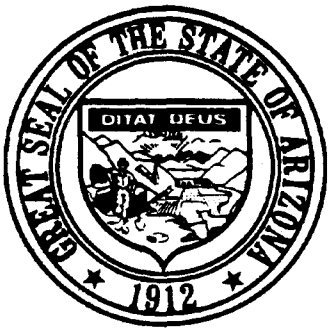

PERFORMANCE AUDIT

THE BOARD OF MEDICAL EXAMINERS

Report to the Arizona Legislature
By the Auditor General
November 1994
Report 94-10

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

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November 22, 1994

Members of the Arizona Legislature

The Honorable Fife Symington, Governor

Dr. Richard E. Zonis, Chairman
Board of Medical Examiners

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Board of Medical Examiners. This report is in response to a May 5, 1993, resolution of the Joint Legislative Audit Committee. This performance audit was conducted as part of the Sunset review set forth in A.R.S. §§41-2951 through 41-2957.

Medical boards in Arizona and other state have traditionally viewed BOMEX as a "model" board. BOMEX's program to monitor and rehabilitate doctors with substance abuse programs has been recognized nationally. In addition, compared to other boards, BOMEX has sufficient statutory authority and a substantial budget to carry out its regulatory responsibilities.

Our review, however, found that BOMEX's performance has declined in recent years. On the regulatory side, we found that the Board suffers from a significant backlog of complaints, takes too long to resolve complaints, does little to investigate complaints, and appears to be too lenient with offending doctors. On the management side, we found that the agency has not been able to manage some operations basic to state agencies. We found violations of both the State's open meeting law and State procurement requirements, mismanagement of the rules of development process, and personnel problems.

My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on November 23.

Sincerely,

Douglas R. Norton
Auditor General

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SUMMARY

The Office of the Auditor General has conducted a performance audit and Sunset review of the Board of Medical Examiners (BOMEX), pursuant to a May 5, 1993, resolution of the Joint Legislative Audit Committee. The audit was conducted under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S.) §§41-2951 through 41-2957.

The Board's primary responsibility is to protect the public. A.R.S. §32-1403.A. states:

> *The primary duty of the board is to protect the public from unlawful, incompetent, unqualified, impaired or unprofessional practitioners of allopathic medicine through licensure, regulation and rehabilitation of the profession in this state.*

Our audit found that the Board is not adequately protecting the public. We present three findings critical of the Board's complaint resolution and licensing functions. In a fourth finding, we criticize management for not addressing these regulatory problems and also for failing to comply with state procurement and open meeting law requirements. Board members need to be more actively involved in overseeing the agency to ensure that problems we identified in our findings are rectified.

A Large Complaint Backlog and Slow Complaint Resolution Impede BOMEX's Ability to Protect the Public (See pages 1 through 10)

BOMEX had a backlog of 1,481 unresolved complaints as of June 30, 1994. In addition, non-malpractice complaints resolved between July 1991 and June 1994 took an average of 355 days to process. Other states comparable to Arizona in number of physicians licensed had an average backlog of 275 complaints. Failure to resolve complaints in a timely manner allows doctors with problems to continue to practice medicine unchecked.

BOMEX can reduce its complaint backlog and improve complaint resolution timeliness. First, BOMEX needs to adopt a complaint prioritization method to ensure that the most serious complaints are addressed first and invalid complaints are quickly eliminated. Second, BOMEX can significantly improve complaint resolution timeliness by eliminating unnecessary administrative delays between important steps in the process. Third, the Board needs to more efficiently utilize time spent adjudicating complaints. Currently, the full Board rules on all complaints. This practice has not reduced the

backlog. The Board should divide into two adjudicatory bodies to double complaint resolution. Other states have adopted these types of changes to address similar problems with complaint resolution.

Discipline and Complaint Investigation Need to Be Improved (See pages 11 through 16)

The Board does not take sufficient action against doctors found in violation of professional conduct standards, nor does it fully investigate complaints. Even when the Board finds doctors to be in violation of standards, some actions have been too lenient. For example, we noted one case in which during a Thanksgiving weekend, a 22 month-old baby girl died of acute bronchial pneumonia, a curable bacterial infection. Although the father called several times about his daughter's worsening condition, the doctors said they did not need to see the child and instead recommended fluids, a vaporizer and cough syrup. The Board issued Letters of Concern against the doctors. Some Board members told us that disciplinary action should have been taken against the doctors. One Board member said that the child's life could have been saved.

In 21 of 30 cases we reviewed, the Board issued Letters of Concern when stronger action appeared to be warranted. In addition, we found that the Board was slow to take strong action against doctors with multiple serious violations. Reasons for the Board's weak discipline are: 1) its lack of disciplinary guidelines; 2) its reluctance to discipline fellow doctors; 3) statutes requiring that most Board members be doctors; and 4) inadequate complaint investigations.

The Board also needs to improve its complaint investigations. Investigations are typically limited to reviewing medical records provided by the doctor in question. Critical parties, including the complainant/patient, the doctor, the nurses, and other potential witnesses are rarely interviewed. One reason for poor investigations may be because the Board has not, until recently, routinely assigned its seven investigators to investigate complaints. Rather, most of their time was spent gathering urine samples from approximately 70 doctors the Board is monitoring for substance abuse problems.

BOMEX Has Issued Some Registrations and Permits to Practice Medicine to Persons Who Did Not Meet Statutory Requirements (See pages 17 through 20)

Although we did not review BOMEX's licensing function due to time constraints, two issues came to our attention during the audit. BOMEX has improperly issued locum tenens registrations and training permits in violation of state statutes. A locum tenens registration is used to authorize an out-of-state doctor to substitute for or assist an Arizona doctor for a limited time. In four cases it appears that the Board used locum tenens registrations as a substitute for its regular licensing process. BOMEX also issued training permits in excess of residency, intern, and fellowship-allotted positions at hospitals. For example, in fiscal year 1993 BOMEX issued 14 training permits to applicants participating in a program that was only authorized 10 positions. BOMEX also improperly dated training permit applications retroactively.

Inadequate Management and Limited Board Oversight Hinder BOMEX (See pages 21 through 26)

Poor management and failure by the Board to assert its statutorily defined role of overseeing the agency has contributed to many of the problems we found during the course of the audit. In addition to problems handling and resolving complaints against doctors, we found that the agency has violated state procurement rules and the open meeting law. Board members need to place more emphasis on monitoring and guiding the agency.

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INTRODUCTION AND BACKGROUND

The Office of the Auditor General has conducted a performance audit and Sunset review of the Board of Medical Examiners (BOMEX), pursuant to a May 5, 1993, resolution of the Joint Legislative Audit Committee. The audit was conducted under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S.) §§41-2951 through 41-2957.

Board Responsibilities

The Board's primary responsibility is to protect the public. A.R.S. §32-1403.A. states:

> *The primary duty of the board is to protect the public from unlawful, incompetent, unqualified, impaired or unprofessional practitioners of allopathic medicine through licensure, regulation and rehabilitation of the profession in this state.*

Statutes authorize the Board to exercise this responsibility through examining and licensing physicians, renewing licenses annually, investigating and resolving complaints, disciplining and rehabilitating physicians, and developing and recommending standards governing the medical profession. During fiscal year 1994, the Board regulated approximately 12,000 doctors with active Arizona licenses.

BOMEX's Performance Has Declined

Medical boards in Arizona and other states have traditionally viewed BOMEX as a "model" board. BOMEX's program to monitor and rehabilitate doctors with substance abuse problems has been recognized nationally. In addition, compared to other boards, BOMEX has sufficient statutory authority and a substantial budget to carry out its regulatory responsibilities.

Our review, however, found that BOMEX's performance has declined compared to some other states and compared to other regulatory and management criteria. On the regulatory side, we found that the Board suffers from a significant backlog of complaints, takes too long to resolve complaints, does little to investigate complaints, and appears to be too lenient with offending doctors. On the management side, we found that the agency has not been able to manage some operations basic to any state

agency. We found violations of both the State's open meeting law and State procurement requirements, mismanagement of the rules development process, and financial and personnel problems.

Staffing and Budget

The Board is comprised of 12 members, including nine licensed physicians, two public members, and a member of the Board of Nursing. The Board employs an executive director who oversees agency operations. For fiscal year 1994-95, the Board was appropriated 42.5 full-time equivalent (FTE) employees. The Board employs investigators, medical consultants, and licensing and other administrative staff to carry out its duties.

