
STATE MEDICAL BOARDS AND MEDICAL DISCIPLINE

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EXECUTIVE SUMMARY

PURPOSE

The purpose of this inspection is to assess the disciplinary practices of State medical boards. It examines the changes taking place that have an important bearing on these practices and the impediments to improved board performance.

BACKGROUND

This report is a follow-up to a 1986 Office of Inspector General report addressing the licensure and disciplinary responsibilities of State medical boards. It concentrates on board disciplinary activities because of their relevance to heightened national concerns about medical malpractice and the quality of medical care. It is based on a review of pertinent literature and documents, an examination of disciplinary action data from the States, a survey seeking detailed information about disciplinary actions taken in a random sample of eight States, and case studies of board disciplinary operations in California, New York, Pennsylvania, and Texas.

FINDINGS

Identification Of Cases

Through mandatory reporting laws, immunity protections, and self-reporting laws, State governments and their medical boards have facilitated the identification of physicians who may warrant disciplinary action.

In recent years, the annual number of referrals or complaints received by boards has been increasing, often significantly.

The Medicare-funded Peer Review Organizations (PROs), which regularly review quality of care cases, still refer few cases to the boards.

Review Of Cases

Case backlogs remain a serious problem for State medical boards. Although some States have been successful in reducing the backlogs, their successes have tended to be limited in duration and scope.

Significant staff shortages continue to impede the boards' disciplinary efforts. Medical license renewal fees, which can serve as a major funding source for addressing these shortages, have been increasing. However, much of the revenue that State governments have obtained from these fees has not been going to the boards.

Many other factors continue to constrain the boards' capacity to review cases expeditiously and effectively. They include:

Limitations on the boards' authority to investigate and prepare cases, conduct hearings, and impose disciplinary actions.

Limitations on authority of Federal or federally funded agencies to share care information with the boards.

Standards of proof calling for "clear and convincing" evidence.

Lack of clear-cut standards concerning competent medical care.

Infrequent information sharing among State boards concerning investigative approaches.

Disposition Of Cases

The annual number of actions that medical boards have been reporting to the Federation of State Medical Boards has been increasing. However, when certain considerations involving the data and the practice of medicine are taken into account, the increase is of modest significance.

There are widespread variations in the rate of actions taken by State boards. They reflect some statistically significant correlations by region and size, but not by fee.

The majority of disciplinary actions that State boards have been taking against physicians are based on consent agreements.

A number of States are beginning to devote more investigative attention to quality of care cases. Yet, as in the mid-1980s, the great majority of disciplinary actions taken by the State boards concern the improper use of drugs or alcohol—be it inappropriate prescribing, unlawful distribution, or self-abuse.

Disciplinary actions of medical boards in other States, information from other State agencies, and information-gathering initiatives of the boards themselves appear to be the three most prominent sources for the disciplinary actions taken by the boards. Those actions emerging from medical malpractice suits and from referrals from physicians, medical societies, PROs, and Medicare carriers account for a relatively small share of the total.

The majority of the disciplinary actions taken by medical boards involve violations that occurred in a physician's office. At the other extreme, few such actions concern violations that took place in nursing homes.

In cases where there is some basis for concern, but not enough to warrant disciplinary action, many boards take private, nondisciplinary action that is not reported to the Federation. Some boards are making increased use of such actions. Others are relying less on them or discontinuing them altogether.

Overall Board Performance

Notwithstanding the many constraints they still face, medical boards have made significant progress in improving their disciplinary capacity. Thus far, however, they have not developed a data base that provides useful indicators of their actual performance.

RECOMMENDATIONS

State Governments

- State governments should assure that all licensure fees collected from physicians and other professional groups under the purview of medical boards are used to support board operations.

United States Department Of Health And Human Services (HHS)

- The Public Health Service (PHS) should collect, analyze, and disseminate State-by-State data on staffing, revenue, expenditure and caseload levels of the State medical boards.
- The PHS should convene a national meeting to focus attention on the importance of the boards' oversight role and to examine how the boards' resource and other limitations should be addressed.
- The PHS, in collaboration with the Health Care Financing Administration (HCFA), should determine ways in which HHS could encourage and assist the State boards to contract with PROs to conduct reviews of quality of care cases.
- The PHS should provide financial support for the development of performance indicators suitable for widespread use by State medical boards.
- The PHS should provide financial support for technical assistance efforts intended to improve the boards' investigative efforts.
- The PHS, through its Agency for Health Care Policy and Research, should provide demonstration funding concerning the use of practice standards and guidelines to guide investigative efforts in quality of care cases.

- The HCFA should propose legislation mandating that the PROs share case information with the medical boards when the first sanction notice is sent to a physician.
- The HCFA should amend Medicaid regulations, or, if necessary, propose legislation to allow State Medicaid agencies to share with the medical boards case information on physicians against whom they have taken adverse action.
- The HCFA should assure that Medicare carriers adhere to their responsibility to refer cases of apparent unethical practice or unprofessional conduct to State medical boards.
- The Administration on Aging (AoA) and HCFA should assure that the Long Term Care Ombudsman Program and the State survey and certification agencies, respectively, provide assistance to State medical boards in identifying instances of improper medical care provided to nursing home residents.

Federation Of State Medical Boards (FSMB)

- The FSMB should facilitate assessments of the performance of State medical boards.
- The FSMB should help State boards improve their effectiveness in reviewing quality of care cases.

National Governors' Association (NGA), Council Of State Governments (CSG), And National Conference Of State Legislatures (NCSL)

- The NGA, the CSG, and the NCSL should take actions that foster greater State government awareness of the crucial roles of State medical boards and of the specific measures that can be taken to improve their capability and performance.

COMMENTS

Within the Department, we received comments on the draft report from the PHS, HCFA, AoA, and the Assistant Secretary for Planning and Evaluation (ASPE). The PHS and AoA agreed with the recommendations directed to them. However, HCFA and ASPE disagreed with a number of the recommendations.

Among the national organizations commenting on the report, the FSMB, the American Association of Retired Persons (AARP), and the Public Citizen Health Research Group expressed support for the report and the recommendations. The AMA supported two of the recommendations but disagreed with or opposed most of the remaining ones.

Our recommendation calling for PROs to be mandated to share case information with State medical boards when the first sanction notice is sent to a physician generated a particularly

strong response. The FSMB and AARP endorsed it, believing it would provide valuable information to the boards. The HCFA, AMA, and ASPE opposed it, citing concerns about its necessity and appropriateness. We have considered all these responses and continue to believe that the recommendation should be carried out.

We provide further information on the comments and on our response to them at the end of the report and in appendix A.

INTRODUCTION

In recent years, as in the mid-1970s, the nation has been experiencing a crisis in medical malpractice insurance. In both periods the crisis has been triggered by significant increases in the number of medical malpractice claims and awards, in the dollar awards made by juries, and in the associated insurance costs for physicians. The result at both times has been to inhibit the access to medical care, to contribute to the practice of “defensive medicine,” and to add strain to the doctor-patient relationship.¹

The search for solutions to these crises have focused for the most part on the legal system. In the 1970s and 1980s, nearly all States passed tort reforms that among other things established caps for pain and suffering awards, imposed limits on attorneys’ fees, and reduced the applicable statutes of limitations. Yet various inquiries into the phenomenon have made it clear that to a considerable degree the crises are also rooted in problems associated with poor medical care, and that over the long term one of the most effective ways to address these problems would be to assure that effective quality assurance mechanisms are in place.²

Notwithstanding the efforts of the Medicare-funded Peer Review Organizations (PROs), liability insurers, professional associations, and others, there are three basic quality assurance mechanisms now in place. Each functions independently of the payment source for the care being provided. Each addresses specific instances of possibly improper medical practice. Each tends to be regarded as having a deterrent effect on such practice. They are the medical malpractice litigation system itself, the review mechanisms carried out by hospital quality review committees, and the oversight conducted by State medical licensure and discipline boards.

In this report, we focus on the State medical boards (hereafter referred to as the boards). For more than a century, dating back to the first modern medical practice act in Texas in 1873, State governments have charged these boards with the responsibility of licensing and when necessary disciplining physicians. For the past 25 years, the Federal Government has relied upon these boards to determine whether a physician is legally authorized to participate in the Medicare and Medicaid programs and to discipline physicians for any transgressions that do not directly relate to these programs. The boards have provided these services at no cost to the Federal Government, or for that matter to State governments, as their revenues derive from fees imposed on the licensees.

The report is a follow-up to one we issued in 1986.³ That report, which focused on the licensure and disciplinary responsibilities of the boards, identified a number of vulnerabilities in both of these spheres. It was widely disseminated and received considerable attention in the print and visual media, in governmental circles, and in the medical community.⁴

In this report, in contrast to the earlier one, we focus strictly on the disciplinary responsibilities of the boards. We do that because these responsibilities are more directly associated with the malpractice concerns mentioned at the outset, because many of the prior

concerns about the boards' licensure operations have abated,⁵ and because a narrower focus allows for a more in-depth look at the disciplinary sphere than we could undertake in 1986.

Thus, the purpose of our inquiry is to assess the disciplinary practices of State medical boards.⁶ Toward that end, we conceptualize the disciplinary sphere as including three major components: (1) the identification of cases, (2) the review of cases, and (3) the disposition of cases. For each of these components, we examine the extent and type of changes occurring, particularly since 1986, and any major impediments to board performance.

In addition, we explore the nature, extent, and implications of the boards' involvement with quality assurance activities. Our background investigations indicated that such activities, which encompass various educational and preventive activities, may be of increasing significance. Our findings and recommendations concerning the quality assurance activities will be presented in a brief follow-up report.

Our methodology for the study is based on five major lines of inquiry: (1) a review of pertinent literature and documents, (2) a review of data from the disciplinary action data bank of the Federation of State Medical Boards (FSMB), (3) a mail survey of a random sample of eight States for information on all disciplinary actions taken in those States in 1988, (4) case studies of board disciplinary operations in the four States having the largest number of practicing physicians (California, New York, Pennsylvania, and Texas), and (5) telephone discussions with board officials in other States and in three Canadian provinces involved with quality assurance activities. (For further elaboration on our methodological approaches, see appendix A.)

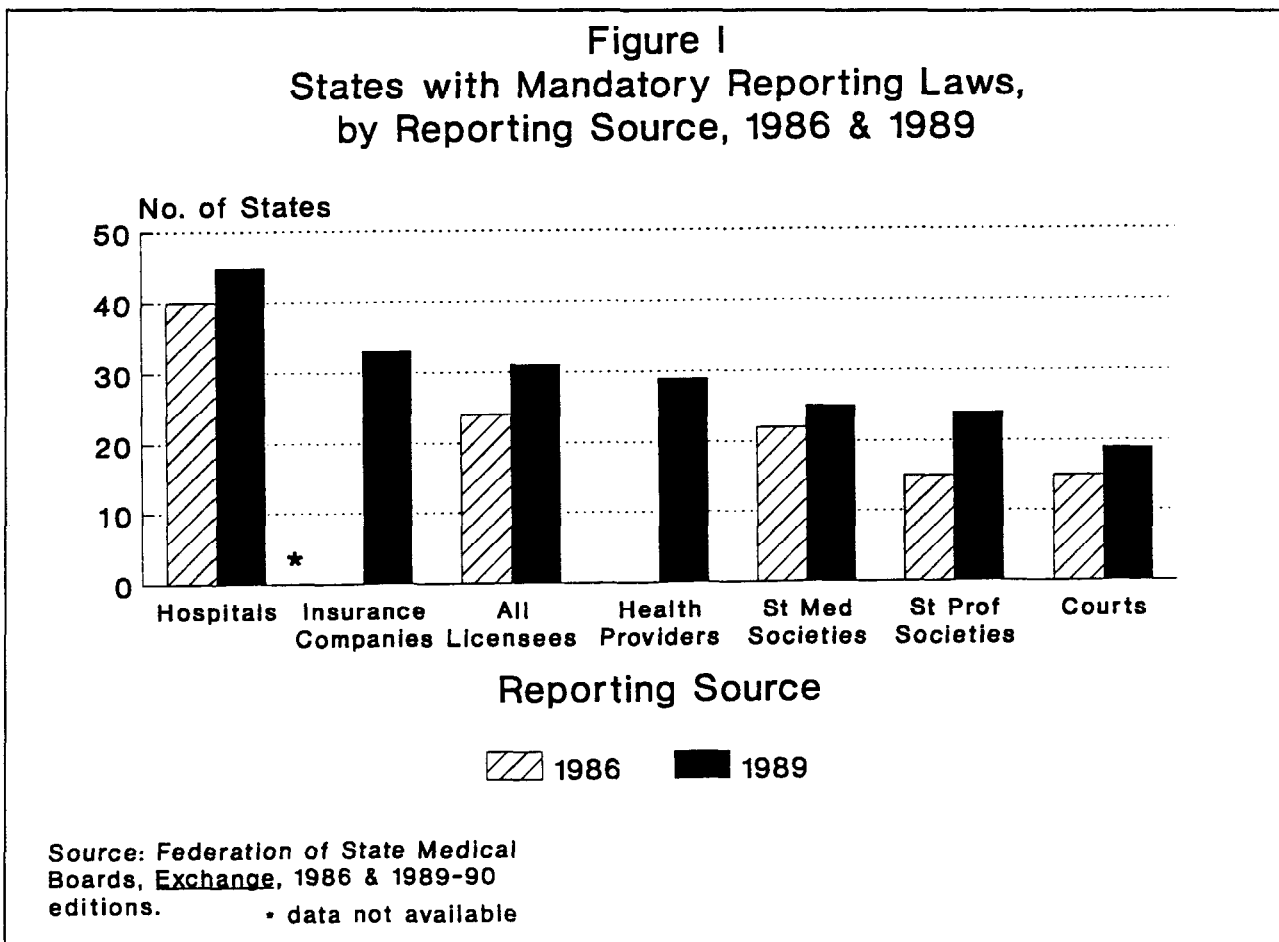
FINDINGS

IDENTIFICATION OF CASES

Through mandatory reporting laws, immunity protections, and self-reporting laws, State governments and their medical boards have facilitated the identification of physicians who may warrant disciplinary action.

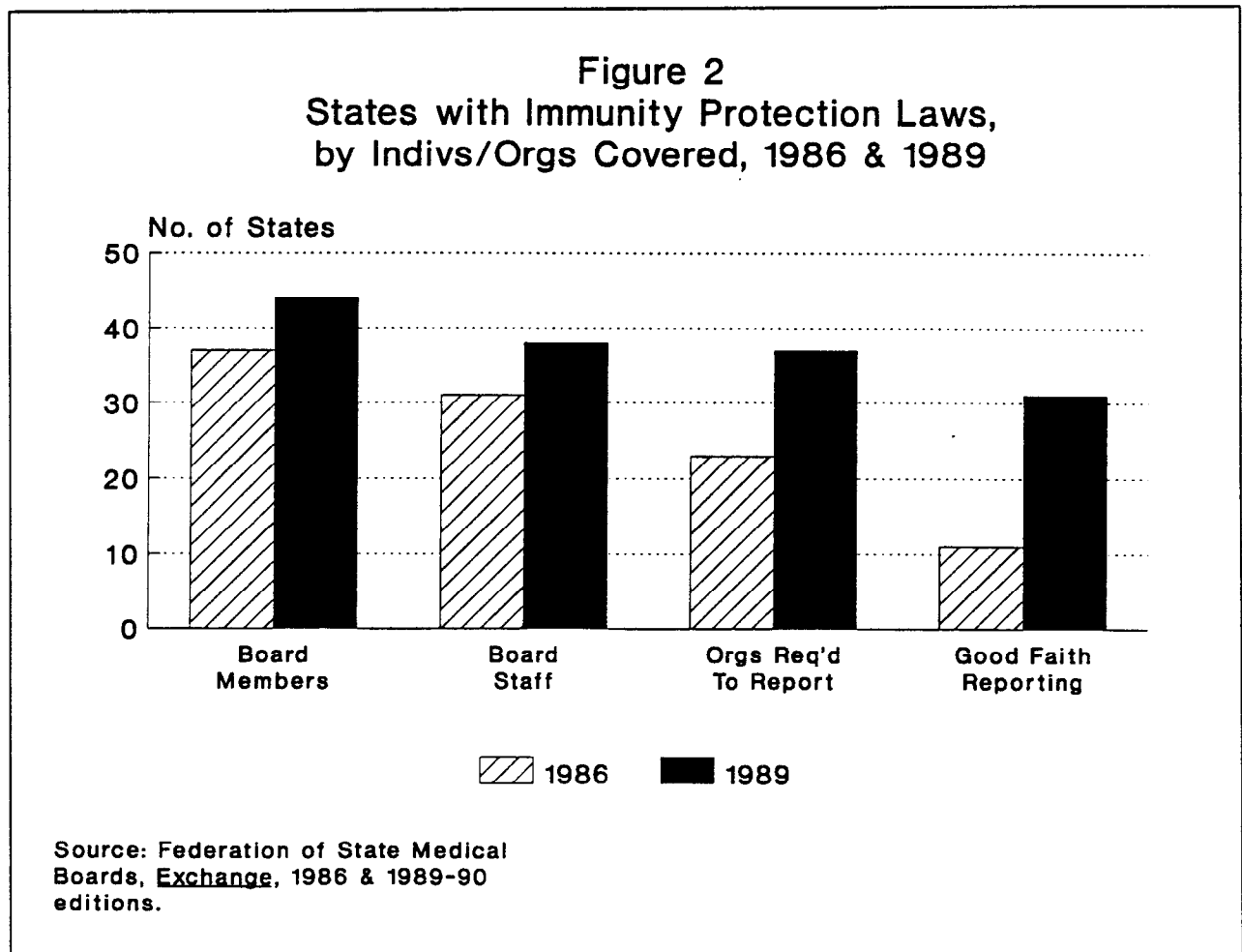
State medical boards rely primarily on referrals or complaints to identify cases for investigation. Thus, if those in good position to identify possible violations of State medical practice acts fail to do so, the capacity of the boards to provide adequate protection to the public can be severely compromised.

It was because of this concern that Congress, in 1986, passed Title IV of the Health Care Quality Improvement Act. That legislation extended legal protection to those providing case-specific information to State medical boards and mandated that hospitals, other health care entities, boards, and professional associations send information on adverse actions they have taken against physicians to a national practitioner data bank. The bank is expected to begin operation in 1990.

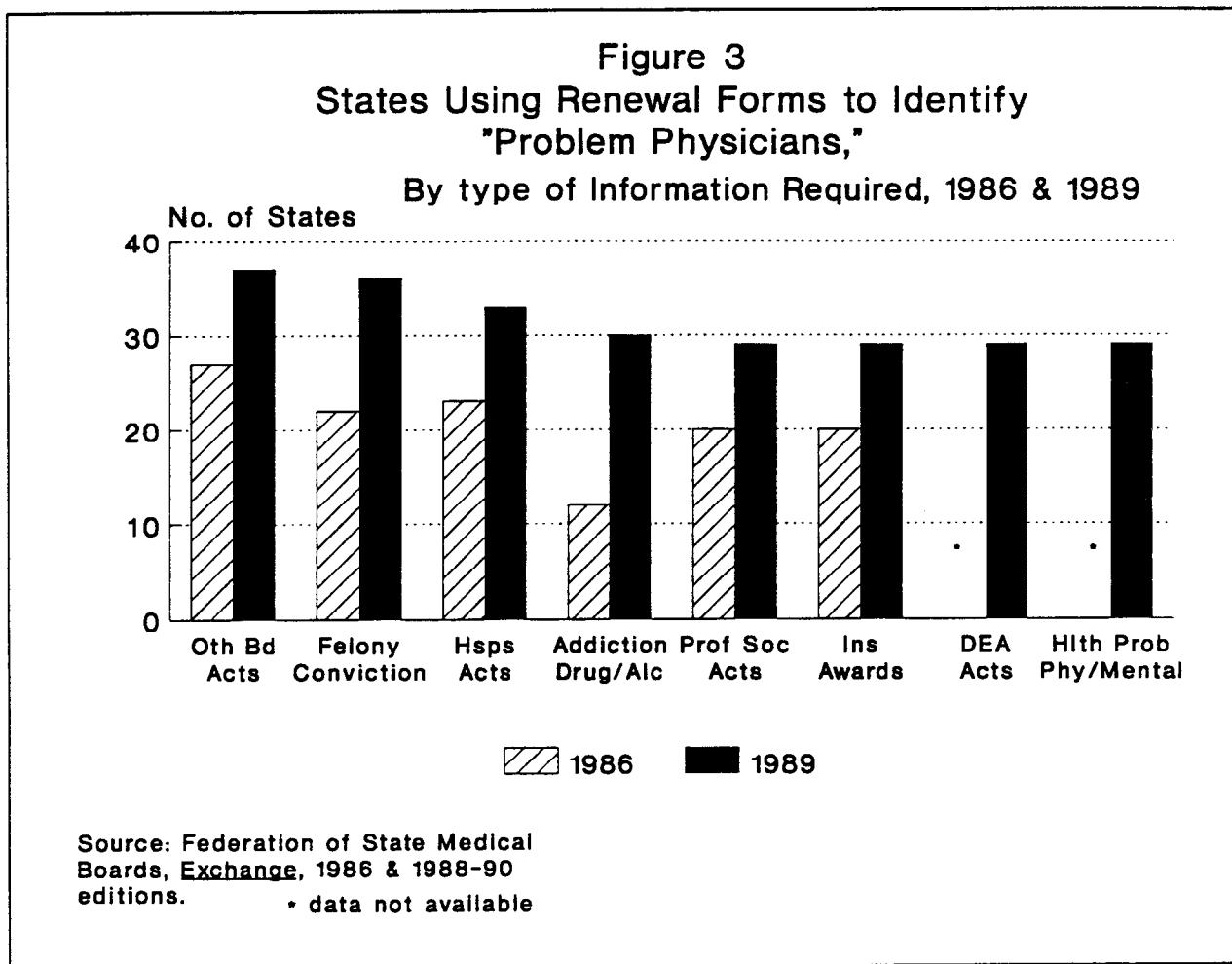


Although many States had immunity protections and mandatory reporting laws prior to the passage of the Title IV legislation, many more have enacted or strengthened such laws since then. In regard to mandatory reporting laws, the increased numbers are apparent in all categories (figure 1). Hospital reporting laws now apply in nearly all the States, with the requirements typically covering revocations, surrenders, suspensions, and restrictions of hospital privileges. Also notable is that by 1989, 33 States passed a law requiring liability insurance carriers to report medical malpractice cases to the board. In 22 of these States, the reporting requirements covered all claims, in 23 all payments, and in 8 payments over a certain amount, ranging from \$5,000 to \$100,000.

