News & Views

Citizen Advocacy Center

Fourth Quarter, 2011 A Health Care Public Policy Forum Volume 23 Number 4

ANNOUNCEMENTS

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INTRODUCTION

David Swankin, President and CEO, Citizen Advocacy Center

Editorial Note: This issue of CAC News & Views contains Proceedings from the 2011 Annual Meeting, ACHIEVING REGULATORY EXCELLENCE: EFFECTIVE DISCIPLINE PROGRAMS, held October 20 – 21, 2011, in Washington, D.C. This is not a verbatim transcript, but the content is faithful to the speakers' remarks. You may want to read these Proceedings in conjunction with the speakers' PowerPoint slides, which you will find at **http://www.cacenter.org/files/powerpoint/AnnualMeeting2011/index.html**.

While licensing boards engage in many important activities, it is the disciplinary function that most frequently attracts media attention. This makes discipline the most important determinant of the public's

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perception of your boards. Whether you like it or not, you don't see many people asking what you do in connection with testing, licensing, education or other functions. It is discipline they are aware of.

And, in fact, nothing is more important to a board's statutory mission to protect and promote the public health, safety and welfare than a well-functioning disciplinary program. The public wants assurance that licensing boards are undertaking appropriate interventions when practitioners fall below minimally acceptable standards of practice.

We have divided these two days so that today, we will look at how boards handle the bulk of cases that fall in the middle of the Bell curve. Tomorrow, we will cover cases at the two extremes: complicated cases that raise serious public safety issues at one end of the curve and so-called minor cases at the other end.

I'd like to point out a couple of examples of why the health professional licensing system is held in less than the highest esteem. Boards are often accused of being too lenient. The *Saint Louis Post Dispatch* carried an editorial on July 17, 2011, which pointed out that "In twenty-five years, the medical board has not one time used its authority to summarily suspend a license of a dangerous doctor."

Some board policies seem to favor the profession rather than the public. For example, in the District of Columbia, the Department of Health, Health Professional Licensing Administration complaint form states that complaints must be signed and dated by the individual making the complaint and the complaint will be made available to the licensee so that he or she may file a response to the allegations. The board will not accept an anonymous complaint." Compare this to legislation recently passed in Texas. HB 680 requires that the medical board know the identity of individuals who file complaints, but the board will keep the complainants' identities confidential from the

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NOTICE

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public. Anonymous complaints currently make up only 4% of 6,800 complaints received by the medical board. Patient advocates contend that protecting the anonymity of complainants ensures protection from retaliation. Provider advocates say banning anonymous sources ensures the validity of complaints.

One's opinion on this and many other subjects depends on where you are sitting. This is one of reasons it is important to have public members on boards, because they bring a different point of view.

Still, there are best practices out there. One purpose of all of CAC's Annual Meetings is to highlight best practices as they are evolving. Boards would do well not only to adopt best practices, but also to explain them to the public.

One bests practice is for a board to self-evaluate its disciplinary program and identify areas for improvement. CAC has a tool on our Web site entitled, "Evaluating Board Disciplinary Programs" at http://www.cacenter.org/files/DisciplinaryPrograms.pdf. This tool advises boards that identify areas needing improvement to determine whether the improvement requires a legislative change, or a change in board policy, or an increase in resources.

CAC has published numerous reports over the years comparing various aspects of disciplinary programs in the states. Many of these reports were generated in response to suggestions from people like yourselves. As you listen to the presentations today and tomorrow, we invite you to jot down any ideas that come to mind suggesting a comparative report by CAC. Please let us know what surveys and other research you think would be most beneficial.

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KEYNOTE

Lisa McGiffort, Director, Safe Patient Project, Consumers Union

Why is Consumer Reports interested in regulating health professionals? It is because we are very interested in quality and safety. This interest prompted Consumer Reports to begin rating such things as patient satisfaction, hospital infection rates, and cardiac surgery groups. We evaluated about

220 cardiology groups on such variables as complication rates, survival rates, use of the best surgical techniques, and correct post-surgery medication.

I work for the advocacy arm of Consumer Reports. In 2003, we launched a nationwide patient safety campaign called "Stop Hospital Infections." We initiated laws all over the country to require disclosure of hospital infection rates. Disclosure laws have since passed in 30 states and twenty-five states have produced reports. Some states are also collecting information from outpatient surgical centers. As of this year, the Federal government is collecting infection rate information from hospitals. We also work on medical errors and drug and medical device safety.

Visit: http://www.safepatientproject.org. Our objective is similar to Consumer Reports in that we strive to get information about the healthcare system to consumers. Specifically, we disseminate information about patient safety so consumers can make choices about where to go for healthcare. The information also enables providers to compare themselves with other providers, because this is what is driving change.

Licensing boards have a huge responsibility, and I admire you for taking it on, especially when there are people like me nipping at your heels and saying what you should be doing. When a professional hangs out his or her shingle, the public assumes that professional has been checked out and is competent to do the work. There is a great deal of gravity in the work you do to ensure that licensees are educated, competent, and not likely to harm their patients. The bottom line: your job is to weed out the bad guys. You need to find out who they are and decide what needs to be done to make sure they do not harm patients.

Most professionals are not crack cocaine addicts or sexual predators or totally incompetent. The vast majority of them do not have problems, but you still have to be vigilant to find the ones who do have problems. Regulators are the thin protective shield between the bad guys and consumers.

Consumers have confidence in licensing of practitioners and hospitals. They expect swift investigation of complaints and timely complaint resolution. This doesn't always happen. Consumers need someone on their side. They need to know what is happening every step of the way. They need to be able to actively participate. They have a right to see the provider's response so they can correct any inaccurate information. You should view yourselves as being on the side of the patients.

There are plenty of signs of trouble in the healthcare system. Medical harm is very common. Three studies in the last year showed that one in three or one in four hospital patients is harmed. One in seven is seriously harmed. We have no idea what the statistics are outside of hospitals. We hear about medical malpractice lawsuits all the time, even though the numbers of people harmed far out shadows the number of suits filed or settled out of court. We see stories of victims every day in newspapers across the country. We see the volume of complaints that boards like yours receive every year. This is all evidence that there is a problem.

Are regulatory agencies in the healthcare field doing a good job? I have no idea. The system is not transparent enough for me to determine the answer. It is sad but true that it is easier to make a decision about cars or refrigerators than about healthcare providers, but that is the case.

The regulation of healthcare professionals is among the most secretive processes in government today. From the outside, it looks as if the culture is more oriented to protecting the licensees than protecting patients. We know that regulatory boards are strapped for resources and often have to face well-resourced, savvy lawyers on the other side.

Still, boards have the information, consumers don't. Making that information public would be an essential step toward rooting out the small percentage of licensees who threaten harm to patients. It is likely that boards don't have the resources to analyze complaints so they can flag problems and examine trends. Boards need to make the information they have more public so others can help them do their jobs.

An example is the hospital infection data now available to the public. The reports from health departments are incomprehensible, so gradually third parties are analyzing and translating that information for the public. We need the same thing to happen in the field of health professional regulation.

Since this conference is about effective discipline, I want to talk about accountability, which is intrinsically tied to transparency. There isn't much information about healthcare in general. What information is available frequently is not accessible to third parties who might want to analyze it and inform the public about what they are seeing.

For example, when we decided to rate surgical groups, we didn't have even a database of the group we were trying to assess. We collaborated with the Society of Thoracic Surgeons, which did have the data, but they would work with us only if participation in our study was voluntary. Less than one-fourth of surgical groups volunteered to participate. Only five of that voluntary group rated below average. You can't really do a good evaluation without seeing the whole picture. The top performers aren't the ones we need to worry about. It is the poor performers that concern us.

Being transparent means that the information boards have is easily accessible. What should the public be able to see? I believe the public should be able to see just about everything you are doing. And, we need to see it without having to search for it.

This includes all board orders, formal and informal. There should be a link to the actual documents – the allegation, the court order, etc. The facts of a case might not concern every patient enough to stop seeing the practitioner, but people have to be able to see what the problems are and decide for themselves.

We believe the content of complaints should be public. It is neither informative to consumers nor fair to the practitioner to disclose only the number of complaints filed against any given provider. What if the complaints are minor? We contend that complaints tell us what kinds of things are happening with this professional.

Complaints are an important resource for boards. They help identify the few professionals who pose a threat. They also reveal what needs to be changed in your regulation. Boards may not be able to propose changes in their regulations, but groups like mine can. Many years ago, we looked at complaints against optometrists in Texas and found that most of the complaints were from people who couldn't get their contact lens prescriptions. So we passed a law giving consumers a right to their prescriptions. So, access to complaints allows third parties to see what problems are on consumers' minds.