The Board was appropriated approximately $2.4 million for agency operations in fiscal year 1994-95. The Board is funded by the Legislature out of a special fund comprised of examination and licensing fees collected by the Board. Table 1 summarizes the Board's actual revenues and expenditures for fiscal years 1992-93 and 1993-94, and the Board's appropriated expenditure budget for fiscal year 1994-95.

Table 1

Board of Medical Examiners
Statement of FTE, Revenues, Expenditures and Changes in Fund Balances for Years Ended June 30, 1993 and 1994 and Statement of Appropriated Expenditures for Year Ended June 30, 1995
(unaudited)

	1992-93 Actual	1993-94 Actual	1995 Appropriated
FTE	40.5	41.5	42.5
Revenues	$2,966,071	$3,134,342	
Expenditures:	$1,030,190	$1,074,693	$1,260,000
Personal Services			
Employee Related	229,451	233,912	288,900
Prof. & Outside Services	639,180	628,117	338,700
Travel - In-state	38,771	34,530	47,300
Travel - Out-of-state	8,343	13,628	8,800
Equipment	14,691	182,530	0
Other Operating	427,257	422,910	416,200
Total Expenditures:	$2,387,883	$2,590,320	$2,359,900
Excess of Revenues over Expenditures	579,189	544,022	
Beginning Fund Balances	$1,170,782	$1,748,971	
Ending Fund Balances	$1,748,971	$2,292,993	

Source: Arizona Financial Information Systems and the State of Arizona Appropriations Report for the Fiscal Year Ending June 30, 1995.

Audit Scope

Our audit contains findings in the following four areas:

- The extensive backlog of pending complaints and the untimely resolution of complaints;
- Lenient disciplinary action and incomplete complaint investigation;
- Issuance of some registrations and permits to practice medicine to persons who did not meet statutory requirements;
- Poor agency management, and the Board's lack of oversight over agency operations.

The audit was conducted in accordance with government auditing standards.

The Auditor General and staff express appreciation to the Board of Medical Examiners, the executive director, and staff for their cooperation and assistance throughout the audit.

FINDING I

A LARGE COMPLAINT BACKLOG AND SLOW COMPLAINT RESOLUTION IMPEDE BOMEX'S ABILITY TO PROTECT THE PUBLIC

BOMEX needs to reduce its significant backlog of complaints and improve the timeliness of its complaint resolution process. Our review found that the Board currently has a large backlog of complaints, totaling 1,481 as of June 30, 1994. Complaints resolved in the past three fiscal years took on average 355 days to process. The Board can address these problems by prioritizing complaints, better managing its complaint process, and adopting alternative complaint adjudication methods.

Timely Complaint Resolution Important

It is vital that the Board resolve complaints in a timely manner. Swift resolution of complaints benefits all parties involved. If a doctor is found in violation, he or she can address the problems identified. The public benefits from timely complaint resolution by being less exposed to possible substandard medical practice. The Board benefits because lengthy delays can affect its ability to discipline. For example:

- A baby was born with severe brain damage and died 17 months later. The complaint alleged that the brain damage occurred because the doctor failed to perform a timely caesarean section during the delivery. The malpractice case was filed with the Board in December 1988. The case appeared before the Board in 1993 and was returned to staff for further investigation. The Board finally adjudicated the case in April 1994, over five years after receiving it. Board members commented that since this case was so old, it was difficult to determine the standard of care at the time it occurred. As a result, the doctor received only a Letter of Concern for "delay in delivering a baby in the face of a prolonged, ominous fetal heart rate tracing."

Board Has an Enormous Complaint Backlog

The Board has not been able to reduce its large backlog of complaints. The backlog, estimated at over one- and one-half years, has remained constant for the past three fiscal years. Under the Board's current complaint resolution process, it appears unlikely that it will eliminate the backlog.

Currently, the Board is faced with a large backlog of complaints. As of July 1994, the Board had 1,481 unresolved complaints. As shown in Table 2, the backlog has remained steady over the last three fiscal years.

Table 2

BOMEX Complaint Statistics
Fiscal Years 1991-92 through 1993-94

Number of Complaints	Fiscal Year 1991-92	Fiscal Year 1992-93	Fiscal Year 1993-94
Beginning of Year	1,175	1,397	1,543
Received	1,020	1,186	821 (a)
Resolved	798	1,040	883
End of Year	1,397	1,543	1,481

(a) A change in reporting requirements resulted in a decrease in the number of malpractice claims reported to the Board. Prior to 1993, all malpractice cases filed were to be reported to the Board. However, as of July 1993, only cases that have been settled must be reported to BOMEX.

Source: Auditor General staff analysis of BOMEX complaint tracking data base.

The Board has resolved an average of approximately 900 complaints annually over the last 3 years. At this rate, even if the Board were to receive no more complaints, it would take 20 months to eliminate its pending backlog.

The Board's backlog is significantly higher than other states with a similar number of doctors. A 1992 survey of other state medical regulatory boards performed by the Federation of State Medical Boards found that 11 other boards comparable to Arizona in numbers of physicians licensed averaged approximately 275 open complaints. Arizona's nearly 1,500 open complaints at the end of fiscal year 1993-94 was over five times greater than similar states' backlogs.

Complaint Resolution Process Much Too Long

The Board has failed to resolve complaints in a timely manner. Our review of Board records for the last 3 fiscal years found that it took the Board an average of 355 days to resolve complaints. The Board should be able to reduce this time to 180 days or less by addressing some administrative delays.

Complaint resolution averaged 355 days — Our review of Board records for fiscal years 1991-92 through 1993-94 found that, excluding malpractice complaints, it took the Board an average of 355 days to resolve complaints adjudicated in those years. Malpractice complaints adjudicated in those years (17 percent of total cases) averaged 1,159 days.[1]

Resolution time could be sharply reduced — The time it takes for the Board to resolve complaints can be improved. Some other boards we studied were able to resolve complaints within 180 days. In addition, Board members and the new executive director concur that the time should be reduced to six months or less.

The Board could improve complaint resolution timeliness simply by shortening the time that cases are pending the next step. We sampled 90 complaints closed in fiscal year 1993-94 to determine how much time the Board takes to complete various steps in the process. We found several steps where the complaint time frame could be reduced. By reducing the administrative waiting time in some of the steps, complaints could be resolved in approximately 180 days or less, as shown in Table 3 on page 8.

Solutions for Reducing Backlog and Improving Complaint Resolution Timeliness

The Board could implement several improvements to rectify its complaint backlog and resolution problems. First, the Board needs to set up a complaint prioritization process. Second, the Board needs to streamline its adjudication process.

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(1) BOMEX is statutorily required to initiate an investigation into malpractice reports upon receipt of the report. However, the Board's practice of working these cases as time permits has resulted in a large backlog and created delays in investigating and adjudicating these cases. Consequently, these cases have taken longer to resolve.

Table 3

Average and Suggested Time Frames For Steps In The Complaint Resolution Process For Fiscal Year 1993-94

Step	Description	Average Time	Suggested Time
1*	Number of days from receipt of complaint until medical records are requested	41 days	7 days (a)
2	Number of days from request for medical records until medical records are received	48 days	20 days (b)
3*	Number of days from receipt of all medical records until the complaint is assigned to medical consultant	39 days	7 days
4	Number of days from assignment of complaint to medical consultant until the medical consultant's report and summary is complete	105 days	60 days
5*	Number of days from completion of medical consultant's report and summary until the complaint is assigned to reviewing Board member	52 days	7 days
6	Number of days from assignment of complaint to reviewing Board member until Board staff receive reviewing Board member's recommendation	11 days	11 days
7	Number of days from receipt of reviewing Board member's recommendation by Board staff until the full board takes action on complaint	88 days	60 days
	Total:	384 days	172 days

* Indicates steps simply waiting for assignment to the next step in the process.

(a) Finding II (see page 11) discusses the need to assign complaints to the Board's medical investigators. The medical investigator would be assigned the complaint at step one and would complete investigation efforts and a written report in concert with the medical consultant's activities in step four.

(b) Current Board requirement is 20 days.

Complaint prioritization needed — The Board needs to prioritize complaints so immediate action can be taken on serious cases. The Board currently does not have formal guidelines to rank cases in order of seriousness. The Board maintains it takes action on the most serious complaints first; however, we found no evidence that this does indeed occur.

