EDWARD S. FLANAGAN
STATE AUDITOR

STATE OF VERMONT

OFFICE OF THE STATE AUDITOR
133 STATE STREET
MONTPELIER, VERMONT 05633-5101

STATE AUDITOR'S REVIEW

OF THE

BOARD OF MEDICAL PRACTICE

DECEMBER 16, 1996

TABLE OF CONTENTS

Page #		
i.-vii.	EXECUTIVE SUMMARY	
1	PURPOSE	
	SCOPE AND SCOPE LIMITATIONS	
	METHODOLOGY	
3.	FINDINGS AND RECOMMENDATIONS	
	I.	INDEPENDENT REVIEW
	II.	MANAGEMENT AND OPERATIONS
		A. Personnel - Shared Staff
4.		B. Personnel - Performance Evaluations
		C. Record keeping
5.		D. Financial Management - Funding
		E. Personal Service Contracts
6.		F. Audits & Independent Review
	III.	INVESTIGATIONS AND DISCIPLINARY ACTIONS
		A. Investigative Outreach
7.		B. Quality - Investigations and Adjudication
8.		C. Monitoring
		D. Disciplinary Guidelines
9.	IV.	PERFORMANCE MEASUREMENT
		A. Output - Productivity
10.		B. Outcomes - Measuring Results
11.		C. Outcomes - Reporting Results (Disciplinary Actions)
12.		D. Client Service
13.		E. Efficiency
	VI.	PUBLIC INFORMATION
		A. Outreach
		B. Reporting
14.	V.	BOARD MEMBERSHIP
		A. Public Members
		B. Physician Members
15.	VII.	INTERNAL CONTROLS
		A. Control Environment
16.		B. Risk Assessment
		1. Structural Issues
		2. Caseload Growth
17.		3. Funding
		C. Control Activities
		D. Information and Communication
18.		E. Monitoring
	VIII.	ADDITIONAL OBSERVATIONS
		A. Prevention
19.		B. Credibility
20.	Appendix A	Schedule of Documents Reviewed
22.	Attachment A	Categories of "Quality Concerns"

EDWARD S. FLANAGAN
STATE AUDITOR

STATE OF VERMONT

OFFICE OF THE STATE AUDITOR
133 STATE STREET
MONTPELIER, VERMONT 05633-5101

December 16, 1996

House Speaker Michael Obuchowski
Senate President Pro Tempore Stephen Webster
Governor Howard Dean

Dear Gentlemen:

Enclosed please find our report on our recent review of the Medical Practice Board. This review was undertaken at the request of several legislators concerned about the operations of the Board. In our review, we examined the Board's compliance with relevant statutes and rules and reviewed the systems necessary for assuring reasonable compliance and financial management.

The Medical Practice Board was established to help protect public health and safety by licensing all physicians who practice in Vermont and investigating complaints regarding allegations of unprofessional conduct. With the exception of litigation in a court, the 14-member Medical Practice Board is the only recourse for members of the public who believe they have been the victims of physician misconduct. In order to accomplish its mission, the Board undertakes investigations that can be either self-initiated or initiated by a complainant. The Board has the authority to discipline doctors found guilty of unprofessional conduct, including the power to remove a doctor from practice in this state by revoking his or her license. While the vast majority of physicians practicing in Vermont are able, dedicated doctors, it is critical that the public have confidence that the Board is undertaking thorough reviews of complaints and that the complaints are resolved in a timely fashion.

One of our most significant findings in this review is that the Board has not been subject to adequate oversight and independent review, which we be believe are necessary to achieve public accountability. Since the Board was removed from supervision by the Secretary of State's office in 1990, there has been no independent review of its operations. Citing a confidentiality statute, the Board refused to allow the Auditor's office confidential access to files and documents necessary to complete our review. We were unable to review the Board's committee decisions for consistency of quality, examine records for post-disciplinary monitoring information, or survey complainants

and doctors about the quality of service. This is significant because about 90 percent of all complaints are dismissed after preliminary investigation and these decisions, therefore, are never reviewed by anyone not involved in the Board's resolution of the case. Moreover, our research indicates that Medical Practice Boards in other states fall under the supervision of broad umbrella agencies, such as a consumer affairs or health agency, and are subject to oversight in that manner. In addition, auditors in other states, including Maryland and California, routinely conduct independent reviews of their respective Medical Practice Boards. These reviews include *confidential* access to all files and documents.

The Vermont Medical Practice Board's position, and the lack of monitoring that has resulted, denies the Board the benefits of constructive recommendations that could improve its performance. It denies the Legislature and public valuable information about how well the Board is doing its job. We have recommended that the Board allow for the kind of monitoring which would assure the public that the Board receives adequate oversight and review.

Our review occurs at a time when other states are also evaluating the performance of professional licensing boards. Some states are encouraging their Medical Practice Boards to become more active in informing consumers about the background and behavior of the physicians in whom they entrust their health. Massachusetts, for example, not only maintains a profile of every M.D. licenced in the state -- which includes malpractice sanctions and awards from the previous 10 years -- but also informs the public of all complaints filed against doctors, including those that are dismissed following preliminary investigation. We hope the issues we have raised will help the Board improve its service and provide the Legislature with a basis for evaluating how changes can be made to this Board so that it can best serve the public.

Yours truly,

Edward Flanagan,
State Auditor

EXECUTIVE SUMMARY

Introduction

In 1996, the State Auditor received inquiries from several legislators about the Medical Practice Board's management and determined to conduct this review in response. We have assessed the Board's compliance with relevant statutes and rules and have reviewed the systems necessary for assuring reasonable compliance and financial management.

According to its 1995 Annual Report, the Board "sets standards for qualification to be licensed as a Medical Doctor ...; and, it investigates and takes disciplinary action against licensees who engage in unprofessional conduct." This review is intended to identify findings and present recommendations that will enable the board to better accomplish its mission and more fully comply with laws and regulations.

Key Findings and Recommendations

I. Independent Review

Finding: The Board is not subject to sufficient independent review of its work.

Until 1990, the Medical Practice Board was overseen by the Secretary of State's office, which performed general oversight functions of Board operations. In 1990, the Legislature granted the Board semi-autonomous status. The Board now hires its own director and staff, produces its own budget and maintains control of its own records. Of the state's more than two dozen boards, it is the only one no longer subject to oversight or review by the Secretary of State's office.

The Attorney General's office is involved in discretionary decisions concerning investigations of complaints, particularly decisions regarding the filing or dismissal of formal charges. This prosecutorial involvement by the Attorney General's office precludes the Attorney General from independently reviewing the final disposition of cases by the Board. Moreover, the Attorney General's office is not responsible for the ongoing administrative management of the Board.

The Legislature enacted 32 V.S.A.§167 to ensure independent periodic review by the Auditor's office of all agencies of state government. Such reviews take into consideration the confidentiality of certain files and documents, which are kept confidential by the Auditor's office. But the Board, citing a confidentiality statute (3 V.S.A.§131), withheld access to records and files. Because the Secretary of State no longer has administrative oversight and because of the Board's current position with respect to access to records by the Auditor's office, the Board is not presently subject to outside independent review, despite the intent of 32 V.S.A.§167 and 3 V.S.A.§131 which anticipate confidential, independent review.

Recommendation: The Board should open its files for periodic independent reviews that maintain the confidentiality of certain data.

II. Management and Operations

A. Personnel

Finding: Staff have received no performance evaluations by the Director and the Executive Committee of the Board has not evaluated the Director.

Recommendation: In accordance with statutory requirements, the Board should conduct a performance evaluation of the Director who, in turn, should periodically evaluate staff.

B. Record keeping

Finding: There are no minutes kept of Executive or Investigative Committee meetings.

Recommendation: In accordance with statutory requirements, minutes should be kept of all committee meetings.

C: Audits

Finding: The Board has never contracted for a management or financial audit.

Recommendation: The Board should consider contracting for an independent audit in accordance with good management principles.

III. Investigations and Disciplinary Actions

A. Investigative Outreach

Finding: The Board does not systematically seek out information about possible incidents of unprofessional conduct either in Vermont's hospitals and other health care facilities, or from other professional boards within the Secretary of State's Office of Professional Regulation.