In regard to immunity protection, a substantial majority of States have applied it to board members; somewhat smaller majorities have applied it to board staff, to those mandated to report violations to the board, and to those not mandated to report but who nevertheless report in good faith (figure 2).



Finally, in the late 1980s, a majority of the boards have come to view the licensure renewal process as a means of obtaining “markers” to identify “problem physicians.”⁷ Specifically, they have required that all physicians seeking to renew their medical licenses provide information on various actions or conditions that would be of concern to the boards. These include disciplinary actions imposed by other entities as well as relevant physical impairments (figure 3).



In recent years, the annual number of referrals or complaints received by boards has been increasing, often significantly.

There is no national data base on the number of complaints or referrals being received by boards. However, the signs of an increasing annual number of such complaints or referrals are widespread. They are apparent in the annual reports issued by the boards, in discussions with board officials, and in the information obtained from our case study States. In New York, for instance, the number of referrals and complaints increased from 1,699 in 1985 to 4,076 in 1988, and to an estimated 5,000 in 1989.

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In general, the mandatory reporting laws and the immunity protections appear to have had the intended stimulative effect. At the same time, it is clear that there is much variation among the States. For example, while hospital reporting laws seem to be working relatively smoothly in some States, they appear to have little effect in others.

Consumer complaints, typically the major source of case identification for the boards, still tend to predominate. Yet, in most States they seem to be accounting for a decreasing proportion of complaints and referrals. The increasing shares tend to be accounted for by referrals from malpractice sources, law enforcement agencies, and hospitals.

The Medicare-funded Peer Review Organizations (PROs), which regularly review quality of care cases, still refer few cases to the boards.

In our 1986 report, we noted that the PROs tended to be an “especially unproductive source of information” for the boards.⁸ Since that time there have been some developments that bear on this relationship. Under the third scope of work that became effective for all PROs in April 1989, the Health Care Financing Administration (HCFA) called for the PROs to develop closer interactions with boards and, in fact, to “consider” sharing confidential case information with them when serious quality of care problems are found. In response, some PROs have developed or begun to negotiate the development of memoranda of agreement with the boards. Furthermore, to identify ways of achieving closer operational relationships, the American Association of Retired Persons (AARP), in December 1989, held a workshop involving representatives of PROs and medical boards from 10 States.⁹

In general, the relationship between the two entities appears to be reasonably cooperative. In a May 1989 survey conducted by the Missouri PRO, about 55 percent of the 38 PROs responding reported that the relationship was good or excellent. Yet, about two-thirds of the PROs responding to the survey indicated that they had not reported any physicians to the boards during the past 12 months.¹⁰ The experiences of our case study and sample survey States reveal a similarly low level of referral activity.¹¹ Thus, despite efforts to address the matter, the PROs still are relatively unproductive sources of information for the boards.

REVIEW OF CASES

Case backlogs remain a serious problem for State medical boards. Although some States have been successful in reducing the backlogs, their successes have tended to be limited in duration and scope.

As in the mid-1980s, many boards still report that they face significant case backlogs.¹² Through various prioritizing and expediting techniques, they attempt to reduce these backlogs, but the rising number of referrals and complaints often frustrates their attempts.

The backlogs tend to be most apparent at the point of cases awaiting investigation. However, they also exist at various other junctures of the review process, such as those involving case reviews by prosecuting attorneys, hearing officers, or board officials themselves. In the 1985 to 1987 period, each of our four case study States faced major backlogs in cases awaiting investigation and to varying degrees, each has made progress in addressing them. Yet, at the beginning of the 1990s, in these as in other States, the gains are not necessarily enduring ones. For instance, in California, the State with the most licensed physicians, the number of cases not yet assigned to an investigator rose substantially during the last 6 months of 1989, after dropping even more substantially between mid-1988 and mid-1989.¹³

Moreover, progress that is made in decreasing the number of cases awaiting investigation is not necessarily matched at the subsequent junctures of the review process. Thus, the expeditious opening of a case does not preclude a long, laborious review process for that case. In fact, cases going through a full evidentiary hearing often take 2 years or more to settle.¹⁴ They then are subject to appeals that can take another 2 years or more, with the physician often continuing to practice through the appeal process.

Significant staff shortages continue to impede the boards' disciplinary efforts. Medical license renewal fees, which can serve as a major funding source for addressing these shortages, have been increasing. However, much of the revenue that State governments have obtained from these fees has not been going to the boards.

Concerned about large case backlogs, some State governments have allowed boards to hire additional investigative staff.¹⁵ Overall, however, the level and scope of the increases are modest. For 31 State boards for which comparative data are available, 17 had no increase at all between 1986 and 1989 in full-time investigative staff.¹⁶ During this period the average number of such staff for the 31 States rose from 4.2 to 4.8, the median from 1 to 2.

With current staffing levels, boards often find each of their investigators handling caseloads of 50-60 or more. They find themselves hard pressed to conduct thorough investigations of hospital referrals, which tend to involve multiple incidents and patients, or even more so, of quality of care complaints from an entity which has not already conducted some investigation of its own. And they find it very difficult to monitor compliance with various probation orders or licensure restrictions which they have imposed on physicians. In this milieu, as the number of referrals and complaints continue to climb, the pressure intensifies to find the quickest possible way to handle each case.

States can improve this situation without cost to taxpayers by increasing medical license renewal fees. Between 1986 and 1989, 38 States (75 percent of the States) did so at least once. During that period the median annual renewal fee increased from \$50 to \$75.¹⁷

Yet, as has long been indicated by many board officials, State governments do not necessarily use all the revenue derived from these fees to help the boards carry out their responsibilities. In Texas, for instance, the State legislature in Fiscal Years 1988 and 1989 imposed a temporary \$110 increase in renewal fees for physicians and other professional groups to help

the State government to balance its budget. The temporary fee raised \$110 million across all the professional groups.

More recently, in Connecticut, the State government increased the annual medical license renewal fee from \$150 to \$450, the highest in the country. The increase went into effect in July 1989 and is expected to increase yearly revenues from about \$4 million to about \$11.5 million. As of April 1990, the State government had not provided any additional revenue in support of board operations. In fact, plans were being proposed for possible reductions in staff.

Many other factors continue to constrain the boards' capacity to review cases expeditiously and effectively. The more significant of them are identified and discussed below.

- Limitations on the boards' authority to investigate and prepare cases, conduct hearings, and impose disciplinary actions

In recent years, nearly all State legislatures have amended their medical practice acts to strengthen the authority of their boards. Some of the changes, as in Massachusetts, Florida, and Maryland, have been major ones, substantially enhancing the oversight authority of the boards. The great majority, however, have been relatively minor ones, typically involving some incremental elaboration of the grounds upon which physicians can be disciplined (for example, a specification of abusive billing practices as a basis for disciplinary action).

In actuality, most boards still function under some major restrictions to their operational authority. Probably the most consequential of these are those that limit a board's involvement to only certain parts of the review process. In California, for instance, the board conducts the investigation, but the Attorney General's office is responsible for the preparation of a formal accusation. If the board does not enter into a stipulated agreement with the physician but proceeds with a formal hearing, the case is then assigned to the Office of Administrative Hearings. The Attorney General's office then prosecutes the case before the administrative judge. Clearly, under such a fragmented system, the board alone cannot be held accountable for the review process. Referring to the responsibilities of the other participating offices, the executive director of the board has stressed, "These people don't work for us. We're subject to their calendars and their processes and the delays that go along with that."¹⁸

In New York, the review process has been more fragmented, with a multi-tiered process involving the Department of Health and the Board of Regents in the Department of Education. At a recent hearing of the New York State General Assembly, a representative of the State Department of Health commented as follows about the process:

"It's not structured to yield the best results. It takes too long. It addresses too few physicians. It imposes unnecessary costs both on the physicians and on the state, and it's totally incomprehensible to the public. The result is inadequate protection of the public health."¹⁹

Other widespread restrictions on board authority relate more directly to the investigative process. They concern statutory provisions that preclude or inhibit boards from reviewing records of patients not directly involved in an incident being investigated; rigorous and time consuming procedures that discourage boards from imposing emergency suspensions, even though patients may be in danger; and considerable limitations concerning the conduct of undercover work.

Still other restrictions involve the grounds on which disciplinary actions can be taken, notwithstanding the incremental additions that State legislatures have granted in this area. Of particular note in this regard are the limitations governing the capacity of boards to take disciplinary actions on the basis of such actions taken by a medical board in another State. In 1989, only nine States could impose a disciplinary action on such a basis without conducting a new hearing. More typically, the allowable grounds are only for specified types of disciplinary action taken by another State and a new hearing must be held.²⁰

- Limitations on authority of Federal or federally funded agencies to share case information with the boards

On the relatively infrequent occasions when Federal or federally-funded entities such as PROs, Medicaid State agencies, and the HHS Office of Inspector General send referrals to State boards, they typically do not provide detailed information from the case files. This omission, which is based on guiding statutes and regulations, leaves the boards in the position of having to conduct their own investigations to obtain information already in the possession of the referring source.

The problem is particularly serious with respect to the PROs, because they could provide a large number of high quality cases for board review. Yet PRO officials point to insufficient statutory and regulatory specificity to support such a sharing of case information. They also point out that State redisclosure laws may result in disclosure of information which PROs must keep confidential. "None of us," said one PRO executive director, "wants to become a landmark case."

- Standards of proof calling for "clear and convincing" evidence

In accord with guiding statutes and/or existing case law, most boards must base any disciplinary actions they take on a "clear and convincing" standard of proof.²¹ This is more rigorous than the "preponderance of evidence" standard that is typically required to justify tort damages for negligence in civil cases. The more rigorous standard provides greater protection for physicians, but adds complexity to the investigative process and appears to make it less likely that a board will persevere on a case through a full evidentiary hearing.

Some State legislatures have amended their statutes to introduce "preponderance of evidence" as a standard. At least one, Wisconsin, has allowed a court finding of physician negligence in a medical malpractice case to serve as conclusive evidence before the medical board. But at

this time, there does not appear to be any significant movement across the States to ease the standard of proof that boards must use.

- Lack of clear-cut standards concerning competent medical care

The “clear and convincing” rule becomes especially burdensome in quality of care cases, because with rare exceptions there are not clear-cut, widely endorsed standards for the boards to rely upon in such cases. One executive director of a board, himself a physician, commented as follows on the matter:

“One of the most difficult problems facing boards and society today is to determine how to define an adequate standard of care. You could get five physicians together to look at some aspect of medical care and they would tell you if it was acceptable medical care, but they still couldn’t give you standards they used to make that decision.”

In such a situation, unless an act is especially egregious, boards tend to look for another basis to take action. If they pursue the quality of care angle, they face what could well be a long, nettlesome process that leads to a hearing where opposing medical experts give conflicting opinions on the appropriateness of the care provided.

- Infrequent information sharing among State boards concerning investigative approaches

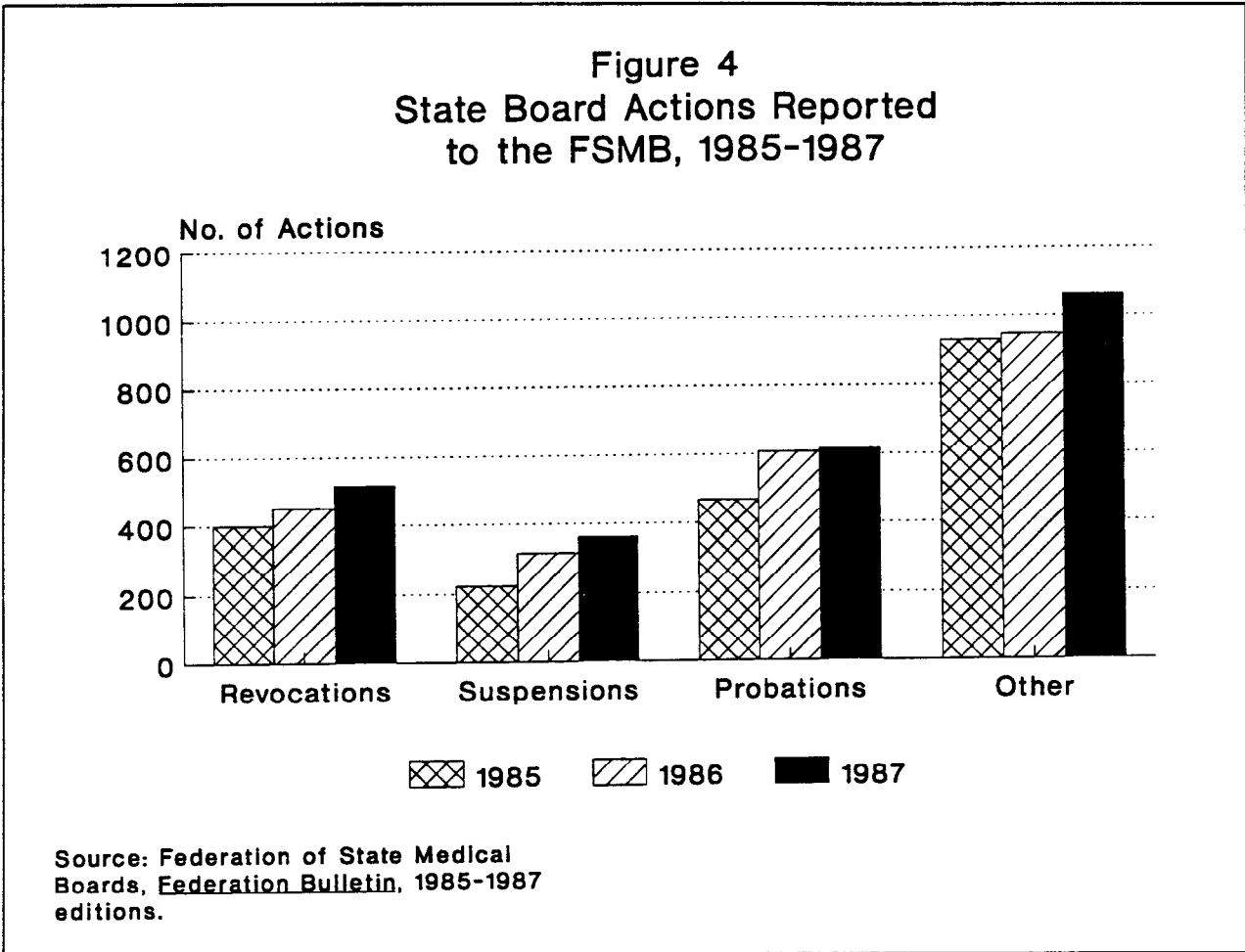
As caseloads have increased and become more complex, it has become increasingly important that boards handle their case investigations in a sound, cost-effective manner. How they prioritize their cases, how they deploy their scarce investigative resources, how they identify potentially productive leads and other such matters have become increasingly significant considerations.

Yet, even though 51 boards are regularly coping with such considerations, there tends to be little interaction among them, particularly at the investigative level. Investigators from different States rarely are able to take advantage of valuable lessons learned by one another. This void is especially striking with respect to the quality of care cases, which confront boards with many new and difficult choices—among which are those concerning the ways to build greater clinical expertise into their investigative process.

DISPOSITION OF CASES

The annual number of actions that medical boards have been reporting to the Federation of State Medical Boards (FSMB) has been increasing. However, when certain considerations involving the data and the practice of medicine are taken into account, the increase is of modest significance.

As in the early to mid-1980s, the annual number of actions which State medical boards report to the FSMB disciplinary action data bank have continued to increase. From 1985 to 1987 (the latest date for which validated data are available),²² the yearly total of reported actions increased by 29 percent, from 2,019 to 2,597. During that period, the more serious actions—revocations, suspensions, and probations—increased at an even higher rate, 37 percent, from 1,089 to 1,495. (Figure 4 below provides annual totals for each of the four categories used by the FSMB.)



These data, which derive from all the State boards, reflect an increasingly activist posture on their part. Yet, upon analysis, the activism is less imposing than initial impressions would suggest.

First of all, it is important to recognize what the data actually represent. They include initial adverse actions, such as revocations, suspensions, probations, and other lesser sanctions. They include modifications to these actions that in some way affect the terms of discipline. And they include various favorable actions involving a physician who has previously been disciplined. For instance, in 1988, in reviewing the monthly disciplinary action reports which

the FSMB sends to State medical boards and various other entities, we counted at least 225 actions under the category "license restored or reinstated."

Further, as is implied in the above discussion, the data include multiple actions involving the same physician. Thus, if a board put an individual physician on probation, subsequently modified the probation, and at a still later point terminated it, that physician would account for three board actions reported to the FSMB. Similarly, if a physician were disciplined in one State and, on the basis of that action, also disciplined in two other States in which he or she is licensed, that physician would account for three actions, one action reported by each of the three States. In our tabulations of the 1988 data, we found that about one-third of all the license revocations reported to the FSMB during that year were based on actions taken in other States.

The key question thus becomes: Across the United States, how many physicians are State medical boards disciplining each year? The FSMB at present does not provide that information. It is clear, however, that the number of physicians disciplined by the boards each year is much less than the number of total actions reported by the FSMB. In our review of the 1988 data, about 25 percent of all actions clearly were not initial disciplinary actions against a physician.

A second important consideration that can help put the FSMB data in perspective revolves around the question of how many physicians *should* be disciplined each year. How many are acting or practicing in a manner that would warrant disciplinary action?

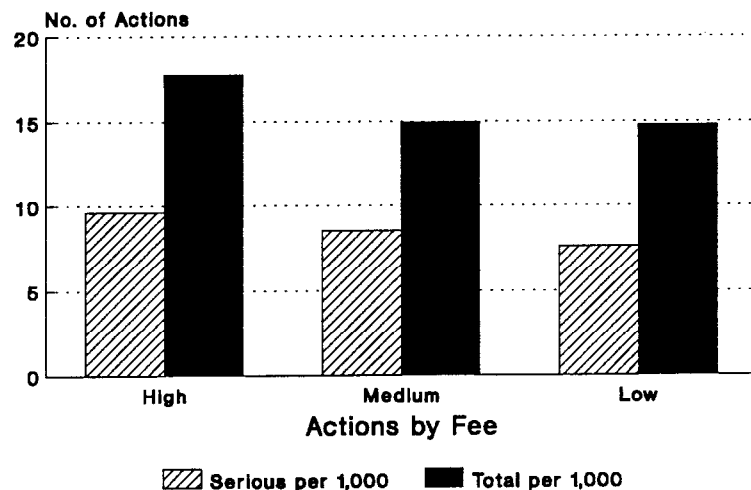
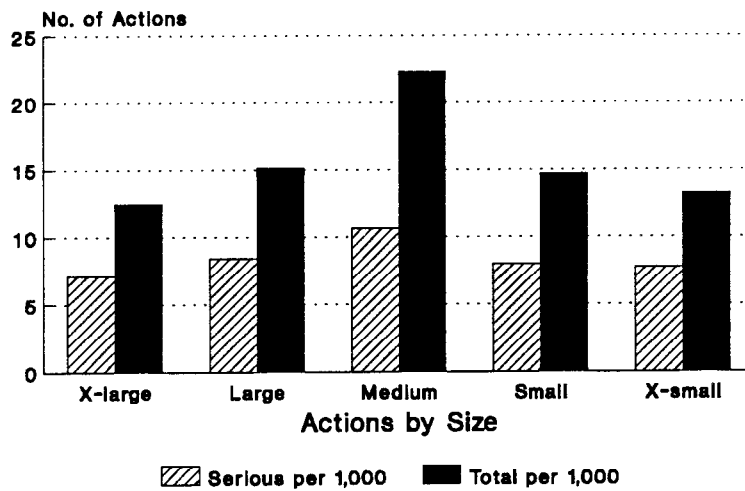
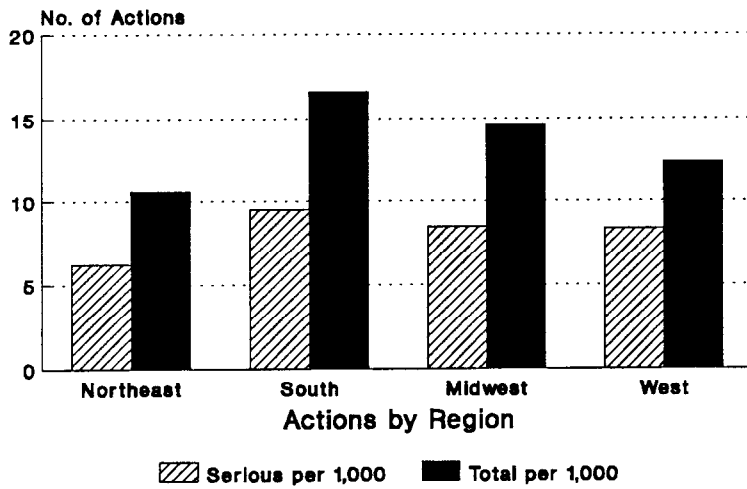
There is, of course, no definitive basis for answering such a question. But some recent studies suggest quite strongly that, even when all appropriate caveats are taken into account, the universe of potentially actionable events far exceeds the number of disciplinary actions actually imposed by the boards. One recent study, based on a national survey of 40 physician-owned insurance companies, found that the overall rate at which these companies disciplined physicians for "substandard performance" was much higher than that of State medical boards.²³ Another, based on a review of patient records of 30,195 randomly selected patients in 51 New York State hospitals, found that the rate of negligent care provided to these patients was far greater than the rate of physicians being disciplined by the New York State board.²⁴

There are widespread variations in the rate of actions taken by State boards. They reflect some statistically significant correlations by region and size, but not by fee.