The Citizen Advocacy Center (CAC), a public citizens' watch group, recommends that, "Boards that process large numbers of complaints should have a system that gives priority to those allegations that are particularly serious, and potentially detrimental to the public welfare." CAC also states that, "...quality of care cases need to be given top priority in terms of time and resources."[1] Other states have adopted prioritization schemes which have helped reduce complaint backlogs and also address more serious cases sooner.

More efficient complaint adjudication needed – Although the Board has conducted lengthy meetings in an attempt to address its large complaint caseload, it has not been able to reduce the backlog. As a result, the Board needs to adopt alternative complaint resolution methods to address this problem. Currently, the Board meets quarterly, with meetings typically running for ten hours per day over six days. In these meetings, the full Board reviews and acts on all complaints. The only time-saving measure now utilized is a mass dismissal of complaints determined to be invalid by both the medical consultant and the assigned Board member.

Since the Board already meets more than most of the boards we interviewed, it is not feasible or necessary to add more meetings if reasonable alternatives are available. One such alternative is to expedite its complaint resolution by dividing the Board into two panels or subcommittees to review complaints. Six of the eight boards we interviewed use either subcommittees or panels to review complaints to speed up the complaint resolution process.

The Board could also resolve more complaints per meeting by streamlining its current process. The Board should consider eliminating the oral reading of the medical consultant's report and summary for each complaint. In addition, some Board members suggested that reducing the number of informal interviews of doctors that the Board conducts would also save time.

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(1) "Licensing Board Policies For Prioritizing Complaints: Results of a Survey by the Citizen Advocacy Center," Fall 1993.

RECOMMENDATIONS

1. BOMEX needs to develop and implement a formal process for prioritizing complaints.

2. BOMEX should improve its complaint resolution time by:

   a. Eliminating administrative delays in its complaint resolution process; and
   b. Further analyzing the process to determine if additional resources are needed to address delays.

3. BOMEX needs to reduce its complaint backlog by:

   a. Using alternative methods to adjudicate complaints; and
   b. Eliminating unnecessary case reviews and interviews at board meetings.

FINDING II

DISCIPLINE AND COMPLAINT INVESTIGATION NEED TO BE IMPROVED

The Board does not take sufficient action against doctors found to be in violation of professional conduct standards, nor does it fully investigate complaints. Doctors found in violation more often receive warnings rather than discipline. In addition, our review found that complaint investigations typically entail only a review of medical records.

Board Should Impose Stronger Disciplinary Actions

In Arizona, as is true nationally, very few doctors are actually disciplined after complaints are filed. Reviewing BOMEX's disciplinary actions, we found the Board appears to be inappropriately using Letters of Concern when formal discipline is warranted. In addition, the Board is slow to take action against doctors with multiple serious violations.

Very few complaints result in disciplinary action by the Board. In fiscal year 1993-94, the Board took 1,034 actions involving 873 doctors. Ninety percent of those actions (788 dismissals and 145 nondisciplinary Letters of Concern) resulted in no disciplinary action being taken against the doctor. The Board disciplined only 65 of the 873 doctors. Most (47) of the disciplinary actions taken against these doctors were of lesser severity, such as stipulations (38), probation (5), and censure (4). Some of these actions included Board orders for substance abuse rehabilitation, a nonquality-of-care issue.[1] Strong disciplinary action was taken against 18 doctors, including 16 license revocations and 2 license suspensions.

Letters of Concern issued when disciplinary action warranted — Our analysis found that Letters of Concern[2] are often issued when disciplinary action is warranted. Although Letters of Concern are intended to be used when there is insufficient evidence

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(1) Because BOMEX does not track the nature of the complaints received (i.e., quality of care versus substance abuse or fee complaints) we could not easily determine whether the Board is appropriately pursuing cases alleging medical negligence or incompetence. However, several recent reports indicate that quality-of-care cases are among the most difficult for boards to address because they tend to be complex, time-consuming, expensive, and controversial.

(2) By statute, a Letter of Concern may be issued when there is not sufficient evidence to support direct action against the doctor's license; however, continuation of the activities that led to the claim being submitted may result in action against a doctor's license.

to support disciplinary action, we found instances in which the Board issued them when the doctor engaged in acts of unprofessional conduct. We reviewed a sample of 30 complaints that resulted in Letters of Concern and found 21 complaints in which statutory violations occurred and stronger action could have been taken, as is illustrated in the next two examples that resulted in the death of one infant and the mistreatment of another.

- **Case Example #1**

  The father of a 22-month-old baby girl repeatedly spoke with doctors on call over a 3-day Thanksgiving holiday, indicating that his daughter had a high fever, ear pain, was vomiting, coughing, not eating or drinking, and had congestion and some difficulty breathing. On Wednesday, the doctor on call advised the father to obtain cough syrup and use a vaporizer that night and call the office in the morning if the child was not feeling better. The father called the office the next day, Thanksgiving Day, and informed the doctor now on call that the child was getting worse. This second doctor said he did not need to see the child and to give her fluids. The father suggested to the doctor that the child should go to the emergency room. The doctor advised him that was not necessary as the child probably had the flu. The child was once again restless that night and her condition did not improve. The parents called the doctor's office early Friday morning and made an appointment to bring the child in. She died that morning prior to the appointment. The autopsy revealed that the child died from acute bronchial pneumonia, a bacterial infection that is curable. Rather than applying a stricter sanction, the Board issued Letters of Concern to the two doctors involved. When Board members were questioned about the actions on this complaint, a few said they should have taken disciplinary actions against the doctors. In addition, one Board member volunteered his opinion to us that the child's life could have been saved.

- **Case Example #2**

  A seven-month-old child was brought to the emergency room by her mother because she fell and appeared to be in pain. The nurse noted that the child's leg was sensitive to touch. The doctor diagnosed an ear infection and prescribed an antibiotic. The mother took the child to another pediatrician two days later because the child was not moving her leg and was irritable. The pediatrician diagnosed a fracture of the leg. The emergency room doctor, in his response to the allegation, admitted that his examination was probably inadequate and that is why he failed to diagnose the fracture. Rather than disciplining the doctor, the Board issued a Letter of Concern.

Inadequate action against doctors with multiple complaints – In addition to issuing Letters of Concern when statutory violations have occurred, the Board in some instances has failed to take progressively stronger actions against medical doctors who

have received numerous complaints over time. Despite the fact that some medical doctors have engaged in repeated acts of unprofessional conduct, and less severe sanctions have failed to change their behaviors, the Board has been reluctant to impose stronger sanctions. The following two case examples came from our review of the 46 most chronic offenders:

- **Case Example #3**

  Between 1983 and 1987 the Board received 15 complaints against one doctor. Many of the complaints were surgery related, alleging unnecessary surgery, inappropriate surgery, below-standard care resulting in shortening of a patient's leg and disability, and releasing a patient from the hospital without properly caring for a surgical wound. In September 1989, the Board grouped seven of the complaints together, placed the doctor on probation, and restricted him from practicing surgery related to the neck and back. The Board had previously issued three Letters of Concern to the doctor relating to malpractice claims.

  Complaints against this doctor, however, continued. In response, the Board issued five more Letters of Concern to him between October 1989 and October 1991. In addition, between 1987 and 1994 the Board received 19 other complaints, many of them surgery related, alleging unnecessary surgery, negligent surgery, and setting a broken leg incorrectly, resulting in a patient being confined to a wheelchair and unable to walk. In May 1994, the Board grouped 11 of the 19 complaints together and canceled the doctor's license.

  When asked, Board members stated several reasons for delaying strong disciplinary action, including the need for developing a strong case by registering numerous complaints, lawyer involvement, and the concern of taking away a fellow doctor's license to practice.

- **Case Example #4**

  Over an 18-year period BOMEX received 38 complaints and malpractice cases against a doctor. In response to these, the Board dismissed 26, issued 8 Letters of Concern, and has 4 cases that are currently open and under investigation. No disciplinary action has ever been taken against the doctor. The Letters of Concern were issued for the following reasons:

  - 3 Letters of Concern (1980, 1989 and 1991) for charging excessive fees;
  - 2 Letters of Concern (1984 and 1990) for errors in surgery;
  - 1 Letter of Concern (1991) for failing to recognize post-operative conditions;
  - 1 Letter of Concern (1991) for mistreatment of a condition; and
  - 1 Letter of Concern (1990) for failure to bring a patient in earlier for examination and evaluation of her condition.

Of the four open complaints, we could not determine the nature of one complaint because it was a malpractice case that has yet to be investigated. The other three open complaints involve 1) prescribing the wrong form of treatment that would have caused harm to the patient and a fee complaint; 2) directing a patient on hospital discharge orders to obtain their prescriptions from a certain pharmacy; and 3) a technical error in surgery.