Hospitals routinely review information about "adverse events" and possible negligence. These internal reviews are confidential, however certain data is reported by hospitals to a regional Professional Review Organization which in turn reports to federal authorities on Medicare patients. But, at present, neither hospitals nor other health care facilities report "quality concern" data to the Board. As a result, the Board is not receiving information that might result in self-initiated investigations. Furthermore, though there is informal sharing of information between

professional boards, there is apparently no routine mechanism by which the board receives information contained in complaints to other professional boards to determine if incidents of physician misconduct were involved. The Board should be more proactive in its efforts to identify incidents of unprofessional conduct and should work out a formal protocol with the Secretary of State's office for the sharing of information.

Recommendation: A) Legislative or administrative action should be taken to authorize the board to review internal findings about possible physician misconduct from all Vermont hospitals and health care facilities to the extent permitted by law. B) The Board should develop a mechanism to receive information from the director of the Office of Professional Regulation of the Secretary of State's office so it can review all cases that concern possible physician misconduct.

B: Investigations and Adjudications

Finding: There is insufficient independent review of internal Board investigative processes or decisions, with the exception of the few cases subject to judicial review.

This is significant because the rare handful of cases which are subjected to judicial scrutiny constitute only a fraction of the 10 percent of the cases that are prosecuted. Another 90 percent of all complaints are never prosecuted and never made public, and these decisions are also never reviewed by an outside agency.

Recommendation: The Board should open its files for periodic, confidential, independent reviews of its internal investigative processes and decisions.

C: Disciplinary Guidelines

Finding: The Board does not have formal disciplinary guidelines.

The Board needs discretion in the application of sanctions, particularly for unique cases with unusual circumstances or mitigating factors. But fairness requires that similar cases be treated consistently. Written disciplinary guidelines is the way to ensure this occurs.

Recommendation: The Board should adopt disciplinary guidelines in accordance with the recommendation of the Federation of State Medical Boards.

IV. PERFORMANCE MEASUREMENT

A: Productivity

Finding: An analysis of 389 cases over the past three years shows the average time elapsed from a complaint filing to closure has decreased 41 percent from 362 to 214 days. In

addition, the number of cases resolved within six months has increased from 34 percent to 48 percent.

One critical measure of the Board's productivity is the time it takes to process a complaint from the day it is initiated to the day it is resolved. Data show the Board has made a concerted effort to reduce the amount of time necessary to resolve cases and improve productivity. However, since 90 percent of all complaints are dismissed after preliminary investigation, it is important to ensure that the improved resolution time is not occurring as the result of hasty or incomplete investigations.

Recommendation: The Board should periodically review the outcomes measures of its investigations to ensure that decreased processing time has not compromised the quality of investigations.

B: Measuring Results

Finding: The Board has never attempted to determine the extent of unprofessional conduct and therefore cannot say with assurance whether public protection against professional misconduct has improved.

At present the Board measures its effectiveness by counting the number of complaints processed and disciplinary actions taken. Identifying and sanctioning physicians guilty of unprofessional conduct tends to reduce risk. But without information about the extent of the risk and a means of measuring changes over time, it is impossible to say whether progress has been made.

Recommendation: The Board should consider adopting methods -- such as a statistical model -- that would allow it to use data available through other agencies to measure annual changes in the number of incidences of unprofessional conduct by physicians.

C: Reporting Results

Finding: The Board, in its Annual Report, reports disciplinary actions by type (e.g. revocation, suspension) but does not list or summarize data about the kinds of conduct that resulted in sanctions. In addition, the report does not differentiate between unprofessional conduct by practicing Vermont physicians and actions by out-of-state physicians seeking licensing or renewal in Vermont. Moreover, a public registry of all complaints and dispositions has not been produced as required by law.

According to the Board's 1995 Annual Report, disciplinary actions have increased from 7 in 1991 to 15 in 1995. Though the Board attaches the stipulation and consent orders to its Annual Report, it provides no summary of what kinds of conduct resulted in disciplinary measures. Without reading the actual stipulation and consent orders for each case, legislators and the public cannot find out the nature of the public health risks posed by physicians guilty of unprofessional conduct.

Moreover, since some of these sanctions are against physicians not practicing in Vermont, it does not necessarily mean there has been an immediate improvement in the practice of medicine in the state.

Recommendation: A) The Board should modify its Annual Report to include summary data about the types of unprofessional conduct that resulted in sanctions. B) It should distinguish in-state from out-of-state incidents to give a clearer picture of the incidence of unprofessional conduct in Vermont. C) A public registry of all complaints and dispositions should be produced, as required by law.

D: Service

Finding: The Board has never surveyed its clients (physicians and complainants) and refused to allow the State Auditor to do so.

Government entities should periodically survey clients to determine their level of satisfaction (i.e. Are staff helpful and professional? Are department procedures user-friendly? Etc.) This information can be useful as the Board seeks to fulfill its mission, reduce costs and provide high quality services. Because no survey has ever been undertaken, there is currently no good data on the quality of service.

Recommendation: The Board should undertake periodic confidential surveys of its clients.

E: Efficiency

Finding: The Board's FY96 performance measurement report did not include unit cost data or any other efficiency information.

The Governmental Accounting Standards Board recommends that efficiency be measured by using "unit costs." Appropriate measures might include median costs of examinations, license and renewal applications and complaints.

Recommendation: The Board should adopt unit costs as its efficiency measure.

V. PUBLIC INFORMATION

A. Outreach

Finding: None of the brochures reviewed were particularly user-friendly nor did they contain information about alternative formats for the visually or hearing impaired (e.g. large type or TTY numbers).

The Board relies almost entirely on complaints from the public to identify cases of unprofessional

conduct. It is essential, therefore, that the public be well-informed about its rights and about the Board's presence in a manner that is accessible to as many members of the public as possible. Following our initial inquiries, the Board has begun to address these issues.

Recommendation: The Board should consider a more user-friendly design for its brochures and make every effort to ensure that the brochures are accessible to all Vermonters.

B: Reporting

Finding: The Board's Annual Report meets the minimum requirements of the statute.

26 V.S.A.§1352 requires the Board to report annually on its activities. Though the Board's Annual Report meets minimum requirements, other states are moving ahead with more comprehensive public information efforts. For example, a recent Massachusetts statute provides increased public access to data concerning physicians. Called the Physicians' Profiles legislation, the Massachusetts law authorizes and directs the Board of Registration in Medicine to collect and disseminate information on all licensees. Information includes: criminal convictions and disciplinary actions within 10 years, disciplinary actions in other states, revocation or restriction of hospital privileges, medical malpractice payments, educational information, awards, specialty board certifications, and hospitals where licensee has privileges.

Recommendation: The Board should monitor the new Massachusetts program and, if it is successful, provide information to the Legislature that would be useful in considering the implementation of a similar model in Vermont.

VI. BOARD MEMBERSHIP

A: Public members

Finding: One of the Board's public members is a past member of the Medical Center Hospital of Vermont (MCHV) Associates, MCHV Board of Governors and MCHV Board of Trustees. The extent of the prior association may be inconsistent with 26 V.S.A.§1351(a) which states that "public members of the Board shall be persons not associated with the medical field."

The role of public members is to bring an unbiased perspective to a Board dominated by physicians. If a public member is not entirely unbiased, the Board may not have the balance intended by the Legislature.

Recommendation: Appointments of public members to the Board should be made with careful consideration of 26 V.S.A.§1351(a) which states that "public members of the Board shall be persons not associated with the medical field."

B: Physician members

Finding: At present there are only two full-time practicing physicians on the Board.

26 V.S.A.§1351(a) states that nine of the Board's 14 members shall be licensed physicians. Retired or semi-retired doctors bring prestige and judgement from long careers and provide a valuable service to the public. But as the Board handles more quality of care cases, there is an increasing need for members to be informed about the latest developments in their fields. There is no way to quantify the costs and benefits of the current membership mix, but in theory Board efficiency might improve if there were more practicing physician members.

Recommendation: Legislative or administrative action should be considered for the purpose of revising 26 V.S.A.§1351(a) or adopting rules to be more explicit about the status of physician members and to require that a certain number be engaged in full-time practice.