Accountability also involves a proactive approach to discipline. In our mobile society, it is important for boards to check national resources, such as criminal background checks.

It is important to analyze trends in complaints. This can reveal changes needed to help licensees and the public. For example, California has a really complicated statute of limitations for complaints against doctors. The description on the medical board's site is so confusing that we have heard from several people who filed their complaints too late. We are advocating for the Web site and the law to be clearer.

Another good example of using lots of data sources is Pro Publica's series of stories about the California nursing board. Through numerous sources, they were able to locate nurses who had been disciplined in other states, but were practicing in California. The fact that boards don't have resources to gather this kind of information is one more reason for making it public so other entities, like Pro Publica, can use the information.

We need a system where licensing boards share information with each other and with hospitals and other institutions. Most of the hospital infection reports I have referred to are being collected by the health department epidemiology section, not the licensing section. In order to access the information CDC collects, states had to sign an agreement that they would not share this information with the regulators in the state. This is a problem.

It is difficult to keep complaints anonymous. Licensees are going to figure out who complained. What we really need is strong protection for whistleblowers.

We did a consumer survey and found very strong support for public disclosure of information about doctors. We were surprised to see that 89% of respondents think doctors under a disciplinary order should be barred from practicing anywhere until the license is cleared. When we asked the polling company to ask this question, they laughed out loud. They said, "Why would you ask that question? Of course they wouldn't be able to practice."

Communication about medical harm is really important. Part of the problem is that people don't know where to complain. Part of your job is reaching out to the public and letting them know how to get you the information you need in order to regulate appropriately.

I leave you with a couple of challenges: Your obligation is to keep patients safe. That means identifying and acting on those licensees who pose a threat to patient safety. Think of the shroud of secrecy that exists in your organization and how that might lead to patient harm. Look at all the information you can supply to the public under your current laws and put it on your Web sites. Make sure it is easy, intuitive, and accessible to the public.

PROCESSING COMPLAINTS AND KEEPING COMPLAINANTS INFORMED

Helen Haskell, President, Mothers Against Medical Errors

My focus is patient safety. Since the death of my fifteen-year-old son as a result of medical negligence, I have worked with people who have suffered egregious medical errors. My son died in the hospital, on the ward, from a perforated ulcer caused by post-operative pain medications. He died after being left for thirty hours while nurses in residence did nothing about it and the attending physician declined to come in. There were three residents, two nurses, and an attending physician involved in this incident. The case was egregious enough that the medical university settled out of court without a lawsuit.

We tried to report these practitioners to the National Practitioner Data Bank, but we weren't allowed to do it because we didn't have the right status. We didn't go to the medical board or the nursing board. The reason was that we didn't think the licensing boards would do anything and we did not want these very culpable practitioners to be able to say they had been exonerated by the licensing authorities.

The public assumes that licensing boards are there to protect patients. They assume that if a health care professional is deemed by a court of law to have committed malpractice, then that case should be closely scrutinized by

the licensing board. Some people think it is all one system, and if there is a malpractice settlement or verdict, the licensing board is automatically involved.

Licensing boards need to be a lot more visible. Most people think there is a place to report health care professionals, but many people don't know what it is called, and most don't have a clue how to find it. Even I had a hard time finding all the medical boards. Other agencies, such as health departments, should be encouraged to send people to licensing boards if there is a possibility that they have a valid complaint.

When people do complain, they are seldom happy with the results. Most start with high hopes, but they often end up thinking the investigation is a whitewash. Here is an email I received yesterday from a complainant's family member:

> The patient and family are closed out completely from the process. You submit your complaint in writing. Then you get a basic form letter. They tell you they can't release anything about the investigation unless there is action found. If there is no action found, a letter of concern is written to the provider. Then the provider has to agree that the patient and family can be privy to that information. Otherwise, you are completely closed out. There is no chance to find out what the investigation consisted of, what the provider said, what the facility said. The very people who serve on the committees that make the decisions are the people who work for the facilities. One of the guys on the committee for my Mother's case was the IT guy for the hospital that my Mom's provider worked for. The head of the committee was a family practice doctor who served on multiple committees with my Mother's doctor. It is incestuous in small states. It is closed to the family. It is unjust.

Here is another family member's experience:

> The conclusions they came to showed how superficial the investigation had been. And yet, when we asked the next question, "Did you ask about the antidote given?" the answer was, "We can't discuss the specifics." The problem is that you have no idea what specifics were considered by the investigative committee. You can keep submitting more information, but it goes into a black hole. I submitted more and more information, three times, to no avail.

Another family member commented:

> Our son's care probably did meet the standard of care, but that standard of care is a sad joke. There really is no standard.

Given all of this, how do boards maintain a degree of customer service that keeps people happy and maintains public faith in your good intentions? The complaint section on board Web sites needs to be immediately visible. I think it is critical to explain the limitations of the process to complainants at the outset and keep them posted throughout. My main points are transparency and reliability. Confidentiality is almost never in the interests of the consumer.

In the 1990s, the issue was the patient's right to know. People wanted information about doctors. We have had patient-sponsored legislation, including profile laws. A major issue now is the right for complainants to testify before a licensing board. Consumers want to be able to complain anonymously. They want healthcare practitioners to be able to complain anonymously. They want to be kept apprised of what is going on. They want everything public. Above all, people want to have input. The only people who know what really happened are the family members.

Healthcare practitioner testimony, even well meaning, is based on momentary encounters with the patient. Without family members'

input, it is not possible to do a comprehensive investigation.

My final comment is that the role of the public member is to stand in the way of the professionals' relationships that can affect the actions of the board. Your job is to be the complainant's ally and to help the licensing boards see themselves as that.

Dwight Hymans, Director of Board Services, Association of Social Work Boards

I prepared for my remarks by asking our member boards some of the questions posed in the session description. I also visited each of our members' Web sites to see how consumers find information about the complaint process.

I asked our member boards if they assist callers who are considering filing a complaint, or help them in put it in writing. The majority does not. The boards direct consumers to the complaint form on the Web site. There were a few members who said they would help if the consumer requests it, but most boards are concerned about staying neutral in the process. Several boards said they would assist individuals who have ADA requirements. The Minnesota board is an example of a board that will help complainants by directing callers to the Web site, providing information in writing, and discussing the substance of the complaint with callers.

Asked whether the complainants are told what to expect from the process, a majority of boards responded that they refer consumers to their Web sites. My experience searching for this kind of information on the Web sites ranged from being unable find it, to finding it easily, to everything in between. I have often talked with our member boards about information accessibility on the Web sites, and have found that the range – from easily accessible to inaccessible – is common for every type of information on the member board's Web sites. On some sites, the information about the complaint process is very extensive and elaborate, and is written from a consumer-friendly orientation. In a few cases, the information was legalistic and intimidating.

When asked whether complainants are kept informed as the process moves forward, about half of the member boards acknowledge receipt of the complaint and send another letter at the conclusion, when an action, if any, is taken. In contrast, a nice example comes from Texas, where the board issues a quarterly report to all parties on the status of a case.

I asked whether they assist individuals whose complaints are outside the jurisdiction of the board. A majority of the boards responded that they direct complainants to the appropriate board or other outside resource, or suggest the complainant contact an attorney.

I asked boards to tell me what they do to make the process user-friendly for the complainant. A majority of boards said their user-friendliness consists of having the complaint form readily available online or by mail. Some boards said they try to enhance communication in some way, such as making a follow-up call. Minnesota tries to respond the same day or the next day to every contact, and they try hard to work with the complainant during the process. Virginia has a triage process managed by the intake staff in the enforcement division and an easily navigated Web site.

In doing this research, I discovered more than I wanted to know about the user-friendliness of the complaint process followed by our member boards. There are some very positive examples, and some not-so positive examples, including at least one board with no complaint information at all on its Web site.

One of our members questioned whether a complainant or a board would ever see the

process as user-friendly. Unfortunately, this board wrote, it is a process defined by legislation, which usually precludes informality. The board tries to make it as clear as possible by using easy-to-understand language and being available to provide information and answer questions, but that may not be enough.

I think many of our members feel caught in this quasi-legal situation, where they can't do more, even though they may want to. In keeping with social work ethics, our boards want to view the situation from the point of view of consumers, but find themselves operating under the restrictions of their laws and regulations.

Nancy Kirsch, Board Member, New Jersey Board of Physical Therapy Examiners and Vice President, Federation of State Boards of Physical Therapy

All of the health care boards in New Jersey are in the Division of Consumer Affairs, which provides the boards with investigative staff. How consumer-friendly is our process? Before a legislated change that took place in the spring, we had no particular response requirement. Complaints could take six to twelve months to investigate. Many times complaints were not resolved; either they wore out, or one or another party passed away. When our current AG came on board, I think our board had a backlog of a couple of hundred complaints, which is not a good thing in terms of consumer protection.

