number require the reporting of malpractice judgments and/or settlements, usually over a certain amount (e.g., \$10,000 in GA, \$25,000 in NJ, \$30,000 in CA). Lastly, a few States have reporting laws directed to individual practitioners.

Nevertheless, reporting laws often have not had the expected impact. When asking why, one often hears reference to the "brotherhood of silence" -- to an inherent resistance to report on one's peers and to a fear of legal liability, even, it seems, in States that have granted criminal and civil immunity to those who report information in good faith.

THE ADMINISTRATIVE PROCESS

Boards are facing increasing strains in handling the disciplinary workload before them. It is not uncommon for them to have backlogs of hundreds of cases waiting to be assigned while investigators are weighted down with caseloads of 60-70 or more cases. Not surprisingly, those board officials who did not identify the FMG problem as their top priority concern were likely to give that billing to the administrative bottleneck they face in carrying out their disciplinary responsibilities.

They identify a number of factors that have contributed to this situation. The rising number of consumer complaints and, increasingly, the mandated reporting of malpractice cases are multiplying the number of cases to be investigated. Severe budgetary constraints are precluding boards from adding sufficiently to their corps of investigators and from making investments in computer technology and training that could improve productivity over time. And, laborious procedures geared to quieter times contribute to the time and complexity of internal review and hearing processes, as do the coordination of efforts with the Attorney General's Office and the propensity of physicians, facing serious charges, to maximize their due process rights.

Thus far the responses that have been made to this situation have tended to focus on ways of easing the burden on board members. Among the changes of this sort are those allowing boards to draw on the work of hearing officers, to delegate the conduct of hearings to individual members and to hire medical and/or legal consultants to help guide the use of investigatory resources. In Colorado, a change that splits board members' time between inquiry and hearing panels seems especially promising. (See Appendix II)

INFORMATION SHARING

It appears that each of the States now provides the Federation (and thereby the other States) with regular reports on disciplinary actions taken. This represents significant progress compared with the situation two to three years ago.

However, the extent of the actions reported varies from State to State. Many boards do not report licensure denials. More notably, many do not report tier-2 disciplinary actions if they did not involve a formal hearing and/or were imposed with the understanding that they would be confidential. The rationale offered for holding back on these cases is that confidentiality or lack of publicity were a key to the agreements that enabled discipline to be imposed without a formal hearing. Yet, the failure to report such cases means that other States are prevented from obtaining information which could prove to be important to them if a disciplined physician decides to relocate to their jurisdiction.

Furthermore, from State to State and even within States, there tends to be considerable inconsistency in the type of disciplinary actions taken in relation to the charges and even in the meaning of the different types of actions. The Federation has sought to promote some consistency in this area by establishing a coding system, concerning different types of violations, for the boards to use in reporting their disciplinary actions to the Federation. But

many States fail to use it or use it irregularly, leaving it to the Federation to apply what appears to be the most appropriate code. To foster greater consistency within the State, California a number of years ago developed a manual of disciplinary guidelines and model disciplinary orders and has regularly revised it to keep pace with changing developments. (See Appendix II)

While the Federation's data base serves as the primary vehicle for the States to keep abreast of disciplinary actions taken in other States, follow-up communication among the States themselves provides the vehicle for obtaining more detailed information concerning the specifics of a case. In this context, there is substantial and, it appears, effective information sharing going on. It occurs through the mailing of the final board orders on a case and through more informal networking among board investigators and administrators. Where problems in gaining access to information have occurred, they have tended to concern cases still pending formal board action or tier-2 cases, where the action was grounded in an agreement of confidentiality.

Finally, within the States, boards typically inform medical societies and Medicaid State agencies of all formal disciplinary actions. They are less likely to do so with respect to other entities, such as HHS, PROs, insurance companies, and hospitals. Most tend not to take an active part in informing the general public or even the medical community of the actions. However, a few boards, on the assumption that publicizing the information has preventive value, see that disciplined physicians are regularly identified in newsletters published by the board, medical society, and/or other parties.

