

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. Financial Management - Expenditures
6.	F. Personal Service Contracts
7.	G. Audits & Independent Review
	III. INVESTIGATIONS AND DISCIPLINARY ACTIONS
	A. Investigative Outreach
8.	B. Quality - Investigations and Adjudication
	C. Monitoring
9.	D. Disciplinary Guidelines
	IV. PERFORMANCE MEASUREMENT
	A. Output - Productivity
10.	B. Outcomes - Measuring Results
12.	C. Outcomes - Reporting Results (Disciplinary Actions)
13.	D. Client Service
14.	E. Efficiency
	VI. PUBLIC INFORMATION
	A. Outreach
	B. Reporting
15.	V. BOARD MEMBERSHIP
	A. Public Members
	B. Physician Members
16.	VII. INTERNAL CONTROLS
	A. Control Environment
17.	B. Risk Assessment
	1. Structural Issues
	2. Caseload Growth
18.	3. Funding
	C. Control Activities
	D. Information and Communication
19.	E. Monitoring
	VIII. ADDITIONAL OBSERVATIONS
	A. Prevention
20.	B. Credibility
21.	Appendix A Schedule of Documents Reviewed
23.	Attachment A Categories of “Quality Concerns”

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, 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.

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 a staff investigator from the Secre-

tary of State's office, the Board's attorney, and an Assistant Attorney General. 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 an on-the-record review. In cases of revocation or suspension, licensees may appeal the Board's decision to the Superior Court which hears the case *de novo*. A further appeal to the Vermont Supreme Court is available.

Prior to 1990, the Board was one of over 30 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 repealed 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 more than 30 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 any independent review of its work.

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 any independent review whatever, 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 Legislature¹, 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 restricted to current cases or emergencies.² The Board has since contracted for legal services.

¹ Act 250 of 1990 (H.254) and subsequent repeals of the scheduled sunsets.

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

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 : The Board should improve its planning and budgeting methodology to reduce (if not eliminate) the need for unbudgeted resources. An independent management audit could help the Board identify opportunities for improving efficiencies.

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 the most efficient and creates confusion about responsibilities and accountability. The Board should work with the Secretary to submit a mutually satisfactory proposal to the Legislature.

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.

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

The FSMB recommends that medical practice boards be authorized to collect fines and be reimbursed for the costs of investigation and adjudication.⁷ The Director is not convinced this would be effective since, in her opinion, some physicians have limited resources following a protracted case and, in the case of revocations, have reduced earning power. It was also noted that such a policy might create the impression that the Board initiated investigations in order to produce revenue.⁸

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. Financial Management - Expenditures:

FINDING: As a result of the need to utilize shared staff (investigators and attorneys) in excess of the planned and budgeted targets (see item II.A. above), the Board requested and was granted additional funds through the "excess receipts" process⁹ for the last three years in a row.

The Legislature has essentially level-funded the Board at \$380,000 for the past three years. But in each of those years, the Board sought approval for and received excess receipts of \$30,105 in FY 94 (7.9% over budget), \$25,000 in FY 95 (6.6% over budget), and \$50,001 in FY 96 (13.2% over budget). The FY 96 percentage would have been over 20% had the Board received approval for its full request of \$76,500.¹⁰ The majority of these funds were used to pay for the services of investigators and attorneys.

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 *op cit.*, August 8 meeting with the Director, Chairman and attorney.

⁹ Departments submit requests to the administration for additional funds not originally appropriated.

¹⁰ Information from Sept. 5 telephone conversation with Larry Daum of the Dept. of Finance & Management.

RECOMMENDATION: The Board should review its budgeting process to ensure that its budget request is based on reasonable estimates, given available data at that time. In addition, an independent management audit could help the Board identify opportunities for improving efficiencies.

F. 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.¹¹ 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.”¹² 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 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.”¹³ 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.

¹¹ Agency of Administration, Bulletin 3.5, Section VI.A.