When you Google the Division of Consumer Affairs, the first thing that comes up is the complaint process. The not-so-good news is that when you click on that link, the information is confusing. It is difficult to determine how to proceed.

The Division has a telephone hotline where consumers get help framing their complaints and putting them in writing. That is for complaints about appliances and the like. Callers with health care professional complaints are referred back to the Division's Web site or to the applicable licensing board.

There may be confusion about which board to go to, particularly if there are a variety of healthcare practitioners involved. When consumers file a complaint against a physical therapy (PT) practitioner, the complaint section on the PT board site explains the process in great detail. This can be intimidating because the information is not consumer-friendly and it doesn't seem to be protecting the consumer.

The complaint is reviewed by the board, which meets at least once a month. A summary is forwarded to the licensee, who is given thirty days to respond. The board reviews the response and recommends a disposition, which could be to ask for more information or to schedule a hearing, or something else. During this entire time, the complainant is not kept up-to-date on what is happening. Every single complaint, however, is investigated. Some complaints are lengthy and every issue needs to be dealt with.

With regard to information disclosure, the individual is told that the information they supplied may be subject to public disclosure and the board may be obligated to provide the information pursuant to the Open Public Meetings Act. Learning this, some consumers feel they have everything to lose and nothing to gain. They are not aware of their rights and protections.

The licensees are given every opportunity to defend themselves and they are told that they may bring counsel if called in for a hearing. Often, complainants will ask to speak to the board, which they may do in a public session as long as they don't mention the name of the licensee. Or, they can come to a board hearing. The board is not permitted to disclose information until a final

determination has been made, so the complainant is unaware of the status of the complaint.

Most consumer complaints have to do with payment. The board has limited jurisdiction over fees, so the complainant will be referred to a free complaint mediation service.

Effective March 21, 2011, all consumer complaints have a 120-day action period, including final disposition. This mandatory time limit is extremely helpful in getting consumer complaints through the pipeline. The time period can be extended, with the approval of the Attorney General's office, if there is a need to gather additional information.

In addition to the 120-day requirement, every board must report to the Attorney General the number of complaints pending, the number closed, the number that have gone to final disposition within the 120 days, and the number that have taken longer, with an explanation.

Many consumer complaints are incomplete and since the 120 days begins when the complaint is perfected, consumers are assisted in making the complaint specific enough to be investigated. In sum, we are trying to move toward a more consumer-friendly response, but our first barrier is consumer awareness of where to submit a complaint.

Timothy Terranova, Consumer Assistant, Maine Board of Licensure in Medicine

Editorial Note: Mr. Terranova was unable to attend CAC's meeting. His remarks were read by David Swankin, CAC's President and CEO.

I was asked to speak about how Maine has tried to help consumers who file complaints against physicians. In Maine the legislature created the position of Consumer Assistant after receiving a complaint from a citizen who was frustrated with the Board's process and outcome. The Consumer Assistant position was created to help people better understand the process. I have filled that position for the past 11 years. As Consumer Assistant I work for both the Board of Licensure in Medicine and the Board of Osteopathic Licensure, which are separate Boards in our state. Although I believe Maine has done some great work in communicating with the public we continue to try to find ways to improve.

Regulation can be confusing to the public, the regulated, and the regulators. An example is a recent Medical Board paper on informed consent. The purpose of the paper is to encourage licensees to provide informed consent in a clear and easily understandable manner. The actual definition is a 105-word sentence. If you were to check the literacy level of the definition it would be rated at a graduate level. It is ironic that an attempt to promote clear communication is so complicated. Despite this example, I truly believe the Boards have improved their communication with the public over the past decade. I would like to talk about the steps the Boards have taken that directly impact the public.

In order to communicate with people, you need to be accessible. We are one of the few Boards in the state that offer access via a toll-free number. This is a huge help to what is often considered a poor, rural population. In addition to phone access, we allow people to submit complaints and ask questions electronically through e-mail, we correspond by mail to those people who do not have either a computer or Internet connection, and we offer the ability for people to meet with us face to face.

If the Board is not the right place for someone to be, we always take the opportunity to find the appropriate resource for them. If someone is looking for a service we do not provide we will do what we can to make sure we find it for him or her. Sometimes this is a simple

transfer to another department, sometimes it involves e-mailing other departments until a satisfactory answer is found, and sometimes it involves Internet searches to find outside or federal organizations that may be able to help. One unintended side effect of this service is that we often receive calls that are not related to what we do. In most cases we hear that the department the person called had no idea how to help, but told the person that the Board would be able to find an answer. We even have the state 211 system refer people to us occasionally because they know we will know where to direct someone if they don't. Although this can take away from time needed for other things, we are proud to offer this service.

Once someone has filed a complaint we assign a specific contact person (me). That person must be available to them any time they have a question. Any of the complainants I work with know that, if I don't answer the phone, I will return their call in a timely manner. Returning phone calls and listening is one of the most time consuming parts of my job. It may take five minutes, or it may take two hours, but people need to feel they have been heard. I recently spent over an hour on the phone with a complainant who asked me for support while she opened and read the doctor's response to her complaint that his actions killed her mother.

Many people file a complaint and feel that they have done all they need to do. However, many times we need to send out additional paperwork. When we send out paperwork we fill out every line we are able to complete. This helps both the complainant and the Board because it is more likely to get the needed information the first time. If we do not receive the information back we have a tickler system that notifies us and we call the complainant.

Our Boards allow complainants to attend the Board meeting and listen (only listen) to the discussion of the case. If a complainant chooses to attend we meet with them before and after the case discussion to answer any questions they might have. If the Board orders an Informal Conference and invites the complainant in to speak with them, we meet with the complainants before and after, but we also sit with the complainants during the conference to offer support.

In addition to having a specific contact person the Board has created several brochures to explain the process. The Guide to the Complaint Process is sent to every prospective complainant and to everyone who files a complaint. If an Informal Conference or Adjudicatory Hearing is ordered the brochure is sent at the time it is ordered and when it is scheduled.

The Informal Conference and Adjudicatory Hearing brochures are also sent to the licensees and the Board has also created a Physician's Guide to the Complaint Process that is sent with every complaint notice. So, the Board's attempts to keep the public informed are helping everyone it communicates with.

During the complaint process there are also several times where we have determined that formal written notification needs to be provided to complainants. Once a complaint is received we send a letter acknowledging that we received the complaint, enclosing the brochure, asking for any additional information, and including our contact information.

Once we receive the licensee's response we send that to the complainant asking for their feedback and letting them know that the case will be placed on an upcoming agenda.

After the Board reviews the case a letter is sent to the complainant telling them what happened. The four things that can happen are;

1) Dismissed;

2) Further Investigated;

3) Informal Conference ordered; or

4) Adjudicatory Hearing ordered.

If a conference or hearing is ordered a letter is sent, with the appropriate brochure. If the case is further investigated, a letter is sent notifying the complainant that more time will be needed. These three letters are form letters.

If the case is dismissed an individualized letter is created. In it the complaint is summarized and the Board's rationale for its decision is provided. A recent example:

A father complained that his son, an adult with some mental retardation, underwent a surgery that caused his death. The father was living out of state at the time of the surgery, but had an agreement with his son that he would be contacted prior to any medical services being rendered. However, the father did not have guardianship or power of attorney as he felt it was important for his son to live his own life. It is clear in all the records that the son consented to the procedure and that there was some communication with the family. Although the Board would have liked to see a better attempt at communication, there was no doubt that a valid consent had been obtained. Here is a part of the letter that was sent that tries to explain the Board's rationale for the decision:

> The Board members understand your concern that when your son developed a small bowel obstruction that failed conservative treatment he should not have undergone surgery without more involvement by the family. In particular, you wanted to discuss the case with the doctor and unfortunately this did not occur. A surgical resident discussed the case with you and you told the surgical resident that your son signs his own consent forms. There is good documentation in the chart that your son signed all of his own consent forms. There is no clear evidence that the doctor understood the complex issues of dealing with your son's limited intelligence. There is also no clear evidence that the doctor made a concerted effort to adequately inform the family of the medical situation beyond using the residents. Nonetheless, your son was not improving and the decision to do surgery appears to have been appropriate. The operative procedure appeared to go well but unfortunately your son developed a pulmonary embolus post-operatively and died. Communication issues were strained because of your son's mental retardation, lack of local family and the complexities of dealing with a large surgical service and surgical residents. It appears the doctor and their team made appropriate medical decisions and attempted to keep the family informed although it is very unfortunate that the doctor did not personally contact you as requested.