During the 1985 to 1987 period, the rate of all board actions taken per 1,000 licensees ranged from 2.6 in one State to 32.2 in another. The median rate for the 3-year period was 14.3.²⁵

When the State actions are compared by region, size of State (in terms of number of practicing physicians), and annual renewal fee, substantial variations are, once again, quite apparent (figure 5). Although overall variations generally are not at a statistically significant level, two particular comparisons are at such a level. One reveals that boards in southern States were significantly more likely than those in northern States to have taken some kind of serious

Figure 5
Serious Disciplinary Actions (Revocations, Suspensions, and Probations)
and Total Actions Per 1,00 Licensees, by Region, Size of State, & Annual Renewal fee
1985-1987



Source: Federation of State Medical Board's Exchange, 1985-1987 editions; American Medical Association's *U.S. Medical Licensure Statistics & Licensure Requirements*, 1984/1985-1986/1987 editions; and *United States Census* data.

action against physicians in the 1985 to 1987 period. Another indicates that boards in medium-sized States were significantly more likely to take action, of any kind, than boards in other States.²⁶

There are, of course, many possible factors that might account for the wide variations in rates of actions taken by State boards. To varying degrees they might be attributable to certain inaccuracies or discrepancies in the reporting or even to differing levels of physician incompetence, negligence, or impairment across the States. Yet, as the editor of the *New England Journal of Medicine* noted some time ago when considering such variations: "...the primary explanation must lie in the relative vigor and effectiveness of the regulatory apparatus of each State."²⁷

The majority of disciplinary actions that State boards have been taking against physicians are based on consent agreements.

The evidence on this point is compelling. In our survey encompassing disciplinary actions taken in 1988 in eight randomly selected States, 57 percent of the actions were based on consent (or as they are often called "stipulated") agreements. Similarly, in each of our four case study States, a clear majority of actions have been resolved in this manner in recent years.

Trend data concerning this issue are not usually available in the States, but there are strong signs that the proportion of cases being resolved through consent agreements has been rising sharply. Whereas only 21 States had the authority to settle cases in this manner in 1986, 41 did by 1989. And board officials and reports suggest that the boards have been quite active in taking advantage of this authority. In Connecticut, for instance, the proportion of cases decided through consent agreements rose from 69 percent in 1986 to 72 percent in 1987 to 89 percent in 1988. In Texas, the rise during the same period was from 76 percent to 77 percent to 89 percent. In 1989, the increase continued, reaching 95 percent.

Given the increasing numbers of referrals and complaints, the staff shortages, and the cumbersome review processes, it is understandable why boards find a consent agreement so attractive compared with the alternative of a full evidentiary hearing. As one board official noted, "It allows appropriate action to be taken without taking up a lot of board time." Yet, as the proportion of cases so settled exceeds 50 percent and, indeed, nears 100 percent in some places, one wonders if the "appropriate" board action is always being taken—if the pressure to settle might not be leading some boards in some cases to act more leniently than the violation would warrant.

One also wonders about the extent to which such settlements, when they represent the initial disciplinary action against a physician, will impede or complicate actions against that same physician by other States in which he or she is licensed. Without a prior action involving a full evidentiary hearing, another jurisdiction may face the prospect of conducting additional investigative work of its own.

A number of States are beginning to devote more investigative attention to quality of care cases. Yet, as in the mid-1980s, the great majority of disciplinary actions taken by the State boards concern the improper use of drugs or alcohol—be it inappropriate prescribing, unlawful distribution, or self-abuse.

In response to increasing public concerns about the quality of medical care, a number of boards are increasingly inclined to conduct case reviews that bear in some way on the adequacy of the medical care provided. The Texas board is a notable example. In 1986, with the board having a substantial backlog of quality of care cases, the State legislature authorized additional funding to address these cases. With the additional money, they added part-time medical consultants and hired an attorney and four clinical investigators trained as nurses or physician assistants.

As noted previously, quality of care cases tend to be among the more complex ones for boards to investigate and thus can take a substantial amount of time before they result in some kind of disciplinary action. Thus, in the coming years such actions may begin to account for a significant proportion of all disciplinary actions, as those now in the pipeline reach the point of disposition. Through 1988, however, they still account for a small share of all actions.

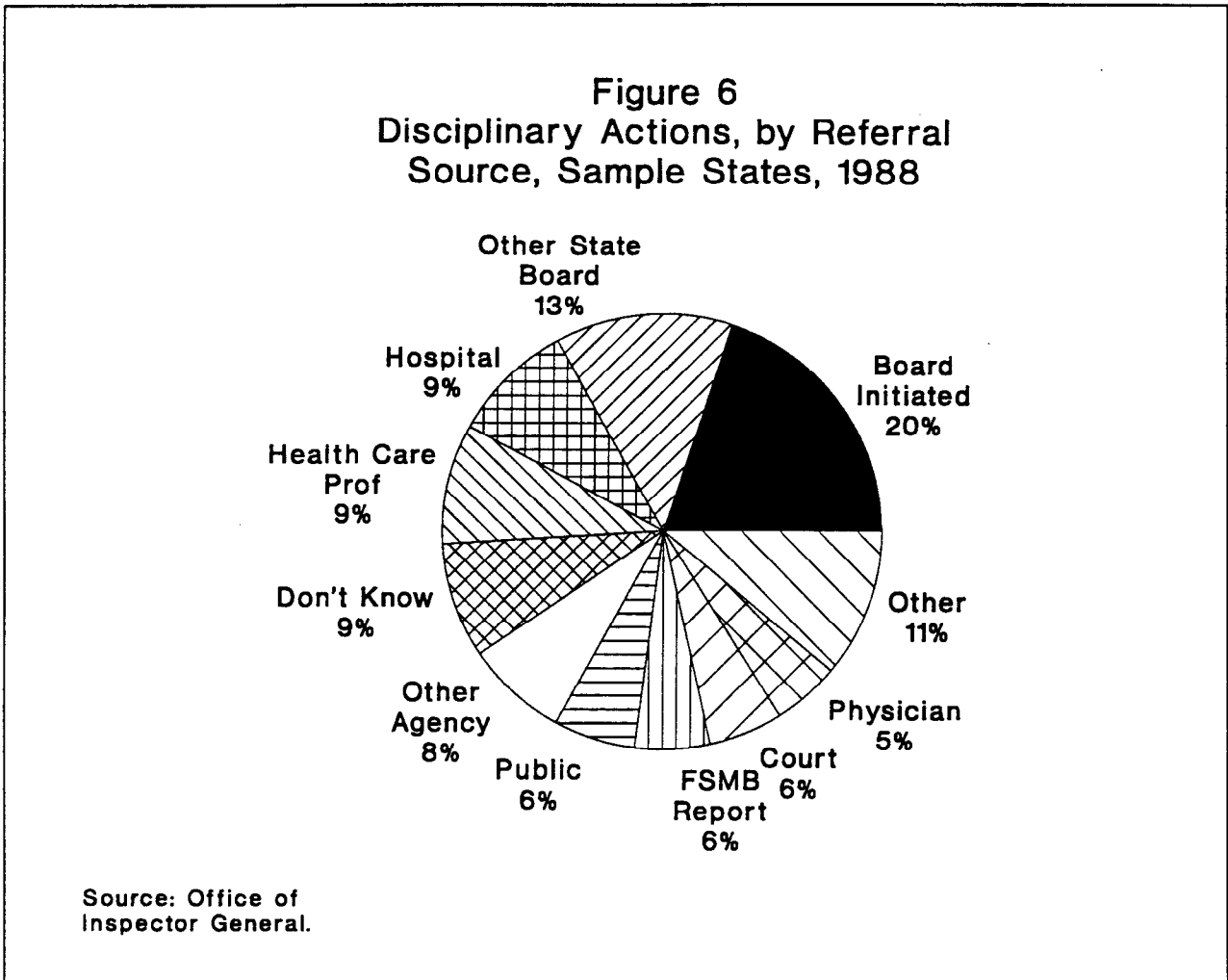
In our sample of eight States, actions taken on the basis of “incompetence” accounted for 11.5 percent of the cases in 1988. In our review of the monthly FSMB reports sent to the States in 1988, cases coded in the category titled “incompetency, malpractice, negligence” accounted for about 5 percent. In both cases, the proportions surely underrepresent the extent to which actions respond to quality of care problems, because when it is possible for a board to take action on the basis of another more provable grounds it will often do so. How much these cases are underrepresented remains unclear.

It is clear, however, that a majority of actions are based one way or another on cases involving the improper use of drugs or alcohol. In our sample, 57 percent of the actions involved “misprescribing,” “impairment,” or “narcotics violations.” In our review of the FSMB’s 1988 reports, 66 percent were in the “alcoholism” or “narcotics violations” categories. The latter was by far the larger component and involves such violations as the over prescribing of pain-killers, the failure to keep proper records on drugs prescribed or dispensed, and the personal abuse of drugs.

Disciplinary actions of medical boards in other States, information from other State agencies, and information-gathering initiatives of the boards themselves appear to be the three most prominent sources for the disciplinary actions taken by the boards. Those actions emerging from medical malpractice suits and from referrals from physicians, medical societies, PROs, and Medicare carriers account for a relatively small share of the total.

Because of definitional discrepancies and incomplete information, it is not possible to provide a definitive or precise delineation of how board disciplinary actions are first identified. Yet, on the basis of our sample survey, discussions with State board officials, and review of board annual reports, it appears that the three above-noted sources are the leading ones. In our

sample survey, they account for about 41 percent of the disciplinary actions taken by the eight States (figure 6).²⁸



With greater certainty, we can report relatively few disciplinary actions are taken as a result of information generated from medical malpractice cases and by referrals from physicians, medical societies, PROs, and Medicare carriers.²⁹ Given the degree of public concern about medical malpractice, and given the fact that 33 States have mandatory malpractice reporting laws of one kind or another, the relative insignificance of those cases to the boards may be surprising. Yet, board officials report that such cases seldom prove to be viable for their purposes. This is most especially true of cases which have not involved any payment. But it is also true, albeit to a lesser extent, for malpractice cases which have resulted in settlements or jury awards. Even in such cases, the complexities associated with developing “clear and convincing” evidence and the lack of clear-cut practice standards tend to inhibit board action.

In attempting to compare the sources of disciplinary action with the sources of complaints or referrals, we find the available information to be even more fragmented and sparse. Yet, what is available indicates that referrals from liability insurers and/or courts and from consumers account for a far higher proportion of complaints than of disciplinary actions. On the other hand, referrals from State agencies, out-of-State medical boards, and hospitals seem to account for a much larger proportion of disciplinary actions taken than do other referral sources.³⁰

The majority of the disciplinary actions taken by medical boards involve violations that occurred in a physician's office. At the other extreme, few such actions concern violations that took place in nursing homes.

State boards seldom provide or even assemble information on the setting of a violation that led to a board disciplinary action. In our sample survey, the boards could not identify the setting for 52 percent of the disciplinary actions they took in 1988.

Yet, for the remaining actions, those for which they could identify the setting, the boards indicated that 68 percent clearly involved violations that took place in the physician's office. Such violations, which are typically outside the purview of hospital quality review committees or PROs, involved a wide variety of unlawful actions concerning improper conduct as well as improper medical care.

At the other extreme, the boards in our sample States did not identify a single disciplinary action they took in 1988 that was attributable in any way to care provided in a nursing home. In view of the numerous complaints that the Long Term Care Ombudsman Program, administered by the Administration on Aging, receives about medical care provided in nursing homes, the lack of board action suggests insufficient board oversight of the care provided to the residents of these facilities.³¹ A recent study of nursing home care in California reached a similar finding.³²

In cases where there is some basis for concern, but not enough to warrant disciplinary action, many boards take private, nondisciplinary action that is not reported to the Federation. Some boards are making increased use of such actions. Others are relying less on them or discontinuing them altogether.

Such actions are particularly common in relation to impaired physicians, who are increasingly treated in a rehabilitative rather than punitive manner. In Connecticut, for instance, between 1986 and 1988, 42 of the 88 "disciplinary" actions that the board imposed were confidential, unreported ones involving physicians who agreed to participate in an impaired physicians' program.

In other situations where a physician's actions involve a "borderline" violation or there is insufficient evidence to prepare a case, many boards will respond by issuing a private letter of concern, reprimand, or warning of some kind. They regard such a response as a useful way of alerting a physician to the danger of certain practices and urging appropriate corrective actions.

The California board has relied particularly heavily on this approach. For instance, in 1988, when it reported 78 disciplinary actions to the FSMB, it also enrolled 78 physicians in a treatment program for impaired physicians, sent about 100 warning letters to physicians, and conducted medical education conferences with another 257 physicians. At these conferences, the physicians and board officials discuss the practices that presented cause for concern and the types of corrective actions that might be taken. Any follow-up actions on the physician's part are voluntary, but if he/she is again brought to the board's attention, board officials report they are likely to respond in a less understanding manner.

At the other extreme, some States, such as Texas, have discontinued the use of such private approaches. Typically, the basis for terminating or phasing down such approaches rests in public suspicions of boards being too understanding or lenient toward physicians.

OVERALL BOARD PERFORMANCE

Notwithstanding the many constraints they still face, medical boards have made significant progress in improving their disciplinary capacity. Thus far, however, they have not developed a data base that provides useful indicators of their actual performance.

Even with the numerous limitations noted in this report, State medical boards are much better equipped to carry out their disciplinary responsibilities than they were 25, 10, or even 5 years ago. Twenty-five years ago, as the Medicare and Medicaid programs were beginning, boards focused almost entirely on their licensure responsibilities and on the development and administration of their own licensure exams. Ten years ago, in the aftermath of the medical malpractice crisis of the mid-1970s, they began devoting more attention to disciplinary activities, but had little wherewithal to provide more than minimal oversight. Five years ago, in response to intensified public scrutiny and criticism, boards, as documented in our previous report, gained considerable authority and began disciplining physicians more frequently, but still were severely underfunded in relation to the responsibilities before them.

During the past 5 years the improvement has continued. Nearly all boards now have the authority to revoke and suspend physicians' licenses, to issue emergency suspensions, to impose probations, and to invoke other lesser forms of discipline, such as reprimands, letters of concern, or fines.³³ Because of supportive changes by their State legislatures, most are experiencing significant increases in the number of referrals and complaints sent to them and a broadening of the grounds available to them for imposing disciplinary action. Not insignificantly, in terms of their accountability to the public, most have also experienced an increase in the number of "public" (i.e., nonphysician) board members.³⁴

Yet, if one were to ask how a particular board or boards in general were actually performing at the current time, one would be hard pressed to offer more than an impressionistic answer. This is because boards typically do not prepare and issue data that allow for meaningful assessments of performance. Most boards issue annual reports, incorporating some statistical information, but the information provided tends to be fragmented and minimal. Further, it is

seldom expressed in terms of ratios or percentages that facilitate comparisons of a board's own performance over time and/or of one board's performance with another.

Thus, even though most board officials decry assessments of their performance based strictly on the number of disciplinary actions they take, the reality is that, with rare exceptions, there is little else available upon which to base meaningful assessments. Moreover, as we've noted, even the disciplinary action data as currently provided is subject to some important qualifications that limit their usefulness. It is rare that in annual reports or even internal agency reports one can obtain data that allow for useful comparisons on matters such as case processing time or case dispositions by source and type of case. Thus, the public and its representatives are deprived of potentially important indicators of board performance and boards themselves are deprived of information that can help them improve their overall performance.

In assessing the performance of boards in recent years, we can point out, with confidence, that they and their State legislatures have made important progress in putting in place many of the elements that enable them to perform more effectively. Yet, in view of the minimal quantitative data available concerning board processes and outputs, neither we nor anyone else can assert with equal confidence that the boards' actual performance has been improving.

At a time when board performance is more important than ever, when the growth of high technology medicine enhances the ability of physicians to do harm as well as good, when expectations of boards are far greater than in the past, this distinction between enabling elements and actual performance is more than of academic interest. Indeed, in the 1990s, as pressures intensify for some kind of national initiatives concerning the nation's health care system, the future role and effectiveness of boards could depend in large measure on their capacity to develop meaningful indicators of their performance, to collect data on a regular basis concerning these indicators, and not least of all, to draw upon the data as guides to improved performance. It is a major challenge, and one that is vital to address.

RECOMMENDATIONS

As one of the nation's basic quality assurance mechanisms, State medical boards can play an important role in mitigating and even averting medical malpractice crises. In so doing, they can be instrumental in facilitating access to medical care, improving the quality of care, and reducing the excessive costs associated with high malpractice insurance rates and the practice of defensive medicine.

The boards' role in this regard is especially crucial in regard to medical care provided in a physician's office and by physicians who are not on hospital staffs or certified by specialty organizations. In such settings and for such physicians, the boards serve by and large alone in protecting the public from improper medical care.

The primary responsibility for assuring that the boards carry out this role effectively rests, of course, with State governments. We strongly encourage State legislatures, State governors and agency heads, and State boards themselves to address the limitations indicated in this report. At the same time, we recognize that in part their success in doing so can depend on the supportive actions of the Federal Government, of the Federation of State Medical Boards, and of other entities representing State government.

STATE GOVERNMENTS

- *State governments should assure that all licensure fees collected from physicians and other professional groups under the purview of medical boards are used to support board operations.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

In line with the Federalism Executive Order issued by President Reagan on October 26, 1987 and reaffirmed by President Bush on February 16, 1990³⁵, the Department's actions concerning State boards, to the maximum extent possible, should be supportive of State government roles.

That has been the thrust of the actions which the Department has taken thus far. In particular, the Public Health Service (PHS) in recent years has provided some financial support to the FSMB to help develop its computerized data bank and to develop useful reference materials for the State boards. In coming months and years, PHS' involvement with the boards will become more regularized and operational through its oversight of the national practitioner data bank. The data bank, once established, will serve as an additional resource which State boards can draw upon in identifying and reviewing cases.

Our recommendations concerning the Department are directed to PHS, HCFA, and the Administration on Aging (AoA). The ones directed to PHS call for it to take a more active and supportive role to the boards and identify ways in which it might provide such support. The

ones directed to HCFA identify actions it can take to facilitate the flow of useful information to the boards. The one to AoA calls for it to increase the relevance of the Long Term Care Ombudsman Program to the State boards.

The Public Health Service

In our prior report, we urged the States to increase license renewal fees of practicing physicians in order “to support expansion and improvement of the enforcement activities of State medical boards.”³⁶ In its 1987 report, the HHS Task Force on Medical Liability and Malpractice urged the States to “assess the adequacy of funding available to their licensing boards” and “develop plans to assure that their medical boards have sufficient funds to conduct an effective disciplinary program.”³⁷

As we have noted in this report, there has been little progress in this direction. Boards still are well short of having “sufficient funds” to carry out their disciplinary activities effectively, and although renewal fees have increased in many States, the additional revenue is not necessarily flowing to the boards. Without a concerted effort to address this funding/staffing shortfall, all other reform efforts are likely to have minimal effect. Moreover, as caseloads rise, some dysfunctional effects, such as an excessive reliance on consent agreements, could intensify.

Thus, the matter, we think, is of sufficiently national interest for the PHS, as the HHS component most closely linked with the boards, to exert leadership in determining how the Federal Government might address the shortfall as well as other limitations confronting the boards. In that regard, we urge the PHS to consider the future Federal relationship with the boards more in terms of a partnership addressing joint concerns than one involving separate spheres of responsibility addressing separate concerns. Such a relationship clearly fits within the nation’s tradition of federalism and the framework of the President’s Executive Order.

- *The PHS should collect, analyze, and disseminate State-by-State data on staffing, revenue, expenditure and caseload levels of the State medical boards.*

An information gathering and distribution effort of this kind would be of considerable value in clarifying the extent and nature of the resource shortfall of the medical boards. If presented in terms of ratios and percentages as well as absolute numbers, it would also facilitate useful comparisons among boards in different States.

- *The PHS should convene a national meeting to focus attention on the importance of the boards’ oversight role and to examine how the boards’ resource and other limitations should be addressed.*

Such a meeting, which should involve widespread participation of officials representing State medical boards and other parts of State governments, should focus on the kind of actions that should be taken by State governments and the Federal Government to improve both the capacity and performance of the boards. If information such as that called for in the prior

recommendation were distributed prior to the meeting, the deliberations of the attendees would be enhanced.

- *The PHS in collaboration with HCFA should determine ways in which HHS could encourage and assist the State boards to contract with PROs to conduct reviews of quality of care cases.*

The PROs typically have much more health care expertise available to them. Such expertise could be of great assistance to the boards in preparing cases involving quality of care deficiencies. Moreover, the development of such an association could help foster a more extensive sharing of information between the two entities.

- *The PHS should provide financial support for the development of performance indicators suitable for widespread use by State medical boards.*

By doing so, PHS, with a relatively small investment, could serve as a catalyst in a vital area in which there appears to be increasing interest.³⁸ The PHS effort should involve widespread participation by board officials and others knowledgeable and/or interested in this field. It should seek the development of relatively few but specific indicators which are expressed in terms of ratios or percentages and which have substantial credibility and support among board officials. Such indicators could be of considerable significance not only to State medical boards but to many other State boards, such as those concerned with dentistry and optometry.

To the maximum extent possible, PHS should foster the development of indicators that facilitate comparisons, both of a particular board's performance over time and between boards in different States. Even though each State board is in some way different and functions in a unique State milieu, inter-State comparisons can serve as useful guides and stimuli to improved performance. For example, if in using a case processing time measure, one State is found to have a much slower processing time than most other States, the major explanation may well be attributable to a highly fragmented review process that divides accountability among various parties. An expanded awareness of this fragmented process and of the implications it has for processing time could enhance the prospects for constructive reform in that State.

- *The PHS should provide financial support for technical assistance efforts intended to improve the boards' investigative efforts.*

The funding should be directed to an organization or to organizations that can assemble some expertise on the "do's and don't's" of investigations and that can make that expertise available to boards, in their own settings, for limited periods of times. The effort should attempt as much as possible to build on prior experiences and focus on key details involving how cases are prioritized, investigations conducted, and evidence assembled. It should give particular attention to the quality of care cases, which tend to be among the more complex ones facing boards and which are becoming increasingly prominent in some boards' caseloads.