A review of the Letters of Concern found that Board medical consultants concluded that inappropriate actions occurred; however, no disciplinary action was ever taken. Board members we interviewed concerning this doctor provided a number of reasons for not taking disciplinary action, ranging from "the doctor is a sharp cookie...good talker," "he has a good attorney;" and the perception that doctors get one "freebie."

In another case we reviewed, we found that even though the doctor had numerous violations of the professional conduct standard relating to substance abuse, the Board appeared hesitant to take strong action even with a preponderance of evidence. Although the doctor continued to use drugs and consistently violated Board orders, including two probations, over eight years elapsed from the time the Board was first notified of the drug use until it revoked his license.

Reasons for inadequate discipline — Although the Board's reluctance to discipline doctors is contrary to its statutory responsibility of protecting the public from poor medical practice, several reasons have been identified to help explain why the Board fails to take adequate action against medical doctors. For example:

- **Lack of formal guidelines** — The Board still lacks formal disciplinary guidelines to help ensure appropriate and consistent discipline. Thirteen years ago, our 1981 Sunset review of BOMEX recommended adoption of disciplinary guidelines. The Federation of State Medical Boards recommends that every state medical board have a basic guidebook on medical discipline to promote consistency in the disciplinary process. Other states have adopted these types of guidelines.

- **Reluctance to discipline** — Our interviews with eight Board members revealed that the Board appears reluctant to strongly discipline doctors because of the impact the discipline may have on the doctor's ability to practice medicine and make a living. For example, Board members said that doctors claim even Letters of Concern can result in a doctor being dropped from a managed care contract, and any disciplinary action almost guarantees that the doctor's contract will be terminated.

  We contacted several managed care organizations and found that they investigate the circumstances surrounding each Board action taken against one of their doctors and, based on their findings and the severity of the violation, determine appropriate action against the doctor. The only Board actions that result in immediate termination of a doctor's contract are revocations and suspensions.

- **Too many medical practitioners on the Board** — The reluctance to discipline fellow doctors has been a problem recognized nationally. A 1990 study of the impact of public member representation on occupational licensing boards found that, "Increased proportions of public members are associated with more serious disciplinary actions." One Board member stated that because the Board consists mostly of doctors, it sometimes makes it hard to take an action against a doctor. He stated that in the back of their minds the doctors may be thinking that they too could make the same mistake.

  A proposal developed by The Federation of State Medical Boards recommends that 25 percent of Board members be unrelated to the medical profession. The Public Citizen, a public interest group involving medicine, recommends that at least 30 percent of the members of each state medical board should be public members. Currently, 2 of the 12 Board members, or 17 percent, are unrelated to the medical profession. Replacing one or two doctors with persons who have nonmedical backgrounds would increase the percentage to 25 percent or 33 percent, respectively. Changes in the Board's composition would require statutory changes to A.R.S. §32-1402.A.

- **Inadequate investigation** — As discussed below, we identified problems in the investigation process that may also contribute to the Board's failure to take adequate discipline against doctors. If cases are not fully developed, the Board may not have sufficient information to make an appropriate decision.

Complaint Investigation Very Limited

The Board's complaint investigations are not comprehensive and need to be improved. The Board's failure to fully utilize investigators is the primary reason for poor complaint investigation. Our review found that investigations seldom incorporate standard investigative techniques such as interviewing complainants, doctors, or witnesses. Without interviewing, public protection may be compromised.

Interviews are needed — Board staff need to interview those involved in the complaint. Currently, a typical complaint investigation involves obtaining and reviewing pertinent records from the doctor the complaint was filed against. Our review of a random sample of 90 complaint files found that complainants, doctors, or potential witnesses are seldom interviewed by Board staff. In fact, we found that only 1 of the 90 complainants was interviewed, and only 10 of the 90 doctors were interviewed (6 of whose cases involved substance abuse allegations where the doctor typically has a personal interview with agency management to assess the problem and begin rehabilitation if necessary). Further, agency records indicate that during fiscal year 1992-93, the Board received 1,186 complaints, took 1,313 actions, and conducted only 71 investigative interviews.

The Board's current investigative process may compromise public protection. Board management and staff believe that interviews are unnecessary in many cases and that the medical records are sufficient to assess the complaint. However, it is unlikely that a complainant could cover all aspects of the complaint in one initial written document. In addition, relying solely on medical records is also problematic for three reasons. First, the source of the records used to evaluate the merits of the case is often the person whom the complaint is filed against. Second, since the complainant is not interviewed, there may be additional facets of the case that may not be apparent during the medical record review. Third, the records may not contain all the necessary information.

Investigators misused — It is particularly difficult to understand why interviews are not being conducted when the Board has 7 investigators. The job description of a medical investigator includes the duties of conducting investigations, writing supporting reports, and providing recommendations. However, we found the 7 investigators spend much of their time collecting urine specimens from 70 doctors under consent orders regarding substance abuse. Not only is this task a lower priority than protecting the public by investigating complaints, but the amount of work involved should only require a small portion of the investigator's time. Ample time should be available to investigate complaints, even if investigators continue to collect samples. The new executive director stated to us that under the former administration, investigators were mainly used to collect urine samples and deliver subpoenas. He stated that he has begun utilizing investigators to investigate complaints.

RECOMMENDATIONS

1. The Board should develop disciplinary guidelines for determining the appropriate level of action against a doctor and to ensure that similar violations are being treated consistently. These guidelines should provide well-defined criteria to be used in determining the type of disciplinary action based on the severity of the violation, the doctor's previous violations, and any other factors the Board feels are relevant.

2. The Legislature should consider amending A.R.S. §32-1402.A. to increase the number of public members serving on the Board who are not involved in the medical profession.

3. The Board should revamp the investigation process in such a way to ensure that investigations are adequate by:

   a. Ensuring the issues raised in the complaint are addressed.
   b. Interviewing the doctors, patients/complainants, and any witnesses.
   c. Ensuring investigators are used to investigate complaints.
   d. Developing policies for prioritizing complaints.

FINDING III

BOMEX HAS ISSUED SOME REGISTRATIONS AND PERMITS TO PRACTICE MEDICINE TO PERSONS WHO DID NOT MEET STATUTORY REQUIREMENTS

During the audit it came to our attention that BOMEX staff have issued some registrations and permits to persons who failed to meet statutory requirements. We identified several cases where locum tenens registrations were issued to applicants who did not meet statutory criteria. In addition, some training permits may have been granted to persons who failed to meet statutory requirements.

Improper Issuance of Locum Tenens Registrations

The Board has granted locum tenens registrations inappropriately. A.R.S. §32-1429.A clearly outlines the criteria for an applicant to obtain a locum tenens registration. A locum tenens registration authorizes an out-of-state doctor to temporarily assist or substitute for an Arizona physician. Applicants with unresolved complaints do not qualify to receive a locum tenens registration. However, during the course of our work on other issues, we found two examples in which BOMEX staff misused locum tenens registrations, issuing them to persons who clearly did not meet the statutory requirements.[1]

- **Example 1**

  An applicant licensed to practice in another state received a locum tenens registration to practice medicine in Arizona, even though the applicant had two complaints pending in another state and he was not substituting for or assisting another physician. This applicant clearly did not meet the statutory requirements for receiving a locum tenens registration.

  There are numerous unusual circumstances surrounding this case which raise many

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[1] Because a comprehensive review was not conducted in this area, it is unknown whether these are isolated incidents or common practice. However, for the three-year period ending June 30, 1994, the Board issued 389 locum tenens registrations.

questions regarding the process of issuing locum tenens registrations. This applicant had a valid license to practice medicine in another state and applied for a license to practice medicine in Arizona in June of 1993. However, BOMEX apparently delayed approval of the Arizona license pending the outcome of complaints filed against the applicant in another state.

In September 1993, BOMEX issued the applicant a locum tenens registration amid curious circumstances. First, we found no evidence that the applicant ever applied for a locum tenens registration. Although there is a locum tenens application in the applicant's file, the application is blank except for a signature by agency management approving the application. Second, there is no written request from any sponsoring doctor as required by statute.[1] A handwritten note in the applicant's file indicated BOMEX staff contacted a doctor in the rural northeastern area to see if he was willing to sponsor the applicant for a locum tenens. The doctor agreed to sponsor the applicant "as long as he wasn't going to get into any trouble for it." However, the applicant was not substituting for or assisting this "sponsoring" doctor, as required by statute. In fact, the applicant had opened his own clinic in a rural community of Arizona and was practicing medicine without an Arizona license. Less than one month after receiving the locum tenens registration, Board staff realized the registration should not have been issued and the doctor relinquished it at the Board's request.