Prior to and after receiving this in writing, there were extended phone calls with the complainant to verbally explain what happened and give him a chance to ask questions and express his frustrations. In the end he remained dissatisfied, but understood why the Board did not discipline the licensee.

Question: Is the complaint mediation service in New Jersey part of the board, or outside the board?

Kirsch: The mediation service is outside the board in the Division of Consumer Affairs. If they are unable to resolve the complaint, it will come back to the board where it originated.

Comment: One speaker said that the number of complaints and lawsuits is evidence of a problem. With so many frivolous suits and complaints that go uninvestigated, I'm not sure I agree with that conclusion. Secondly, I believe complaints need to be investigated, and the size of the

backlog in New Jersey is scary, but making complaint information public before it is investigated seems improper to me. Shouldn't the standards imposed on healthcare professionals also be imposed by state Bar Associations on attorneys, by the Federal Aviation Administration on airline pilots? Finally, my personal experience with two licensing boards makes me question the statement that licensing boards protect the licensees.

McGiffort: The evidence of the problem is the amount of harm that is being experienced by patients. In fact, there are a small number of lawsuits and settlements compared to the incidence of harm. On the subject of making complaints public, remember that the information is public when someone is accused of committing a criminal act. The accused has rights in court, but the arrest and accusations are public information. Licensees definitely have rights, but being able to practice medicine or any other profession is not a right, it is a privilege. Making all complaints public may well protect licensees because the public can see what kinds of complaints are being filed, and they may not be very serious. Hiding the facts behind the numbers may imply that a whole lot of serious things are going on, and that may or may not be the case.

Hymans: The Association of Social Work Boards has a database of actions against all licensees. Over the years, we have seen an increase in the number of reports. It is not just the number of complaints; it is the types of complaints that are actually being investigated and the seriousness of the actions taken. We are seeing more egregious kinds of behavior by professional social workers.

Question: Have you notified the social work boards that have Web sites you found weren't user-friendly?

Hymans: I intend to bring this information to the attention of the administrators of many of our boards who are meeting in a couple of weeks.

Question: I believe Ms. Haskell recommended that licensing board processes should parallel court processes. My concern is that we want to process complaints in a timely manner, but criminal cases take years and are often followed by a civil case. A licensee is unlikely to appear at our hearing or enter into a settlement until the judicial case has been adjudicated. Meanwhile the person continues to practice.

Haskell: My point was not that the two processes be linked, but that a civil judgment or settlement should be brought to the board's attention and investigated.

Question:, Has the new time limit for resolving cases in New Jersey caused you to close some, or have you added staff to be able to meeting the deadline?

Kirsch: The deadline has been in effect since March and what has happened is that cases are being handled as quickly as possible. But often cases are backlogged to find more information. I think it is going to become a problem handling all the complaints in that limited amount of time.

Question: We can develop attractive, easy-to-use Web sites, but how do we inform the public that we exist and where to go with complaints?

McGiffort: Public service announcements (PSA) on radio and TV are a possibility. Perhaps all the licensing agencies in a given state could come together to develop a PSA and create a portal on the state's Web site that links to every profession.

Haskell: This may not be a popular idea, but posting notices in healthcare professionals' waiting rooms would be

helpful, as would brochures in appropriate places.

Hymans: The Tennessee social work board recently undertook a project to disseminate information to the public, with funding from the state. Our association is developing a few standardized posters that we share with our members.

McGiffort: Some states require posting information in offices about where to complain. This is helpful, but not sufficient, because people don't seek this information until they have had a problem. We need to think about where consumers go for information when a problem occurs.

Comment: Most of us agree that a license is a privilege, but the judicial system in our state considers a license to be a property right. To take a license away, we have to go through due process, which can take a long time. Most of what we are talking about has to do with small numbers of people – in social work, for example. With nurses and doctors, the number of complaints is far greater and we struggle to deal with them.

McGiffort: That is why I believe the complaints should be made public because boards don't have the resources to investigate everything. If complaints are public, patients can make more informed choices. Only the most tenacious people go through the process of filing complaints. It is just the tip of the iceberg.

INVESTIGATING COMPLAINTS

Faye Lemon, Director, Enforcement Division, Virginia Department of Health Professions

The Enforcement Division is authorized by law to receive and investigate complaints, to inspect certain types of facilities, to conduct background checks, and to conduct reinstatement investigations. We are part of an umbrella agency with thirteen health professional regulatory boards, including nursing, medicine, pharmacy, dentistry, funeral industry, long term care, optometry, physical therapy, behavioral sciences, and veterinary medicine. Enforcement works for all the boards and does not report directly to any board executive. We are not influenced by what the boards think about how a practitioner should be treated.

We inspect pharmacy facilities, veterinary medicine facilities, and funeral homes. Complaints can arise from these inspections.

In 2010, we received about 4,966 complaints, not all of which became cases. Complaints are received in writing according to a format on the Web site. Complaints are received via a toll-free phone number and also from walk-in complainants.

We accept anonymous complaints, but do not guarantee anonymity. A licensee can figure out who the complainant is through handwriting, or the nature of the complaint.

The majority of our complaints come from consumers. We get a lot of information from required reporting from hospitals, nursing homes, and so on. Entities are becoming creative in deciding when a report is required. We are being more proactive about informing entities how to comply with the reporting requirements. Criminal courts are supposed to report licensees to the Department, but the court does not always know that the individual is a licensee. Occasionally, people report themselves.

The complaint intake unit is staffed by four analysts who are all healthcare professionals. They decide whether we have jurisdiction over the individual and whether there is a possible violation. We are evidence-gatherers; the boards make the final decisions. We refer people to other state or federal agencies if we do not have jurisdiction.

Receiving 10,000 complaints a year, we need a system for prioritizing complaints, or there would be chaos. Our priority system is based on severity of harm to the public. We talk to the source and get as much information as possible to determine what priority to assign a case. And that priority may change up or down as more information comes in. For example, a case involving serious patient harm could turn out to be a problem with the system, rather than the fault of one individual.

Priority A is the most severe and could lead to a summary suspension. Cases in this category pose a significant, substantial, imminent danger to the health and safety of any person. Examples include sexual assault, adulteration of medications, and substantial impairment.

Priority B cases are harmful acts which do not pose an imminent danger, such as dispensing a controlled drug without a lawful order, or impairment that interferes with providing patient care. Priority C cases involve harmful or substandard care, such as malpractice judgments or verbal abuse. Priority D cases do not involve patient harm, but may involve something like loss of property, misleading a patient, or failure to release a body to an authorized representative.

We keep data on the types of cases we receive. The categories we use include substandard care, fraud, sexual misconduct, and various other patient care categories.

A typical case, to the extent there is one, starts with receiving the complaint and prioritizing it. After that, we consult with the applicable board, assign the case to an investigator, collect information, interview, subpoenaing records, send the complaint to the respondent, interview the respondent, consult with the attorney general, and compile a report for the board. The board decides whether there is probable cause. Ninety percent of our cases should not be older than 250 business days. Enforcement has only 150 business days to adjudicate from receipt of a complaint to referral to a board.

We work closely with law enforcement, the federal government, attorneys, other boards, and the media. We want better press and we want the public to know about us.

Julie D'Angelo Fellmeth, Administrative Director, Center for Public Interest Law, University of San Diego School of Law

For thirty years, my organization has been monitoring activities of California agencies that regulate businesses, professions and trades, including the Medical Board of California and other healthcare licensing boards. I'm here today to talk about vertical enforcement (VE), a widely used model for conducting investigations and prosecutions in complex cases.

I am going to discuss how physician discipline matters have been investigated and prosecuted historically in California, the kinds of problems that that law caused, and the new way that physician discipline matters are now investigated and prosecuted. The sheer size of our state creates problems. Investigators are housed in the medical board's twelve district offices scattered across the state. The prosecutors who prosecute physician discipline matters are employed by the Attorney General's Office, which has offices in five districts. So, the size of our state and the geographical disconnect of our investigators and prosecutors are part of the problem. We have encouraged the use of vertical enforcement to help resolve that problem.

California's use of vertical enforcement came about through what is called the Enforcement Monitor Project, which was created by the California legislature in 2002. The bill grew out of a multi-day series in the *Orange County Register* called "Doctors Without Discipline." It focused on a single Orange County physician, an OB-GYN, who had botched a number of births, killing babies and devastating their families. Although he was

the subject of numerous medical malpractice judgments and settlements and hospital privileging actions, the medical board had not taken any disciplinary action against this physician.