- *The PHS, through its Agency for Health Care Policy and Research, should provide demonstration funding concerning the use of practice standards and guidelines to guide investigative efforts in quality of care cases.*

In recent years, largely in response to the medical malpractice crisis, increasing attention has been devoted to producing practice related information that can minimize or eliminate avoidable medical injuries. The Agency's medical treatment effectiveness research efforts are expected to generate data that can be useful in this regard as well as in promoting more effective treatments and better patient outcomes generally.³⁹ In the near term, guidelines or standards which insurers and professional associations have developed for certain medical specialties have even more operational significance.⁴⁰ Also, as a preventive measure some boards themselves have been distributing some practice information, for instance on procedures for treating chronic back pain, to licensed physicians.

Yet, there has been little effort to date to integrate the use of practice standards and guidelines into the investigative and case preparation process. Given the link between clear practice standards and boards' capacity to review quality of care cases effectively, this would seem to be a fertile area for PHS to provide demonstration support to some boards. It could provide useful feedback on the viability of certain standards and guidelines and at the same time enhance the boards' effectiveness in handling these cases.

The Health Care Financing Administration

- *The HCFA should propose legislation mandating that the PROs share case information with the medical boards when the first sanction notice is sent to a physician.*

In our 1986 report, we called for HCFA to amend the PRO regulations to "require more extensive and timely reporting to State medical boards."⁴¹ Since that time, in addition to introducing the PRO scope of work changes calling for closer interaction with the boards,⁴² HCFA has proposed a regulatory change that, if enacted, would provide a somewhat stronger base for PRO sharing of information with the boards.⁴³ Yet, given the scope and intensity of PRO concerns about how much and how soon they can share information with the boards, neither of these HCFA initiatives, according to PRO officials themselves, are likely to have much impact.⁴⁴

Thus, we strongly urge a statutory mandate as indicated above. Such a mandate would provide the PROs with the unambiguous protection they feel they need to share detailed case information with the medical boards.⁴⁵ Moreover, by calling for such information to be shared at a point when a physician is first provided with a sanction notice rather than when a sanction recommendation is sent to the Office of Inspector General, it would provide medical boards with many more PRO referrals on cases involving serious quality of care problems.

- *The HCFA should amend Medicaid regulations, or, if necessary, propose legislation to allow State Medicaid agencies to share with the medical boards case information on physicians against whom they have taken adverse action.*

Current Medicaid regulations concerning confidentiality provisions require that case information shared with a board must be for “purposes directly connected with the administration of the (Medicaid) plan.”⁴⁶ This requirement has precluded Medicaid agencies from sharing their investigative records with the boards, even in instances where they have terminated a provider’s participation in the Medicaid program.⁴⁷ This situation provides an unnecessary impediment to board action and should be corrected by HCFA.

- *The HCFA should assure that Medicare carriers adhere to their responsibility to refer cases of apparent unethical practice or unprofessional conduct to State medical boards.*

The Medicare Carrier Manual requires that such cases be reported to the boards. Yet, as we have noted, such cases account for few of the disciplinary actions taken by the boards. The HCFA, as part of its oversight of carrier activities, should assure that the carriers are being sufficiently diligent in referring cases to the boards. Such cases, as the manual points out, can involve overutilization or misutilization of services, overcharging, a harmful pattern of treatment, and a violation of ethics.⁴⁸

The Administration on Aging and the Health Care Financing Administration

- *The Administration on Aging and HCFA should assure that the Long Term Care Ombudsman Program and State survey and certification agencies, respectively, provide assistance to State medical boards in identifying instances of improper medical care provided to nursing home residents.*

The Long Term Care Ombudsman Program, funded under the Older Americans Act, serves as an important vehicle in the States for addressing the conditions of nursing home residents and complaints by or on behalf of these residents. Similarly, the State survey and certification agency has responsibility for assuring the adequacy of nursing home care and for addressing complaints.

Because of concerns raised about the adequacy of medical care offered to nursing home residents in California and other States, because of the numerous complaints concerning medical care in nursing homes received by the Ombudsman program, because of a recent Office of Inspector General study indicating the inadequacy of State and Federal efforts to prevent abuse of nursing home residents⁴⁹, and because boards have not had much involvement with such cases, the AoA and HCFA should determine if the training provided to the Ombudsman staff and volunteers and State survey and certification staff could provide more and better information about the medical boards. Further, AoA should determine if there are ways in which the program could help nursing home residents and their families become

more informed about the medical boards as a forum for addressing complaints about improper medical care.

FEDERATION OF STATE MEDICAL BOARDS (FSMB)

For many decades, the FSMB has served as a valuable resource for State medical boards, mainly in relation to licensure matters. During the past decade, the FSMB, as the boards themselves, has become increasingly focused on disciplinary matters. This focus has resulted in the development and operation of its computerized disciplinary action data bank and, among other things, in the issuance of extremely useful reference documents, such as *Exchange*, *Guide to the Essentials of a Modern Medical Practice Act*, *A Model for the Preparation of a Guidebook on Medical Discipline*, and, most recently, *Elements of a Modern State Medical Board: A Proposal*. The later document, based on considerable inquiry, is a particularly valuable reference point that States can draw upon in determining how they might increase the capability of boards.

For the FSMB, we urge that in the 1990s, at a time when most State boards are likely to face severe challenges and stresses, it continue and, indeed, intensify its efforts to assist boards to carry out their disciplinary responsibilities more effectively. In this context, we urge that the FSMB give particular attention to mechanisms for assessing board performance and to approaches boards might take to enhance their effectiveness in addressing cases involving the quality of medical care.

➤ *The FSMB should facilitate assessments of the performance of State medical boards.*

Such an effort would be a logical and timely follow-up to the *Elements* document noted above. Indeed, we urge the FSMB to undertake a similar effort resulting in a companion document which might be called "Assessing the Performance of a Modern State Medical Board." Such a document might encompass the licensure as well as the disciplinary responsibilities of the boards. In any case, it should identify some very precise quantitative measures that could be used to facilitate assessments of board performance.

In addition, we urge the FSMB to determine what other actions States can take to facilitate an assessment of boards' performance. One such action that would be especially helpful would be a detailed specification of the disciplinary data that should be included in the annual reports of the State boards. The *Elements* offers a general review of information that might be included but does not address the specific ways in which data might be presented.

Another action would be for the FSMB to issue its annual summary of State board actions in a manner that at a national level clearly distinguishes the number of *disciplinary* actions taken and the number of physicians disciplined. Presenting the data in this fashion, at least at an aggregate national level, would foster a more precise and meaningful understanding of one very important aspect of board performance: the imposition of disciplinary actions.

- *The FSMB should help State boards improve their effectiveness in reviewing quality of care cases.*

In large measure, the effectiveness of the boards in the 1990s is likely to rest on how and how well they address such cases. In this regard, we urge the FSMB, to the maximum extent possible, to serve as a helpful reference point to the boards. To a considerable degree, it can achieve this end by serving as a vehicle for the identification and distribution of “best practice” information. Such information could concern particular techniques found to be effective in investigating quality of care cases. It might also cover educational or other “nondisciplinary” interventions which some boards have found to be useful in responding to physicians whose actions raise concern but may not be serious enough to warrant disciplinary action.

NATIONAL GOVERNORS’ ASSOCIATION (NGA), COUNCIL OF STATE GOVERNMENTS (CSG), AND NATIONAL CONFERENCE OF STATE LEGISLATURES (NCSL)

Each of these organizations is a national one that addresses a wide variety of issues concerning State government. Because of their broad purview and their credibility with State governments, we urge each of them to take initiatives aimed at enhancing the capability and performance of State medical boards.

- *The NGA, the CSG, and the NCSL should take actions that foster greater State government awareness of the crucial roles of State medical boards and of the specific measures that can be taken to improve their capability and performance.*

The specific kinds of actions that should be taken are most appropriately determined by those organizations themselves. What is most important from our perspective is that they encourage State government efforts to strengthen the boards. Inevitably, this would call for some attention to the staffing and funding limitations but also to the many other factors identified in this report that impede the effectiveness of the boards.

In regard to the latter, the National Clearinghouse on Licensure, Enforcement and Regulation (CLEAR), which is run under the auspices of the CSG, is in a particularly good position to provide assistance. Formed in 1980, CLEAR functions as an informational resource for State officials involved with occupational licensure and regulation issues. Through its conferences and publications, it can serve as a particularly important vehicle for identifying ways in which State medical and other boards can become increasingly effective entities in the 1990s.

COMMENTS ON THE DRAFT REPORT

Within the Department of Health and Human Services (HHS), we received comments on the draft report from the Public Health Service (PHS), the Health Care Financing Administration (HCFA), the Administration on Aging (AoA), and the Assistant Secretary for Planning and Evaluation (ASPE). In addition, we received comments from the Federation of State Medical Boards (FSMB), the American Association of Retired Persons (AARP), the Public Citizen Health Research Group, and the American Medical Association (AMA).

In appendix A, we present the detailed comments offered by these HHS components and national organizations and our response to their comments. As indicated there, the responses to our recommendations were mixed. The PHS concurred with each of the six recommendations we directed to it, and the AoA agreed with the one directed to it. On the other hand, HCFA and ASPE disagreed with a number of the recommendations.

Among the national organizations commenting on the report, FSMB and AARP concurred with all of our recommendations, albeit in some instances with qualifications. The Public Citizen Health Research Group indicated general support for the report, but expressed concern about how we assessed the benefits of good medical quality assurance. Finally, the AMA indicated support for our recommendations calling for States to assure that licensure fees are used to support board operations and for PHS to convene a national meeting on State medical boards. However, the AMA disagreed with or expressed reservations about most of our remaining recommendations.

Among our recommendations, one generated a particularly strong response by the commenters. This is the recommendation urging HCFA to propose legislation mandating that the PROs share case information with the medical boards when the first sanction notice is sent to a physician.

The FSMB supported the recommendation, noting that if enacted it would provide the State medical boards with useful information. Such information, it added, could be used to "initiate appropriate action if the remedial efforts of the PRO are ineffective, or if the physician attempts to avoid review by relinquishing his participation in Medicare." The AARP had a similarly positive response, but urged that the mandated data sharing be extended even further "to include material produced by PROs' quality review, beneficiary complaint, and utilization review processes." Finally, during a June 8, 1990, Congressional hearing focusing on our report, Congressman Ron Wyden, Chairman of the Subcommittee on Regulation, Business Opportunities and Energy of the Committee on Small Business of the U.S. House of Representatives, also supported the recommendation. He indicated that he would be introducing legislation to carry it out.

However, three of the commenters clearly opposed the recommendation. The HCFA, to whom the recommendation was directed, believes that current legislation and regulations allow for data exchange when it is appropriate. The AMA indicated that the sharing of case

information at a time when the first PRO sanction notice was sent to a physician would be premature — that it would violate the due process rights of the physicians involved. Finally, ASPE noted the same kind of concerns and added that the justification was lacking in “evidentiary support.”

We regret this opposition. We continue to think that the proposed legislation is very important. We base our position on the following considerations.

First, it is quite clear that if the PROs are to refer more than a very small number of cases to the State medical boards, a Federal mandate is, indeed, necessary. This was strongly indicated by a number of PRO representatives at a December 1989 workshop on PRO-State medical board relationships that was convened by the American Association of Retired Persons. Those representatives expressed considerable concern about the legal liabilities they faced under existing law by sending case information to the boards.

There is considerable documentation that reveals that the PROs are, in fact, referring few cases to the boards. As we cited in our report, a May 1989 survey conducted by the Missouri PRO indicated that of 38 responding PROs, two-thirds had not reported any physicians to a State medical board during the past 12 months. Further, HCFA’s own data on PRO quality interventions reveal that from October 1, 1988, to December 31, 1989, only seven of the PROs referred one or more cases to a board. Still further, in our own sample survey of 8 States, we found that only 1 of 199 State board disciplinary actions taken in 1988 originated from a PRO referral.

A second consideration that underlies our support for the proposed legislation is that a PRO’s decision to send a sanction notice to a physician is a very serious and infrequent one. It represents a finding that a physician has committed a “substantial violation” of his or her Medicare obligations “in a substantial number of cases” or a “gross and flagrant” violation in a single case. While many of these cases result in corrective actions imposed on a physician, it is true that extremely few of them result in an actual sanction by the Office of Inspector General. Yet, it is also true that some of the physicians involved may have committed a violation of a State medical practice act and/or may also be under investigation by the State board.

We do not believe that the PROs would be violating a physician’s due process rights by sharing case information with the medical boards at the time they send a first sanction notice to a physician. A referral to the board is not tantamount to a disciplinary action. The board, if it is to pursue the case, would still have to assemble the necessary evidence and assure that the physician’s due process rights are upheld.

Finally, there is little likelihood, as some have suggested, that the PROs would add significantly to the boards’ case backlog problems by referring to them those cases for which they have sent an initial sanction notice. From October 1, 1988, to December 31, 1989, HCFA reports that throughout the United States, the PROs issued only 349 sanction notices to physicians.

APPENDIX A

DETAILED COMMENTS ON THE DRAFT REPORT AND OIG RESPONSE TO THE COMMENTS

In this appendix we present the full comments of all the parties that responded to the draft report and our brief response to each set of comments. Our response supplements that offered in the final section of the text.

Within the Department of Health and Human Services, we received comments on the draft report from the Public Health Service (PHS), the Health Care Financing Administration (HCFA), the Administration on Aging (AoA), and the Assistant Secretary for Planning and Evaluation (ASPE). In addition, we received responses from the Federation of State Medical Boards (FSMB), the American Association of Retired Persons (AARP), the Public Citizen Health Research Group, and the American Medical Association (AMA).



Memorandum

JUN 20 1990

Date .

From Assistant Secretary for Health

Subject Office of Inspector General Draft Report, "State Medical Boards and Medical Discipline," OEI-001-89-00560

To Inspector General, OS

Attached are the comments of the PHS on the subject draft report.

PHS strongly supports the intent of the draft report's recommendations. The Agency for Health Care Policy and Research has already begun discussions with the Federation of State Medical Boards on the need to strengthen and accelerate the Medical Boards' research and evaluation capabilities.

The draft report acknowledges that the primary responsibility for assuring the effectiveness of Medical Boards rests with the States. In implementing recommendations, we consider it important to maintain and support the current role relationship of the Public Health Service with the Boards, the Federation of State Medical Boards, and the States.


James O. Mason, M.D., Dr.P.H.

Attachment

COMMENTS OF THE PUBLIC HEALTH SERVICE ON THE OFFICE OF
INSPECTOR GENERAL (OIG) DRAFT REPORT, "STATE MEDICAL
BOARDS AND MEDICAL DISCIPLINE," OEI-011-89-00560

General Comments

State Medical Boards are integral to the Nation's efforts to assure the quality of medical care. Their endeavors have been, and should continue to be, promoted by the Public Health Service (PHS). As noted in the draft report, PHS has provided support to the Federation of State Medical Boards (FSMB), the Boards' national membership organization for several significant projects. We consider it important to maintain that supportive relationship while avoiding any actions that could be interpreted as encroachment on State prerogatives or interference with the State functions of professional licensure and discipline.

The primary responsibility for assuring that the Boards function effectively rests with the States. Because of competing priorities at the State level, the Boards have been underfinanced and understaffed and resources available to the FSMB have also been limited. We are pleased to see the report emphasizing these points.

We believe, however, that the report might further acknowledge one Federal activity, the National Practitioner Data Bank, and the role it could eventually play as a resource to State Medical Boards.

OIG Recommendation

PHS should collect, analyze, and disseminate State-by-State data on staffing, revenue, expenditure, and caseload levels of the State Medical Boards.

PHS Comment

We agree that this information should be collected, analyzed, and distributed. The FSMB already collects some of this information, and with assistance, would have the capacity to expand its efforts to include additional data elements.

OIG Recommendation

PHS should convene a national meeting to focus attention on the importance of the Boards' oversight role and to examine how the Boards' resources and other limitation should be addressed.

PHS Comment

We concur, provided that it is clear that sponsorship of such a conference is not taken to signal a change in the current roles of the Federal Government and the States in professional licensure and discipline. Federal sponsorship of a conference may be helpful in drawing public attention to problems faced by the Boards, provided it is done in a way that cannot be interpreted as Federal meddling in State responsibilities.

OIG Recommendation

PHS, in collaboration with the Health Care Financing Administration (HCFA), should determine ways in which HHS could encourage and assist the State Boards to contract with Professional Review Organizations (PROs) to conduct reviews of quality of care cases.

PHS Comment

We see this as essentially a HCFA concern. In general, we would encourage the fostering of active working relationships between the PROs and State Medical Boards and would support exploration of ways such relationships could be promoted.

OIG Recommendation

PHS should provide financial support for the development of performance indicators suitable for widespread use by State Medical Boards.

PHS Comment

We concur. PHS intends to continue promoting efforts intended to strengthen State Medical Boards. Support for the development of methods for assessing Board performance could be a logical next step.

OIG Recommendation

PHS should provide financial support for technical assistance efforts intended to improve the Boards' investigative efforts.

PHS Comment

We concur. Identification of investigative "best practices" and technical assistance in their use might logically follow the development of methods for assessing State Medical Board performance.

OIG Recommendation

PHS, through its Agency for Health Care Policy and Research (AHCPR), should provide demonstration funding concerning the use of practice standards and guidelines to guide investigative efforts in quality of care concerns.

PHS Comment

We concur. AHCPR, on its own initiative, has begun discussions with FSMB on the need to strengthen and accelerate the Boards' research and evaluation capabilities. Initially this will take the form of developing evaluation methods and a protocol for monitoring State medical Board performance. Further attention will be shown to FSMB as AHCPR's work expands in the general areas of quality assurance and medical liability.

OIG RESPONSE TO PHS COMMENTS

We appreciate PHS' positive response to our recommendations. We believe that PHS can play an important leadership role in helping State medical boards address their limitations. Its response indicates that it is ready to play that role.

The PHS' agreement to convene a national meeting on State medical boards is particularly encouraging. We urge that that meeting be held in Washington, D.C., and that it involve representatives from various parts of State government, not just from the boards, as well as researchers and others who can contribute to the deliberations. We also urge that the meeting devote major attention to how boards can become more effective in reviewing quality of care cases in the 1990s.

With respect to the National Practitioner Data Bank, which PHS mentioned in its response, we do believe it can eventually serve as a useful resource to the boards. However, it is not directly related to the major needs and limitations identified in our report.



JUL 19 1990

Memorandum

Date Gail R. Wilensky, Ph.D. *grw*
From Administrator
Subject OIG Draft Report - State Medical Boards and Medical Discipline
(OEI-01-89-00560)
To The Inspector General
Office of the Secretary

We have reviewed the subject report which finds that State medical boards have made significant progress in improving their disciplinary capability. However, case backlogs remain a serious problem due to increasing numbers of referrals and severe staff shortages. The report also claims that the Peer Review Organizations (PROs) refer few cases to the boards, and that lack of clear authority to share information with the boards prevents PROs and Medicaid State agencies from providing detailed information when cases are referred.

The report contains five recommendations that involve HCFA. Our comments on these recommendations, as well as general and technical comments are attached.

Thank you for the opportunity to review and comment on this draft report. Please advise us whether you agree with our position at your earliest convenience.

Attachments

Comments of the Health Care Financing Administration
on the OIG Draft Report - State Medical Boards
and Medical Discipline
OEI-01-89-00560

Recommendation 1

HCFA should propose legislation mandating that the Peer Review Organizations (PROs) share case information with medical boards when the first sanction notice is sent to a physician.

Response

We nonconcur with this recommendation, because we believe that legislation is unnecessary. We believe that the current legislation and regulations allow for data exchange when it is appropriate. Licensing and certification bodies have access to relevant PRO information upon request under the current regulation at 42 CFR 476.138(a)(1). The PRO may also provide the information without a request when it believes it is appropriate.

We also are currently working on two initiatives that should further facilitate the disclosure of sanction information to licensing and certification bodies. One initiative is a possible regulatory change that would require PROs to provide the appropriate licensing and certification bodies with a copy of the Medicare sanction report at the time the PRO forwards its recommendation to OIG. Subject to clearance by our Office of General Counsel, we also plan to advise all PROs that relevant sanction information can be released to these bodies under the authority of 42 CFR 476.138(a)(1). We had previously maintained that any information about sanction activities prior to the final sanction action was not disclosable. This revised disclosure policy will provide PROs with a clear understanding of their obligations and options, and PROs should then be more willing to initiate disclosure of information to medical boards.

Recommendation 2

HCFA should amend Medicaid regulations, or if necessary, propose legislation to allow State Medicaid agencies to share case information on physicians against whom they have taken adverse action with medical boards.

Response

Although we agree with the intent of this recommendation, we do not believe this action is necessary. The release of provider information is not covered by Federal law, but rather by State law. If recipient information is contained in the transferred information, the purpose of the transfer must be related to the administration of the Medicaid program. Paragraph (d) of 42 CFR 431.302 states that transfer of recipient information is allowed for conducting or assisting an investigation, prosecution, or criminal proceeding related to the administration of the plan.

It is our interpretation, based on advice from the Office of the General Counsel, that recipient information can be released to medical licensing boards under paragraph (d) for the purpose of assisting an investigation. We view the role of State medical licensing boards as an integral part of maintaining the quality of care within the Medicaid program.

Recommendation 3

HCFA should assure that Medicare carriers adhere to their responsibility to refer cases of apparent unethical practice or unprofessional conduct to State medical boards.

Response

In accordance with Medicare Carrier Manual section 10040.E.4.b-c, carriers are expected to refer to State medical boards or PROs physicians suspected of practicing in a manner that could endanger the health of, or otherwise harm, their patients. We sent a letter to our regional offices in June 1989 for distribution to carriers to dispel any confusion concerning their obligations in such cases (See Attachment A). Therefore, we believe that we have carried out the intent of this recommendation.

Recommendation 4

The Public Health Service (PHS) in collaboration with HCFA should determine ways in which HHS could encourage and assist the State boards to contract with PROs to conduct reviews of quality of care cases.

Response

We agree with this recommendation, and would be happy to work with PHS to accomplish this. Currently, PROs can conduct private reviews as long as these reviews do not conflict with their contracts with HCFA. This type of private review could enhance the PRO's effectiveness in its Medicare quality review efforts.