A FINAL NOTE

During the 1970s the widespread adoption of the FLEX had contributed significantly to the simplification and routinization of medical licensing. In so doing, it enabled boards to devote more attention to medical discipline, which was becoming a much more visible and controversial issue. Yet, as this shift was occurring, the FMG problem began to intensify and by 1982-1983 had become the dominating issue for most boards. Licensing responsibilities gained renewed attention, often consuming board resources and energies that would otherwise be directed to medical discipline. Thus, to the extent that the FMG problem can be brought under control, the opportunity to develop more substantial and effective efforts in the area of discipline would seem to be enhanced.

Whatever happens with respect to FMGs, however, boards face a festering problem in the discipline area that may prove to be even greater than the FMG problem. That problem concerns the phenomenon of physician incompetence. Boards, as noted, have been taking some initiatives in this area. But, unquestionably, public expectations for results have been rising much faster than the boards' capacity to perform. Indeed, the increased appropriations and/or authorities made available to boards in recent years have often been with the understanding that boards would do something to help stem the tide of malpractice cases.

Contributing to the impending sense of urgency is that medical malpractice (or incompetence) has major implications concerning not only the quality of medical care, but also its cost. This is most obvious with respect to the escalating

malpractice insurance premiums and awards and the defensive medicine often practiced to minimize the likelihood of successful malpractice suits. But also involved are the extra expenses generated by physicians whose clinical competence is deficient. Their mistakes, many observers believe, unnecessarily add billions of dollars to the nation's annual health expenditures.

For boards to play an important part in addressing this major issue, it is clear that there must be substantial changes in the legal ground rules governing their handling of malpractice cases. No less clear is that the resources available to them must be increased. At the present time, most boards lack sufficient resources to devote serious attention to such cases without jeopardizing their other disciplinary and licensing responsibilities.

RECOMMENDATIONS

Consensus Recommendations

Based on initial reactions to the draft report and recommendations and further discussion within the Department of Health and Human Services, there is consensus on the following recommendations:

o Peer Review Organizations (PRO) regulations and Medicare carrier instructions should be amended to require more extensive and timely reporting to State medical boards of cases involving physician misconduct or incompetence.

The result of this would be to foster better communication among those in a position to identify unprofessional practice and those with authority to do something about it.

o HHS should notify hospitals of the changes noted above concerning PROs and Medicare carriers and should urge hospitals to be more active in reporting to State medical boards cases of physician misconduct or incompetence.

A communication of this kind would generate greater attention to what this study has shown is a problem area. It would also help to reinforce the reporting laws that have been passed in many of the States.

o Federal legislation requiring States to report disciplinary actions to HHS (or its designee) and allowing HHS to exclude from Medicare and Medicaid physicians whose licenses have been revoked or suspended by a State board (H.R. 1868, S. 1323) should be enacted as quickly as possible.

Passage of this legislation would facilitate more extensive and effective sharing of disciplinary information among the States. It would provide a vehicle for fostering (1) further and more timely reporting of disciplinary actions to a central clearinghouse, (2) more extensive nationwide distribution of information on such actions, and (3) more consistent definitions of the type of violations committed by physicians.

o Financial assistance by the U.S. Department of Education and the Veterans Administration for medical education should follow the same limitations set forth in the various health professional education assistance grants programs of the Public Health Service, in that eligibility should be limited to students attending U.S. and Canadian medical schools.

Such action would eliminate what in effect now serves as a stimulus for U.S. students to attend unaccredited foreign medical schools, mainly in the Caribbean area.

Office of Inspector General Recommendations

The Office of Inspector General has two additional recommendations for Federal action. One concerns direct medical education costs and the adequacy of education received by FMGs. The other concerns indirect medical education costs and the implications of subsidizing the training of individuals who will not be practicing medicine in the U.S. Both recommendations are set forth below:

o Medicare funding for the direct medical education costs for FMGs should be limited to graduates of schools accredited by HHS or by a private body designated by HHS. This should be accomplished over a phase-in period.