At the time, there was a wide ranging set of mandatory reporting requirements that should have brought this physician to the attention of the medical board, but clever doctors and their clever lawyers were exploiting loopholes in the reporting requirements to avoid medical board detection. Without mandatory reports, the medical board was left to rely on consumer complaints. In this matter, the families were not aware of the medical board and thought that their only remedy was a civil lawsuit. (By the way, California now has a requirement that all doctors post in their waiting room or insert onto to a document given to patients the statement that "Medical doctors are licensed and regulated by the Medical Board of California," with the toll-free number and the board's Web site.)

The legislature passed a law requiring the appointment of a Medical Board Enforcement Monitor, independent from the board and the medical profession, who would look at the overall structure and functioning of enforcement processes and make recommendations on ways to strengthen enforcement for the benefit of patients and physicians. My team applied for the job and was awarded the contract. We served as the monitor from October 2003 to November 2005.

We issued our first report in November 2004. The report included hundreds of findings and sixty-five specific recommendations for strengthening the enforcement program at the board. You can find that report at http://www.cpil.org. The report walks you through each step of the physician discipline process, from receipt of the complaint, screening of the complaint, to request for medical records, to formal investigation, to use of expert witnesses, to referral to the Attorney General's office, to evidentiary hearing before an Administrative Law Judge, to the drafting of proposed decision, which is then considered by the medical board, and then judicial review of the medical board's decision. Chapter by chapter, we laid out each of the steps. We quantified the delay at each step, and the recommended changes to make the process more efficient and the output of higher quality and improved fairness and consistency. In November 2005, we published our final report, which is also on our Web site. In 2005, Senate Bill 231 Figuroa incorporated most of our recommendations for change. The law went into effect January 1, 2006.

The centerpiece recommendation was our call for the medical board investigators and the Attorney General's prosecutors to shift to a vertical enforcement model of investigation and prosecution. VE involves earlier involvement of the prosecutor in a matter that has been screened and referred for formal investigation. It calls for much greater teamwork between the prosecutor and the investigator in an effort to more efficiently and effectively identify weak cases and dismiss them at an earlier stage and identify meritorious cases and pursue them vigorously within the confines of the medical board's resource restraints.

California had been tinkering with VE for about fifteen years prior to passage of Senate Bill 231, but had never formally adopted the model. The problem we encountered was abuse of what we called the "hand-off" method. This was the prior way the medical board investigated and prosecuted cases. Here's what I mean by hand-off. A complaint comes in. It is screened and handed off to an investigator who unilaterally, with no legal advice, attempts to analyze the elements of the offense alleged in the complaint and identify the kinds of evidence needed to prove the elements of that offense, and then obtain the evidence in a manner that it is admissible at the evidentiary hearing. Pre-VE,

investigators had little or no access to a deputy AG. The investigators were on their own in requesting medical records and they were on their own in enforcing the meager laws we had on the books at that time regarding medical records procurement and non-compliance by doctors. They were on their own when it came to interviewing the subject physicians, if the physician would even agree to appear. They were on their own working with medical consultants, who are physician employees in our twelve district offices. These physician employees help investigators decipher medical records and help choose expert witnesses. They were also on their own working with those expert witnesses, physicians who were asked to review the medical records and opine as to whether the physician's conduct in a given case departed from the standard of care, and to what extent.

After this long process was over, the investigator would just hand off the completed investigation to a prosecutor who had had no role in designing the investigation, no ability to review the evidence as it came in, no ability to issue subpoenas or other mechanisms to induce doctors to turn over medical records, and no ability to work with the expert witness. Yet, that person had to draft formal charges and try the case before an Administrative Law Judge. And, that prosecutor had little or no investigative follow up assistance from the investigator who knew the case best.

This disconnect – investigators working on their own with no legal advice and prosecutors working on their own with no investigative assistance – created the following problems. There was inadequate communication and coordination between investigator and prosecutor. If the prosecutor needed follow up investigative assistance, there were time-consuming requests to the medical board and the handing back and forth of the completed investigative package. There were unclear and frustrating working relationships. Some investigators did try to seek legal advice from prosecutors; others did not. There was no jointly developed investigative plan. The investigators devised it, with no help from prosecutors who later had to file and try the case. That kind of hand-off method might work very well for street crimes handled by the police department and district attorney's office, but it does not work well in a complex physician discipline matter and it does not work well when prosecutors come up against the kind of legal fire power that physicians are usually able to bring to bear.

Once the investigation was handed off to the prosecutor, the medical board considered its job done. The investigator who knew the case best was not available to the prosecutor to do investigative tasks or assist at the hearing. Any prosecutor worth his or her salt begs for the assistance of that knowledgeable investigator at the evidentiary hearing. In the hand-off model, there was reduced commitment to cases, especially by the investigators. They had no ability to see the fruits of their labor at the hearing. They didn't feel part of the team. Finally, under the old model there were missed training opportunities for both investigators and prosecutors; missed opportunities to work together and learn from each other and develop respect for each others' unique contributions to the process.

Under our VE statute, a matter that survives screening and is referred to formal investigation must be jointly referred to both the investigator and the prosecutor who is later going to be responsible for filing the accusations and trying the case. So, there is early coordination of effort, early designation of trial counsel. Under the VE model, investigators and prosecutors work together from day one, and stay with it for the life of the case. Although both investigators and prosecutor play vital roles, under our statute, the investigation proceeds under the direction of the prosecutor. That is because this is an

inherently legal process. The person who must file the changes and try the case has to oversee the investigation. Under VE, the prosecutor assists in designing the investigation, observes the evidence as it comes in, files subpoenas as necessary, and assists in choosing the expert witness and designating what documents the experts should look at.

The VE concept is not new. It is widely used on the federal, state and local levels to investigate and prosecute specialized or complex matters. We believe the advantages of VE are numerous and obvious, and they are the converse of all the disadvantages of the prior system.

Based on our experience in California, it is better if the investigators and prosecutors are employed by the same agency – or at least located in the same city – so they can work together. It is not working as well as it should because the investigators continue to be employed by the medical board and the prosecutors by the AG. The goal is high quality government decision making in which patients and practitioners have a huge stake.

Question: In an umbrella system, how do you find investigators and AGs with broad enough expertise to interview and investigate a doctor and interview and investigate a mortician? They are very different professions.

Lemon: Our investigators have medical backgrounds. Many are licensees. Many have investigative or law enforcement backgrounds. We do a strong in-house training through CLEAR. Also, the boards train them about policies, procedures and laws. It would be impossible for an investigator to know all the nuances of all thirteen boards. But, the majority of the investigators are very well versed in the standards and laws of the medical and nursing boards. For some of the smaller boards, we interact with board staff and board members, when appropriate, to be sure we have the correct training. We are also allowed to have consultations with outside entities. We look at cases with board staff, in-house lawyers, and also possible prosecutors.

Question: In your experience, what is the most fruitful source of information?

Lemon: If the source of a complaint can provide us with the information we need up front, this information is usually reliable. Of course, some sources are vindictive or otherwise unreliable. Some of our anonymous complaints are the best we get. If they come by telephone, our intake people are skilled at getting as much information as possible. The strength of a case depends on the evidence we collect.

Fellmeth: As the medical board enforcement monitor, I was required by the statute creating the position to look at recent medical board disciplinary decisions and determine the sources of information that were most reliable in leading to disciplinary actions in high priority cases. We found that reports made by hospitals based on internal peer review actions against physicians were of the highest reliability. Second in reliability were reports of medical malpractice judgments and settlements.

Lemon: We also find that required reports are very reliable. The problem is getting the institutions to file the required reports.

NEGOTIATED SETTLEMENTS: DO THEY PROTECT THE PUBLIC?

Kimberly Anderson, Assistant Executive Director, Investigations, Compliance and Enforcement, State Medical Board of Ohio

We have twelve board members, including three consumer members. The board meets monthly for two days. Two board members are appointed to oversee the investigative

process, the secretary and the supervising member. No settlement agreement can be approved without the prior approval of these two individuals.

About half our staff of seventy-nine people is investigative, enforcement and compliance staff. We also have four nurses, who help us with medical record cases. Our board has more than 63,000 licensees, the majority of whom are MD or DOs. We also license PAs and massage therapists.

Complaints and investigations and cases closed with no formal action are confidential. Public information includes board-approved citations, board-ratified consent agreements or settlement agreements, administrative hearings and board orders. After investigation, the board may approve a citation, agree to a hearing, and ultimately issue an order.

The alternative route is to enter into a consent agreement, which must be accepted by the full board. We receive more than 4,000 complaints and take more than 200 actions per year. A consent agreement allows us to streamline the process. A consent agreement is a negotiated contract, which is not subject to appeal. So there is clarity and finality when a consent agreement is signed.