STATE AUDITOR'S REVIEW

OF THE

BOARD OF MEDICAL PRACTICE

REPORT

STATE AUDITOR'S REVIEW OF THE BOARD OF MEDICAL PRACTICE

PURPOSE: To review the Medical Practice Board's compliance with relevant statutes and rules and assess the systems necessary for compliance and financial management.

SCOPE: The scope of the review included the Board's operations, budget, and performance as related to its mission, and compliance with 26 V.S.A. Ch. 23, Administrative Bulletin 3.5, and 32 V.S.A.§307(c)(2). A review is substantially less in scope than an audit conducted in accordance with applicable professional standards. The purpose of an audit is to express an opinion. The purpose of this review is to identify findings and recommendations to enable the Board to better accomplish its mission and to more fully comply with laws and regulations. This review relies solely upon representations of and information provided by the Board and staff. If an audit had been performed, the findings and recommendations may or may not have differed.

SCOPE LIMITATIONS: The Board imposed severe limitations on our access to internal documents and files. As a result, we were prevented from conducting a standard internal control review of record keeping and information systems. Furthermore, we could not: a) review Board or committee decisions for consistency or quality; b) review post-disciplinary monitoring information; and, c) survey complainants about the quality of service. Finally, the Board failed to provide information and various documents which were promised but never delivered.

METHODOLOGY: The review was conducted in accordance with Section VI of the Professional Standards Manual of the State Auditor's Office. Our definition of internal controls is based upon the current standards of the American Institute of Certified Public Accountants (Statement on Auditing Standards No. 78).

We made several written and oral information requests and reviewed the materials provided by the Board. The materials reviewed included, but were not limited to: the 1995 Annual Report, Budgets for FY 94-96 (including performance measurement reports), contracts for consultants, Board minutes, various policy and informational documents of the Board and the Federation of State Medical Boards (FSMB), job descriptions, and information about fees and license renewals. We interviewed the Director, Board Chairman, a non-physician Public member, attorney for the Board, Secretary of State, Deputy Secretary of State, a former Board member, an investigator, the Secretary of State's computer programmer, research director for the FSMB, and director of information systems of the Northeast Health Care Quality Foundation and executive directors of Medical Practice Boards in other states.

BACKGROUND: According to the 1995 Annual Report, the Board "sets standards for qualification to be licensed as a Medical Doctor ... in Vermont; and, it investigates and takes disciplinary action against licensees who engage in unprofessional conduct." The Board's primary goal is "to protect the public health, safety, and welfare" (FY 96 Budget, Form 4).

The 14-member board is, by statute, comprised of: nine physicians, three public members, one physician's assistant and one podiatrist. Board members serve on three investigative committees divided geographically (North, South and Central). Each investigative committee consists of three medical doctors/podiatrist and one public member. When the investigative committees meet

to consider complaints, they are usually accompanied by an investigator and an attorney. Complaints filed in one region of the state are handled by committees in some other region to reduce the possibility that a Board member may know the licensee. Based on the available evidence and with the advice of the attorneys, the committee decides, after preliminary investigation, whether to proceed with prosecution or close the case. (Only 10% of all complaints result in prosecution.) At the time the Board formally charges the doctor, the charges become public. All hearings are also open to the public, as is the final order. The Board may revoke, suspend, condition, limit, reprimand, institute probation, or take such other action as the Board determines is proper, or, in cases requiring emergency action, suspend a license immediately (in cases where the alleged misconduct poses a grave threat to the public health, safety, or welfare). Licensees may appeal a Board disciplinary decision to an Appellate Officer whose review is conducted on the basis of a review of the record. In cases of revocation or suspension, licensees may appeal the Board's decision to the Superior Court. A further appeal to the Vermont Supreme Court is available.

Prior to 1990, the Board was one of about 15 entities within the Secretary of State's Office of Professional Regulation (OPR). Act 250 of 1990 created the Board's unique semi-autonomous status whereby the Secretary's of State's OPR provides limited staff support and other resources; however, the Board hires its own director and staff, produces its own budget, and retains control of its own records. Sunset provisions in Act 250 have been extended on two occasions by the Legislature and the Board's semi-autonomous status remains in effect. The Board is funded by licensing fees set by the Board within statutory limits. In 1996, the State Auditor received inquiries from several legislators about the Board's management and activities and decided to conduct this review in response.

FINDINGS AND RECOMMENDATIONS

I. **INDEPENDENT REVIEW:** Until 1990, the Medical Practice Board was overseen by the Secretary of State's office, which performed general oversight functions of Board operations. In 1990, the Legislature granted the Board semi-autonomous status so that the Board now hires its own director and staff, produces its own budget and retains control of its own records. Of the state's two dozen professional boards, it is the only one no longer subject to oversight or review by the Secretary of State's office.

FINDING: The Board is not subject to independent review of its work.

The Attorney General's office is involved in discretionary decisions concerning investigations of complaints, particularly decisions regarding the filing or dismissal of formal charges. However, this prosecutorial involvement by the Attorney General's office precludes the Attorney General from independently reviewing the final disposition of cases by the Board. Moreover, the Attorney General's office is not responsible for the ongoing administrative management of the Board.

The Legislature enacted 32 V.S.A. §167 to ensure independent periodic review by the Auditor's office of all agencies of state government. But the Board, citing a confidentiality statute (3 V.S.A. §131), withheld access to records and files. Because the Secretary of State no longer has oversight and because of the Board's current position with respect to access to records by the Auditor's office, the Board is not presently subject to independent review, despite the intent of 32 V.S.A. § 67 and 3 V.S.A. §131 which anticipate confidential, independent review.

RECOMMENDATION: The Board should open its files for periodic independent reviews that maintain the confidentiality of certain data.

II. MANAGEMENT AND OPERATIONS

A. Personnel - Shared Staff: Although the Medical Practice Board has been granted special semi-autonomous status by the Legislature[1], it retains an administrative relationship with the Secretary of State's office. This includes shared use of certain staff, equipment and services.

FINDING: Due to increased caseloads and a few particularly complex and lengthy cases, the Board's use of attorneys and investigators from the Secretary of State and Attorney General's offices exceeded the budgeted targets for at least the past three years.

The additional unplanned time spent working for the Medical Practice Board reduced the availability of attorneys and investigators to other professional boards. In response, the Deputy Secretary of State informed the Board that use of these individuals would be re-

[1] Act 250 of 1990 and subsequent extensions of the scheduled sunsets.

stricted to current cases or emergencies.[2] The Board has since contracted for legal services.

Problems with shared staff due to unplanned staffing requirements suggests the need for improved caseload projections, resource allocation planning, and personnel management. Although unintended, excessive use of shared staff has created difficulties for other professional boards. It is unavoidable that growth in the number and complexity of cases exerts pressure on the Board's budget and staff. As with other units of government, this presents difficult choices: the Board can reduce its activities, improve efficiency, and/or increase revenues. While the Board has managed to reduce average complaint processing time (see item IV.A. below), the "quality of care" cases are creating increased pressure due to the need for the services of investigators, attorneys and consultants.

RECOMMENDATION : In attempting to improve its planning and budgeting methodology the Board should include contingency plans for unusually expensive disciplinary cases such as those experienced during the past year.

Ultimately, the ambiguous structural relationship between the Board and Secretary of State's office should be clarified and made permanent. Although beyond the scope of this review, it is apparent that the current arrangement is not ideal and creates confusion about responsibilities and accountability.

B. Personnel-Performance Evaluations: 3 V.S.A. §322 requires that all classified state employees receive annual performance evaluations. Such evaluations are a valuable tool for supervisors and management. Evaluations can establish shared goals, help identify problems, reward meritorious service, and document unsatisfactory performance.

FINDING: There have been no employee performance evaluations for at least the past two years and there is no record of the current Director having been evaluated by the Board.

RECOMMENDATION: In accordance with statutory requirements, the Board should require the Director to evaluate all staff annually and the Board should evaluate the performance of the Director on a regular basis.

C. Record keeping: 1 V.S.A. §312(b) requires all "public bodies" [1 V.S.A. §310(3)] to keep minutes of all meetings (including committees but not including quasi-judicial bodies).

FINDING: No minutes have been kept for the Executive or Investigative Committees.