This legislative action is a direct response that would greatly relieve State concerns about inadequately trained physicians seeking licensure. It would provide a mechanism for graduates of the better foreign medical schools to enter the U.S. pathway to licensure and, if phased in gradually, would allow those teaching hospitals that are heavily dependent on FMGs to make necessary adjustments. In New York, which accounts for one-third of all FMG residency positions in the U.S., a recent report of the Governor's Commission on Graduate Medical Education urges State policy directions that would lead to a reduction in residency positions within the State. Their efforts would, therefore, be consistent with the above recommendation.

Accreditation is practical if HHS is allowed to (1) accept the decisions of accrediting entities which it has approved and/or accredited in other countries; (2) use the services of a private accrediting body; and (3) use standards that are substantially equivalent to those used in accrediting U.S. medical schools. Moreover, it would involve relatively little governmental expense if schools seeking the accreditation were required to bear the associated costs.

During the comment period on the draft report and recommendations, we made another recommendation which has since been enacted into law. That recommendation called for requiring current residents who have not passed the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS) to do so in order for hospitals to receive Medicare funding of their direct medical education costs. Since 1984, passage of the FMGEMS has been required in order to obtain ECFMG certification, which is required to gain entry to an accredited U. S. training program. The effect of our recommendation and the new law is to impose the same requirement on current FMG residents and on FMGs who obtained an ECFMG certificate prior to July 1984, but have not yet entered a residency program.

This provision was contained in the Consolidated Omnibus Reconciliation Act of 1985. HCFA actuaries estimate that it will save \$41 million over a five year period (beginning in 1987.)

o HCFA should consider examining the effect on indirect medical education costs of FMGs being subsidized who are ineligible to practice medicine in the U.S. or participate in Medicare upon completion of residency.

With large Federal deficits, it would seem prudent for the Federal government as a general rule to pay for the indirect medical education costs of only those residents who will practice medicine in this country or who will be eligible to participate in Medicare upon completion of their residency.

Beyond the above recommendations for the Federal Government, we offer the following recommendations to State governments and private organizations concerned with medical licensure and discipline.

o The Accreditation Council for Graduate Medical Education (ACGME) standards should be amended to require that hospitals (1) conduct thorough credential screening of residents and (2) inform State medical boards of resident performance and conduct.

Such action by the private organization responsible for accrediting residency training programs would reinforce teaching hospital and medical school responsibilities in this area and would provide an added measure of oversight. It would also serve as an important signal of the medical community's concern about the integrity of the licensing function.

o Residency training licenses should be required by all States.

Although residents are students in a supervised setting, they are also physicians, practicing medicine. Accordingly, all State boards should have the authority to license them and, if necessary, to discipline them.

o The Federation of State Medical Boards should (1) send its disciplinary action reports to all Medicare carriers, Medicaid agencies, and Peer Review Organizations, (2) provide additional guidance to State boards on how to be more effective in addressing cases involving possible medical malpractice or incompetence, and (3) intensify its efforts to promote greater inter-State consistency both in defining violations and in imposing disciplinary actions on the basis of these violations.

The Federation has played an important part in helping to improve the licensure and discipline practices of the States. The above three areas are important ones where further Federation leadership is warranted. Particularly important here would be an assembling and distribution of best practices concerning the areas of malpractice and incompetency. This could include specific statutory changes that could be made in State medical practice acts.

o Renewal fees charged to practicing physicians should be increased sufficiently to support expansion and improvement of the enforcement activities of the State medical boards.

Most boards face a resource shortfall that severely limits their capacity to protect the public. Until this situation is addressed and the annual renewal fees are increased to a level that far exceeds the current \$50 average, the possibilities for major overall improvement in board performance will be minimal.

APPENDIX I

BACKGROUND AND METHODOLOGY

The licensure and discipline of physicians is a traditional function of State government. It dates back to the pioneering efforts of the American colonies, such as Virginia's medical practice act of 1639. But it did not gain permanence until the late 1800s, when Texas passed the first modern medical practice act (1873) and the U.S. Supreme Court upheld West Virginia's act as a valid exercise of State police powers (1889).