There are safeguards in place to be sure consent agreements are not too lenient. The Secretary and Supervising Member must approve the terms before a consent agreement can even be offered to the licensee. After a consent agreement has been approved, the entire board must ratify it. There have been a few cases in which the board has refused to ratify when board members thought the terms of the agreement were not in proportion to the admitted conduct. We require an admission as part of the document and the settlement agreement on our Web site contains this admission.

There are two types of settlement agreements – a pre-cite settlement, which is reached before charges have been issued, and a post-cite settlement, which is reached after changes have been issued. Settlement agreements include consent agreements, permanent surrenders or voluntary retirements, and application withdrawals. All of these are public and on the Web site.

A step one consent agreement takes someone out of practice. The standard form for a step one agreement is approved by the board and reviewed on a regular basis. This generally includes a minimum time for suspension, interim monitoring terms, treatment and aftercare requirements, conditions for the person to re-enter practice, and willingness to enter into a step two consent agreement as a condition of re-entering practice.

A step two consent agreement reinstates the license. It includes probationary terms, which, if violated, can lead to formal disciplinary action. Staff meets quarterly with licensees on probation to be sure they are in conformance.

We may be one of the few boards that has fewer consent agreements than formal citations. We had 75 consent agreements in 2009 and 76 in 2010, and more than 100 cites in both years.

A few things incorporated in our structure ensure consistency between consent agreements and board orders. We have established disciplinary guidelines. For each type of sanction there is a minimum and a maximum recommended sanction. We have a rule saying that any settlement that is more lenient that the disciplinary guidelines must be approved by the board President, in addition to the Secretary and Supervising Member before being offered to the licensee.

We have had situations where licensees have been charged with very serious crimes. We can go forward with an indictment and conviction. In the alternative, we have developed a consent agreement based on non-cooperation, where the individual declines to

cooperate with a board investigation while a criminal case is pending, but will agree to have the license suspended during the criminal process and subsequently agree to either enter into another consent agreement or face board charges. This has been a valuable way to get these licensees out of practice.

Ben Massey, Executive Director, North Carolina Board of Physical Therapy

Keep in mind we are a small independent board, with an attorney under contract rather than on staff. We have 10,000 licensees. Our practice act gives us statutory authority to determine disciplinary action.

Sixteen years ago we created an investigative committee – similar to a probable cause committee – to conduct investigations and make recommendations to the board. The investigative committee consists of the executive director and one board member appointed by the chair. We are assisted by the attorney, who serves as an advisor to the board and prosecutor, and also by an investigator who was formerly with the FBI.

This small group has continuity and experience. They attorney has served 33 years, the investigator 20 years, executive director 15 years, the board member rotates on and off every two or three years. The years of working together have allowed us to develop trust and a certain consistency and synergy that complements board members who come and go on the board.

We don't necessarily believe our consent orders are stronger than a board order, but we feel that they are more effective in protecting the public and changing the behavior of the licensee.

The philosophy of our board is Just Culture. We realize that licensees make mistakes. What we try to do is help them see the error of their ways, make corrections, and become effective licensees from that point forward. The board is much less forgiving of licensees who make conscious choices to violate the rules.

Our investigator and I work together to conduct investigations. I am a licensed physical therapist so I know what physical therapists should be doing. We meet with complainants, so we know what kind of witnesses they will be. We also ask them what their expectations are. Sometimes they say the only thing they want is that the licensee learns not to treat other people the way he or she treated the complainant. So, we get a sense of what the complainant wants when we start the investigative process.

If we determine after the investigation that there has been a violation of the practice act, we invite the licensee in for an informal meeting. Informal meetings are better than hearings because there is no testimony and no court reporter. Licensees may bring their attorneys, but there are no formalities, such as objecting to this and that. It is an informal meeting where we present the evidence. At that point, the evidence is usually pretty overwhelming. We look for a solution that is in the best interest of the public, but doesn't necessarily put the licensee out of practice.

Consent orders are not plea bargains. A plea bargain is an agreement in a criminal case when a prosecutor offers the defendant an opportunity to plead guilty to a lesser charge that the original charge, with a recommendation for a lighter than maximum sentence. A consent agreement is a judicial decree expressing a voluntary agreement among parties to a suit, especially an agreement by a defendant to cease activities alleged by the government to be illegal in return for an end to the charges.

As the previous speaker said, negotiating a consent agreement involves working out what is in the best interest of the public and also works well for the licensee. Consent agreements must then be approved by the board. We are a small board and probably 99

percent of our complaints end up in consent orders. Usually, I feel we have a good consent order if the licensee is still upset when leaving the room. Licensees have a couple of weeks to decide whether they want to sign the consent agreement. They have learned at the informal meeting what evidence the board has gathered and are usually willing to sign the agreement. If they opt for a hearing, evidentiary rules apply, so if we can get an effective consent agreement in an informal meeting, we feel this is the best way to handle it.

One example of a consent order involved a sexual boundary issue. We did the investigation and were convinced the person was guilty, but it was a “he said, she said” situation. Unfortunately, the board did not believe there was enough evidence and failed to approve the proposed consent order which contained practice restrictions.

A second example involves a rural practitioner whose administrator did a bad job with billing resulting in major fraud issues. If this case had gone straight to the board, it is likely they would have imposed a stiff suspended sentence. That would not necessarily have been in the best interest of the community. The investigative committee negotiated a short suspension, with practice management consultations with experts from across the country. He was able to keep his practice open and his community continues to have good physical therapy services.

At the opposite end of the spectrum, we had a complaint about a physical therapist working in an urban community. She was interested in making a large profit from her practice. She was using aides she shouldn’t have been using. Again, we brought in practice management experts who totally revised her practice and brought her into compliance with federal and state regulations. She was grateful to the board.

A final example involved a physical therapist manager who allowed a new graduate who had failed the exam to treat patients. His associates in the practice were complicit. Instead of suspending the licenses of everyone in the practice for aiding and abetting unlicensed practice, we held the manager accountable. We had an educational program for the rest of the licensees in the practice and we feel we had a good outcome because the practice is still running and all the practitioners understand the laws and regulations.

Does the public have input? We believe the investigator and I represent the complainants. We have met with them and understand what they want. Our attorney says we don’t represent the complainant, but we can’t help feeling that we do. We maintain contact with the complainant. We let them know what is going on throughout the process. We try to be consistent with our consent orders, but on the other hand, we try to take into account what the complainant wanted.

The key to disciplinary action is to be effective in protecting the public and remediating licensees. We feel that consent orders protect the public.

Comment: I am a public member and feel it is one of the highest callings in life and am honored to serve in that capacity. My comment is that board members need to have the courage to decline to accept a consent agreement when they believe it is not appropriate

Question: In Ohio, do patients have any role in negotiating consent orders?

Anderson: By the time we are negotiating a consent agreement, we are already very far into the process. There is no direct input from the patient complainant at that point. But, earlier in the process, our investigators are required to talk with the complainant, in person if at all possible. This generally

happens before the investigators interview the licensee.

Comment: There is an unintended consequence of consent orders. When somebody is put on probation, many times insurers or medical care organizations restrict the licensee's ability to practice or to participate in maintenance of competence activities.

Question: When you say permanent sanction, does that mean they are never allowed to return to practice?

Anderson: Yes, permanent sanctions are forever. In the consent order, the licensee agrees never to apply again. A permanent surrender is the maximum penalty.

Question: How often do you see the end result change when the board becomes involved in accepting or rejecting a consent order?

Anderson: I don't know the answer to that, but there have times when the board recommends something less than the disciplinary guideline and a consent agreement is offered at the disciplinary guideline. This has prompted a re-working of the disciplinary guidelines.

ASSURING COMPLIANCE WITH BOARD ORDERS

Arthur Levin, Director, Center for Medical Consumers

When I started to prepare my introduction to this session, I thought back to the good fortune we had in New York State in the 1980ies to have what was probably the best Commissioner of Health in the U.S., David Axelrod. He was an extremely hard-working and dedicated Commissioner, but most important, always put the public interest ahead of professional interests and the interests of the healthcare industry. We knew that he was on the right track because every so often the medical society would vote to have the Commissioner fired.

I recall a press conference when Dr. Axelrod presented his plans for publishing hospital performance data in a way that hadn't been done before. This made public something that was already known by those who studied the issues: there is great variation in safety, quality and performance within the professions. Dr. Axelrod explained that the state simply doesn't have the resources to put an observer in every operating room. The alternative is providing information to enable the public to be the observer, in a sense, to give consumers the information to make the right choices for themselves. He was saying it was not only the right thing to do to make the information public; it was a practical thing to do because it expanded the observer population.