- **Example 2**

BOMEX staff issued locum tenens registrations to three applicants practicing in southwestern Arizona who did not meet the statutory requirements. These doctors were recruited and practiced medicine at a clinic under locum tenens registrations for periods ranging from two to ten months. Two of these applicants eventually obtained permanent Arizona licenses. However, these applicants did not meet the statutory requirements for obtaining a locum tenens registration. Specifically:

1. The applicants were not licensed by another state, as required by A.R.S. §32-1429.A.[2].

2. None of the applicants had a certificate issued by the Educational Council for Foreign medical Graduates as required by A.R.S. §32-1423.2. This certificate is required when the applicants graduate from unapproved schools of medicine and are not licensed by another state.

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(1) Statutes require that the doctor for whom the applicant is substituting or assisting must provide a written request to the Board for locum tenens registration of the applicant.

(2) The applicants were licensed in Puerto Rico. A.R.S. §32-1429.A has since been amended to include applicants licensed by districts, territories, or possessions of the United States.

3. The locum tenens registrations were issued at the request of a clinic administrator rather than a doctor, as required by A.R.S.§32-1429.A.3.

   Prior to issuing these locum tenens registrations, the Board received information that three of these applicants were already practicing medicine without a license, a felony violation punishable under A.R.S. §32-1455.A. Although a subsequent BOMEX investigation confirmed the allegations, the Board later approved locum tenens registrations for the applicants.

Training Permits Granted Improperly

BOMEX staff may have inappropriately issued training permits to persons who did not meet the statutory requirements. Newly adopted policies and procedures should address this problem.

A.R.S. §32-1432.02 authorizes the Board to grant training permits to any person participating in an approved teaching hospital's internship, residency, or clinical fellowship training program. A training permit authorizes a person to practice medicine only in a supervised setting of a hospital's accredited graduate education program. According to A.R.S. §32-1401.3, only programs that have been accredited by the Accreditation Council for Graduate Medical Education qualify for training permits. Frequently, the Accreditation Council limits the number of accredited positions within each program. Each year BOMEX receives hundreds of training permit applications.

An April 1994 internal review of the Board's training permit policy found:

- In fiscal year 1993 BOMEX issued 14 permits to a program with 10 accredited positions. In addition, permits have been issued to applicants who are not participating in an approved program.

- BOMEX staff retroactively dated hundreds of training permit applications for July 1 of each year—even though applications were not usually received until months later. This practice has been in effect for years. Consequently, hundreds of applicants practiced medicine for months prior to receiving formal authorization to do so.

These problems occurred because Board members and management failed to implement proper oversight or controls. For example, BOMEX staff conducted no verification of an applicant's background, failed to determine whether the applicant would be participating in an approved program, and performed no reconciliation to ensure that

the quota of accredited positions for a particular program had not been exceeded. BOMEX staff relied on the sworn statements submitted by applicants and training program officials to ensure applicants were participating in accredited programs. As a result, if a signed application was received a training permit was issued.

After being informed of the various problems associated with training permits, the Board adopted new policies and procedures to help ensure that only qualified applicants receive these training permits. On June 30 and July 1, 1994, Board staff notified training hospitals that 1) permits will no longer be retroactively dated; 2) the number of permits issued will not exceed the total number of accredited positions in the program; and 3) no permits will be issued to any person in a nonaccredited program. Board members formally adopted this policy at their July 1994 meeting.

RECOMMENDATIONS

1. Board members and staff should review the procedures for issuing locum tenens applications and ensure controls are in place to prevent applicants who do not meet statutory criteria from obtaining a registration.

2. Board management should ensure that staff follow the new procedures for issuing training permits.

FINDING IV

INADEQUATE MANAGEMENT AND LIMITED BOARD OVERSIGHT HINDER BOMEX OPERATIONS

The Board of Medical Examiners suffers from inadequate management and limited oversight. We identified numerous problems that management has failed to recognize or adequately address. Many of these problems stem from poor management practices. The 12-member Board needs to provide more direction and oversight to the agency.

Numerous Problems at BOMEX

Management has failed to identify and take timely action to correct problems that are basic to the Board's existence. These include problems we identified in the previous three findings that relate to the Board's primary regulatory responsibilities of addressing patient complaints and licensing doctors. We also found that BOMEX has not managed functions basic to any state agency, such as complying with procurement and open meeting law requirements. BOMEX also failed to adopt rules as required by 1989 legislation. Furthermore, BOMEX has yet to fully address internal control weaknesses identified by our Office in 1991 and 1993. Finally, BOMEX has yet to fully utilize some key functions of its automated complaint tracking system.

Procurement violations – BOMEX has failed to follow Arizona procurement code requirements in several areas. For example:

- BOMEX failed to contract for lab services. BOMEX paid over $20,000 to one vendor for lab services in fiscal year 1993-94. However, the vendor was not under contract with BOMEX as required by law. Board staff have been advised of this deficiency and plan to obtain a contract for this service.

- A review of the Board's contract for monitoring impaired physicians revealed the Board paid the contractor approximately $25,000 more than the contract allowed during fiscal years 1993 and 1994. Specifically, the Board inappropriately paid performance bonuses and contractor billings that overestimated the amounts owed. Further, we found BOMEX paid the contractor without sufficient documentation of expenses and work performed. A lack of oversight by the State Purchasing Office may have contributed to some of these problems.

- Board staff did not comply with state procurement laws when arranging accommodations for the July Board meeting. First, staff failed to obtain advance authorization from the State Procurement Office (SPO) for the amount in excess of their delegated authority; July meeting expenses totaled over $14,000 and BOMEX is delegated authority to make procurements without SPO authorization only if the amount is for $10,000 or less. Second, staff failed to take the proper steps to ensure they obtained the best price. The Board did not use the State's authorized travel agency to secure the best available price nor did they obtain competitive bids.

Open meeting law violations — The Board has not fully complied with open meeting law requirements for its quarterly meetings. Statutes governing open meetings require the agency to file a statement with the Secretary of State identifying where meeting notices will be posted. However, the Board no longer posts notices at one of the two locations identified in the statement and, as a consequence, did not comply with the statutory notice requirements. The lack of proper notice renders any action taken by the Board at these meetings invalid. In August 1994, the Board realized they had violated open meeting laws. To remedy the situation they held a special meeting on August 26, 1994, "to ratify actions of the Board of Medical Examiners that may have been taken in violation of the Open Meeting Law." (See Sunset Factor #5, page 28, for further information.)

Failure to develop rules — BOMEX did not properly oversee a major rules package required by 1989 legislation. Although a rules package was prepared and progressed through most of the required stages, the package stalled late in the process because management failed to monitor its status and progress. The package recently submitted to the Attorney General's Office for certification was incomplete and untimely. The Attorney General's Office has informed BOMEX that it will probably need to restart the rules development process from the beginning. (See Sunset Factor #4, page 28, for further information.)

Weaknesses in internal controls — Our review of BOMEX operations revealed that management has neglected to fully address control weaknesses in its accounting system identified by our Office in 1991 and 1993. Among other things, the reviews identified weaknesses in the way BOMEX handles cash receipts. Since BOMEX receives thousands of checks for licensing and application fees each year, ensuring that adequate controls are in place is critical.

Utilization of EDP resources — To date, BOMEX has not fully utilized a computer system installed three years ago. Complaint and licensing information is now tracked on the computer and, according to staff, the system has improved agency functions such as license renewals and complaint processing. However, we found the Board has been slow to implement several functions. For example, a monitoring system designed to identify cases that need follow up is not fully used and cannot be relied on because needed data is not appropriately entered on the system. Also, BOMEX has not fully implemented the security features of the automated system. We found unauthorized staff can access and modify complaint and licensing information.

Management Practices Contributed to BOMEX Problems

BOMEX's management practices have impacted the agency's ability to perform its duties. Funneling almost all responsibility and decision making through the executive director is insufficient for addressing the growing workload and other challenges facing the agency. In addition, as cited previously, management has not fully utilized some staff resources.