In recognition of this traditional State role, Congress, when it established the Medicare and Medicaid programs in 1965, left it to the States to determine whether a physician is legally authorized to participate in these programs. Subsequently, Congress has empowered HHS and its predecessor (HEW) to impose sanctions on physicians and other health care programs who have abused or defrauded these programs. However, the Federal government has continued to depend on the States to serve as the disciplining agent for transgressions that do not directly relate to the Medicare and Medicaid programs.

Thus, States have been providing valuable protection for participants in these two Federally funded programs. This protection has been at no cost to the Federal government and at only minimal cost to State government. Nearly all the costs have been covered by fees imposed on physicians.

The growth of Medicare and Medicaid, to the point where they now account for about one-fourth of U.S. health care expenditures, has fostered Federal interest in the effectiveness of State medical boards. However, in the 1980s, three General Accounting Office (GAO) reports have both intensified and directed this interest.

Two of the reports, one published in November 1980 and the other in September 1985, raised concerns about the quality of the education being received by the increasing number of U.S. citizens who attend foreign medical schools and then seek licensure in the United States. Both reports urged the Federal government to take action that would help State medical licensing agencies deal more effectively with this matter.

The other GAO report, published in May 1984, helped crystallize national concern about physicians who have their licenses revoked or suspended in one State and who then move their practice to another State in which they are licensed. This report contributed to the introduction of Federal legislation that, among other things, would (1) require State licensing boards to report all their disciplinary actions to the HHS Secretary (or a designee thereof), who would then share that information with other entities, including all State licensing boards; and (2) allow HHS to exclude from Medicare or Medicaid any physician whose license has been revoked or suspended by a State board. This legislation passed the House of Representatives in July 1985 (H-1868) and is being considered in the Senate (S-1323).

During this same period, the Office of the Inspector General (OIG) was involved in a number of activities that made it increasingly aware of the limitations within which State medical boards were operating. Out of the OIG's work with the U.S. Postal Inspectors and the Federal Bureau of Investigation concerning the scandals involving (1) fraudulent medical credentials from two Caribbean medical schools and (2) the administration of the Federation Licensing Exam (FLEX) used by the States it became apparent that the credentials verifications capabilities of most States were quite limited. Also, out of the OIG's efforts in imposing close to 1,000 exclusions on health care providers, it became apparent that communication between those in a position to witness unprofessional practice and those with the authority to do something about it was inadequate.

Given these developments, the Inspector General's Office conducted a program inspection to help HHS and other interested parties gain a broadly based and up-to-date overview of State medical licensure and discipline -- of the pressures being exerted, the issues being addressed, the changes taking place, and the effects being achieved. Such an overview, it is expected, will facilitate an analysis of policy directions that should be taken at Federal and State levels.

This report presents the major findings of the inspection. It focuses separately on the licensure and discipline spheres, and concludes with some assessments concerning the two spheres and recommendations calling for action by Federal and State governments and by private organizations.

The information base supporting the presentation, emerges from four major types of inquiry:

- o Reviews of literature and data bases, including journal articles, books, governmental reports, and statistical compilations of public and private organizations.
- o Visits to fourteen States (CA, CO, FL, IN, MA, MO, NJ, NY, NC, OR, PA, TX, VT, WI), involving discussions with medical board members, directors, and staff; directors of central agencies responsible for medical boards; directors of hospital residency programs; and representatives of medical societies, peer review organizations (PROs), State Medicaid agencies, and Medicare contractors. The States visited account for about 58 percent of the physicians licensed in the U.S.
- o Telephone discussions with medical board directors in another ten States (AL, AZ, CT, DE, IN, KS, MI, VA, WA, WY) and the District of Columbia. These jurisdictions account for 14 percent of the physicians licensed in the U.S.
- o Discussions with representatives of a wide range of organizations and agencies that have been addressing medical licensure and discipline issues. These include the Accreditation Council for Graduate Medical Education; Association of American Medical Colleges; American Hospital Association; American Medical Association; Educational

Commission for Foreign Medical Graduates; Federation of State Medical Boards; General Accounting Office; Liaison Committee on Medical Education; National Clearinghouse for Licensure, Enforcement and Regulation; National Commission for Health Certifying Agencies; and the National Resident Matching Program.