I'm going to refer to two CAC publications that examined how well boards are making information about their activities available to the public. The first was published in the 1990ies and the second was published in 2006 when my organization and the New York Public Interest Research Group worked with CAC to survey boards. The good news is that boards were moving in the direction of making more information about their activities accessible in published form and on the Web.

As was said earlier, transparency is really important, but if nobody knows where to look for information, it doesn't matter whether you have the most user-friendly, wonderful, accurate Web site in the world. It is not easy to make people aware that there is access to this kind of information. As Lisa McGiffort said this morning, part of the problem is that interest in this information is time-dependent. If people aren't sick, or in the midst of an encounter with the system, they don't think about why the information is important to

have. We need to have information available to people at the point where they need it and want it.

Earlier today, you heard presentations about negotiated settlements. Many such settlements allow practitioners to continue to practice under restricted conditions written into board orders. Board orders can take many forms, including mandating re-education; limiting scope of practice by, for example, requiring a monitor to be present during certain procedures; eliminating certain procedures from practice altogether; or requiring a third-party to be present during every patient encounter. Unfortunately, these kinds of board actions are not transparent to patients at the point and time of an encounter with that practitioner, which is, arguably, the time that knowledge is most needed for making an informed decision. It should be up to the patient to decide – just as the board previously decided after having full access to all the facts – whether the potential benefits of seeking care from a sanctioned provider outweigh concerns about the risks of seeking this care.

When a professional has been sanctioned for sexual or physical abuse of a patient, but that professional is allowed to return to practice, the board may issue an order requiring the professional to have a third-party, or "guardian," present during all encounters or certain types of encounters in order to protect patients from another lapse in behavior. I'm not here to talk about the rationality of these kinds of board actions in the face of serious professional misbehavior or incompetence. I am here to talk about how realistic it is for boards to assure compliance with the restrictions and conditions that in their wisdom they have deemed necessary to prevent further patient harm. Kathleen will speak to this more specifically from the perspective of her experience with the Oregon Board of Medical Examiners, which is, to Kathleen's credit, a board that takes very seriously the responsibility to be sure orders are followed.

My remarks have to do with the opacity of this aspect of the discipline process. Imagine a physician has been the subject of complaints about inappropriate, unprofessional behavior with a patient or patients. Whether through a negotiated settlement or final action, the board allows the physician to return to practice with the condition that a third party always be present in the exam room. My gut tells me it is impossible for a board to monitor such a condition of practice on a regular basis. Yet, to my knowledge there is absolutely no effort to make patients aware of this condition so they can protect themselves from the risk of harm. They can be their own "guardians," or at least make the most informed decision about seeking care from that professional. The calculus is: I am aware of the risk, but I think the benefit outweighs the risk.

Just as Dr. Axelrod understood that the health department couldn't have a safety monitor in every OR, clearly boards cannot routinely visit every professional practice that is the subject of an order. A better-informed patient can potentially be a check – an observer – of compliance. After an order is issued, the affected professional's license to practice hanging on that office wall remains unblemished by any indication that they are under a restriction or practice limitation. I remind you that driver's licenses indicate certain types of conditions to drive. But we don't do that with professional licenses.

The professional's patients are never notified that the physician is subject to restrictions or limitations on their practice. Prospective patients haven't a clue that a physician they are considering having an encounter with is practicing under restrictive orders. In other words, there is no opportunity for a patient to have the information necessary to make an informed decision to proceed with the encounter.

There are possible ways to remove this unfortunate veil of silence. We could provide all current and future patients with notice from the board that a professional is practicing under board orders that involve conditions or restrictions on their practice. The notice could describe the conditions and the underlining findings. In the alternative, patients could be referred to another easily accessible source of information. We could post the board-order on the wall next to the license in the professional's office. Or, we could require that the license have a legend showing that it is restricted.

None of these remedies would be well received by the professions and their trade associations. To my knowledge, no such public notice is required in any state. But, I ask you whether you would like to know when someone in your family is seeking care from a health professional that that professional's practice is subject to limitations and restrictions as a result of a board order.

I turn you over to Kathleen, who will talk about a board's efforts to enforce these orders.

Kathleen Haley, Executive Director, Oregon Board of Medical Examiners

I've been associated with CAC for seventeen years and I always try to get my public members to come and participate because this is an important educational opportunity for every public member. Regardless of your organization or your board, everyone in this room is here because we want to see safe patient care, whether by physicians, physical therapists, social workers, or another profession.

I talk with you this afternoon after a masterful job this morning of setting up the whole disciplinary process. Now, we are at that point where the order is in place, whether as a result of a contested case hearing, or the result of a settlement between the two parties. A settlement is like a contract between the board and the licensee who both agree to the terms.

In Oregon, we have a twelve-member board. We license and discipline physicians, podiatric physicians, physician assistants, and acupuncturists. We are blessed to have something that few other boards have – a complaint resource officer on staff who does assist the public and other complainants through the process.

Oregon concerns itself with three aspects of health care: quality, access and cost. My view is that not having a compliance officer in place to follow up on board orders doesn't deal with quality or access. The only way we can assure the public that we are providing safe healthcare is to follow up on orders and be sure they are being complied with.

We also see it as the licensee's responsibility. About 95% of our cases are resolved by settlement agreements, which we call stipulated orders. We have a range of options. Sometimes we remove a person from practice; sometimes we put certain terms in place for the professional to follow through on; sometimes we require remediation. Regardless of the terms, they are formalized in a public order. So there is always a public order patients can look at to see what terms a particular physician has agreed to as a result of the disciplinary action. Those formal orders are available on the board Web site.

Only when a physician or other licensee agrees to compliance monitoring does our compliance officer follow up on an order. We do have an investigator dedicated solely to that responsibility. Oregon is a big state, so depending on the number of licensees we have in a compliance situation, we may transfer some of our investigative staff over to help with compliance monitoring.

There is a varying degree of responsibility associated with compliance monitoring. They may have to verify that there is a chaperone in place, confirm that the licensee has done the

required CME, or verify something else. Compliance monitors talk with the licensee's office staff. They can do "no-notice" inspections where they ask how Dr. So-and-So is doing. They don't talk to patients, but they do talk to other healthcare professionals practicing around the licensee. It is important to find out what is going on day to day on a confidential basis.

Once the probation is in place and the public protection is being followed through, we look at compliance monitoring as a deterrent to future disciplinary action. That isn't to say we don't have some who fall off the wagon. We address these licensees in one of two ways. Sometimes we may open a new investigation; sometimes we modify an order that is already in place.

We can be creative in orders and in follow up. We recently had a physician assistant who applied for licensure in Oregon. He failed to mention on his application that he had been on probation. The board made the applicant design and teach a course in medical ethics to a physician assistant class. He had to submit a curriculum to our medical director for approval. Our medical director sat through the course. I think this was a creative solution that taught the young man about honesty and professionalism and how to fill out applications truthfully.

Another group of cardiac thoracic surgeons were engaging in what I will call fraudulent billing practices. The board employed another creative solution involving community service. The surgeons were required to practice in their community in low-income clinics that really needed this kind of service. The community service had to be approved by the board's medical director.

As a regulator, it took some time for me to realize that access to healthcare, particularly in rural states like Oregon, is an important consideration. I have had educated legislators say to me that some healthcare provider is better than none at all. People who are on compliance monitoring are able to provide healthcare services. When there is a compliance monitor going out to their offices, we can assure the public that those people are safe to continue to practice.

We have different categories of monitoring because we have some licensees on probation that is not time-limited. We require regular reports, sometimes from a practice mentor, sometimes from a substance abuse monitor. Sometimes we have voluntary limitations. An example would be a surgeon who has a hand injury that temporarily prevents practice. This would still be a public order, posted on our Web site and followed by a monitor, but less frequently. Random visits are critical. Board members also meet quarterly with licensees on probation.

What happens when we find non-compliance? We modify the orders. We don't have a lot of legal tools, but licensees want to continue to practice so they are usually amenable to modifying their orders. An example would be a physician under a restriction requiring a chaperone for a certain age group of female patients. If we find the physician straying from the terms of probation, we would modify the order, perhaps tighten the chaperone requirement or expand the patient populations covered by the order.

We began with one compliance officer and found that our numbers of re-offenses continued to go up. So, we persuaded the legislature we needed two compliance officers. Presently, we have 100 active orders and a total of 200 various types of orders that require follow up. Of those, 5% have had a complaint within the last three years.

I close with the thought that an important way boards can assure the public that we are doing a good job and that there are good healthcare providers in our communities is to provide compliance monitoring once board orders are in place.