RECOMMENDATION: To the extent required by law (and for good management), the Board should keep minutes of all of its committee meetings.

---

[2] Letters from the Dep. Secretary of State to the Executive Director dated March 1, April 11, and August 6, 1996.

D. Financial Management -Funding:

FINDING: The Board's funding comes entirely from license and renewal fees (approx. 70% from physician renewals) and the budget for the past few years has been level-funded at just over $380,000. Due to the increased number and complexity of cases handled by the Board, it is expected that the need for investigators' and attorneys' time will increase.[3]

At present, Vermont's license renewal fees are $225 (every two years), which is just below the national average of $250.[4] The Board intends to raise the fee to $300 on July 1, 1997, which is a 100% increase since 1992.[5] The Board has also requested that stipulation agreements prepared by the Attorney General's office include a provision that financial responsibility for monitoring of a sanctioned physician be borne by the respondent.[6] In addition, the FSMB recommends that medical practice boards be authorized to collect fines and be reimbursed for the costs of investigation and adjudication.[7]

RECOMMENDATION: The Board should review its projected workload and resources beyond the normal budget horizon and, if warranted, identify additional or enhanced funding sources, including fines and cost reimbursement.

E. Personal Service Contracts:

FINDING: The Board is not in compliance with competitive bidding rules outlined in Administrative Bulletin 3.5 with respect to documentation of certain contracts with physician consultants.

The Board periodically engages physicians as consultants on specific cases. At present, there are three such contracts and all are for less than $10,000. As a result, the Board is not required to competitively bid the contracts as long as certain information is placed on file including an explanation of the qualifications of each contractor and the cost-effectiveness and reasonableness of their fees.[8] In each instance, however, the files contain only perfunctory information that does not meet the requirements of Bulletin 3.5.

When asked for the required information, the Director indicated that because the contracts are "case specific, ... [t]here is not much to disclose about qualifications at this stage because of the contested nature of the these cases. At the time of contracting, these cases are at the beginning of the adjudicatory phase."[9] Since Bulletin 3.5 provides no authority to avoid compliance with these provisions due to the "contested nature of [the] cases," the Board appears to be in violation. In response to a request for justification for lack of

---

3 August 8, 1996 meeting with the Director, the Chairman of the Board, and the Board's attorney.
4 Data from the FSMB publication "Exchange" 1995-1996.
5 Minutes of the Board's meeting on February 7, 1996, p. 3, and September 11 communication from the Director.
6 ibid, Minutes, p. 4.
7 FSMB Model Practices Act, Section IX. A.12 and Section XVIII, A..
8 Agency of Administration, Bulletin 3.5, Section VI.A.
9 See July 19, 1996 information packet (section 6) in the written response to State Auditor's inquiry.

compliance, the Board advanced a different explanation for their actions. According to the Board, "consultants/expert witnesses are usually selected during the investigatory stage of a case on a *pro bono* basis." If charges are later initiated, the expert is contracted to provide testimony at depositions and hearings if required. The reasons cited as justification for sole-sourcing are familiarity with the case and a shortage of experts willing to work *pro bono* in the early stages. These are not unreasonable assertions but they would be more compelling if documented.

RECOMMENDATION: The Board should comply with the principles of Bulletin 3.5. In particular, for contracts of $10,000 or less, the Board "must maintain an up-to-date contract file - [including] - the written explanation for contractor selection."[10] In addition, we recommend that the Board utilize the pre-qualified bidding procedures described in section V.A. of Bulletin 3.5 and adopt its own internal guidelines regarding Bulletin 3.5.

F. Audits and Independent Review:

FINDING: According to the Director, the Board has never been independently audited and, although the Department of Finance and Management conducts a monthly review of expenditures and receipts, there is no written record of any analysis, findings or recommendations. In addition, there is no evidence that the Board or staff have conducted a follow-up internal review of the continuing shortfalls resulting in requests for excess receipts.

Regular audits can be a valuable tool for management and help ensure fiscal responsibility and accountability.

RECOMMENDATION: The Board should consider contracting for an independent audit. Such an audit should be conducted using Government Auditing Standards.

III. INVESTIGATIONS AND DISCIPLINARY ACTIONS

A. Investigative Outreach: In addition to responding to complaints, the Board may initiate an investigation "if the Board has reason to believe, without a formal complaint, that any person practicing medicine or surgery in the state has been guilty of unprofessional conduct."[11]

FINDING: The Board does not systematically seek out information about possible incidents of unprofessional conduct in Vermont's hospitals and other health care facilities, or from other professional boards within the Secretary of State's Office of Professional Regulation.

Hospitals routinely review information about "adverse events" and possible negligence. These internal reviews are confidential, but the hospitals are required to report certain data to the regional Professional Review Organization (PRO) which in turn reports to federal

[10] Bulletin 3.5, Section VIII.C.2.
[11] 23 V.S.A. §1355(a).

authorities on Medicare and Medicaid patients. The PRO reviews a sample of hospital case files and identifies cases with "quality concerns." Some of the hospital-based "quality concerns" identified by the PRO may be the result of physician misconduct. At present, neither hospitals nor other health care facilities report "quality concern" data to the Board. As a result, the Board never reviews such cases and the health and well-being of Vermonters may be compromised.

In addition, although we were denied access to files for verification, there is anecdotal evidence that the Board does not have in place a routine mechanism for reviewing complaints made to other professional boards to determine if incidents of physician misconduct were involved.

RECOMMENDATION: A) Legislative or administrative action should be taken to authorize the board to review internal findings about possible physician misconduct from all Vermont hospitals and health care facilities to the extent permitted by law. B) The Board should develop a mechanism to receive information from the director of the Office of Professional Regulation of the Secretary of State's office so that it can review all cases that concern possible physician misconduct.

B. Quality - Investigations and Adjudication: It is essential that the work of the Board be - and be perceived as - thorough, impartial and fair. Periodic independent review serves to ensure that decisions are fair and based upon the facts presented.

FINDING: There is insufficient independent review of internal Board investigative processes or decisions, with the exception of rare cases subject to judicial review.

Relatively few cases are subject to judicial review. Indeed, since 1992, only 5 disciplinary actions (out of 46) have been appealed. In 3 of the 5 appeals, some or all the cases were remanded to the Board for further action, usually for insufficient findings. But, generally speaking, the courts have affirmed the Board's decisions.[12]

But the Board considers many more complaints than those that result in disciplinary actions. For example, from 1992 to 1995, the Board received 499 complaints and resolved 407 cases. Of those 407 cases, there were 46 disciplinary actions.[13] In those instances where a complaint does not lead to disciplinary action (90% ±), staff from the Attorney General's office are involved in the decision to file or dismiss charges. However, there is no formal independent review. These internal (and confidential) decisions are no less important than disciplinary actions and represent the majority of the Board's work. In these cases, we have no information about the quality of Board decisions since independent review has never been undertaken.

We have no reason to believe the Board does not thoroughly investigate all complaints, is reluctant to discipline doctors, or is inconsistent in the application of sanctions. But without an independent review, it's impossible to say. The Auditor was denied access to case files so we were unable to review Board actions.

---

[12] Information from Board attorney Phil Cykon in telephone conversation September 10, 1996.

[13] 1995 Annual Report, Attachment G.

RECOMMENDATION: The Board should open its files for periodic, confidential independent reviews of its internal investigative process and decisions.

The Board should consider contracting for an independent review of its investigative processes, committee and Board decisions, and post-disciplinary monitoring. Such a review could demonstrate the Board's competence and/or suggest areas for improvement. In any event, the result would be greater public confidence in and support for the Board.

C. Post-disciplinary Monitoring: 23 V.S.A. §1361 allows the Board to "reprimand the person complained against, as it deems appropriate; ... or take such action relating to discipline or practice as the Board determines is proper." It is not uncommon for the Board to require disciplined physicians to undergo rehabilitation, training, or counseling related to the behavior that gave rise to the sanctioned misconduct. The Board refused access to files regarding post-disciplinary monitoring so we could not determine if the Board monitors disciplined physicians to ascertain if they have fulfilled their obligations and what steps are taken, if any, to ensure compliance.

FINDING: We were unable to determine the extent or quality of Board monitoring of sanctioned physicians.