Failure to delegate — Management needs to delegate more responsibility and decision making. Although the agency has grown to more than 40 employees, many duties and decisions are still funneled through the assistant director and executive director. For example, the executive director interviews all doctors regarding substance abuse allegations. This is time consuming and is also a duty of the consultant retained to administer the substance abuse program. Furthermore, all licensing exceptions and most enhancements of the new computer system have been handled directly by the assistant director.

The former executive director stated that this management style was appropriate up until the late 1980's, when growth in the agency's workload made it difficult for one person to "oversee and be involved in everything." He stated that he and the assistant director were "so involved in day-to-day operations that we haven't had the luxury of stepping back — the next step is to reevaluate and reassign responsibilities."

Staff resources not used effectively — Our review found that BOMEX management has not effectively utilized some of the staffing resources appropriated by the Legislature. Investigator positions have been misused and other critical positions have been left vacant for significant periods of time.

As mentioned in Finding II (page 11), seven investigators have been used primarily for collecting urine samples from physicians being monitored for substance abuse problems. Another example of poor utilization of the seven investigators involves their assignment to various duties at the week-long Board meetings. Although assigned to operate the tape recorder, provide security, and perform other tasks, our observations were that most, if not all, of their presence was unnecessary. Because the meetings are long, investigators accrued 435 "comp time" hours at the last three Board meetings.

BOMEX management has left critical positions vacant for extended periods, two of which are middle management positions. The medical consultant supervisory position has been vacant for several years, and the licensing supervisor position has been vacant for over a year. Finally, a nurse ombudsman position, authorized and funded by the Legislature in 1992, has yet to be filled. This position was created to assist people filing complaints against doctors.

Little Oversight Provided By the Governing Board

The Board needs to improve its governance of the agency. Its lack of involvement in agency matters has contributed to the many management problems we found during the audit. The Board needs to revise its operating method to allow time to provide guidance and oversight.

The Board is responsible for ensuring that the agency fulfills its statutory responsibility to regulate doctors. Daily administration of the Board's office and functions is performed by the executive director, who is appointed by the Board. The executive director's statutory duties include carrying on the Board's work, managing the Board's offices, executing Board directives, and performing all other duties required. This arrangement of a governing board utilizing an executive director is typical for medical regulatory boards in Arizona.

Inadequate monitoring and direction of agency management – It appears that the Board has not adequately directed and monitored agency management. The Board was not aware of, or had not acted on, the problems described earlier in this finding. Three other examples of the Board not being sufficiently involved in agency affairs are as follows:

- Without prior knowledge of the Board, the former executive director inappropriately "dismissed" 300 to 400 pending malpractice complaints. Misinterpreting a statutory change, the former director sent letters in August 1993, notifying plaintiffs' attorneys that their cases would not be investigated. The Board was informed of the director's action at their October 1993 meeting and instructed the director to reopen and investigate the cases.

- In early 1994, the former executive director requested the Attorney General replace of the two attorneys assigned to BOMEX. The Board had no knowledge of this until four days before the April 1994 Board meeting, when the former executive director wrote a letter to the Board informing them of his request. In this letter, the former executive director cited, among other things, the attorneys' "fault-finding memos" to the Board. The Board reacted strongly to this issue at their April meeting and directed agency management to keep the currently assigned attorneys.

- The Board has not formally assessed the performance of either the executive director or the assistant executive director in several years. Annual performance evaluations provide a formal structure to assess past performance and set goals for the upcoming year.

The Board should have been involved in each of these examples for two reasons: because they are the body that formally resolves complaints, and they are the body that provides policy direction to the executive director.

Our review of Board minutes and interviews with Board members identified several reasons for the Board's inadequate oversight:

- **Misperception of role** – Some Board members felt that their role was to review and adjudicate complaints against doctors, leaving agency administration up to the executive director. Others, however, have expressed concern about the Board's limited role and the need for more oversight.

- **No structure or policies for Board involvement** – The Board has never outlined what its role is and how that role should be implemented. The Board does not have any formal policies and procedures as to how and when direction is given to the executive director or how the Board will monitor agency management and activities.

- **Overloaded with complaints** – As mentioned in Finding II, (see page 11), the Board is overloaded with complaints. The Board meets more than most other boards but spends most of its time adjudicating complaints. Little time is left for oversight.

Board action needed to address problems – The Board needs to establish a structure and policies to ensure that it provides guidance and monitors agency management and activities. For example, policies and guidelines should be adopted in key areas such as complaint handling, licensing, and discipline. The Board should also be kept abreast of all major agency activities. Other boards we have observed utilize verbal reports from the executive director and/or other top agency officials, which the current BOMEX director initiated at the July 1994 board meeting. Other boards also receive written reports from agency management that provide statistics and narrative on programs, budget, and other activities. Recently, the new executive director initiated a monthly written report to board members.

The Board needs to develop an action plan to address the many serious problems identified in this report. Several of the problems identified relate to the Board's basic mission of protecting the public. Other problems involve complying with important laws and rules required of any agency in the State. To act on the problems we found during the audit, the Board will have to revise its board meeting process to free up time to perform its guidance and monitoring duties.

RECOMMENDATIONS

1. The Board needs to improve its oversight of BOMEX operations. Specifically:

   a. The Board should revise its board meeting operating practices to allow time for monitoring and oversight of agency activities; and
   b. The Board should formalize its oversight role through development of policies and procedures that specify Board and management duties and provide for communication and reporting between the Board and agency management and staff.

2. BOMEX upper management needs to address management problems by:

   a. Delegating routine duties to middle management;
   b. Utilizing staff resources provided to the agency by the Legislature.

3. BOMEX needs to comply with state procurement and open meeting law requirements.

4. To comply with A.R.S. §32-1491.E., BOMEX should:

   a. Review Chapter 11 of the Arizona Agency Handbook detailing steps required to adopt a rule; and
   b. Initiate steps to adopt required rules.

5. BOMEX needs to address internal control weaknesses and shortcomings with their EDP system.

SUNSET FACTORS

In accordance with A.R.S. §41-2954, the Legislature should consider the following 12 factors in determining whether the Arizona Board of Medical Examiners should be continued or terminated.

1. Objective and purpose in establishing the Board.

A.R.S.§32-1403.A states:

> *"The primary duty of the board is to protect the public from unlawful, incompetent, unqualified, impaired or unprofessional practitioners of allopathic medicine through licensure, regulation and rehabilitation of the profession in this state."*

To carry out this responsibility, a 12-member board is statutorily empowered to examine candidates for licensure as allopathic physicians; initiate and conduct investigations to determine whether a doctor has engaged in unprofessional conduct or provided incompetent medical care; and discipline and rehabilitate physicians.

2. The effectiveness with which the Board has met its objectives and purpose and the efficiency with which the Board has operated.

The Board can improve its effectiveness and efficiency in fulfilling its statutory responsibility to protect the public from incompetent allopathic physicians. Our review shows that the Board has not ensured the timely resolution of some serious complaints, has not taken adequate disciplinary actions in many of the complaints it has addressed, and has not acted against licensees who have had numerous complaints and violations (see Findings I and II, pages 5 and 11). In addition, the Board has improperly allowed some persons to practice medicine in Arizona (see Finding III, page 17). Inadequate management and limited Board oversight and direction have contributed to some of these problems (see Finding IV, page 21).

3. **The extent to which the Arizona Board of Medical Examiners has operated within the public interest.**

The Board can do more to operate in the public interest. The Board's failure to take adequate and timely enforcement actions in some cases has limited its ability to properly protect the public from incompetent and potentially dangerous doctors. In addition, inappropriately allowing some doctors to practice may place the public at risk. Furthermore, the Board could do more to make disciplinary information on doctors available to the public. Currently, the public cannot obtain any complaint information on a doctor over the phone. We found other boards will provide disciplinary action information by phone. The executive director drafted a new public information policy in January of this year indicating more information will be provided by phone; however, as of August 1994 the policy had not yet been implemented.

4. **The extent to which rules adopted by the Board are consistent with the legislative mandate.**

1989 legislation directed the Board to promulgate rules and regulations in order to enforce statutes addressing the dispensing of drugs by allopathic physicians. However, the Board has not yet promulgated the necessary rules. The Board drafted the rules and held public hearings in October 1992 and January 1993. However, the package recently submitted to the Attorney General's office for certification was incomplete and untimely.[1] An Attorney General representative stated that the Board will probably need to repeat the entire process.