Recommendation 5

The Administration on Aging and HCFA should assure that the Long Term Care Ombudsman Program and State survey and certification agencies, respectively, provide assistance to State medical boards in identifying instances of improper medical care provided to nursing home residents.

Response

We are not clear what assistance HCFA is to provide the State medical boards under this recommendation. It would be helpful if this recommendation could be clarified and made more specific in the final report.

General and Technical Comments

- o The report reflects our ongoing problem with the State medical boards. As we have previously discussed with OIG, the lack of communication with the boards is two-sided. The State medical boards give no information to the PROs, but this problem is not reflected in the report.
- o The report states in endnote 42 that HCFA requires PROs to "consider" sharing information about a weighted severity score of 25 for one quarter with the State licensure boards. The implication of this statement is that OIG believes this "consideration" is insufficient. We continue to believe that a score of 25 may not truly reflect a practice pattern that should be reported to the board. If PROs were to report all of these cases, the boards would be burdened with information about cases not severe enough

for them to act upon. The PRO's contract with HCFA states that there must be documentation of the "consideration" and a written rationale for not referring the physician. Our regional offices will monitor the PRO's to determine whether the action taken was appropriate.

- o In paragraph 3 on page 9, the report indicates that detailed information may not be available to medical boards. Under 42 CFR 476.138(a)(1), information on confirmed quality problems is available to the boards. Further, after OIG imposes a sanction, the PRO sanction report on the case is also available.
- o Paragraph 4 on page 9 indicates that PROs are hindered in disclosing information by insufficient statutory and regulatory support. However, 42 CFR 476.138(a)(1) clearly provides the authority for the PRO to disclose appropriate information. Further, any State redisclosure laws would be subordinate to the related Federal statute.
- o Endnote 6 of Appendix B (page B-1) states that all references to State boards include the District of Columbia as well as the 50 States. To avoid confusion, we recommend that the endnote explain whether this statement is applicable to both the graphs and the text. (For example, figures 1 and 2 say that there are 50 States.)
- o We recommend that the first sentence of paragraph 2 on page 4 be revised to read as follows: "Regarding immunity protection, in 1986 only one-fourth of the States had extended it to those not mandated to report violations to the board. In 1989, the amount increased to two-thirds of the States."
- o In paragraph 3 on page 6, it should state that there are now 53 PROs, not 54.
- o In the first paragraph on page 12, the first full sentence should be revised as follows: "Similarly, if a physician were disciplined in one State and, on the basis of that action, also disciplined in two other States in which he or she is licensed, that physician would account for three actions, one action reported by each of the three States."
- o We note that the percentages in Figure 6 on page 16 total 102 percent. If this is not due to rounding, this should be changed.

Page 5

- o On Page 23, last paragraph, 2nd sentence, the last word "PROs" should be changed to "medical boards."
- o On page B-6, endnote 46, it should read: "See Title 42 Code of Federal Regulations, section 431.302."



April 18, 1989

Jean A. Harris
Director
Division of Carrier Procedures

Dear Jean:

Two issues of carrier communications have developed in Tennessee.

The first concerns our relations with Tennessee Medical Society, the Tennessee Board of Medical Examiners and the Medical Director of the TMA Impaired Physician Program. In the course of my involvement in medical review, appeals and post-payment analysis, patterns of provider practice strongly suggest the probability of impairment or dysfunction. As an example, I currently have on my desk the file of a physician in his 40's who shows a pattern of practice that is more consistent with that of a third year medical student. He is unable to identify clues to disease diagnosis and, as a result, has a marked over-utilization pattern that brought him to the attention of our post-payment review staff. He apparently attempted to take a residency in the last few years but did not complete the training. I believe that my review indicates the need for peer evaluation for possible impairment or dysfunction. Does HCFA have a position in writing to support a confidential referral to the Impaired Physician Program Medical Director?

My second need for communication is with the Medical Director of the Tennessee PRO. During preliminary meetings, it quickly became obvious that we are both working on issues of over-utilization and quality concerning the same providers. The PRO recently received communications from the HCFA IG encouraging such communication, but there does not appear to be concrete authorization for the specific discussion concerning a given provider. Is such authorization currently present or is it in the process of being issued? Only by evaluation of the total pattern (inpatient and outpatient) of practice can we effectively detect quality, abuse and/or fraud issues.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert M. Zone".

Robert M. Zone, M.D.
Medical Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES

JUN 20 1989

Refer to: BPO-011

Robert M. Zone, M.D.
 Medical Director
 EQUICOR, Medicare Administration
 P.O. Box 1485
 Nashville, Tennessee 37202

Dear Dr. Zone:

Thank you for your letter to Jean A. Harris concerning disclosure of physician information to the PRO, the TMA Impaired Physician Program, the Board of Medical Examiners and the State Medical Society. I apologize for the delay in my response.

You not only may, but should refer information on individual physicians such as you described, to the Impaired Physician Program Medical Director. Section 10040 E.4.b.(1) of Part III of the Medicare Carriers Manual addresses these referrals (enclosed). Such disclosure is permitted under the Privacy Act.

You may also freely exchange information concerning individual physicians with the PRO and fiscal intermediaries in support of quality, abuse, and/or fraud related issues. The governing citation is 42 CFR 476.103 (~~enclosure~~).

I strongly encourage such exchanges of information, and agree that evaluation of the total pattern of practice enhances detection of poor, fraudulent and abusive providers.

Sincerely,

Carol J. Walton
 Director
 Office of Program Operations Procedures

2 Enclosures

cc:

Barbara J. Gagel
 Richard Husk

Associate Regional Administrators
 for Program Operations
 Regions II, IV-VII, IX-X
 Associate Regional Administrators
 for Medicare
 Regions I, III, VII, VIII

BPO-011:KEMmonsdef 5/16/89

Dr. Robert Zone:KEMmons 85

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE
BPO-011	Katzenberg	5/19			
BPO-011	Schubert	6/5			
H5QB	R. Husk	6/9			
	J. M. Davis	6/16			

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4. Referral to State Licensing Boards, Medical Review Boards, and Professional Societies.--

a. Referral of Suspended Practitioners.--Section 1862(e)(2)(B) of the Social Security Act requires the Secretary to notify the appropriate State or local licensing authority (i.e., State licensing board or medical review board) whenever a physician or other practitioner has been suspended from participation in the Medicare program. Thus, whenever HCFA suspends a practitioner from participation in the Medicare program because the practitioner has been convicted of a criminal offense related to his participation in the title XVIII or XIX program, HCFA will promptly notify the appropriate State or local licensing authority(ies) to (1) make appropriate investigations, (2) invoke any sanctions available under State law which the authority(ies) deems appropriate, and (3) keep HCFA and the Inspector General fully and currently informed of any action it takes.

b. Referral By Medicare Carriers.--In addition to the referrals made by HCFA under section 1862, Medicare carriers are authorized to refer title XVIII-related cases of apparent unethical practices or unprofessional conduct to medical or other professional societies, and State or local licensing authorities (licensing boards or medical review boards). (See the routine uses for the Medicare Carrier Claims Records system as described in the system notice published in the Federal Register.)

When considering a case for referral, the carrier should assure itself that substantial basis for referral exists; that more than mere suspicion is involved. It need not compile evidence sufficient to prove misconduct before referral; it should ascertain the probability and severity of misconduct and leave further investigation, review, and disciplinary action to the appropriate society or board. Isolated instances of questionable practices or conduct should not normally be referred.

Further, referral of apparent unethical practices or a course of unprofessional conduct by a practitioner should only be made after proper professional advice has been obtained from the carrier's physician staff members, medical consultants, or other professional advisors.

Since State licensing boards and medical review boards are responsible for the licensing and sanctioning of practitioners, cases should be referred to those boards only where the apparent unethical practices or unprofessional conduct is of a severity to possibly warrant such sanctions; cases involving less severe improprieties should typically be referred only to professional or medical societies for action.

The following are examples of cases that should be referred:

(1) Overutilization.--This refers to a pattern of medical care which consists of providing more services than are medically

When a case is pending prosecution, or when a decision is pending on whether to proceed with prosecution, delay referral to the professional society until: (1) the prosecution action is completed, (2) the decision is made not to prosecute, or (3) BQC authorizes the referral.

c. Requests for Assistance by State or Local Licensing Boards, or State or Local Medical Review Boards.-- While cooperation on the part of HCFA ROs and carriers with State or local licensing/medical review boards is generally encouraged, there seems to be three distinct situations in which these boards might request assistance:

(1) When a case has been referred to a State or local licensing/medical review board for investigation and possible sanctions (either by HCFA as a result of the conviction and suspension of the subject practitioner, or by a carrier), it would seem appropriate for HCFA and carriers to provide assistance to the board in its investigative activity, provided the demands on staff time and resources do not become burdensome or unreasonable. All requests for carrier assistance should, however be channeled through the servicing HCFA RO for a determination regarding the reasonableness of the request. Appearance by HCFA personnel before board meetings involving a case which has been previously referred would also be permitted.

(2) When a State or local licensing/medical review board requests information or assistance on a case which was self-initiated (i.e., not previously referred to the board by HCFA or a Medicare carrier) as a result of a complaint, allegation, inquiry, etc., relative to a specific physician/practitioner's practices, this request should be treated as a Freedom of Information Act request. Therefore, any requested material should be screened for sensitive information, with the decision to release/withhold such information made on a case-by-case basis. Further, the board would be responsible for the costs involved in providing such information (searching costs, duplicating costs, etc.). In such instances, the appearance of HCFA personnel at a board hearing would be discouraged.

(3) When the State or local licensing/medical review board's request is for general information pursuant to a study or investigation of physician/practitioner impropriety or abuse, and is not related to a complaint, allegation, etc., against a specific physician/practitioner; or when the request would represent a clearly unwarranted invasion of personal privacy, cooperation by HCFA or contractor personnel would be discouraged. In such instances it would be appropriate to release general or statistical information which did not identify specific individuals, however, the request for identifying information would constitute an improper search for information.

OIG RESPONSE TO HCFA COMMENTS

For each of the recommendations directed only to HCFA, HCFA either disagrees or notes that no additional action is needed.

On the matter of PROs sharing case information with the boards, we urge HCFA to reconsider its position. We elaborated on our rationale in support of this recommendation in the comments section concluding the report. We agree, as HCFA indicates in the "General and Technical Comments" portion of its response, that it is also important for the boards to share information with the PROs. That is an issue that the PROs and boards should address, but it was not part of the scope of our study.

On the matter of allowing State Medicaid agencies to share case information with medical boards on physicians against whom they have taken adverse action, HCFA responds that no Federal regulatory or statutory change is necessary — that the matter is covered by State, not Federal, law. It adds, based on advice from the Office of the General Counsel, that State Medicaid agencies, under Federal law, can share case information with the boards.

We are pleased to receive this response, but it is contrary to advice previously given to the Pennsylvania Department of Public Welfare by the Region III Office of the General Counsel of the U.S. Department of Health and Human Services. If HCFA's interpretation is to be the guiding one, then we urge HCFA to communicate this position to each of the State Medicaid agencies. Such follow-up would help reduce the confusion and facilitate referrals to the boards.

Similarly, we urge HCFA to take some action to assure that Medicare carriers are, in fact, referring cases of apparent unethical practice or unprofessional conduct to State medical boards. Based on the minimal number of referrals sent by carriers to the boards, the June 1989 memorandum on the subject to the carriers appears to have had little effect.

On the recommendation calling for HCFA to assure that State survey and certification agencies provide assistance to State medical boards in identifying instances of improper medical care provided to nursing home residents, HCFA asked for clarification on the type of assistance envisioned. In that regard, we note that our recommendation was based on the widely documented indications of improper medical care in nursing homes and on the minimal involvement of boards in addressing such cases. State survey and certification agencies as well as the Long Term Care Ombudsman Program can serve as useful channels for helping nursing home staff and the families of nursing home residents become better informed about the roles and responsibilities of the State boards.

Finally, we made a number of minor changes in the report based on HCFA's technical comments.



Administration on Aging

Washington, D.C. 20201

AUG 8 1990

TO: Richard P. Kusserow
Office of the Inspector General

FROM: U.S. Commissioner on Aging

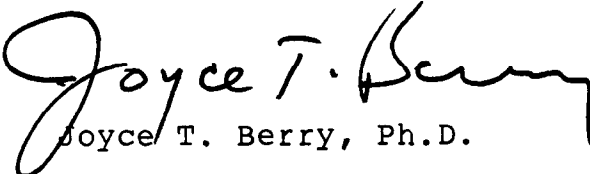
SUBJECT: Draft Inspector General Report - State Medical Boards

This memorandum provides a response from the Administration on Aging (AoA) to the draft report on "State Medical Boards and Medical Discipline."

Page 24 of the draft, third arrow, refers to activities to be undertaken by AoA regarding training of staff and volunteers in the Ombudsman program to alert nursing home residents and their families about medical boards providing a forum for complaints about improper care.

Our response to the recommendation is that AoA will be pleased to disseminate information about State medical boards and their role in identifying improper medical care for nursing home residents. When the final report on this subject is issued, AoA will disseminate the report to State and Area Agencies on Aging and the LTC Ombudsmen. In addition, AoA will work with the National Center for State Long Term Care Ombudsman Resources to incorporate information in training materials for professional ombudsman and volunteers about the role and function of State medical boards in pursuing disciplinary action with physicians who warrant such actions.

Thank you for the opportunity to comment on this report.


Joyce T. Berry, Ph.D.

OIG RESPONSE TO AOA COMMENTS

We are delighted with AoA's response. We believe that over time the follow-up activities it has identified can be quite helpful in alerting State medical boards to cases involving improper medical care to nursing home residents.



TO: Richard P. Kusserow
Inspector General

JUN 15 1990

FROM: Assistant Secretary for
Planning and Evaluation

SUBJECT: OIG Draft Report: State Medical Boards and Medical
Discipline -- COMMENTS

The objectives of the recommendations are ones I strongly support -- to identify and discipline physicians who are delivering substandard care. I recognize the challenge of identifying "substandard care" when standard practices are just being defined, sometimes by specialty societies and quality care is largely undefined. Furthermore, some critics of the health care system are calling for fundamental changes in the way health care is managed, including limiting external regulation of medical practices. Because of these difficulties, I think your work deserves praise for its ability to showcase some of the best practices in the states and reach toward continued improvement in state medical board efforts.

Because the report is necessarily succinct, it does not specify how its recommendations might be executed. I have therefore a number of questions about them as well as some suggestions. Let me discuss the recommendations in turn.

1. The Public Health Service (PHS) should collect, analyze, and disseminate State-by-State data on staffing, revenue, expenditure and caseload levels of the State medical boards.

According to PHS, collecting analyzing and distributing the information itself would be a major change in PHS responsibility. Currently, PHS contracts with the Federation of State Medical Boards (FSMB) to collect, analyze and advise states on ways to improve their practices.

The OIG recommendation raises a question: Does OIG intend any major change or is the recommendation simply an exhortation for PHS to continue to support FSMB's data collection and analysis? If a major change is being recommended, why? It seems unwise for PHS or the Department to take on an activity currently conducted by a private organization and financed partially by the states.

A second and more significant concern to me is the utility of the information on staffing, revenue and expenditures. Will expanded availability of the specified information improve states' ability to discipline physicians who deliver substandard care? The IG's

report suggests it will not. The problem, as identified in the IG's report, is not simply that states do not have enough funds but that a state may intentionally withhold revenues from the Boards, even when it collects sufficient funds through licensure fees. If the IG's report is correct, is the purpose of the recommendation simply to shame outlier states into increasing support for their medical boards?

2. The HCFA should propose legislation mandating that the PROs share case information with the medical boards when the first sanction notice is sent to a physician.

I have two objections. First, the case information ought not be shared when the first sanction notice is sent because of the likelihood of successful appeal. I understand that more than half the sanctions are appealed and most are overturned. Second, legislation requiring PROs to give state boards the case information is not necessary. Current regulation (42 CFR 476.137) requires PROs to give case information to state licensing and certification bodies upon request. Even absent a request from the state board, a PRO may provide the case data to the state board.

The OIG justification, that PROs are reluctant to give out the information because of the threat of violation of anti-trust, lacks evidentiary support. OIG does not, for example, identify instances where PROs failed to give the requested information. Based on information in the OIG's report on case backlogs that state boards face, it is questionable if boards could handle any more opportunity to investigate.

3. The HCFA should amend Medicaid regulations, or, if necessary, propose legislation to allow State Medicaid agencies to share with the medical boards case information on physicians against whom they have taken adverse action.

I understand there is a difference of opinion within the Office of the General Counsel as to whether Medicaid agencies may now share the case information. I defer to GC to resolve the need for any change in regulation or legislation.

4. The PHS, in collaboration with HCFA, should determine ways in which HHS could encourage and assist the State boards to contract with PROs to conduct reviews of quality of care cases.

I question whether it is wise to dilute the duties of PROs which were created principally to serve HCFA.

A second concern to me is the absence of any generally accepted methodology for evaluating care in a non-institutional setting. Our Department has major efforts underway to attempt to develop

methods for measuring quality of care in physician offices and other non-institutional settings and to determine optimum patient outcomes that maximize patient satisfaction. For example, HCFA has had underway for more than one year the "design of an approach to the assessment of quality of care in the noninstitutional setting." According to HCFA, the purpose is to "develop a methodology to characterize patient populations, the patterns of care they receive and the effects on their health...." The project began in May 1989 and will be completed in 1991. It might be appropriate to refer briefly to the measurement problem and HHS research efforts as background, if the recommendation is to be made.

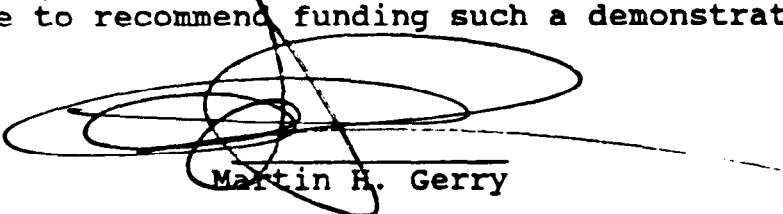
5. The PHS should provide financial support for technical assistance efforts intended to improve the boards's investigative efforts.

The PHS should provide financial support for the development of performance indicators suitable for widespread use by State medical boards.

Again, I assume OIG intends that these would be funded through the FSMB. The second of these recommendations is timely since, I understand, FSMB has begun development of performance indicators and is looking for additional funding.

6. The PHS, through its Agency for Health Care Policy and Research, should provide demonstration funding concerning the use of practice standards and guidelines to guide investigative efforts in quality of care cases.

As I indicated above, since we are only beginning to look at measurements of quality of care in non-institutional settings, it seems premature to recommend funding such a demonstration at this time.



Martin H. Gerry

OIG RESPONSE TO ASPE COMMENTS

Below we respond to ASPE's comments on each of the six recommendations it addressed.

1. We recognize that PHS has had a close and effective relationship with FSMB. We urge it to continue that relationship. At the same time, in response to the question posed by ASPE, we note that there are also other organizations that PHS might contract with on specific matters concerning medical and other kinds of State boards.

With respect to the comment on the utility of State-by-State information on staffing, revenue, and expenditures, we believe that the collection and widespread dissemination of such information can contribute to constructive change. It would identify the outlier States and raise legitimate questions about the performance of the boards in those States.

2. We urge ASPE to reconsider its position on the basis of the rationale we developed in the comments section of the report. As noted there, we believe that there is more than ample evidentiary support for our recommendation and that the proposed legislation is, indeed, necessary.
3. Our position on this recommendation is stated in response to HCFA's comments concerning it.
4. We do not believe that the enactment of this recommendation would "dilute the duties of PROs." Further, as HCFA notes in its response: "This type of private review could enhance the PRO's effectiveness in its Medicare quality review efforts."
5. Once again, while we recognize the importance and leadership role of FSMB, we do not regard it as the only possible vehicle of financial support concerning State boards.
6. Given the significance of the work of State medical boards, we believe it is important for PHS to move immediately in providing some demonstration funding concerning the use of practice standards and guidelines to guide investigative efforts in quality of care cases. We are pleased that PHS concurs with the recommendation.



July 31, 1990

**THE FEDERATION OF
STATE MEDICAL BOARDS
OF THE UNITED STATES, INC.**

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FORT WORTH, TEXAS
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Richard P. Kusserow
Inspector General
Health and Human Services
330 Independence Ave., SW
Washington, DC 20201

Dear Mr Kusserow

The Federation of State Medical Boards of the United States appreciates this opportunity to comment on the draft of the report titled *State Medical Boards and Medical Discipline* recently released by your office.

As you know, I presented the Federation's views on the report on June 8, 1990, during testimony before the Subcommittee on Regulation, Business Opportunities and Energy of the House Committee on Small Business. Rather than repeat those remarks here, I am attaching a copy of that testimony to this letter. Please consider it the Federation's formal response to your request for comment.

Sincerely

James R. Winn, MD
Executive Vice President

JRW:lm

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ASSISTANT EXECUTIVE
VICE PRESIDENT

UNITED STATES HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES
AND ENERGY OF THE COMMITTEE ON SMALL BUSINESS

June 8, 1990

James R. Winn, M.D.

Executive Vice President

Federation of State Medical Boards of the United States, Inc.

TESTIMONY ON THE REPORT OF THE INSPECTOR GENERAL,
DHHS, ON STATE MEDICAL BOARDS AND MEDICAL DISCIPLINE

Good afternoon, Mr Chairman and members of the committee. I am James R. Winn, MD, executive vice president of the Federation of State Medical Boards of the United States. Founded in 1912, the Federation is the national voluntary association of state medical boards, both allopathic and osteopathic, and is comprised of sixty-six member boards. The Canadian provincial medical licensing authorities hold affiliate membership in the Federation as well. The Federation is a parent and member organization of the National Board of Medical Examiners, the Educational Commission for Foreign Medical Graduates, the Accreditation Council for Continuing Medical Education, and the American Board of Medical Specialties. It also maintains liaison with major medical organizations in the United States and with the medical licensing authorities of several foreign countries.