RECOMMENDATION: The Board should open its files for periodic independent reviews that maintain the confidentiality of certain data.

D. Disciplinary Guidelines: In its investigations, the Board is guided by 26 V.S.A. §1354 which defines various types of unprofessional conduct. If the person complained against is found guilty of unprofessional conduct, the Board "may reprimand ... as it deems appropriate; condition, limit, suspend or revoke the license or practice of the person complained against; or take such action relating to discipline or practice as the Board determines is proper." [26 V.S.A. §1361(b)]

It is essential that the Board have some discretion in the application of sanctions, particularly for unique cases with unusual circumstances or mitigating factors. Nevertheless, fairness requires that similar cases be treated consistently. Without access to case files, there is no way to determine if sanctions are applied consistently. The Federation of State Medical Boards recommends that state boards adopt disciplinary guidelines to "promote consistency in the disciplinary process, and to permit accurate interpretation of its actions by similar bodies in other jurisdictions ... and to facilitate a better understanding ... of the process" by the general public.[14]

FINDING: At present, the Board does not have disciplinary guidelines.

The Board is updating its policies and procedures but, after repeated requests, we were not provided with a copy of the document for review. The Director and Chairman have expressed dissatisfaction with the Federation of State Medical Boards' model guidelines[15] but have made no effort to develop their own.

---

[14] FSMB, "A Model For The Preparation Of A Guidebook On Medical Discipline", Third Edition, February 1992, p. iii.

[15] Comments made during an interview on August 8, 1996.

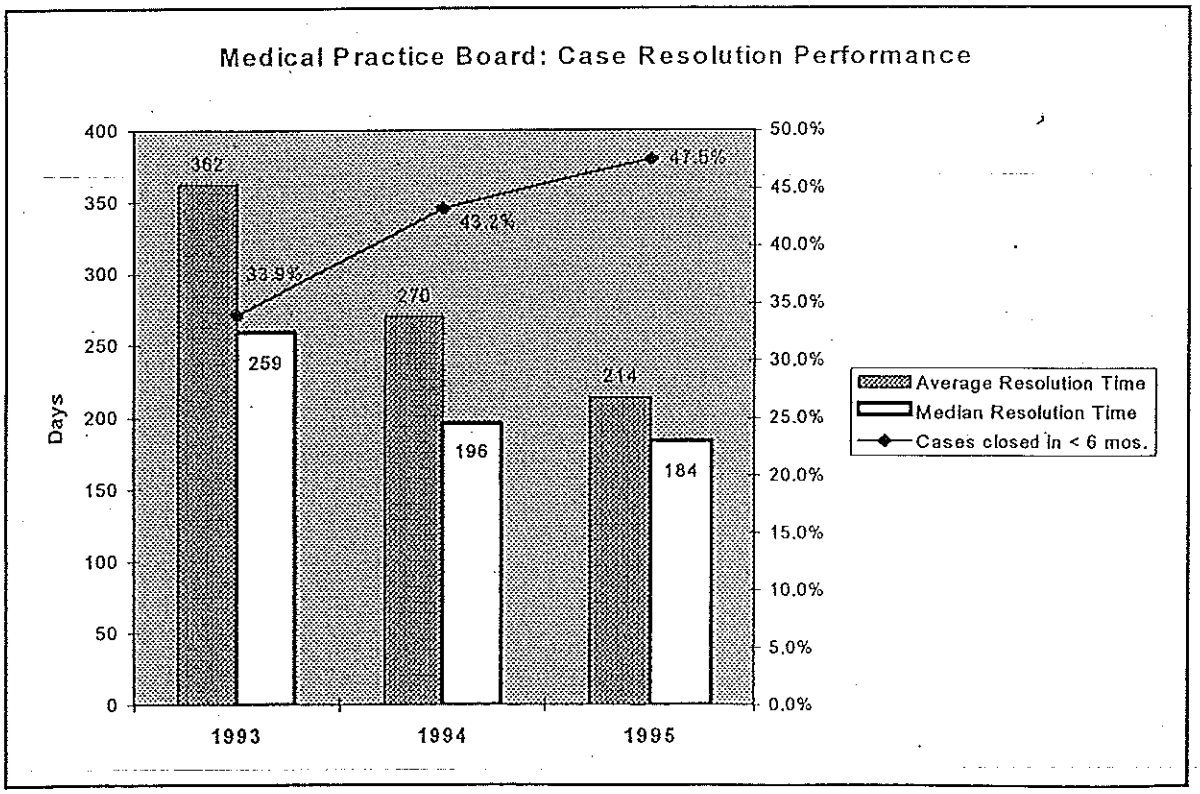
RECOMMENDATION: The Board should adopt disciplinary guidelines in accordance with the recommendations of the FSMB.

IV. PERFORMANCE MEASUREMENT

A. Productivity:

FINDING: An analysis of the 389 cases filed over the past three years shows the average time elapsed from a complaint filing to closure has decreased 41%,[16] from 362 to 214 days.[17] In addition, the number of cases resolved within six months has increased from 34% to 48%.

One critical measure of the Board's productivity is complaint processing time. Data show that the Board has made a concerted effort to reduce the amount of time necessary to resolve cases and improve productivity. However, since 90 percent of all complaints are dismissed after preliminary investigation, it is important to ensure that the improved resolution time is not occurring as the result of hasty or incomplete investigations. Without access to case files, it is impossible to say whether the decrease in processing time has compromised the quality of investigations or decisions.



[16] Raw data on case filings and closures supplied by the Director. Calculations performed by the author.

[17] Including weekends and holidays.

RECOMMENDATION: The Board should periodically review the outcomes measures of its investigations to ensure that decreased processing time has not compromised the quality of investigations.

B. Measuring Results:

FINDING: The Board has never attempted to determine the extent of unprofessional conduct and therefore cannot say with assurance whether public protection against professional misconduct has improved.

The Board's FY96 performance measurement report[18] included productivity data but failed to provide information about whether public protection against professional misconduct has improved as a result of its efforts. The 1995 Annual Report refers to the Board's rating by the FSMB as "one of the 10 most effective medical boards in the country," which implies that the Board's efforts have improved public health. Indeed, the national ranking has improved since 1990. From 1986-1989, the Board was ranked 40th, 31st, 43d, 44th. Beginning in 1990, the Board was ranked in the top 10 of the nation for three years, achieving its highest ranking of 6th in 1995.

However, the FSMB defines effectiveness as the number of disciplinary actions per 1,000 practicing physicians. This measure allows comparisons across diverse jurisdictions. But there are several key assumptions in the FSMB's model that may limit its value as a measure of effectiveness. For example, it assumes that: 1) the behavior and skill of physicians is similar in all states; 2) that levels of public awareness are similar; 3) that Board structure and funding are comparable; 4) that the frequency of complaints is not affected by cultural differences; and, 5) that Boards use the same criteria for evaluating complaints and applying sanctions.

Since the Board's mission is to protect the public health, its goal is, or should be, to reduce the incidence of unprofessional conduct and, thereby, reduce the risk to patients. Identifying and sanctioning physicians guilty of unprofessional conduct tends to reduce risk. But without information about the extent of the risk and a means of measuring changes over time, it is impossible to say whether progress has been made. The Board has never attempted to determine the extent of the problem and, without this information, it is impossible to say whether public protection against professional misconduct has improved.

RECOMMENDATION: The Board should consider adopting methods -- such as a statistical model -- that would allow it to use existing data to measure annual changes in the number of incidences of unprofessional conduct by physicians.

Available data would permit creation of a statistical model that could provide a basis for such an annual estimate. Hospitals routinely review information about "adverse events." The internal reviews are confidential, but the hospitals are required to report certain data to the regional Professional Review Organization (PRO), which analyzes a sample of the

[18] FY96 Budget, Form 4, pp. 1-3.

data on Medicare patients and reports to federal authorities. This data can be aggregated for the entire state and used as a surrogate measure of the incidence of certain types of unprofessional conduct.