5. **The extent to which the Board has encouraged input from the public before adopting its rules and the extent to which it has informed the public as to its actions and their expected impact on the public.**

We found that the Board has not fully complied with open meeting law requirements. The Board of Medical Examiners holds quarterly meetings to discuss disciplinary and licensing matters. Our review found that some of these meetings have not been appropriately posted as required by law. For example, notices were not posted at all required locations. In addition the Board failed to provide at least 24 hours' notice for two of their quarterly meetings as required by law. The lack of proper notice renders any action taken by the Board at these meetings invalid. Late in the audit the Board realized they had violated open meeting laws and held a special meeting on August 26, 1994, "to ratify actions of the Board of Medical Examiners that may have been taken in violation of the Open Meeting Law."

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[1] A.R.S. §41-1024.B requires that rules be submitted to the Attorney General's Office for certification within 120 days after noticing the proposed rule adoption or after the close of the record on the proposed rule, whichever occurs last.

The Board has not promulgated rules in many years. However, it is unclear to what extent the Board encouraged input from the public in their most recent efforts to adopt rules for prescribing and dispensing practices. The Board could not provide us with a public rule-making docket which would have identified the number and types of notices published. The Board did publish the rules in the Board's Medical Directory; however, this occurred after the Board had already adopted the rules.

The Board also does little to keep the public informed of its actions against physicians. Although the Board has historically published a newsletter on an infrequent basis, it fails to identify the names of doctors who it has disciplined. In addition, the Board does not typically notify the media of actions taken against physicians. Finally, the Board does not notify individual complainants before holding hearings or taking disciplinary action in relation to their complaint.

6. The extent to which the Board has been able to investigate and resolve complaints that are within its jurisdiction.

The Board needs to strive to improve the overall timeliness of its complaint resolution process (see Finding I, page 5). In addition, the Board can take steps to improve the investigation process and strengthen disciplinary actions (see Finding II, page 11).

7. The extent to which the Attorney General or any other applicable agency of State government has the authority to prosecute actions under the enabling legislation.

A.R.S. §41-192 authorizes the Attorney General's Office to prosecute actions and represent the Board. BOMEX retains two Assistant Attorneys General in-house who represent and provide counsel to the Board at their meetings, and prosecute violators of Board statutes.

8. The extent to which the Board has addressed deficiencies in its enabling statutes which prevent it from fulfilling its statutory mandate.

According to BOMEX staff, numerous technical and administrative changes have been made to agency statutes over the years. For example, the Board has expanded the type of actions that constitute unprofessional conduct, clarified the power and duties of the Board and executive director, developed new types of licensure, and increased mandatory reporting requirements. According to Board personnel, current statutes are directly in line with the recommendations of the Federation of State Medical Boards, ***"Elements of a Model Medical Practice Act."***

9. The extent to which changes are necessary in the laws of the Board to adequately comply with the factors listed in the Sunset laws.

The Board needs to adopt rules addressing the dispensing of drugs and devices in order to comply with statute. A.R.S. §32-1491.E directs the Board to establish rules regarding labeling, record keeping, storage, and packaging of drugs. Although this statute has been in effect since 1989, the Board has not yet promulgated rules in this area. In addition, the Board is considering proposing changes to clarify A.R.S. §§32-1432.02 and 32-1432.03.

10. The extent to which the termination of the Board would significantly harm the public health, safety, or welfare.

Termination of the Board would significantly endanger the public. The unregulated practice of allopathic medicine could pose a threat to public health, safety, and economic well-being. For example, several of the complaints we reviewed involved critical health and safety considerations, such as inadequate or inappropriate surgical procedures and sexual abuse. Other complaints dealt with excessive fees and misdiagnosis and mistreatment.

11. The extent to which the level of regulation exercised by the Board is appropriate and whether less or more stringent levels of regulation would be appropriate.

Our review found that the Board is not exercising appropriate regulation over licensees. As discussed in Findings I (page 5) and II (page 11), the Board is too lenient in disciplining doctors and slow to resolve complaints against doctors. In addition, the Board should exercise more caution when authorizing persons to practice medicine in Arizona. We found that the Board has issued some locum tenens registrations inappropriately.[1] For example, the Board issued a locum tenens registration to an applicant who had complaints pending against him in another state even though A.R.S. §32-1429.A.2 specifically prohibits issuing a locum tenens registration to applicants who have unresolved complaints (see Finding III, page 17).

12. The extent to which the Board has used private contractors in the performance of its duties and how effective use of private contractors could be accomplished.

The Board has used private contractors for services it cannot provide in-house. Specifically, the Board has contracted for the aftercare monitoring and treatment of substance-abusing physicians, hearing officers to conduct formal hearings, medical consultants to review complaints, and development of an automated complaint tracking system. However, our audit revealed that the Board has

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[1] A locum tenens registration allows the holder to practice medicine in Arizona without supervision.

overpaid the provider of the aftercare monitoring program (see Finding IV, page 21). In addition, the Board does not have a contract for laboratory analysis of bodily fluid samples. BOMEX paid almost $23,000 to one lab in fiscal year 1994. State procurement regulations require that any recurring expenditure in excess of $100 be competitively bid and contracted for. BOMEX management is aware of this deficiency and plans to contract for this service.

ARIZONA BOARD OF MEDICAL EXAMINERS

RESPONSE TO THE REPORT OF THE AUDITOR GENERAL
November 18, 1994

Summary

While the Board disagrees with the conclusion that the public is not adequately protected through its actions, the Board agrees with many of the findings made in the report of the Auditor General. The Board believes, however, that the report does not address many of the changes made since July 1994.

A large complaint backlog and slow complaint resolution impede BOMEX's ability to protect the public.

BOMEX agrees that it has a significant backlog of complaints, and agrees that the complaint process should be improved and expedited.

The new Executive Director of the Board proposed a 180 day complaint time frame; the Auditor General found that the complaint timeframe (see table 3) should be 172 days. The Board plans to implement the time frame guidelines given by the Auditor General's office. The Board further believes that better management of the complaint process is necessary, and that many steps to expedite the complaint process have already been implemented. These steps additionally address the finding of the Auditor General that complaint investigations are not sufficiently thorough and that investigators are misused. However, the Board agrees with the conclusion regarding the length of the complaint investigation process, the Federation of State Medical Boards found that nationally only 69.5 percent of all cases were resolved within a single fiscal year.

The Board agrees that a complaint prioritization process should be developed, and such a system will be reviewed by the Board at its January, 1995 meeting. However, no system is foolproof, and may have the following weaknesses:

1. Complaints are generally prioritized based on the allegations. When the allegations are false, time is misspent on complaints that should not have become a high priority. When the allegations do not include information in a high priority category, even though such conduct occurred in the patient's treatment, those complaints are not prioritized.

2. The prioritization of complaints adds another step to the complaint investigation.

All complaints are currently being assigned to investigators, a process which was established under the Board's new Executive Director.

More Efficient Complaint Adjudication Needed

The Board agrees that more efficient processes need to be implemented to adjudicate complaints. However, the length of the Board meeting is not related to the number of complaints the Board feels it must address; in fact, no system had ever been used prior to October, 1994 to determine how many complaints should, or would, appear on the Board's agenda, nor was a system in place for prioritizing complaints to be placed on the Board's agenda.

Such a system for prioritizing interviews and complaints for on the Board's agenda has been developed and is currently in use.

The Board agrees that to divide the Board into panels or to use subcommittees to review complaints is a good suggestion and one which will be reviewed by the Board, after a plan for implementation is developed by the Executive Director and the Chairman. The Board expects to review an implementation plan at its January, 1995 meeting.

However, other ideas have already been implemented. These include:

1. Prioritizing those complaints to be placed on the Board's agenda;

2. Separating the physician rehabilitation program interviews from the rest of the Board meeting, so that the has appropriate time to adjudicate complaints;

3. Giving time guidelines to interviews;

4. Adding a report for Board members containing specific information focusing on the reasons a physician was invited for an informal interview;

5. Considering consent agendas to dismiss complaints in the months between Board meetings so that the Board effectively meets more frequently than quarterly.

Another suggestion made in the draft report by the Auditor General, that letters of concern also be placed on a consent agenda, was to be implemented during the Board's October, 1994 Board meeting. However, the Board received legal advice at its October, 1994 Board meeting that its system of issuing letters of concern should not be changed at this time, and it is unknown when this can be implemented.

Discipline and Complaint Investigations Need to be Improved

This finding of the Auditor General's office that the Board's actions lack sufficient seriousness fails to consider several points:

1. The Board of Medical Examiners ranked third in the nation in 1993 (the most recent year for which figures are available) in the number of actions per 1000 physicians according to the Federation of State Medical Boards.