Through its FLEX Board and in cooperation with the National Board of Medical Examiners, the Federation structures and conducts the Federation Licensing Examination (FLEX), the test instrument for medical licensure used by all states and several other jurisdictions. In early 1988, the Federation introduced the Special Purpose Examination (SPEX), a test instrument designed to assist boards in assessing the qualifications of candidates for licensure by endorsement who have not been examined for some years. A complete computer record of FLEX and SPEX scores, along with appropriate biographical information on examinees, is maintained by the Federation.

Today, the Federation and the National Board of Medical Examiners are cooperating in the development of the United States Medical Licensing Examination, a three step test instrument that will provide, for the first time, a single examination program for medical

licensure. As a result, within a few years, all eligible candidates for medical licensure will sit the same examination sequence. This will be a major accomplishment in medical licensure in this country, a step thought almost impossible not many years ago.

The Federation also operates the nationally recognized Board Action Data Bank, the preeminent system for collecting, recording, and distributing to state medical boards and appropriate agencies data on disciplinary actions taken against licensees by the boards and other governmental authorities, including the military and the Department of Health and Human Services. In the past six years, over 550,000 inquiries have been processed by the data bank. In 1988 and 1989, the Federation developed and implemented the Direct Access System (DAS), a program for allowing secure on-line access to the Board Action Data Bank by state medical boards and other authorized users. The Board Action Data Bank is the most sophisticated and reliable resource of its kind. It has effectively assured that no board-sanctioned licensee can move within the medical system undetected.

Along with its other activities, the Federation collects and publishes the most complete information available on physician licensing and disciplinary boards and maintains a resource library of the various practice acts and rules under which its member boards operate. That library is the only central collection of such material in the country. The Federation also offers the states and the boards specific policy recommendations related to medical licensure and discipline. Those recommendations are actively promoted in several publications, such as the *Guide to the Essentials of a Modern Medical Practice Act* and the *Model for the Preparation of a Guidebook on Medical Discipline*. The Federation's educational activities include its Annual Meeting and publication of the monthly *Federation Bulletin*, the quarterly *FSMB Newsletter*, and the biennial *Exchange*. The *Federation Bulletin*, by the way, is the world's only journal devoted exclusively to medical licensure and discipline. Under federal

contract, we have also developed and disseminated the *Elements of a Modern State Medical Board*, designed to encourage boards to review and assess the effectiveness of their structure and function.

The Federation, as I believe you can see, is the national clearinghouse, forum, and representative body for state medical boards. It occupies a unique position of responsibility in relation to its member boards and the people of the states they are charged to serve. It makes and will continue to make significant contributions to the effectiveness and integrity of the medical licensing and disciplinary systems that are essential components of medical quality in the United States.

For your information, I have attached to these prepared remarks copies of the Federation publications I have mentioned.

I deeply appreciate this opportunity to share with you the views of the Federation relative to the report titled *State Medical Boards and Medical Discipline* recently prepared and issued by the Office of the Inspector General of the Department of Health and Human Services. Like you, we have looked forward to the appearance of this report. We cooperated closely with those who prepared it and believe it reflects a thoughtful effort to summarize the current situation in medical discipline. I should note that we also worked with the Office of the Inspector General in 1986 when it produced its first report on state medical boards. That study was a healthy exercise that reinforced and supported many positions advocated by the Federation for years. Our response to that earlier effort was presented in detail in an editorial in the *Journal of the American Medical Association*, a copy of which I have attached to these remarks and also ask be included in the record.

I should like to compliment you, Mr Chairman, and the members of this committee for your recognition of the role of state medical boards in enhancing the quality of medical care

in this country. Your interest in the current report clearly indicates your concern. Those of us who have served on and work with state medical boards appreciate, possibly better than any other group, the importance of this issue. Based on our real and sometimes painful day-to-day experience, we recognize the need to assure the qualifications and fitness of licensed physicians in an effective and practical way.

As you know, in this country, the duty and responsibility for medical licensure resides in the states. We who function within that pluralistic system and strive to make it as effective as possible feel our obligations deeply. We are always pleased to find support for our efforts and a recognition of our problems in the halls of Congress.

The power exercised by the people of the states, acting through their legislatures, to establish those systems they believe would best protect their interests is fundamental to responsive and responsible government. One of the strongest elements of our state-based pluralistic licensing structure is the flexibility it allows the people of the states to develop and test a variety of approaches to the problems facing all boards. From the oversight of residency training to initial licensure, from license reregistration to disciplinary process, improvements have been dramatic over the past two decades, thanks in many ways to the power of the states to seek better approaches to meeting their responsibilities. Yet we have far to go.

As the IG's report makes clear, many state boards must struggle to fulfill their regulatory obligations within financial and/or statutory constraints that can effectively block their efforts to protect the public. Board revenues should be dedicated to board use and boards should be authorized to set fees at levels adequate to provide the funds required to do the job expected of them. Obviously the boards should be fully accountable for their use of funds and reports to the legislature and the public should demonstrate the level of their

performance. Many of the suggestions made in the report must focus, finally, on the question of proper financial support of the boards. The Federation has done all in its power over the past few years to emphasize the importance of this issue.

The "clear and convincing evidence rule", most common now, should not be applicable in board cases. That standard of evidence is unrealistic when measured against the potential danger presented the public by the unqualified or the unfit practitioner. The public interest would be best served if the "preponderance of the evidence rule" were applied in board cases. We have been urging this change on the states for some time.

In many states, there is room for significant improvement in board structure, function, and authority. I would urge you to review our *Guide to the Essentials of a Modern Medical Practice Act* and the *Elements of a Modern State Medical Board* for detailed proposals relating to this point. I will not attempt to outline all those proposals here.

I would like, however, to emphasize the vital importance of a systematic and coordinated effort to find and act on problem physicians.

I am presenting materials to you today for inclusion in the record that describe a concept of license reregistration that centers on the steadily improving identification of unqualified, unfit, and impaired physicians. Building on information that is generated every day reflecting physician performance and behavior, it places attention where it belongs -- on the problem physician. The system is based on mandatory reporting to boards by health professionals, health care institutions, liability insurance carriers, courts and law enforcement agencies, professional and specialty organizations, specified state agencies, and others. This mandatory reporting is complemented by an annual or biennial self-reporting program requiring the licensee to report to the board all relevant adverse information about himself or herself that may have developed during the reregistration period. At the same time, the licensee's

professional profile (practice location, specialty, professional memberships, hospital privileges, CME activities, licenses held, etc) is updated, allowing a review of sudden changes or patterns of change. Taken together, mandatory reporting and self-reporting permit a board, operating as all do with finite resources, to concentrate time and effort on markers and indicators of possible problems -- red flags for board attention and potential board action.

Today, most states are moving to such a system. Data accompanying the material I have made available for the record will provide you a clear idea of the progress that has been made over the past several years.

But I must add that the system of license reregistration I have described could have still more impact if professional review organizations were mandated to communicate more effectively and promptly with state medical boards. Peer review organizations are currently funded to evaluate the quality of care rendered to Medicare patients. As a result of their quality assurance review, PRO's identify those physicians who are deemed to have a substantial number of quality issues in a substantial number of cases and they subsequently institute corrective action plans for the physicians so identified. State licensing agencies should be promptly notified of all physicians who have been identified as requiring corrective action in order to establish an effective monitoring plan by the medical board. State medical boards could then initiate appropriate action if the remedial efforts of the PRO are ineffective, or if the physician attempts to avoid review by relinquishing his participation in Medicare.

Here is a specific area where federal legislation is appropriate and needed. The Congress can establish parameters for mandatory reporting to the boards by PROs. I would urge you to concentrate on such an effort as soon as possible. Unfortunately, effective reporting by the PROs may not develop without the specific mandate of Congress. I believe the

commendable purpose behind the IG's report would be well-served at the federal level by swift action to enhance the reporting responsibilities of PROs: already existing and funded agencies whose role in quality assurance would be dramatically improved by effective cooperation with the state boards. The states are doing their job better each year, as the IG's report indicates. Appropriate action by Congress in this area would assist them in doing it still more effectively.

Enhance and fund the quality review activities of the PROs and mandate their reporting to the boards. Focus the energy and resources we have available on the problem physician.

Let me say a word about the recommendations made by the report, because, finally, they are its substance.

I have already expressed to you our strong support of the first recommendation, directed to the states, about adequate board funding. I will not repeat the point but only stress again its vital importance.

The second recommendation, directed to the Public Health Service like the five that follow it, calls for the collection and analysis of state-by-state data relating to board staffing, etc. I would suggest that this is a task best left to the Federation, though it would be helpful if Congress would authorize funding in the credentials area that could be awarded through HRSA to assist in such an endeavor. The Federation's already existing publication, the *Exchange*, would be the ideal vehicle for the collection of data. It is our understanding that Congress has not included funds that can be used to support programs related to state licensure and discipline in recent PHS appropriations. This should be corrected if the federal government is to be of service to the states in this area.

The third recommendation, calling for a national meeting on the role of state medical boards, should be pursued by working in conjunction with the Federation's Annual Meeting,

at which every state board is represented and to which key state legislators are invited. We would be happy to discuss this with the PHS at any time.

The fourth recommendation, related to boards contracting with PRO's to conduct reviews of quality of care cases, is worthy of discussion in an age when the quality improvement question is becoming more and more central to board concerns.

The fifth recommendation calls for funding of the development of performance indicators for use by the boards. It correlates with the twelfth recommendation, calling on the Federation to facilitate board performance assessment. The thrust of these recommendations is the same, and I am pleased to tell you the Federation has already initiated a project that will develop a performance self-assessment instrument for the state boards over the next fourteen months. This project has been in the planning stages for some time and will complete the cycle of studies that has produced the *Guide to the Essentials of a Modern Medical practice Act*, *A Model for the Preparation of a Guidebook on Medical Discipline*, and the *Elements of a Modern State Medical Board: A Proposal*. Needless to say, the recommendations in the IG's report encourage us in our effort and we appreciate the support they provide.

Recommendation six, which encourages PHS funding to support the improvement of the investigative efforts of boards, is commendable. The Federation has appreciated the financial support it has received from PHS in the past. That support has been of great benefit in several Federation programs that have led to significant changes and improvements in boards. Further assistance, such as that proposed, could be of great value.

Recommendation seven calls on the PHS to provide demonstration funding concerning the use of practice standards and guidelines in the investigation of quality of care cases. That would be useful, of course, but only when such standards and guidelines have been

effectively developed with significant input from and acceptance by the medical profession. At that time, boards will certainly seek efficient methods for using them -- an effort that will justify such funding.

Recommendation eight concerning the sharing of PRO information with boards is clearly important. I have already discussed that issue at some length. Recommendations nine, ten, and eleven also deal with providing additional information to boards from Medicaid, Medicare, and several other sources. As you can tell from my previous remarks, having access to such information is an essential part of an effective markers and indicators system. Our major concern is that the boards have the funds necessary to use the information promptly and well.

Recommendation thirteen, concerning the continuing efforts of the Federation to assist boards in improving their licensing and regulatory processes, is, I can assure you, a fundamental part of the Federation's organizational commitment. Even the most cursory look at our efforts over the past decade indicate that fact. I sincerely believe that much if not most of what appears in the report and much of the debate concerning licensure and discipline in the country today stems from work the Federation has done throughout these years. Recently, thanks to changing professional and public attitudes and to media attention, people have begun to listen. State legislatures have begun to feel the pressure. Needless to say, we do not intend to stop.

We certainly agree with the final recommendation, number 14, that state governors and legislators should make every effort to address the problems of the boards more effectively. As suggested, their various national organizations can serve a role as stimulus in this, but we would suggest they begin with a careful study of all the material already developed and disseminated by the Federation and the IG's office. Efforts to reinvent the wheel will only

slow the process. The time has come to move.

On page twenty of the report, the statement is made that the actions of DHHS "concerning State boards...should be supportive of State government roles." We wholeheartedly agree with that and consider it a healthy recognition of the obligation of the states. We are a bit less comfortable, I must tell you, with the statement on page 21 that PHS "consider the future Federal relationship with the boards more in terms of a partnership addressing joint concerns than one involving separate spheres of responsibility addressing separate concerns." I agree we have joint concerns. That is patently obvious. But there are separate, recognized spheres of responsibility that cannot be allowed to blur simply because we find them inconvenient. Support and cooperation are appropriate and necessary -- they are essential. But the word partnership may be seen by many to imply something else -- to suggest some level of direct federal authority in medical licensure. I believe even the hint of that should be avoided. This responsibility falls to the states and they must meet it directly.

A question that rather naturally arises from this report -- and one I have often been asked -- is how one differentiates between a good board and a bad one. I wish there were a simple answer to that, but there isn't. The issues and forces involved are too complex. But I must say, I believe the question itself is wrong. Boards are not good or bad. They are strong or weak -- and their strength or weakness is largely attributable to the statutes and policies of their states.

Underfunded, understaffed boards attempting to function with outmoded statutes, inexperienced legal counsel, and inadequate investigative resources will be weak and will perform accordingly. States that fail to empower and equip their boards and make them accountable -- all at the expense of licensees, please recall -- fail in their duty to the public.

That is inexcusable and the public should demand corrective action by state legislators. The media, I should note, have provided a valuable service in the past ten or fifteen years in focusing attention on this issue and on stimulating that public demand. We hope they continue to do so.

The Federation does not pretend there is one best form of medical statute or medical board. In its *Essentials* and the *Elements*, however, it has tried to provide some suggestions to stimulate a useful dialogue in and among the states. There is no doubt that stronger boards are being created as a result of that dialogue.

At the same time, through the self-assessment program now being developed by the Federation, states and their boards will be enabled to evaluate overall board performance more efficiently, determine board needs more precisely, and strengthen board efforts more effectively.

Unfortunately, there are no legislative magic wands, either state or federal, with which we can wave away the challenges that face the boards or conjure perfect solutions. We are dealing, after all, with human beings functioning in human systems and limited by human knowledge and experience. Working together, however, in our appropriate roles, with the commitment and concern that motivates us all, the states and their medical boards, the federal government, and the medical community can realistically address the issue of quality improvement. Dr Oliver Wendell Holmes once wrote that "the great thing in this world is not so much where we stand, as in what direction we are moving." I believe we have been moving in the right direction and that the IG's report is a valuable signpost along the way.

Thank you.

OIG RESPONSE TO FSMB COMMENTS

We appreciate FSMB's positive response to the report as a whole and to the recommendations. We believe that FSMB can make particularly valuable contributions in the 1990s by leading efforts to develop and disseminate quantitative indicators of State medical board performance and to improve the boards' effectiveness in reviewing cases involving the quality of medical care rendered.



Bringing lifetimes of experience and leadership to serve all generations.

August 15, 1990

Richard P. Kusserow
Office of the Inspector General
Department of Health and Human Servi
330 Independence Ave. S.W.
Washington, D.C. 20201

Dear Inspector Kusserow,

The American Association of Retired Persons is very pleased to submit these comments on your draft report entitled "State Medical Boards and Medical Discipline."

The Association commends the authors of the report for their excellent work. The document makes a significant contribution to the effort to improve state boards, patients' "front-line" defense against incompetent medical practice.

AARP has been increasingly active in that effort, and we are delighted that the report acknowledges several recent activities.

We have reviewed the findings and recommendations of the draft and find that we are in agreement with most of its thrust, focus and content. Accordingly, the following comments address those areas where we have additional suggestions.

Peer Review Organization-Medical Board Data Sharing

AARP applauds the report's emphasis on the importance of increased data sharing between Peer Review Organizations (PROs) and medical boards. In particular, we support the move to mandate specific kinds of PRO data sharing.

The interests of patients require earlier rather than later PRO notification to the appropriate medical board of quality of care concerns. Towards this end the draft report's data sharing recommendation needs to be expanded beyond sanctions-related information to include material produced by PROs' quality review, beneficiary complaint, and utilization review processes. In addition, medical boards' sharing of information with PROs, i.e., a two-way flow of information would, we believe, enhance and facilitate PROs' quality assurance responsibilities.

Mandated data sharing related to the various PRO review activities will need to encompass a number of decisions on the timing of board notification, as well as the severity of problems triggering communication. In this connection, a mandated sharing prescription will need to differentiate between data sharing for

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Robert B. Maxwell *President*

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supervision of staff, high staff turnover, low staff to resident ratios, and the use of temporary services were deemed to be contributory factors.

It concerns us, therefore, that in this latest report nursing home administrator boards are not identified as agencies in a position to monitor or correct these problems. Neither, apparently, were nursing home administrator board organizations interviewed by the IG in the course of the study. We urge that nursing home administrator boards be included as part of the solution to the problem of improper care, working as they do with their "cousin" agencies, the medical boards, in the state regulatory apparatus.

Improved Effectiveness in Reviewing Quality of Care Cases

We agree that the FSMB is well suited to help state boards improve their effectiveness in reviewing quality of care cases. However, we would like to see the list of groups in a position to help boards expanded to include other organizations such as advocacy and public interest groups.

Development of Performance Indicators

We strongly support the need for developing performance indicators suitable for widespread use by state medical boards. Towards that end, a very promising source of input into the development of such indicators, namely, public members of medical boards, has been proposed by the OIG draft report's director, Dr. Mark Yessian.

Speaking to those members at a 1989 meeting conducted by AARP's Citizen Advocacy Center, Mr. Yessian observed:

"...it would be important to begin to develop some consensus about those variables that really are key indicators of board performance and that should be used to compare performance in different states.

...This is a good area for public members of medical boards to exert some leadership....(including) making the case for the kind of indicators that will help boards have more credibility with the public.

These aren't matters of medical discretion. These are matters that intelligent people can address and that depend on good common sense."¹

¹ The full text of his address is attached.

Conclusions:

We strongly commend the draft report and appreciate this opportunity to share our reactions. In particular, we welcome the emphasis on data sharing between PROs and state medical boards, as well as greater involvement by other agencies and associations to help state boards improve their effectiveness in reviewing quality of care cases. We also strongly support the commitment of the report to improve and evaluate the boards' oversight role through increased funding and greater national attention. We look forward to further communication with your office and other interested parties concerning these important matters.

Sincerely,

A handwritten signature in cursive script that reads "John Rother".

John Rother
Director
Legislation and Public
Policy Division

"DARE TO COMPARE: ASSESSING THE PERFORMANCE OF STATE MEDICAL BOARDS"

Luncheon Address by MARK R. YESSIAN, Ph.D., Regional Inspector General, HHS, at the Citizen Advocacy Center Fall, 1989 meeting of public members of medical boards

My remarks today have to do with a perplexing question: How do you know a good medical board when you see one?

Based on documents such as Ken Wagstaff's reports to the California Joint Legislative Budget Committee; AARP's report, Effective Physician Oversight: Prescription for Medical Licensing Board Reform; Bob Fellmeth's Code Blue Emergency report; the Federation of State Medical Board's Elements of a Modern State Medical Board: A Proposal; my office's reports; and other such "enlightened" sources; a good medical board might have the following characteristics:

It would have a full complement of enforcement tools, including revocation, suspension, probation, reprimand, and fines of a substantial size. A good board would have authority to impose immediate suspensions, to issue subpoenas, and to require a licensee to come in to take a medical exam when there is reasonable cause.

It would have annual license renewal fees of \$200-\$300 or more that would be put in a special fund just for the board. The money would be used to hire ample investigatory and legal staff, computerize records, establish a tracking system, and provide board member training. The board would be composed of 12-24 members -- at least 25% of whom are public members -- who are adequately compensated for their time, maybe at a rate of 3/4 the salary of the State Commissioner of Health.

A good board would have a sophisticated system for prioritizing cases. It would have guidelines for determining appropriate sanctions. It would have close cooperative relationships with PROs, with state medical societies, with state Medicaid fraud units, and with state Attorneys General. It would provide immunity for all those reporting cases to the board. It would conduct computerized detections of patterns of errant behavior. It would take on complex cases. It would issue its phone number in all the white pages and yellow pages throughout the state. It would have a toll-free number.

I think if any of us saw a board with all of these characteristics, we would tend to say it was a good board. It would probably impress us. Yet, as important as all these elements

are, they leave out one essential factor: actual performance. For instance, who is to say that a board with ample resources and ample authority will necessarily use these resources and authorities effectively? If I might get a little closer to home, who is to say that a board with 25 percent or more public members is necessarily an effective one?

I would say that all the elements I have run through quickly and haphazardly are really only enabling elements. They are elements which, if put in place, enable a board to function effectively. You might even call them prerequisites, although we might argue about some of them. Essentially, they are not performance indicators, but rather enabling elements.

So, if we want to answer the question, "Is the board a good one?" don't we have to go the next step and look at actual performance -- that is, at the actual work being done and the outputs of the board? If the answer is "yes," the question is still the same. How do we know a good board from a mediocre board from a poor one? Or, maybe better yet, how do we compare the performance of a particular board from one year to the next? How do we know if it is doing better or worse?

There is a school of thought out there that, except perhaps at the margin, you can't and probably even shouldn't ask this question about performance. It is a well ingrained school of thought, I would say, and will exert significant constraints on any initiative to address performance. The arguments against performance assessment go something like this:

Each case reviewed by a medical board is unique, with its own particular circumstances and characteristics. The board has a responsibility to recognize these distinctive features and to respond in a fair manner, balancing the rights of the individual with those of the public. Its job is to dispense justice, not to generate statistics.

This leads to a concern about quotas -- about the pressures to produce increasing numbers of scalps. To that I might add that the critiques by the Sidney Wolfes and the Bob Fellmeths and even the Mark Yessians tend to add to these pressures. Such pressures could lead some boards, I think it is fair to say, to act hastily and to focus on easier cases to generate more numbers. I am sure there are various other ways these pressures could lead to unhealthy distortions.

Another argument against performance assessment is that boards tend to deal with complex matters involving the performance of highly trained professionals. In determining whether these professionals should be sanctioned, particularly in cases involving the quality of care, the boards need substantial latitude to make decisions based on expertise. They need to operate with

a good bit of independence and public trust.

Finally, just as each case is unique, each state medical board is unique and works within a different political, economic, and administrative context. A board is a product of its state government and can't be held accountable for matters it can't control. Thus, comparison of boards across states is inherently flawed.