Notwithstanding some limitations[19], the PRO's have a substantial data base and the model could be adapted for use by the Board. This model offers one possible method of measuring changes in public health due to the incidence of physician misconduct. As can be seen below, both the percentage of cases with "quality concerns" and the percentage of "quality concerns" per case have increased from 1994 to 1995. Obviously, without more historical data, it is impossible to know if the change is part of a trend. The intent of the chart is only to demonstrate how the information could be used.

1994 & 1995 Vermont Cases of "Confirmed Quality Concerns"

	1994		1995	
Total Claims Received	33,699	100%	35412	100%
Total Claims Reviewed	1,856	6%	1,084	3%
Claims with Confirmed Quality Concerns[20]	110	6%	78	7%
Confirmed Quality Concerns[21]	218	12%	154	14%

Data from the Northeast Health Care Quality Foundation (PRO)

C. Reporting Results (Disciplinary Actions): The Board is required to "issue annually a report ... which shall contain a summary of all disciplinary actions undertaken by the Board during the year of the report" [26 V.S.A. §1352 (3)]. The content of the required summary is not specified but, ideally, should include sufficient information to educate the public and the Legislature, enhance strategic planning, and improve performance measurement reporting.

FINDING: The Board, in its Annual Report, reports disciplinary actions by type (e.g. revocation, suspension) but does not list or summarize data about the kinds of

---

[19] Possible limitations include: 1) the universe includes only hospitalized Medicare patients which, although a large sample, may not be representative; 2) the hospital setting may not be representative of all doctor-patient interactions; 3) "adverse events" would have to be carefully defined to ensure consistency; 4) unless reported by the patient, or resulting in injury, sexual misconduct would not likely be included in the data base; 5) to the extent the patient is not readmitted to the hospital, the PRO's will not have follow-up data to determine the severity of the injury suffered as a result of physician or staff misconduct; 6) some "adverse events" may be the result of non-physician hospital staff; and, 7) the hospitals themselves are not independent or disinterested parties, which may affect the reliability of the data.

[20] Categories of Quality Concerns and frequency can be found in Appendix A.

[21] More than one quality concern can be found on a reviewed case.

conduct that resulted in sanctions. In addition, the report does not differentiate between unprofessional conduct by practicing Vermont physicians and actions by out-of-state physicians seeking licensing or renewal in Vermont. Moreover, a public registry of all complaints and dispositions has not been produced as required by law.

According to the 1995 Annual Report, disciplinary actions increased from 7 in 1991 to 15 in 1995. The report includes copies of the stipulation and consent orders, and lists disciplinary actions by type of action (e.g., revocation, suspension), but contains no summary data about the kinds of unprofessional conduct that resulted in sanctions. Therefore, without reading the stipulation and consent orders, legislators and the general public would not know the nature of the public health risks posed by physician misconduct.

The summary also contains no information about the residence and place of business of the sanctioned physicians. This is noteworthy because each year a certain number of disciplinary actions are taken against out-of-state physicians seeking licensing or renewal in Vermont. The FSMB's national "Board Action Data Bank" has made it easier for states to determine if physicians have been disciplined in other jurisdictions. This is an important tool for the Board because many physicians obtain licenses in several states which, prior to the Data Bank, allowed sanctioned physicians to move easily without discovery.

A review of the Board's 15 disciplinary actions in 1995 reveals that 6 involved activities in other states that resulted in sanctions in Vermont. But while sanctions against doctors not practicing in Vermont protects Vermonters from potential unprofessional conduct, (a good outcome), it does not necessarily mean there have been any changes in the behavior of physicians currently practicing in Vermont. The success of the Board Action Data Bank may explain some part of the growth in the number of Vermont disciplinary actions, but it may also contribute to a misleading perception about the incidence of unprofessional conduct and the effects of the Board's disciplinary actions.

RECOMMENDATION: A) The Board should modify its Annual Report to include data about the types of unprofessional conduct that resulted in sanctions. B) It should distinguish in-state from out-of-state incidents to give a clearer picture of the incidence of unprofessional conduct in Vermont. C) A public registry of all complaints and dispositions should be produced, as required by law.

D. Client Service: The Board's clients include complainants from the public and physicians who are licensed to practice in Vermont. The Governmental Accounting Standards Board recommends that government entities periodically survey their clients to determine their level of satisfaction, whether staff are helpful and professional, and if the department's procedures are user-friendly. This information can be very helpful to the Board and staff as it seeks to fulfill its mission, reduce costs, and provide high quality services.

FINDING: The Board has never surveyed its clients (physicians and complainants) and refused to allow the State Auditor's office to do so. As a result, other than anecdotal evidence, there is no good data on the quality of service.

As part of this review, the State Auditor sought to survey a sample of complainants. The Board refused to release the names of complainants citing statutory confidentiality provisions. The Auditor's staff then suggested a compromise designed to protect the identity of complainants and case-specific confidential information through a voluntary joint survey effort. This proposal was resisted. Ultimately, the Auditor decided not to pursue the matter because the Board agreed to conduct the surveys in a timely manner and allow the Auditor's staff to review both the methodology of the survey and the non-confidential results.

RECOMMENDATION

The Board should undertake periodic confidential surveys of its clients.

The Auditor's staff is available to review the proposed survey instrument.

E. Efficiency: The Governmental Accounting Standards Board recommends that efficiency be measured by using "unit costs."[22]

FINDING: The Board's FY96 performance measurement report did not include unit cost data or any other efficiency information.

RECOMMENDATION: The Board should adopt the Governmental Accounting Standards Board unit cost measurement and report the data annually.

V. PUBLIC INFORMATION

A. Outreach: The Board relies almost entirely on complaints from the public to identify cases of unprofessional conduct. It is essential, therefore, that the public be well-informed about its rights and about the Board's purpose in helping to protect against physician misconduct.

FINDING: The Board's brochures[23] describe its functions and patient rights and are distributed to physicians, town clerks, newspapers, and other media. None of the brochures reviewed were particularly user-friendly nor did they contain information about alternative formats for the visually or hearing impaired (e.g., large type or TTY numbers). In addition, the brochures are only available in English. Following our initial inquiries, the Board has begun to address these issues.

RECOMMENDATION: The Board should adopt a more user-friendly design and make every effort to ensure that the brochures are accessible to all Vermonters.

B. Reporting: 26 V.S.A. §1352 requires the Board to report annually on its activities.

---

[22] op. cit., GASB Concepts Statement #2, 50(c)(1).

[23] "Bill of Rights for Hospital Patients", "Grounds for Unprofessional Conduct", "A Patients Guide to the Complaint Process", "A Consumer's Guide to the Medical Practice Board", and "The Typical Complaint Process".

FINDING: The Board's annual report meets the minimum requirements of the statute.

Though the Board's Annual Report meets minimum requirements, other states are moving ahead with more comprehensive public information efforts. For example, a recent Massachusetts law known as the Physicians' Profiles Legislation directs the Board of Registration in Medicine to collect and disseminate information on all licensees.[24] Information includes: criminal convictions and disciplinary actions within 10 years, disciplinary actions in other states, revocation or restriction of hospital privileges, medical malpractice payments, educational information, awards, specialty board certifications, hospitals where licensee has privileges.

RECOMMENDATION: The Board should monitor the new Massachusetts program and, if it is successful, provide information to the Legislature that would be useful in considering the implementation of a similar model in Vermont.

VI. BOARD MEMBERSHIP

A. Public Members: 26 V.S.A. §1351(a) states that "public members of the Board shall be persons not associated with the medical field." Similarly, the Federation of State Medical Boards (FSMB) Model Medical Practice Act suggests that "public members [should] have no substantial personal or business connection to the practice of medicine." (Section III. 1.).

FINDING: One of the Board's public members is a past member of the Medical Center Hospital of Vermont (MCHV) Associates, MCHV Board of Governors, and the MCHV Board of Trustees.[25] The extent of the prior association may be inconsistent with the intent of the statute.

There is no reason to believe that this member's official actions have not been independent or impartial. But there could be a public perception of bias due to the history of service to the hospital and, indirectly, the medical profession. The role of public members is to bring an unbiased perspective to a Board dominated by physicians. If one or more public members are not entirely unbiased, the Board may not have the balance intended by the Legislature. Public confidence in the Board depends on this balance and it should be protected.

RECOMMENDATIONS: Appointments of public members to the Board should be made with careful consideration of 26 V.S.A. §1351(a) which states that "public members of the Board shall be persons not associated with the medical field."