2. In deciding when to discipline a physician, the Board must make the distinction between incompetent physicians versus serious errors by otherwise capable physicians.

3. Disciplinary actions, such as censures or probations, effectively end a physician's career with managed care plans. This may mean, truly, the complete end to a physician's career. The Board believes, then, that it may not always be appropriate to discipline a capable physician who makes an isolated error, even if the error results in a tragic outcome. While the Auditors indicate that health plans do not

"automatically" terminate physicians for disciplinary actions, this is contradicted by, for instance, the case of a physician who appealed a censure by the Board and presented evidence that several health plans had terminated him due to the censure.

4. Like many Boards in this country, the Board feels that the rehabilitation of physicians who may benefit from education, training, monitoring or other forms of non-disciplinary action, should generally be attempted before true disciplinary action is used, and that rehabilitation can protect the public as effectively as discipline.

However, improving the quality of the investigation process, speeding up the process, improving the way the results of the process are communicated to the Board, and considering guidelines for disciplining physicians (especially those with prior Board actions), will improve the Board's ability to adjudicate complaints.

Regarding the finding of the Auditor General that there are too many medical practitioners on the Board, there have been no cases in the last year where the public members of the Board of Medical Examiners voted in concert against the physician members regarding disciplinary action.

The average medical Board in the United States has 16.5 members, of whom 3.0 are public members. This is clearly less than the 25 percent recommended by the Auditor General.

One of the Board's medical practitioners is not a physician, but is rather a nurse. It seems unlikely that the nurse member would consistently feel that it was a difficult or inappropriate action against a physician, simply because the nurse member was an allied health provider.

The Board's investigation process does need to be improved. The finding regarding the misuse of the investigators has already been addressed by assigning each and every complaint to an investigator. In fact, this was implemented prior to the Auditors leaving this office. A staff education program, to teach investigators how to evaluate which investigative tools are best for different types of complaints, is underway.

Improper Issuance of Registrations and Permits

The Board agrees that an applicant received a locum tenens registration even though the applicant had two complaints pending in another State. The Board's staff discovered this problem soon after the locum tenens was issued. However, under the previous locum tenens statute, open complaints were not considered in issuing locum tenens registrations. During the illness of the Executive Director, this locum tenens registration was issued by the Assistant Director, who was not generally familiar with the issuance of locum tenens registration.

This was not a "questionable" locum tenens registration. This physician's licensure was delayed, awaiting the outcome of the investigations in Florida before issuing a full license. The Assistant Director mistakenly believed that a locum tenens registration, for six months, could be issued awaiting the outcome of those complaints. No locum tenens application was filed because the locum tenens application almost identical to the endorsement application which was already filed by the applicant.

In addition, a physician in the rural northeastern area of Arizona (the same area to be served by this physician) agreed to sponsor the locum tenens physician. In this way, the physician was assisting the sponsoring physician, by seeing many patients in northeastern Arizona whom the other physician could not see, due to geographic distance or volume. Once it was found that the locum tenens registration was issued inappropriately, the Assistant Director brought it to the Board's attention at the next quarterly public meeting. The issue was reviewed at a public meeting long before the Auditor General began its audit.

Regarding those individuals practicing in southwestern Arizona who did not meet statutory requirements, they did not meet statutory requirements because they were licensed by Puerto Rico, which was not a state as required by A.R.S. §32-1429(A). As indicated by the auditors, A.R.S. §32-1429(A) has since been amended to include applicants licensed by districts, territories or possessions of the United States. Some of the applicants outlined, additionally, graduated from approved schools rather than unapproved schools, and so did not require ECFMG certification. Once again, this issue was discovered by the Board's staff and appropriately brought to the Board.

These are two examples out of more than hundreds of locum tenens registrations issued each year.

Training permits were not granted inappropriately. The Board did not make a finding that permits were granted inappropriately. The statutes regarding training permits refer to "participating" in an approved program. "Participating" is not defined by law to mean that an individual must be in a position specifically accredited by the ACGME. The new Executive Director simply chose to propose this policy to the Board for issuing permits in the future.

Proper controls for the issuance of these permits were in place: The forms required the affidavit of the director of medical education of each program, under penalty of perjury. The Board's staff relied on this affidavit when issuing permits. In the same way, the Board relies on affidavits from many individuals when processing all types of licenses. Frequently, no independent check is run, or even possible. For example, when a license by endorsement is issued, we rely on the director of medical education to affirm, under penalty of perjury, that an individual was indeed a resident in the program. We do not go back to the ACGME to determine how many positions were approved for that year, or how many residents the program had in place. This amount of checking would render the Board paralyzed as far as issuing licenses and permits.

In addition, licensing controls have been changed under the new Executive Director. For each license issued, the license application is reviewed and approved by one individual, and will be issued (after a second review of the application to ensure requirements are met) by a second individual.

Inadequate Management and Limited Board Oversight Hinder BOMEX Operations

While the Auditor General claims that the Board has failed to fully address accounting internal control weaknesses identified by the office in 1991 and 1993, the Board has adequately addressed some of these concerns, and many raised in the letter report of 1991 which found the office in "disarray." In fact, the information generated by B.O.M.E.X.'s computer system was used in auditing the Board during this performance audit. In areas such as accounting controls, the Board has requested staff in previous budget submissions (and again this year) to correct those weaknesses.

The Board's complaint tracking system is fully implemented and fully in use, and was so during a portion of the auditors' five-month stay in our office. After the appointment of the new Executive Director, an internal audit of all cases was carried out and the current status of all cases was included on the Board's computer system. This makes the system completely up-to-date and completely implemented.

The new Executive Director was to have taken a class offered by the procurement office to ensure that pertinent regulations were complied with, on November 1, 1994. Unfortunately, the class was canceled. Nonetheless, the Board has taken the following steps regarding purchasing:

1. The Board has initiated the proceedings to contract for laboratory services as pointed out in the audit.

2. The contract for monitoring impaired physicians clearly included an amount to be paid as a "performance bonus," and amounts for other "optional" services. These items were clearly stated in the contract, which was awarded by the Procurement Division of the Department of Administration. The Board was never advised, and the new Executive Director was unaware, that such a performance bonus could not be paid since it was clearly included in the terms of the contract. No bonus will be paid this fiscal year.

3. Regarding the July, 1994 Board meeting, competitive bids were obtained for the previous year and verbal bids were obtained to ensure that prices had not change from the previous year (1993). However, the Board acknowledges that it did not anticipate expenses would exceed $10,000, and did not obtain written bids.

The open meeting law violations were inadvertent, yet certainly serious. The statement with the Secretary of State was not updated after the Board's move to DOA facilities in June, 1993. In August, 1994 the Board realized that the statement was not updated to the Board's new address and the situation was remedied.

The Board agrees that the rule package, which was prepared and progressed through most of the required stages, was not submitted for final approval because the Executive Director, who was responsible for this submission of the rule package became seriously ill. Once the changes to the rule making processes are effective (January 1, 1995) the Board's staff will submit the rules according to the new rule making process. The staff has received training in the rule making process so that this can be carried out expeditiously.

The Board acknowledges that previously investigators were not always properly used for investigating complaints, and that some positions were left vacant for extended periods of time. This situation has been remedied by changing the role of the investigator and the entire complaint investigation process, and in filling all but two of the Board's vacant positions. Those two positions are being recruited at this time.

The Board has taken steps to adequately monitor the agency. The Executive Director gives a quarterly report to the Board at a public meeting, and sends periodic written information to Board members to ensure they are kept apprised of developments. The Board reviewed with the new Executive Director its expected performance criteria, and performance indicators for all areas of the Board's functions either have been or are being developed at the present time.

In addition, the true role of the Board members is to ensure the public is protected. The Board feels that this is best and most efficiently done when the Board can spend most of its time adjudicating complaints, and oversees the agency in a manner that is effective yet not time consuming.

The Board reviewed, but did not approve, a number of written policies and procedures at the October, 1994 Board meeting. They directed the Executive Director to continue work on the written policies.

In conclusion, the Board agrees with many of the findings of the Auditor General's office. The Board disagrees on how those findings specifically impact the Board's ability to protect the public, but, nonetheless has quickly embarked on a course to implement many of the suggestions and recommendations of the Auditor General's office. In addition, the Board has developed a number of its own program changes which it plans to implement over the next calendar year in order to remain, as recognized by the Auditor General's office, one of the premier medical Boards in the country.