¹² See July 19, 1996 information packet (section 6) in the written response to State Auditor’s inquiry.

¹³ Bulletin 3.5, Section VIII.C.2.

G. 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 short-falls 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.”¹⁴

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 Responsibility.

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 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 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 appro-

¹⁴ 23 V.S.A. §1355(a).

priate professional boards so that it can review all cases with possible physician misconduct that come from other boards within the Secretary of State's office.

B. Quality - Investigations and Adjudication: It is essential that the work of the Board be - and be perceived as - thorough, impartial and fair. Independent judicial review serves to ensure that the decision was fair and based upon the facts presented.

FINDING: Other than rare cases of judicial review, there is no independent review of internal Board investigative processes or decisions.

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.¹⁵

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.¹⁶ In those instances where a complaint does not lead to disciplinary action (90% ±), there is no formal review procedure. 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 no independent review has ever 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.

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

¹⁵ Information from Board attorney Phil Cykon in telephone conversation September 10, 1996.

¹⁶ 1995 Annual Report, Attachment G.

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: Administrative or legislative action should be taken to ensure confidential access to all files for periodic independent audits and reviews.

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.¹⁷

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 guidelines¹⁸ but have made no effort to develop their own.

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%,¹⁹ from 362

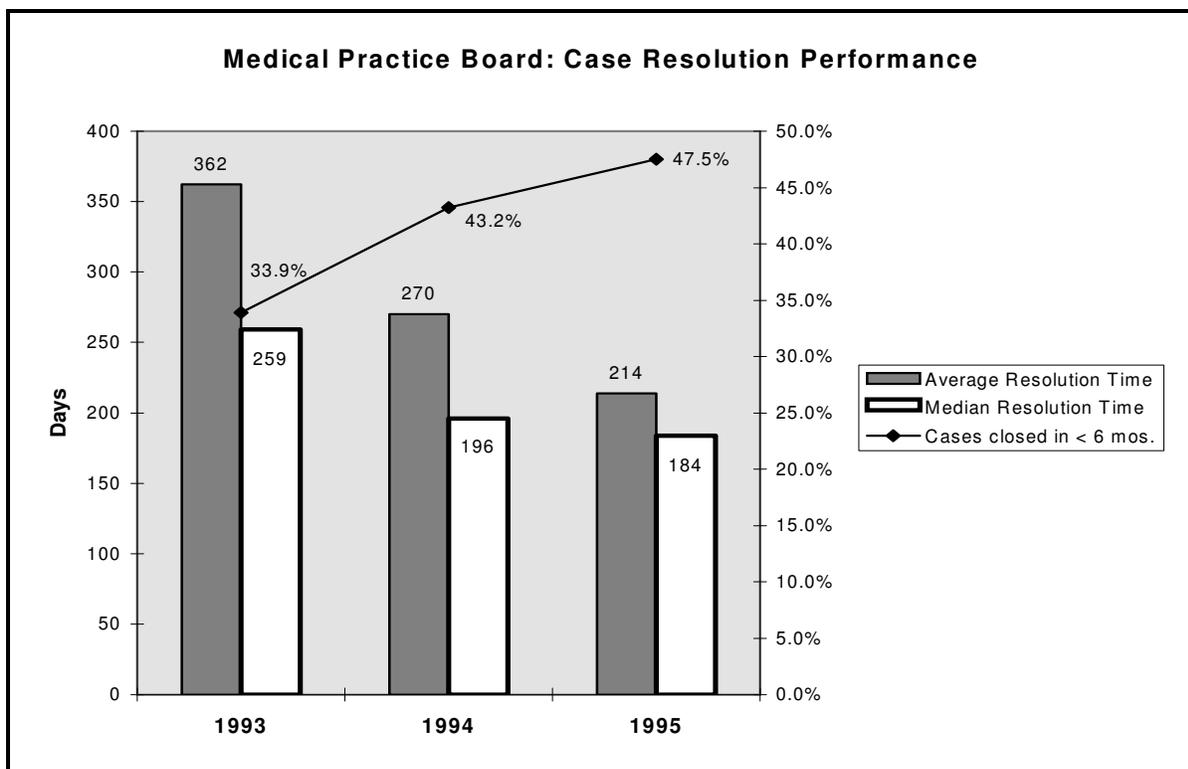
¹⁷ FSMB, “A Model For The Preparation Of A Guidebook On Medical Discipline”, Third Edition, February 1992, p. iii.