B. Physician Members: 26 V.S.A. §1351(a) states that nine of the members shall be licensed physicians.

FINDING: At present there are only two full-time practicing physicians on the Board.

---

[24] Massachusetts House Bill H5662, signed into law on August 9, 1996.

[25] Information supplied by the Chairman of the Board, June 19, 1996.

Serving on the Board is time-consuming and practicing physicians may be less inclined to serve than their retired colleagues. The current membership includes only two full-time practicing physicians out of nine physician members.[26] Retired doctors bring prestige and judgment from long careers and provide a valuable service to the public. But as the Board handles more quality of care cases, there is an increasing need for members to be informed about the latest developments in their fields.[27] Up-to-date knowledge about standards of care is of great value to the Board during investigations and practicing physicians are more likely to be knowledgeable about current standards of care than their retired colleagues. There is no way to quantify the costs and benefits of the current membership mix but in theory Board efficiency might improve if there were more practicing physician members.

RECOMMENDATION: Legislative or administrative action should be considered for the purpose of revising 26 V.S.A. §1351(a) or adopting rules to be more explicit about the status of physician members and to require that a certain number be engaged in full-time practice.

VII. INTERNAL CONTROLS: "Internal control is a process - effected by an entity's board of directors, management and other personnel - designed to provide reasonable assurance of achievement of objectives in ... financial reporting, effectiveness and efficiency of operations [performance measurement], and compliance with applicable laws and regulations."[28] Internal control consists of five interrelated components including control environment, risk assessment, control activities, information and communication, and monitoring.

A. Control Environment: "The control environment sets the tone of an organization, influencing the control consciousness of its people. It is the foundation for all other components of internal control, providing discipline and structure. The control environment encompasses the following factors: a) integrity and ethical values; b) commitment to competence; c) Board of Directors participation; d) management's philosophy and operating style; e) organizational structure; f) assignment of authority and responsibility; and, g) human resource policies and practices."[29]

FINDINGS:

a) we did not observe any breach of integrity or ethical values by the Board or staff;
b) without employee performance evaluations (or evidence of internal or external evaluations of Board actions or finances), we cannot comment on the Board's commitment to competence, except to say that there appears to be a very serious commitment to the core function of the Board;
c) information about the Board's participation in (or monitoring of) management is unavailable because there are no minutes of the executive committee;
d) in light of our findings in risk assessment, information processing, and personnel matters, management's operating style should be improved (see our recommendations in the areas listed);

---

[26] Information supplied by the Executive Director.

[27] Observation offered by former Board member Susan Spaulding during August 20 telephone conversation.

[28] American Institute of Certified Public Accountants, Statement on Auditing Standards (SAS) No. 78, Journal of Accountancy, February, 1996, pp. 85-90.

[29] ibid, pp. 87 - 88.

e) the Board's organizational structure is both imposed by statute and internally determined; the Board's committee system is both logical and, under the circumstances, appropriate for adjudicatory purposes; the relationship with the Secretary of State's office is not ideal but is beyond the control of both parties;
f) as with the prior item, there are some functions for which authority and responsibility are either vested outside the organization or are shared and which can only be changed through legislation;
g) the Board and staff must adhere to state personnel policies but, as noted elsewhere, there has been an absence of employee performance evaluations.

RECOMMENDATION: Management's operating style, the Board's organizational structure, and human resource policies and practices are addressed above in sections I & II, and below in VII. B.

B. Risk Assessment: Risk assessment includes "identification, analysis, and management of risks relevant to" the organization.[30] Risks relevant to the Board include: 1) its place within and relationship to state government; 2) caseload growth; and, 3) funding.

1. Structural Issues

FINDING: As noted above, the Board's semi-autonomous status and continuing relationship with the Secretary of State's office is not an ideal solution for either party. However, it is a political issue that requires further analysis and a policy decision by the Legislature.

The Board is aware of the problem but has not yet adequately framed the debate for the Legislature. Given the demands on the Board and staff from a growing caseload and the Legislature's other pressing priorities, it is not surprising that the issue remains unresolved. Nevertheless, these structural issues appear to be creating difficulties. For example, the OPR which is responsible for producing a registry documenting all complaints to the Board and the outcomes of those complaints, may not have easy access to the necessary data because of the Board's semi-autonomous status and views on confidentiality. If structural issues are an impediment to improving Board effectiveness and efficiency, than finding a satisfactory resolution must be the predicate for progress in other areas.

RECOMMENDATION: We concur with the Legislature's current review of the impact of Act 250 (1990).

2. Caseload Growth

FINDING: The number of complaints received has grown 69% from FY90 to FY95[31].

[30] op. cit., SAS No. 78, p. 87.
[31] Board of Medical Practice Annual Report, Calendar Year 1995, p. 8.

Caseload growth presents challenges to the Board and staff and, perhaps more importantly, raises questions about whether the incidence of unprofessional conduct is growing. The Board has been successful in reducing processing time but is likely to face more complex and time-consuming quality of care cases that will further stress the system. To date, the Board has not attempted to analyze this trend.

RECOMMENDATION: The Board should make an effort to identify the cause(s) of caseload growth and consider the implications for public health, the budget, and Board and staff work loads.

3. Funding: See section II.D. above.

C. Control Activities: "Control activities are the policies and procedures that help ensure that necessary actions are taken to address risks to achievement of the entity's objectives."[32] Control activities usually include performance reviews, information processing, physical controls, and segregation of duties. In the case of small entities such as the Board, however, some control activities may be less formal and "not relevant because of controls applied by management"[33] (e.g., segregation of duties may present difficulties due to the size of the staff and authority for approving significant purchases may vest elsewhere).

FINDING: The Board's performance measurements did not fully comply with GASB Concept Statement number 2.

The Board could improve its performance measurement and reporting in almost all areas, particularly outcomes (effectiveness) and efficiency (unit costs). The Director has recently reviewed the Auditor's 1996 report on performance measurement and both the director and the Board's attorney attended a workshop on the subject.

RECOMMENDATION: The Board's performance measurements should be improved.

D. Information and Communication:

FINDING: Delays in obtaining information from the board appear to result from limited information processing capabilities.

Information related to financial transactions is handled with the assistance of the Secretary of State's business manager and is part of the state's Financial Management Information System (FMIS). Since the FMIS is audited annually by the State Auditor, we assume appropriate internal controls are in place. Other non-confidential information processing duties are shared with the Secretary's programmer, who performs similar functions for the other professional boards.

---

[32] op cit., SAS No. 78, p. 89.
[33] op. cit., SAS No. 78. p. 89.

Information about complaints are handled exclusively by Board staff due to concerns about confidentiality. As is noted above, confidentiality is critical in some instances but may have become a barrier to improved management and dissemination of useful public information. It is noteworthy that the Secretary's programmer handles confidential information from other professional boards but is not allowed to use his skills and equipment to assist the Board. It is fair to deduce that some of the delays we experienced in obtaining information from the Board were the result of limited information processing capabilities.

Finally, as is noted above, we have found that the Board would improve its ability to communicate through better data collection and reporting.

RECOMMENDATION: The Board and the Director should make a commitment to improved record keeping and data collection in order to enhance their ability to report to the Legislature and the public.

E. Monitoring: "Monitoring is a process that assesses the quality of internal control performance over time. It involves assessing the design and operation of controls on a timely basis and taking the necessary corrective actions. This process is accomplished through ongoing monitoring activities, separate evaluations, or a combination of the two."[34]

FINDING: Our internal control findings (see above) include a number of areas where the Board can improve. These include performance measurement, planning, evaluation, and information processing.

RECOMMENDATION: As has been discussed previously, the Board should: 1) expand and refine its ability to measure and report on performance; 2) augment its budget and staff planning capabilities and time horizon; 3) undertake regular employee performance evaluations, and contract for a financial and management audit; and, 4) consider the limitations of the current information processing and communication systems and take necessary corrective actions.