APPENDIX II

BEST PRACTICES

During the course of the program inspection, we identified many State practices that would appear to be of considerable interest across the country. Below are a number of such practices in four broad areas.

FACILITATING THE DISCIPLINARY PROCESS

- o California has adopted a set of model disciplinary guidelines which include minimum and maximum recommended penalties for each of 24 statutory violations within the board's authority. The set includes model disciplinary orders.
- o Colorado and Vermont divide their boards into separate inquiry and hearing panels. The former panels administer the investigatory phase of complaint processing, while the latter conduct the formal hearing. Individual board members serve on both panels, but for any individual case will serve on only one.
- o Massachusetts statutes (MGL 112-64) preclude the issuance of a court stay during the appeal of a final decision by the board.
- o Illinois maintains a diary control system under which the investigator of a complaint which resulted in probation is reminded and required to monitor continuing compliance with the terms, usually at six month intervals. Also, at the board's discretion, the initiator of a complaint report is required to send progress reports at six month intervals. If the reported problem is corrected, the complaint file is purged.

ADAPTING THE DISCIPLINARY PROCESS TO DIFFERENT SITUATIONS

- o Florida empowers the board to issue cease and desist orders for unlicensed practitioners as an administrative remedy which, if violated, forms a basis for the State Attorney's petition to the courts.
- o New Jersey, New York, and Florida boards have discretion to assess administrative fines or penalties, up to \$2,500 per count in New Jersey. The monetary assessment is additional to any other license action the board may take.
- o Pennsylvania may purchase a display advertisement in a local newspaper in an area where a disciplined physician resides and/or practices. Affirmative publicity can also be a negotiating point in the process of reaching an agreed settlement.
- o Texas and Florida charge license renewal fees which are higher for those with out-of-State addresses than for residents. The Florida fee is currently \$1,000 for the 2-year registration.
- o New Jersey excludes from time counted toward fulfillment of a suspension any time spent in practice in another State.

PROTECTING THE INTEGRITY OF THE LICENSING PROCESS

- o Missouri and Wisconsin are among the States which have recently revised and expanded their application forms for physician licensure. The forms directly ask for unequivocal answers to complete license and disciplinary history. They require detailed education and work histories which are reviewed for consistency, and they include broad authorizations and waiver statements.
- o Florida requires personal interviews of applicants who meet defined criteria (e.g., graduates of a particular foreign school, those with a history of impairment, or attendance at more than one medical school). The interview can detect information which fails to surface through the paper credentialing process: English proficiency, for example.
- o New York issued through its Department of Health a memorandum (84-90) clarifying health facility responsibilities for physician credentials verification. As a State policy, the health facility has responsibility to assure that all staff, including physicians, are properly trained and qualified and have the appropriate credentials.

ADDRESSING ISSUES OF IMPAIRED/INCOMPETENT PHYSICIANS

- o California diverts from the formal disciplinary process certain physicians who participate voluntarily in a State-run rehabilitation program. Participants generally continue to practice during rehabilitation and recovery under a signed agreement with the diversion program, which includes accepting random drug abuse tests. Some 40% of entrants to the program are self-referred. The success of the program is reflected in low sanction figures for drug self-abuse in California (JAMA-Jan. 1983).
- o Oregon operates a monitored treatment program through the State medical association. Unlike programs in many States, the Oregon approach to alcoholism and chemical dependency permits deferral of formal board disciplinary action during a structured long-term treatment and follow-up of the chronic illness. The program gives major emphasis to inpatient treatment and to follow-up monitoring.
- o North Carolina and other States have referred some physicians whose competency comes into question to an education and retraining program directed by Dr. Edward Kowaleski at the University of Maryland. Personal evaluations of retraining potential are discussed with the individual subject and reported to the referring board. The program reports an 85% success rate, improving both quality of care and safety.
- o Wisconsin is another State operating an impaired physician program under a memorandum of understanding with the State medical society. A portion of the program run through two rehabilitative facilities in Milwaukee has proved attractive to younger physicians who develop alcohol and drug problems during residency. The board is finding that some licensure applicants are impaired physicians and is attempting to assist these persons to enter the medical mainstream through the rehabilitation programs.