¹⁸ Comments made during an interview on August 8, 1996.

¹⁹ Raw data on case filings and closures supplied by the Director. Calculations performed by the author.

to 214 days.²⁰ 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.



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 safety has improved.

²⁰ Including weekends and holidays.

The Board's FY96 performance measurement report²¹ included productivity data but failed to provide information about whether public health had improved as a result of its efforts. On the other hand, 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. But the FSMB defines effectiveness as the number of disciplinary actions per 1,000 practicing physicians. This measure allows comparisons across jurisdictions but says nothing useful about the state of public health.

There are several key assumptions in the FSMB's model that may limit its value as a measure of effectiveness, however. 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 safety 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 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 limitations²², 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

²¹ FY96 Budget, Form 4, pp. 1-3.

²² 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.

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 ²³	110	6%	78	7%
Confirmed Quality Concerns ²⁴	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 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.

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 dis-

²³ Categories of Quality Concerns and frequency can be found in Appendix A.

²⁴ More than one quality concern can be found on a reviewed case.

ciplinary 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: The Board should modify its Annual Report to include data about the types of unprofessional conduct that resulted in sanctions. It should distinguish in-state from out-of-state incidents to give a clearer picture of the incidence of unprofessional conduct in Vermont.

D. Client Service: The Board's clients include complainants from the public and physicians who, through examinations and licensing, are certified 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.”²⁵

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 that the Board exists to help ensure they are protected against physician misconduct.

FINDING: The Board’s brochures²⁶ 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.

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.²⁷ 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.

²⁵ op. cit., GASB Concepts Statement #2, 50(c)(1).

²⁶ “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”.

²⁷ Massachusetts House Bill H5662, signed into law on August 9, 1996.

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.²⁸ 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.

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.²⁹ 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.³⁰ 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 mem-

²⁸ Information supplied by the Chairman of the Board, June 19, 1996.

²⁹ Information supplied by the Executive Director.

³⁰ Observation offered by former Board member Susan Spaulding during August 20 telephone conversation.

bership 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.”³¹ 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.”³²

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);**
- 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 the most efficient but is beyond the Board’s control;**
- 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.**

³¹ American Institute of Certified Public Accountants, Statement on Auditing Standards (SAS) No. 78, Journal of Accountancy, February, 1996, pp. 85-90.

³² *ibid*, pp. 87 - 88.

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.³³ 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 recommend the Legislature consider the findings in this report as it reviews the impact of Act 250 (1990).

2. Caseload Growth

FINDING: The number of complaints received has grown 69% from FY90 to FY95³⁴.

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.

³³ op. cit., SAS No. 78, p. 87.

³⁴ Board of Medical Practice Annual Report, Calendar Year 1995, p. 8.

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.”³⁵ 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”³⁶ (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 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.

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.

³⁵ op cit., SAS No. 78, p. 89.

³⁶ op. cit., SAS No. 78, p. 89.

RECOMMENDATION: The Board should consider increased utilization of the Secretary’s information systems staff (rather than attempting to duplicate their capacity). Furthermore, we recommend that the Board and the Director 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.”³⁷

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.”³⁸ 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 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.”³⁹

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,

³⁷ op. cit., SAS No. 78, p. 90.

³⁸ Minutes from the “Dorset Conference” on physician impairment issues, 8/24/95.

³⁹ *ibid*, Minutes from the Dorset Conference.

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.