Well, have I destroyed the case for performance assessment? I don't raise these issues cynically, or dismiss them. There is a lot of truth in these arguments. There are inherent limitations to addressing board performance. If handled unwisely, performance assessments can be counterproductive and very detrimental. Without question, there are many sensitivities and subtleties that surface reviews can easily miss.

But, where does that leave us? In this era of bottom-line accountability, are we then to conclude that boards shouldn't be held accountable for their performance? that there aren't any specific quantitative ways performance can be measured? that it is enough just to focus on the enabling elements?

Obviously, I think not.

Isn't it an obligation of public entities such as boards to develop yardsticks that can be used as guides -- not proof positive, but guides -- in assessing their performance? Shouldn't taxpayers expect this? Wouldn't such yardsticks be useful in the sunset reviews that are performed in 40-some states? Corporate leadership has all kinds of quantitative measures of their performance. Is our world of public boards so much more complex, so much more unique, that we can't expect to do some of the same?

While the job is a difficult and sensitive one, I really do think the difficulties here are much more political than technical. Boards, I think, can and should develop specific quantitative indicators of performance expressed in terms of ratios and percentages that facilitate comparison. True, such indicators might expose boards to more "pot shots" by people like us and others in your own state, but you're going to get those anyway. Might they not also let the boards be more proactive in determining the bases on which they are to be evaluated?

I would argue that specific indicators of this sort over time would add a lot of credibility to the boards and would help significantly in improving their performance. If you can buy that for a moment at least, how do we go about doing it? How do we even start? The first thing I think is to promote the idea --to make a case that addresses some of the concerns I raised earlier. It is important to stress that in trying to get specific quantitative measures of performance, we are looking just for indicators of

Let me start with the most provocative part -- the disposition of cases. This includes reported disciplinary actions, informal settlements, and cases that are dismissed. Reported disciplinary actions is easy to focus on. It's tangible and readily available. The AARP report says, "The simplest way to ask how well a board is performing is to ask how many disciplinary actions it takes." In defense of this simple indicator, I think it is a pretty useful yardstick, especially if it is used as a ratio -- disciplinary actions per licensed physician or per active physician -- and if it is aggregated over two or three years. The data should reveal actions by type and actions based on the grounds, the reason for the action.

If all we focus on is the number of disciplinary actions, there can be some of the negative consequences I mentioned. But, consider this: if a board is consistently on top, it is fair to ask if that board is being overzealous. Good performance is not necessarily just more scalps. It is reasonable for physicians and others at some point to say, hey, that board's not being fair to physicians. I think that should be part of the debate.

What other kind of indicators might be developed concerning the disposition of cases? What about the educational interventions and other remedial actions not reported in the Federation's data bank? Frankly, I am surprised that the boards and the Federation have not put more emphasis on documenting such dispositions. If such data were tabulated along with data on formal disciplinary actions, the boards and the Federation would be in a better position to respond to the critics who suggest they are not doing enough.

In the sphere of case review, I would say the most important thing to measure is processing time. How long does it take to process cases, however you define the beginning and ending points? Wouldn't such data provide a powerful comparative tool? In the sphere of identification of cases, California leads the parade by publicizing detailed statistics in an annual report, including even disciplinary actions by type of referral source. I think that kind of data can be enormously helpful.

The last sphere, quality of care, is tougher to define and more qualitative. We see significant stirrings as boards get more involved in preventive actions that are informational rather than disciplinary. Some boards are actually doing peer review or overseeing the peer review activities of hospitals. We even hear of practice audits, and things of that nature. Well, these actions should have more status than just "other." If this kind of activity increases in scope and significance, we need to develop measurement indicators to determine whether a board is doing a good job.

Let me tease you with one final thought. In 1994 or 1996, or

1998, or whenever, there will probably be a time when there is some kind of universal medical coverage at the national level. Who will have the prime public responsibility for overseeing minimum standards of care? Will it be the medical board? Will it be the PRO, or some successor federally funded entity? Or, will it be both? And, if it's both, what are the complications associated with that? I pose the question because I think the answer, at least in part, can be determined by what the boards do today and in the ensuing years.

Now, let me wrap up by telling you the criteria we use in evaluating boards. We did a study three years ago and are initiating another one right now of state medical boards. In our prior work in this area, we have used essentially two basic criteria. One focuses on those enabling elements I talked about. We do some counts and are able to say things like, X number of boards don't have sufficient authority or sufficient resources. The second criterion is the "how many" questions -- how many disciplinary actions are being taken by each state? Such a review always reveals significant variations that raise questions about the performance of some boards.

With the upcoming study, we're going to add something new. I think it will provide some data that will be helpful in moving us toward some of the performance indicators I have been talking about. What we will do is seek information on all disciplinary actions taken in 1988 in a randomly selected sample of states. This will involve about 200 cases. For each case, we are going to ask questions about the referral source, the date of the initial complaint, the date of the final action, whether the action was stayed or appealed, the reason for the action, even the setting for the action. I think this will be the first time anyone has gathered quantitative information about a sample of cases that will provide us with a good profile of disciplinary action. Most important, it will let us make some correlations by disciplinary action, by processing time, by basis for referral.

Lastly, we will take a look at the quality of care realm, more in a descriptive than an evaluative way. We want to try to get a picture of whether these preventive-type actions that boards are taking are only marginal activities or perhaps indicators of an evolving board role that will be more significant in the future.

With plenty of limitations and caveats, we hope the data we gather will let us say a little bit more about a board's performance. But, most importantly, I hope it will stimulate broader discussion of performance indicators. If critics don't like the indicators we have used, perhaps they will think of a better way to do it. The fundamental challenge to the leadership in this field is to dare to compare -- to develop a few basic indicators of medical board performance and then to use these indicators as comparative guides to performance.

OIG RESPONSE TO AARP COMMENTS

We are pleased by the AARP's supportive comments on the report. Below are some of our own comments responding to particular points made by the AARP.

On PRO-State board data sharing. We welcome further consideration of even more extensive data sharing along the lines proposed by AARP. We also recognize that it may be useful to make some distinctions between data sharing intended as an early warning and that concerning cases where there is compelling evidence of poor quality care. Our major concern is that there should be more exchange of detailed case information between PROs and boards in cases involving serious quality of care problems and that in some way such sharing be mandated.

On a national meeting. We agree that AARP and other consumer and public interest organizations should be part of the meeting. The participation should be broadly based, involving many participants not directly associated with State medical boards. It should be convened under the PHS' auspices in Washington, D.C.

On the Ombudsman Program. We suggest that the AARP take note of the AoA's response to our recommendation on the Ombudsman Program. We find it encouraging and expect that AoA's efforts can contribute to better opportunities to identify cases of improper medical care in nursing homes.

PUBLIC CITIZEN

Buyers Up Congress Watch Critical Mass Health Research Group Litigation Group

Memo to: Richard Kusserow
Inspector General
U.S. Department of Health and Human Services

From: Sidney Wolfe, M.D.
Director, Health Research Group

Re: Comments on "State Medical Boards and Medical Discipline"
OEI-01-89-00560

Public Citizen's Health Research Group applauds the Office of Inspector General for its report "State Medical Boards and Medical Discipline." The report, and Inspector General Richard Kusserow's accompanying Congressional testimony, lay out the unvarnished facts about our nation's appallingly lax system of medical discipline.

We disagree, however, with the report's implication that the major benefit of good medical quality assurance is to reduce medical malpractice insurance rates.

The true goal of those who seek to bolster the United States' medical discipline system must be to reduce medical malpractice, and the hundreds of thousands of deaths and injuries this malpractice causes each year.

Public Citizen submits the following recommendations to bolster medical discipline in this country. These recommendations are excerpted from our June 1990 report, "6892 Questionable Doctors."

RECOMMENDATIONS

I. To the federal government.

should be tied to the boards' agreements to meet certain performance standards, to be developed by the Public Health Service, as the Department of Health and Human Services Office of Inspector General has recently recommended.⁴¹

The standards should include: processing complaints within a certain time limit; maintaining a certain level of staffing and having staff meet certain qualifications; disseminating disciplinary information to the public; and more.

2. Require cooperation. Congress should promptly remove any legal barriers to the sharing of investigative information between the Medicare Peer Review Organizations, the state Medicaid agencies, the Drug Enforcement Administration and state medical boards.⁴¹ It should mandate such information-sharing. Rep. Ron Wyden, D-Ore., has promised to introduce legislation on this matter.⁴⁸

3. The Medicare Peer Review Organizations, which have been practically moribund in disciplining physicians for substandard care, should become more aggressive. The PROs should hire investigators and advisers trained in law enforcement, so that fewer of their sanctions will be overturned.

As a recent Institute of Medicine report noted, the PROs are not evaluated on their ability to detect and correct poor quality care.²⁸ The Department of Health and Human Services should change its evaluation procedures to place more emphasis on quality.

4. Open the data bank. The Bureau of Health Professions should keep the National Practitioner Data Bank, which will collect and disseminate disciplinary information on health care practitioners, on track to begin operations in September.

Congress should pass legislation to open the data bank to the public.

5. The Drug Enforcement Administration should release a monthly list of all practitioners whose controlled substance prescription licenses have been revoked, restricted or denied, whether by voluntary agreement or publication in the Federal Register. The list should be widely distributed to pharmacies, state pharmacy and medical boards, and the general public.

Far too many doctors continue to prescribe controlled

substances after their DEA licenses have expired or been revoked. The DEA should consider requiring pharmacies to subscribe to an on-line service with which they could check the validity of these numbers.

6. Require doctor recertification. Congress should consider legislation proposed by Rep. Pete Stark, D-Calif., to require physicians who accept Medicare patients to be periodically recertified for competency.

II. To the states:

1. Strengthen the statutes. States that have not already done so should adopt a modified version of the Model Medical Practice Act developed by the Federation of State Medical Boards.¹²
2. Restructure the board. States should sever any remaining formal links between state licensing boards and state medical societies. Members of medical boards (and separate disciplinary boards, where present) should be appointed by the governor, and the governor's choice of appointees should be unconstrained, not limited to a medical society's nominees.

At least 30 percent of the members of each medical board and disciplinary board should be public members who have no ties to health care providers.

The governor should appoint medical board members to the Medical Board whose top priority is not providing assistance to physicians, but protecting the public's health.

3. Inform the public. Each state's Open Records Law and its Medical Practice Act should state that all formal disciplinary actions against licensed professionals are fully public records.

Each Legislature should require widespread dissemination of final disciplinary orders. Lists of those disciplined and full disciplinary orders should be promptly available to all who ask, through the mail.

Notices of disciplinary actions should be sent to the news media and to all hospitals, HMOs, and other health care providers in the state, as well as to other state agencies, the federal Department of Health and Human Services, and the federal Drug Enforcement Administration.

4. Strengthen board authority. Every medical board should have the authority to impose emergency suspensions pending formal hearing where there is a potential danger to the public health. Boards should aggressively use this authority when they learn of a potentially dangerous doctor.

Every medical board should have the authority to impose civil fines of up to \$100,000 for violations. Boards should

aggressively use this authority to enforce the requirements for all health care providers to report violations.

Medical boards should have the authority to accept the findings of other state boards and of the federal Department of Health and Human Services and the Drug Enforcement Administration. If a physician has been disciplined by another state, the second state's medical board should be required to impose sanctions at least as stringent as those imposed by the first state.

States should require already-licensed physicians to submit affidavits that they are not under investigation elsewhere before resuming practice in the state. Physicians who are under investigation should not be permitted to return.

Each Legislature should provide the Board with authority to examine physicians for physical, mental and professional competence and to test them for alcohol and drug use.

4. Encourage complaints. Each Legislature should provide the protection of confidentiality and immunity to those who report violations of the Medical Practice Act to the Board and to board members, staff and consultants.

Each Legislature should require all licensed health care practitioners to report Medical Practice Act violations by other practitioners to the medical board, with large civil penalties for failure to do so. It should require hospitals to report all revocations, restrictions, or voluntary surrenders of privileges.

It should require courts to report all indictments and convictions of physicians to the medical disciplinary board. It should require liability insurers to report all claims, payments, and policy cancellations. It should require reports from other state agencies, Medicare, the DEA and other federal agencies. It should require impaired physicians programs to report the names of doctors who fail to successfully complete the program.

Medical boards should conduct random audits of institutions to check compliance with these reporting requirements, and should fine those who fail to comply. After a doctor is disciplined, a board should fine any other practitioners who knew of that doctor's offense, but failed to report it.

5. Keep the courts in check. Each Legislature should instruct its state's courts to give deference to disciplinary decisions by the board. Stays should be prohibited; medical board actions should always take effect pending appeal.

Each Legislature should adopt the 'Preponderance of the Evidence' standard of proof in medical disciplinary cases,

replacing the tougher-to-meet 'Clear and Convincing Evidence' standard now in effect in most states.

6. Beef up funding and staffing. Each Legislature should permit the medical board to set its own fees and spend all the resulting revenue, rather than being forced to give part to the state Treasury. The medical boards should raise their fees to \$500 a year.

All boards could benefit from hiring new investigators and legal staff. Boards should ensure adequate staff to process and investigate all complaints within 30 days, to review all malpractice claims filed with the board, to monitor and regularly visit doctors who have been disciplined to ensure their compliance and to ensure compliance with reporting requirements.

They should hire investigators to seek out errant doctors, through review of pharmacy records, speaking with medical examiners, and targeted office audits of those doctors practicing alone and suspected of poor care. "Physicians who have problems," comments Department of Health and Human Services Inspector General Richard Kusserow, "have retreated to areas where they cannot be observed."

7. Require risk management. States should adopt a law, similar to one in Massachusetts, that requires all hospitals and other health care providers to have a meaningful, functioning risk management program designed to prevent injury to patients. Massachusetts also requires all adverse incidents occurring in these institutions or in doctors' offices to be reported to the medical board.

8. Require periodic recertification of doctors based on a written exam and audit of their medical care records.

III. To patients...

1. Complain. Use the addresses in this report to file your complaints about poor medical care or medical misconduct with your state medical board and with the federal Department of Health and Human Services. If the offense occurred in a hospital, also file a complaint with the hospital peer review committee.

Your complaints are needed to protect others!

2. Organize. Form citizens action or victims rights groups to improve medical quality assurance in your area. The American Association of Retired Persons publishes a guide that can help you mobilize a group for reform.¹ Try to get a representative of your group appointed to the state medical board or the Medicare Peer Review Organization for your state.

OIG RESPONSE TO PUBLIC CITIZEN COMMENTS

We appreciate Public Citizen's positive assessment of the report. However, we do not intend to imply that the major benefit of good medical quality assurance is to reduce medical malpractice insurance rates. In this regard, we now state on page 1 that "to a considerable degree" the malpractice crises are "rooted in problems associated with poor medical care, and that over the long term one of the most effective ways to address these problems would be to assure that effective quality assurance mechanisms are in place."



AMERICAN MEDICAL ASSOCIATION

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JAMES S. TODD, M.D.
Acting Executive Vice President

June 11, 1990

Richard P. Kusserow
Office of Inspector General
Room 5350
Cohen Building
330 Independence Avenue, SW
Washington, D.C. 20201

Dear Inspector General Kusserow:

We are pleased to comment on the April 1990 draft report of the Office of Inspector General, "State Medical Boards and Medical Discipline." We understand that this report is a draft and is subject to revision. We commend you for devoting the time and resources to develop this report on the important issue of medical discipline.

In examining the medical disciplinary functions, we believe that it is important to keep in mind that quality assurance is a broad concept which encompasses many activities, e.g., medical education, facility accreditation, continuing education, technology assessment, medical licensure, peer review, risk management and medical discipline. Medical discipline should be viewed as one end of the spectrum of quality assurance activities.

The AMA has an extensive history of working to assure quality of care and to reduce the excessive costs associated with the liability crisis. We have long advocated that medical boards should be strengthened, and accordingly we strongly agree with the recommendation that "state governments should assure that all licensure fees collected from physicians and other professional groups under the purview of medical boards are used to support board operations." This is long-standing AMA policy.

We also agree that the medical discipline system has progressively improved over the past decade. This is due primarily to several factors. First, states have amended their statutes to expand board authority, reporting requirements, and grounds for discipline. Also, the Federation of State Medical Boards (FSMB) has become an increasingly active "player" in improving board operations through the development of "A Guide to the Essentials of a Modern Medical Practice Act," "A Guidebook on Medical Discipline," "The Exchange," and development of a

system of "markers" for identification of "problem" physicians. The FSMB also distributes a monthly report of adverse licensure actions reported by the state boards. We note that the draft report recommends that the Public Health Service collect data regarding board staffing, revenue, and expenditures. We believe such an effort would duplicate existing activities since FSMB is already in the process of collecting, analyzing, and disseminating this information.

We support the draft report's recommendation that a national meeting be convened to focus attention on the importance of state medical board oversight of physicians and to examine how to further improve board resources and efficiency. We believe that an important topic for discussion at such a conference would be federal financial support to states for technical assistance efforts intended to improve board operations and investigative efforts. We strongly believe that the AMA, the FSMB, state agencies, and state legislators all should play prominent roles in the discussions that would take place at any national conference on state medical boards.

We are continuing our study of the OIG Report but at this time wish to state a number of concerns regarding certain recommendations contained in the draft report. The report recommends an expanded role for PROs in the medical disciplinary process. Specifically, it calls for legislation mandating that PROs share case information with medical boards when the first sanction notice is sent by the PRO to a physician. Differentiation must be made between sanctions for matters of physician incompetence and those for Medicare infractions not affecting health care. In any event, we oppose sharing of case information, including that obtained from the Quality Improvement Program, with state medical boards prior to final resolution of the recommended sanction. The AMA believes that before any physician is reported to a state licensing body for alleged quality deficiencies, the physician should be provided a due process hearing to include representation by an attorney, a record of the proceedings, an opportunity to call, examine, and cross-examine witnesses, and an opportunity to submit a written statement at the close of the hearing. Our process must also include an appropriate appeal process. Statistics excerpted from a past OIG report indicate that approximately 50% of sanction recommendations are overturned on appeal. On balance, PROs have been cautious regarding the types of information that they release. We believe that extreme caution is warranted. A report of substandard physician care, where that report is later found to be unjustified, could become a permanent unfair mark against the physician's reputation. The severity of this unjust mark against the physician's reputation is magnified in the current environment of computerized information-sharing, as exemplified by the establishment of the National Practitioner Data Bank. The AMA is opposed to this potentially onerous activity proposed in the draft report.

The draft report also recommends that state boards contract with PROs to conduct reviews of quality of care cases. We believe that this idea warrants extreme caution. In addition, while we would generally support cooperative endeavors where appropriate, we would do so only with the proviso that the due process rights of the physician under review be fully and completely protected throughout the process.

We are also concerned that the draft report fails to make a distinction between "medical malpractice," which relates injury due to negligence (i.e., an error or omission) and "professional incompetence," which is the inability to practice medicine with reasonable skill and safety. The discussion on page 12 and page 16 seems to indicate that the rate of physician discipline should be equivalent to the incidence of negligence. Data shows, however, that the number of medical negligence claims fail to be reliable indicators of negligence. The recent New York State Harvard Study showed that 80% of the claims for medical negligence filed in New York did not correspond to a negligent adverse event. In addition, we must point out that the draft report's characterization of the New York State Harvard Study (page 12) ignores the fact that the Harvard study examined all types of hospital negligence, not just those directly involving physician care (e.g., falling out of bed incidents), thus making the rate correlation argument specious.

We also note the report's concern that "clear practice standards and guidelines" have not been integrated into the disciplinary process. This observation assumes that such guidelines, or "parameters" as they are known in much of the medical field, exist and are appropriate indicators of physician competency. In fact, practice parameters address utilization issues as well as physician competency and patient safety concerns and therefore will not always be relevant to the competency evaluation process. We agree, however, that as appropriate patient-safety oriented parameters, such as those disseminated in the anesthesia field, are developed, they may be indicators of appropriate practice.

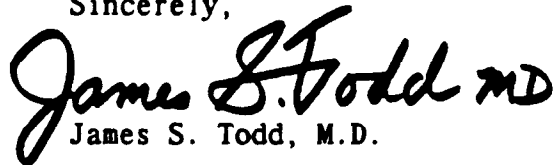
We also are concerned that the draft report repeatedly suggests changes in statutes that will allow "shortcuts" and medical board action without the board's own full investigation. We oppose such statutory modifications. Medical boards have a responsibility - a duty - to fully investigate the facts of each case prior to taking disciplinary action. Licensure action is a grave matter that should never be undertaken using shortcuts. Where an urgent situation is presented to a board, boards have, in all jurisdictions, the authority to issue a restraining order during the pendency of its investigation.

Lastly, we are concerned about the discussion contained in the draft report regarding the modification of the standard of proof in disciplinary actions from a "clear and convincing" standard to a "preponderance of evidence" standard. Such a major change in the

required standard of proof could have far-reaching negative effects on the due process protections for individuals who are subject to government oversight.

Again, we are pleased to have had the opportunity to comment on the draft report of the Office of Inspector General. We welcome the opportunity to work with all interested parties on an ongoing basis to formulate improved mechanisms to address physician discipline and to continue to better the performance of the state medical boards.

Sincerely,


James S. Todd, M.D.

JST/lp
cc: Mark R. Yessian, Ph.D.
3953x

OIG RESPONSE TO AMA COMMENTS

We completely agree with the AMA's assertion that the due process rights of a physician under review should be fully and completely protected during the review process. However, unlike the AMA and for reasons we have already indicated, we believe that the PROs' sharing of case information with boards and the PROs' contracting of boards to conduct reviews are quite compatible with the protection of those rights. We must also note that the boards, in addition to assuring that physicians' rights are upheld, also are responsible for protecting the public from unscrupulous and/or incompetent medical practice.

With respect to the AMA's concern about "shortcuts," we believe that in States where a case going through a full evidentiary hearing takes two years or more, some expediting of that process is vital if the boards are to carry out their responsibilities to the public. We believe that a quicker process can still afford ample protection of physicians' due process rights.