VIII. OTHER OBSERVATIONS

A. Prevention: At present, there are no organized prevention programs for impaired physicians suffering from substance abuse or sexual boundary problems, although some physicians are required to seek treatment as part of a stipulation and consent order. To date, the Board "has felt unable to balance its obligation to protect the public safety with the need to be reasonable and fair to those impaired physicians who have as yet brought no harm to patients."[35] This sounds reasonable but assumes no harm has been done because no complaints have been filed. This is questionable since it further assumes that "harm" will always be evident to a patient and that all injured patients will file complaints. The former is unlikely because patients have inadequate training to know when they've been harmed by omission, and the latter is improbable. As the Board noted, however, "[r]eliable monitoring has not been available" and "[we] have recognized that according

[34] op. cit., SAS No. 78, p. 90.

[35] Minutes from the "Dorset Conference" on physician impairment issues, 8/24/95.

to traditional wisdom in the field of addiction medicine, this rigid policy has probably been counterproductive by discouraging early and voluntary reporting of impairment problems."[36]

Since caseload growth (particularly quality of care cases) has been identified as a risk, prevention is an appropriate response. Successful prevention programs would reduce the incidence of unprofessional conduct (improving public health), decrease the pressure on the Board's members, budget and staff, and avoid potential personal and professional damage to physicians who are valuable resources to the community.

The Board has acknowledged the problem and is participating in discussions with neighboring states and the Vermont Medical Society about the feasibility of establishing a regional "Impaired Physicians Program" (IPP). If implemented, this program will alert physicians (particularly those experiencing problems) that the Board and the public will not tolerate unprofessional conduct but will provide assistance to impaired physicians willing to seek help. The Board and other interested parties (e.g., Vermont Medical Society, University of Vermont College of Medicine) should continue to work together to create an Impaired Physicians Program.

The Board declined to provide a copy of the draft IPP so we were unable to review it.

B. Credibility: The public receives most, if not all, of its information about the Board through press accounts of the most serious, contentious and time-consuming cases. Given this, there are many reasons the public may be skeptical about the Board's effectiveness. These reasons may include cynicism about the appropriateness of doctors policing themselves, sensitivity about the nature of some of the offenses (e.g., sexual misconduct), the personal nature of our relationships with doctors and a sense of vulnerability, and frustration with what may appear to be excessive due process protections.

Media focus on these issues is unavoidable. And while such scrutiny is not inappropriate, the Board could make more of an effort to better educate the public about the full range of its activities and provide a framework within which to view the high-profile cases. For example, better information about the incidence of unprofessional conduct could help the public understand the comparatively limited scope of the problem and (assuming improvement over time) build support for the Board's efforts. Publicizing the Board's improved case resolution performance would help the public appreciate the unusual circumstances of the high-profile cases. Sharing the results of customer surveys would demonstrate the Board's openness and commitment to quality service (in addition to gaining useful information about how to improve). Explaining the value of the National Board Action Data Bank would inform the public about the Board's continuing effort to ensure that the system protects us from unscrupulous doctors attempting to locate here.

The Board needs the support of the public, the profession, and the Legislature. The best way to gain (and maintain) that support is to collect and disseminate accurate information about the Board's activities and their effect on public health.

[36] ibid, Minutes from the Dorset Conference.

Appendix A: Schedule of Documents

Documents	Tab	Notebook
Review Planning Memorandum	1	1
23 V.S.A. 26	2	1
5 V.S.A. 3, §131	2	1
Executive Order No.8-91	2	1
"Ranking of State Medical Licensing Boards 1995" Public Citizen	3	1
"Exchange" 1995-1996, Federation of State Medical Boards	3	1
"Professional Licensing Report" March 1996	3	1
H.5662, statute re: Mass. Board of Registration in Medicine	3	1
Northeast Health Care Quality Foundation data on "quality concerns"	3	1
1/94 Performance Audit-Rhode Island Board of Medical Licensure & Discipline	4	1
5/94 Report on the Alabama Board of Medical Examiners	4	1
11/94 Performance Audit-Arizona Board of Medical Examiners	4	1
Correspondence		
From DRH to SAO: 5/28/96, 6/27/96, 7/12/96, 7/15/96, 7/16/96, 7/23/96, 8/1/96, 8/23/96, 9/6/96	5	1
From DRH to Board: 6/6/96, 6/10/96, 7/1/96, 7/23/96, 8/2/96, 8/7/96, 9/6/96, 9/23/96, 9/30/96	6	1
From Board to SAO: 6/19/96 }		2
7/19/96 } Cover letters for each notebook sent by the Board		4
9/11/96 }		5
From Board Attorney to DRH	7	1
From the Dep. Sec. of State to the Board: 3/1/96, 4/11/96, 8/6/96	8	1
From Rep. Lynn Bohi to State Auditor	9	1
Board responses to information requests		
#1 19 June 1996		
Board membership, bio's & attendance	1	2
List of staff and related info.	2	2
Board Rules (11/1/95)	3	2
Various reports & publications of the FSMB	4	2
Board budget submissions: FY 94-96	5	2
1995 Annual Report	under separate cover	6
'94 & '95 Report on Prof. Licensing- excerpts (Sec. of State)	5	2
Two information items related to financial management	6	2
News release from & 1996 Annual Report of the FSMB	6	2
List of case file numbers and dates of complaint & resolution	7	2
Contract information on outside contractors	under separate cover	3
Administrative Bulletin 3.5 (8/10/95)	9	2

Documents		Tab	Notebook
#2	19 July 1996		
	Info. on meeting warnings and Board minutes from 1/3 - 6/5/96	1	4
	Denial of information on complainants	2	4
	Informational brochures	3	4
	Information on preventive measures	4	4
	Info. on impaired physicians & Report of the Dorset Conference	5	4
	Statement re: consultant contracts	6	4
#3	11 September 1996		
	Statement re: shared staff issue with the Sec. of State	1	5
	Statement re: unavailability of new rules & procedures	2	5
	Statement re: unavailability of Impaired Physician Program draft	3	5
	Information re: license and renewal fees	4	5
	Additional information about brochures	5	5
	Statement re: travel expenditures	6	5
	Statement re: consultant contracts	7	5
	Information on practice status of physician Board members	8	5
	Information on license renewals	9	5
	Reference to telephone conversation re: litigation	10	5
	FSMB credentials verification information	11	5
	Employee job descriptions	12	5
	Statement re: lack of employee performance evaluations	13	5
	Statement re: Investigative Committee minutes	14	5

Northeast Health Care Quality Foundation

Robert A. Aurilio, C.E.O. Jon Michael Vore, M.D., President

Northeast Health Care Quality Foundation
Review Statistics for the State of Vermont
Calendar Years 1994, 1995

Report Date: 08/15/96

Calendar Year	1994	1995
Total Number of Claims Received	33699	35412
Total Number of Claims Reviewed	1856	1084
Claims with Confirmed Quality Concerns	110	78
Confirmed Quality Concerns Found*	218	154
Quality Concerns Found in Category**:		
C01	39	30
C02	43	15
C03	27	4
C04	34	21
C05	8	3
C06	20	25
C07	0	11
C08	5	2
C09	14	5
C10	13	14
C11	9	20
C12	1	0
C13	2	0
C14	2	2
C99	1	2

* - More than one quality concern can be found on a reviewed claim
** - See attached list for the meanings of quality concern categories

QUALITY CATEGORIES (Physician, Nursing or Other)

C00	Concern is resolved
C01	Apparently did not obtain pertinent history and/or findings from examination
C02	Apparently did not make appropriate diagnoses and/or assessments
C03	Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09) and procedures (see C07 or C08) and consultations (see C13 and C14)]
C04	Apparently did not carry out an established plan in a competent and/or timely fashion (e.g., omissions, errors of technique, unsafe environment)
C05	Apparently did not appropriately assess and/or act on changes in clinical/other status
C06	Apparently did not appropriately assess and/or act on laboratory tests or imaging study results
C07	Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed
C08	Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)
C09	Apparently did not obtain appropriate laboratory tests and/or imaging studies
C10	Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans
C11	Apparently did not demonstrate that patient was ready for discharge
C12	Apparently did not provide appropriate personnel and/or resources
C13	Apparently did not order appropriate specialty consultation
C14	Apparently specialty consultation process was not completed in a timely manner
C40	Apparently did not follow-up on patient non-compliance
C99	Other quality concern not elsewhere classified