APPENDIX B

METHODOLOGICAL NOTES

Literature and Document Review

We reviewed the 1986 through 1989-90 editions of the FSMB's *Exchange*, which include up-to-date information on the State boards. The *Exchange* provided us with data on the boards' structure, operations, review, and disciplinary functions. This included information regarding statutory reforms, budget allocations, board composition, disciplinary grounds and other basic board facts.

In addition, we reviewed the annual reports of most State medical boards and numerous publications from entities that were in some way associated with or interested in State medical boards and their disciplinary processes. Some of these entities included the American Association of Retired Persons, the American Medical Association, the Public Citizen Health Research Group, the Office of Inspector General, the U.S. Public Health Service, and the American Medical Peer Review Association.

FSMB Data

We obtained validated disciplinary data for the years 1985 through 1987 from the FSMB's publication entitled the *Federation Bulletin*. (See endnote 22.) These yearly compilations consist of State board actions reported to the FSMB during the year broken down by four major categories: revocations, suspensions, probations, and other actions.

As FSMB validated data was not available for 1988, we examined the unvalidated data from the FSMB's *Disciplinary Action Reports* for the months of January 1988-March 1990. Since all the 1988 actions were not reported in 1988 we felt it necessary to capture those 1988 actions reported late in the 1989 reports. We reviewed these 1988 actions not to obtain a precise count of the number of disciplinary actions taken, but to gain a better understanding of the types of actions being undertaken in that year.

We performed a trend analysis of the 1985-1987 data. This included comparisons of revocations, suspensions, probations, and other actions, as well as total actions, from year to year and over the 3-year period. We also made comparisons on the basis of annual physician renewal fees, size of State medical doctor populations, and regions. Information concerning renewal fees and physician populations were taken from the FSMB and the AMA publications, regional groupings were obtained from U.S. census data. In analyzing the data, statistical measurements were made to judge the significance of the data.

Random Sample of States and Cases

We obtained a random sample of States stratified by the number of practicing doctors and the number of actions taken by the medical boards in those States in 1988. To identify the actions we used the 1988 disciplinary action report data as reported to the FSMB by individual States (as discussed above).

The stratified sample consists of four sample categories: large States taking many actions, large States taking few actions, small States taking many actions, and small States taking few actions. Within each category, we randomly selected two States, resulting in a sample of eight States.

Within each of the selected States, we examined all the disciplinary actions taken in 1988. This resulted in 199 disciplinary actions in the eight States.

For each case we obtained, if available, the referral source (hospital, insurance company, consumer, PRO, state medical society, etc.), initial complaint date, date action went into effect, whether the action was stayed—pending appeal—or overturned on appeal, the basis for the action, and the setting in which the event/events occurred (hospital inpatient or outpatient, private office, nursing home, or other). These data were analyzed using cross-tabulation statistical methodologies.

Initially, it was our intention to draw on the survey data to determine how long it took the States to process cases, from time of initial complaint until time of case disposition. We also intended to correlate this processing time variable with other variables, such as basis for action, type of action, and referral source. Such an effort appears to be achievable, but did not succeed in our study.

Our failure in this regard is attributable to inconsistencies and gaps in the initial complaint data provided to us by the State boards. The inconsistencies were based on different definitions of “initial”—that is, of when the board first received a complaint. In many instances, boards have multiple complaints/referrals on a particular physician that have come in at different times. The first such complaint/referral is not necessarily the one that trigger the case review.

The gaps in initial complaint data reported to us were attributable to limitations in the data readily available to the boards. In some cases, information could not be garnered from the case records held by the boards. While we cannot be certain, it appears that with more investigation such information could be attained.

Site Visits and Other Contacts

Visits were made to the four States having the largest numbers of medical doctors. These included California, Texas, Pennsylvania, and New York, which together account for approximately 37 percent of the practicing doctors in the country. Prior to the site visits we

conducted pre-inspection site visits to the Connecticut and Maryland boards. During the site visits it was our aim to talk with the primary people involved in the process of disciplining physicians at each of the boards. These visits included numerous discussions with executive directors, chief prosecuting attorneys, chief investigators, and hearings officers. For one State we were allowed to attend the investigative hearing committee meeting of the board.

For each of the interviews we followed discussion guides which focused on the issue areas of the study. Numerous questions were asked concerning the identification of cases, the case review process, case dispositions, and impediments in those areas. Telephone discussions were held with representatives of the Peer Review Organizations in the four site States. The questions asked of PROs centered on the relationship of the board and the PRO in regard to the referral of cases between them.

Questions were also asked about the State or board's efforts in assuring quality medical practice. Additional contacts were made with other State boards and other associated entities to discuss quality assurance efforts. Contacts were also made with Canadian Provinces to discuss their efforts in this area. We will address the extent and results of these efforts in detail in a subsequent report.

APPENDIX C

ENDNOTES

1. See United States Department of Health and Human Services, *Report of the Task Force on Medical Liability and Malpractice*, August 1987; Office of Inspector General, *Medical Malpractice: A Monograph of Current Information*, May 1989; United States General Accounting Office, *Medical Malpractice: No Agreement on the Problems or Solutions*, February 1986; and United States General Accounting Office, *Medical Malpractice: A Framework for Action*, May 1987.
2. See *Medical Economics*, April 18, 1988. The entire issue is devoted to an examination of medical malpractice.
3. See Office of Inspector General, *Medical Licensure and Discipline: An Overview*, June 1986.
4. See, for examples, Kusserow, Richard P., Handley, Elisabeth A., and Yessian, Mark R., "An Overview of State Medical Discipline," *The Journal of the American Medical Association*, Vol. 257, No. 6, February 13, 1987, pp. 820-824; and "Tighter Reviews of Doctors Urged," *The New York Times*, June 6, 1986.
5. In 1985, at the time we began our prior study of State medical boards, there were widespread concerns about recent scandals involving fraudulent medical credentials from two Caribbean medical schools and the administration of the Federation Licensing Exam (FLEX) used by the States. In the ensuing years, no such scandals have been reported and both State medical boards and hospitals have improved their credential verification processes.
6. Throughout the report, in referring to the State boards, we refer to the boards in the 50 States and the District of Columbia. This includes data in the figures as well as in the text.
7. For further explanation of this development, see Braeden, Dale G., "Concentrating on the Problem Physician: Perspectives in Medical Discipline—Part II," *Federation Bulletin*, Federation of State Medical Boards, Vol. 76, No. 3, March 1989, pp. 71-2.
8. *Medical Licensure and Discipline*, p. 15.
9. The workshop included representatives from Alabama, California, Colorado, Iowa, Minnesota, Missouri, Ohio, Rhode Island, West Virginia, and Wisconsin. See American Association of Retired Persons, *Proceedings of a Workshop to Discuss Information Exchange between Peer Review Organizations and Medical Licensure Boards*, April 1990.

10. See Jaco, Dan and Neikirk, H.J., "Exploring the Relationships between Peer Review Organizations and State Medical Licensing Agencies: Results of a Survey of PROs," Missouri Patient Care Review Foundation, Paper presented at the Tri-Regional PRO Conference, St. Petersburg, Florida, June 16, 1989.
11. In the 4 case study States, the boards report that they have been receiving few referrals from the PROs. In our 8 sample survey States, only 1 of 199 disciplinary actions taken in 1988 is reported as originating from a PRO referral.
12. The Intergovernmental Health Policy Project of the George Washington University provides a regular listing of changes made in State laws involving the oversight and regulation of physicians. In its September 1988 report it noted that "the overwhelming administrative backlog of cases to be investigated and reported" remained as one of the major problems plaguing State medical boards. See Intergovernmental Health Policy Project, *Focus on—State Oversight and Regulation of Physicians*, No. 22, September 1988, p. 7. See also Weinstein, Michael, "Medical Boards Police Profession Amid Physician, Public Criticism," *Observer*, American College of Physicians, Vol. 9, No. 11, December 1989, pp. 1, 6-7.
13. From June 30, 1988 to June 30, 1989, the number of complaints awaiting assignment to an investigator declined from 911 to 671. From June 30, 1989 to December 15, 1989, the number rose to 731.
14. In Pennsylvania, the board reported that in Fiscal Year 1988/89 the 451 physician cases that were closed took an average of 642 days to complete. In New York, at a December 11, 1989 hearing on physician discipline before the Committee on Health and the Committee on Higher Education of the Assembly of the State of New York, a State health department representative indicated that in 1988 "the average case from the service of the charges to the final service of the order" (p.91) took 21 months. That period of time, he noted later in his testimony, follows an average 6 to 7 month period during which an investigation would have been conducted (p. 93).
15. It must be recognized that some boards depend upon investigative staff of an umbrella agency of which they are a part. In such instances individual investigators may have responsibilities involving a number of different kinds of boards.
16. For the 1986 to 1989 period, each of these State boards had responsibilities for disciplinary investigations, hearings, and decisions and in each year reported investigative staffing data in FSMB's *Exchange*. They are: AL, AR, AZ, CA, CO, DC, GA, IA, ID, KS, KY, LA, MA, ME, MN, MO, MS, MT, ND, NH, NM, NV, OH, OK, OR, RI, SC, SD, VT, WV, and WY.
17. American Medical Association, *U.S. Medical Licensure Statistics and Licensure Requirements*, 1986 and 1990 editions.

18. Zeitlin, David I., "An Update on How—And What— BMQA is Doing," *Los Angeles County Medical Association Physician*, March 6, 1989, p. 37.
19. Assembly hearing, December 11, 1989, p. 84.
20. Federation of State Medical Boards, *Exchange*, 1989-1990.
21. To our knowledge, there is not available at this point any inventory that specifies the number of State boards bound by the "clear and convincing" rule. However, FSMB officials note that the majority are so bound. Our own discussions with board officials in many States suggest the same.
22. The FSMB has a thorough process for checking the validity of each of the actions reported in its disciplinary action data bank and for eliminating any actions subsequently overturned on appeal. The validated counts for a calendar year are regularly published in the *Federation Bulletin*.
23. Schwartz, William B. and Mendelson, David N., "The Role of Physician-Owned Insurance Companies in the Detection and Deterrence of Negligence," *The Journal of the American Medical Association*, Vol. 262, No. 10, September 8, 1989, pp. 1342-1346.
24. See "Hospital Study Finds Few Suits, Much Negligence," *The New York Times*, January 30, 1990. See also, Hiatt, Howard H. et al, "Special Report: A Study of Medical Injury and Medical Malpractice," *New England Journal of Medicine*, Vol. 321, August 17, 1989, pp. 480-4.
25. Data are derived from FSMB data on State board actions as reported in *Federation Bulletin*, 1985-1987 editions.
26. When serious actions taken by boards in southern States were compared to those by boards in northern States, the difference was significant at the .03 level. When all actions taken by boards in medium-sized States were compared to those in States of all other sizes, the difference was significant at the .003 level. It must be recognized that the disciplinary activity of particular States during the 1985-1987 period may be quite different than that in prior or subsequent periods.
27. Relman, Arnold J., "Professional Regulation and The State Medical Boards," *New England Journal of Medicine*, Vol. 312, No. 12, p. 785.
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36. *Medical Licensure and Discipline*, p. 20.
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44. This point was strongly endorsed by the PROs participating in the AARP conference noted in endnote 9.
45. In this regard, the Office of Inspector General, once it imposes a sanction on the basis of a PRO referral, should also make detailed case information available to the medical board. The necessary regulatory or statutory changes to allow for such sharing should be addressed at the same time that such changes are being addressed with respect to PRO sharing of data.
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48. See Medicare Part B Carrier Manual, Section 10040. See also United States General Accounting Office, *Medicare and Medicaid: More Information Exchange Could Improve Detection of Substandard Care*, March 1990. This study found that there was minimal exchange of case information among Medicare carriers, State Medicaid agencies, and PROs.
49. See Office of Inspector General, *Resident Abuse in Nursing Homes: Resolving Physical Abuse Complaints*, November 1989.

APPENDIX B

METHODOLOGICAL NOTES

Literature and Document Review

We reviewed the 1986 through 1989-90 editions of the FSMB's *Exchange*, which include up-to-date information on the State boards. The *Exchange* provided us with data on the boards' structure, operations, review, and disciplinary functions. This included information regarding statutory reforms, budget allocations, board composition, disciplinary grounds and other basic board facts.

In addition, we reviewed the annual reports of most State medical boards and numerous publications from entities that were in some way associated with or interested in State medical boards and their disciplinary processes. Some of these entities included the American Association of Retired Persons, the American Medical Association, the Public Citizen Health Research Group, the Office of Inspector General, the U.S. Public Health Service, and the American Medical Peer Review Association.

FSMB Data

We obtained validated disciplinary data for the years 1985 through 1987 from the FSMB's publication entitled the *Federation Bulletin*. (See endnote 22.) These yearly compilations consist of State board actions reported to the FSMB during the year broken down by four major categories: revocations, suspensions, probations, and other actions.

As FSMB validated data was not available for 1988, we examined the unvalidated data from the FSMB's *Disciplinary Action Reports* for the months of January 1988-March 1990. Since all the 1988 actions were not reported in 1988 we felt it necessary to capture those 1988 actions reported late in the 1989 reports. We reviewed these 1988 actions not to obtain a precise count of the number of disciplinary actions taken, but to gain a better understanding of the types of actions being undertaken in that year.

We performed a trend analysis of the 1985-1987 data. This included comparisons of revocations, suspensions, probations, and other actions, as well as total actions, from year to year and over the 3-year period. We also made comparisons on the basis of annual physician renewal fees, size of State medical doctor populations, and regions. Information concerning renewal fees and physician populations were taken from the FSMB and the AMA publications, regional groupings were obtained from U.S. census data. In analyzing the data, statistical measurements were made to judge the significance of the data.

Random Sample of States and Cases

We obtained a random sample of States stratified by the number of practicing doctors and the number of actions taken by the medical boards in those States in 1988. To identify the actions we used the 1988 disciplinary action report data as reported to the FSMB by individual States (as discussed above).

The stratified sample consists of four sample categories: large States taking many actions, large States taking few actions, small States taking many actions, and small States taking few actions. Within each category, we randomly selected two States, resulting in a sample of eight States.

Within each of the selected States, we examined all the disciplinary actions taken in 1988. This resulted in 199 disciplinary actions in the eight States.

For each case we obtained, if available, the referral source (hospital, insurance company, consumer, PRO, state medical society, etc.), initial complaint date, date action went into effect, whether the action was stayed—pending appeal—or overturned on appeal, the basis for the action, and the setting in which the event/events occurred (hospital inpatient or outpatient, private office, nursing home, or other). These data were analyzed using cross-tabulation statistical methodologies.

Initially, it was our intention to draw on the survey data to determine how long it took the States to process cases, from time of initial complaint until time of case disposition. We also intended to correlate this processing time variable with other variables, such as basis for action, type of action, and referral source. Such an effort appears to be achievable, but did not succeed in our study.

Our failure in this regard is attributable to inconsistencies and gaps in the initial complaint data provided to us by the State boards. The inconsistencies were based on different definitions of “initial”—that is, of when the board first received a complaint. In many instances, boards have multiple complaints/referrals on a particular physician that have come in at different times. The first such complaint/referral is not necessarily the one that trigger the case review.

The gaps in initial complaint data reported to us were attributable to limitations in the data readily available to the boards. In some cases, information could not be garnered from the case records held by the boards. While we cannot be certain, it appears that with more investigation such information could be attained.

Site Visits and Other Contacts

Visits were made to the four States having the largest numbers of medical doctors. These included California, Texas, Pennsylvania, and New York, which together account for approximately 37 percent of the practicing doctors in the country. Prior to the site visits we

conducted pre-inspection site visits to the Connecticut and Maryland boards. During the site visits it was our aim to talk with the primary people involved in the process of disciplining physicians at each of the boards. These visits included numerous discussions with executive directors, chief prosecuting attorneys, chief investigators, and hearings officers. For one State we were allowed to attend the investigative hearing committee meeting of the board.

For each of the interviews we followed discussion guides which focused on the issue areas of the study. Numerous questions were asked concerning the identification of cases, the case review process, case dispositions, and impediments in those areas. Telephone discussions were held with representatives of the Peer Review Organizations in the four site States. The questions asked of PROs centered on the relationship of the board and the PRO in regard to the referral of cases between them.

Questions were also asked about the State or board's efforts in assuring quality medical practice. Additional contacts were made with other State boards and other associated entities to discuss quality assurance efforts. Contacts were also made with Canadian Provinces to discuss their efforts in this area. We will address the extent and results of these efforts in detail in a subsequent report.

APPENDIX C

ENDNOTES

1. See United States Department of Health and Human Services, *Report of the Task Force on Medical Liability and Malpractice*, August 1987; Office of Inspector General, *Medical Malpractice: A Monograph of Current Information*, May 1989; United States General Accounting Office, *Medical Malpractice: No Agreement on the Problems or Solutions*, February 1986; and United States General Accounting Office, *Medical Malpractice: A Framework for Action*, May 1987.
2. See *Medical Economics*, April 18, 1988. The entire issue is devoted to an examination of medical malpractice.
3. See Office of Inspector General, *Medical Licensure and Discipline: An Overview*, June 1986.
4. See, for examples, Kusserow, Richard P., Handley, Elisabeth A., and Yessian, Mark R., "An Overview of State Medical Discipline," *The Journal of the American Medical Association*, Vol. 257, No. 6, February 13, 1987, pp. 820-824; and "Tighter Reviews of Doctors Urged," *The New York Times*, June 6, 1986.
5. In 1985, at the time we began our prior study of State medical boards, there were widespread concerns about recent scandals involving fraudulent medical credentials from two Caribbean medical schools and the administration of the Federation Licensing Exam (FLEX) used by the States. In the ensuing years, no such scandals have been reported and both State medical boards and hospitals have improved their credential verification processes.
6. Throughout the report, in referring to the State boards, we refer to the boards in the 50 States and the District of Columbia. This includes data in the figures as well as in the text.
7. For further explanation of this development, see Braeden, Dale G., "Concentrating on the Problem Physician: Perspectives in Medical Discipline—Part II," *Federation Bulletin*, Federation of State Medical Boards, Vol. 76, No. 3, March 1989, pp. 71-2.
8. *Medical Licensure and Discipline*, p. 15.
9. The workshop included representatives from Alabama, California, Colorado, Iowa, Minnesota, Missouri, Ohio, Rhode Island, West Virginia, and Wisconsin. See American Association of Retired Persons, *Proceedings of a Workshop to Discuss Information Exchange between Peer Review Organizations and Medical Licensure Boards*, April 1990.

10. See Jaco, Dan and Neikirk, H.J., "Exploring the Relationships between Peer Review Organizations and State Medical Licensing Agencies: Results of a Survey of PROs," Missouri Patient Care Review Foundation, Paper presented at the Tri-Regional PRO Conference, St. Petersburg, Florida, June 16, 1989.
11. In the 4 case study States, the boards report that they have been receiving few referrals from the PROs. In our 8 sample survey States, only 1 of 199 disciplinary actions taken in 1988 is reported as originating from a PRO referral.
12. The Intergovernmental Health Policy Project of the George Washington University provides a regular listing of changes made in State laws involving the oversight and regulation of physicians. In its September 1988 report it noted that "the overwhelming administrative backlog of cases to be investigated and reported" remained as one of the major problems plaguing State medical boards. See Intergovernmental Health Policy Project, *Focus on—State Oversight and Regulation of Physicians*, No. 22, September 1988, p. 7. See also Weinstein, Michael, "Medical Boards Police Profession Amid Physician, Public Criticism," *Observer*, American College of Physicians, Vol. 9, No. 11, December 1989, pp. 1, 6-7.
13. From June 30, 1988 to June 30, 1989, the number of complaints awaiting assignment to an investigator declined from 911 to 671. From June 30, 1989 to December 15, 1989, the number rose to 731.
14. In Pennsylvania, the board reported that in Fiscal Year 1988/89 the 451 physician cases that were closed took an average of 642 days to complete. In New York, at a December 11, 1989 hearing on physician discipline before the Committee on Health and the Committee on Higher Education of the Assembly of the State of New York, a State health department representative indicated that in 1988 "the average case from the service of the charges to the final service of the order" (p.91) took 21 months. That period of time, he noted later in his testimony, follows an average 6 to 7 month period during which an investigation would have been conducted (p. 93).
15. It must be recognized that some boards depend upon investigative staff of an umbrella agency of which they are a part. In such instances individual investigators may have responsibilities involving a number of different kinds of boards.
16. For the 1986 to 1989 period, each of these State boards had responsibilities for disciplinary investigations, hearings, and decisions and in each year reported investigative staffing data in FSMB's *Exchange*. They are: AL, AR, AZ, CA, CO, DC, GA, IA, ID, KS, KY, LA, MA, ME, MN, MO, MS, MT, ND, NH, NM, NV, OH, OK, OR, RI, SC, SD, VT, WV, and WY.
17. American Medical Association, *U.S. Medical Licensure Statistics and Licensure Requirements*, 1986 and 1990 editions.

18. Zeitlin, David I., "An Update on How—And What— BMQA is Doing," *Los Angeles County Medical Association Physician*, March 6, 1989, p. 37.
19. Assembly hearing, December 11, 1989, p. 84.
20. Federation of State Medical Boards, *Exchange*, 1989-1990.
21. To our knowledge, there is not available at this point any inventory that specifies the number of State boards bound by the "clear and convincing" rule. However, FSMB officials note that the majority are so bound. Our own discussions with board officials in many States suggest the same.
22. The FSMB has a thorough process for checking the validity of each of the actions reported in its disciplinary action data bank and for eliminating any actions subsequently overturned on appeal. The validated counts for a calendar year are regularly published in the *Federation Bulletin*.
23. Schwartz, William B. and Mendelson, David N., "The Role of Physician-Owned Insurance Companies in the Detection and Deterrence of Negligence," *The Journal of the American Medical Association*, Vol. 262, No. 10, September 8, 1989, pp. 1342-1346.
24. See "Hospital Study Finds Few Suits, Much Negligence," *The New York Times*, January 30, 1990. See also, Hiatt, Howard H. et al, "Special Report: A Study of Medical Injury and Medical Malpractice," *New England Journal of Medicine*, Vol. 321, August 17, 1989, pp. 480-4.
25. Data are derived from FSMB data on State board actions as reported in *Federation Bulletin*, 1985-1987 editions.
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