Comment: Our board has used community service. Community organizations tell us they don't want us to send licensees most likely to have ethical or practice issues. They say, "Send us the good ones." So, we are backing away from community service because we don't want to subject people to the worst doctors in the state.

On the subject of notification, at some point patients have to be informed. I struggle with the idea of putting notices in doctors' offices. In our state, patients have access to orders, transcripts, evidence, and other records from a public setting. I think we have to trust that patients who want information will seek it out.

Haley: Your comment about community service is well taken. We use community service very judiciously. The example I used involved four physicians who had billing issues, but were top quality practitioners. We would not send someone with competence issues to do community service.

Levin: In response to your comment about giving proactive notification of conditions placed on practice. Yes, there are Web sites that have the information. The point is that most people believe that a state license means the bearer has been vetted in some way and that the state has verified his or her character and competence. I don't think most people are aware that conditions of practice exist. I think there would be disbelief that a physician who had been found to have sexually abused patients is allowed to continue to see patients. I think you have to remember where you are and what your experience is, compared to what the average person knows and understands. I think we should provide more information than just the license on the wall and let patients make their own decisions about whether they want to see that professional. I don't think it is enough to have this information on a Web site.

Question: If you have a licensee who has an active order in another state, what would you do?

Haley: We would follow up on the order ourselves, because we can discipline solely on the basis of an action in another state.

Question: The Office of the Inspector General has exclusions for certain care programs, some of which are substandard care, poor quality care. What do you do about exclusions?

Haley: We have not seen any physicians with OIG exclusions in Oregon.

Question: When you stay a suspension, how do you monitor compliance?

Haley: We try to use the carrot rather than the stick. We may state in the order that we will revisit the situation in a year. It is an incentive to get the licensee to try to comply. Our goal is to get these licensees back in practice and provide quality healthcare.

Question: You spoke of having probation agreements of different lengths. How do you determine which probation agreements are lifetime?

Haley: We make these decisions on a case-by-case basis. Some situations are so egregious that the board agrees that lifetime monitoring is appropriate. Sometimes the licensees are so grateful to keep their licenses, they don't object to the lifetime monitoring. Sometimes lifetime monitoring is imposed on repeat offenders.

Comment: I think hanging the conditions of licensure in somebody's office for everybody to view is akin to the scarlet letter for someone who has had an abortion or somebody wearing a plaque saying "I have HIV." I really don't see that the consequence of a disease becomes the reason to sensor and potentially remove a professional from practice.

Levin: We obviously differ. I think you can parse out the kinds of conditions requiring notice. That's why I mention physical or sexual abuse and the requirement that there be a third party in the examining room. It seems to me perfectly fair and pragmatic to say to patients, we want you to know that you should not be in the examining room alone with this doctor. If the board, in its wisdom, looking at all the facts, says it thinks it is imperative for public protection that there be a third party in that examining room for all encounters or an encounter with one gender or one age group, it seems to me the way to police that most effectively is to alert the most affected parties – the patients. That's different than posting a notice that this doctor has a substance abuse problem and is in treatment because there isn't anything proactive a patient can do with this information. The point is the oversight agency can't be everywhere all the time to ensure the quality and safety of care is of the highest level. I agree the scarlet letter is not what we should be striving for, but I do believe there are conditions of practice that patients deserve to know about so they can decide whether to seek care from that professional.

Question: We are talking about protecting the public. My question has to do with boards sharing information. My board supplies information to the nursing board data bank and checks to verify our licensees on a daily basis. How many boards proactively look to their data banks in this way?

Levin: We will hear more about that in a later session.

Comment: Since a year ago October, hospitals have to check the OIG data bank monthly. So, it is now the responsibility of hospitals to verify that their professionals have complaints in their records.

USING DISCIPLINARY DATA TO IMPROVE A BOARD'S DISCIPLINARY PROGRAM

Donna Liewer, Executive Director, Federation of Chiropractic Licensing Boards

Like other associations of regulatory boards, we have a database system called CIN-BAD. We are constantly balancing the due process rights of our licensees against the public's right to know. I am going to talk about CIN-BAD, some reasons why we collect and study data, some statistical trends, cautions when reviewing data, and finally strategies for improving disciplinary databanks.

CIN-BAD stands for Chiropractic Information Network / Board Action Databank. CIN-BAD is an internet-based, password-protected system. The data is checked for accuracy. In addition to collecting data, we help our member boards report to the federal HIPDB and NPDB data banks.

We have three databases. One contains public board actions, another contains exclusions from reimbursement by the Department of Health, and another a list of currently licensed chiropractors. We have18.300 actions involving 7,600 individuals currently in the database, of which well over 1200 are for student loan defaults. We find that the federal government is more likely take action for competency- or practice-based violations based on licensing board actions, than the other way around.

We consider this to be a red-flag service, similar to the federal data banks. It says that more conversation is warranted. It says to go back to the original agency that took the reported action(s) and get adequate information to assess the context.

Our boards report voluntarily to CIN-BAD. All of our US boards participate under a self-imposed requirement to report within 30 days. Access is free to our member boards, but there is a modest fee charged to insurance companies. Chiropractic colleges access the information because they like to assess supervised practice situations for students. We provide information to the general public for a $26 fee, but we try to teach people who call us how to use free databases to get the same information.

Our Web site is http://www.fclb.org. It is simple and free. Members of the public can click on their states' Web site to check on a licensee's status.

Boards care about what is happening in more than one jurisdiction. The database enables boards to access name, birth date, education, license jurisdiction, address, action(s) against the practitioner, and other professional credentials and certifications. Data can be accessed by any alias a practitioner has used. Users of the system promise they will not take action based on a CIN-BAD report without going back to the original agency that took the action and getting the whole file.

What are some statistical trends during the last decade? There were 10,721 public actions in the last decade. The trend is an increase in complaints during this time. Regarding the types of violations, "not classified" is by far the largest category – 46% of the violations reported to our data bank. This concerns us. There should be at least a little information that gives a general idea about the reasons for actions. Unprofessional conduct is the next largest category. Violation of state or federal law is third, and then practicing without a license, followed by conviction of a felony. The types of actions boards take consist mostly of probation, followed by suspension, then revocation. Stayed actions are being used more than in the past.

Why study this data? We want to learn trends and identify common violations. We look for consistency in sanctions, timeliness in processing complaints, and overall effectiveness of boards. But, there are cautions, including non-specific coding. "Unprofessional conduct" can be a catch-all, which dilutes its meaning. We also worry about "non-disciplinary discipline," such as board orders that are revised so they aren't reportable and public orders that are sealed after a certain period of time. Such things affect our statistics, and more importantly, our work.

So, the number of cases is not necessarily indicative of the board's ability to protect the public. If a board is effective in communicating causes of disciplinary action, this can lower the number of actions. That board may not look so good to the media, but it is actually doing a better job of protecting the public. Limited investigative resources also affect the numbers.

Strategies for improving performance include being more specific in orders – the findings of fact, conclusions of law, and conditions for reinstatement. Don't make the public hunt for the information. Collect the federal numbers – one for the person and one for the practice – to be sure the right person is being reported. Revocation may be temporary or permanent. The public thinks revocation is permanent, so it may be better to suspend than to revoke with the option to reapply in a short period of time. Finally, be very clear about what is public record. Make sure licensees understand what will be reported to data banks. Also, keep your Web site postings current. Reinstatements are very important actions, so they should require a formal board action.

Maryann Alexander, Chief Officer, Nursing Regulation, National Council of State Boards of Nursing

I want to tie my presentation to Lisa McGifford's opening address, where she talked about the need for boards to analyze their data to find trends and other important information. At the National Council of State Boards of Nursing, we are not only doing this, we are doing it with a specifically designed database called the TERCAP project. This is in addition to our disciplinary database, which is free to member boards, the public and employers.

The purpose of TERCAP (Taxonomy of Error, Root Cause Analysis and Practice responsibility) is to collect adverse event data from boards of nursing and to identify the root causes of nursing practice breakdown. We believe there is a wealth of information contained within the cases boards of nursing see on a daily basis. If you look at the aggregate of those cases, you can determine information that will help prevent errors in the future.

The TERCAP database has been used for the past three years. It consists of data submitted by member boards related to complete cases and cases under investigation. The submission form asks for demographic information – the nurse's age, education, and years of practice. It asks about the patient's disease process, and reason(s) for this care episode. It asks about system factors within the institution, including environment and other staff. It looks at what we call practice breakdown categories, which gets at the general reason the error or adverse event occurred. All of this information helps give a better understanding of where and why practice issues occurred. We refer to this as practice breakdown because we are interested not only in errors, but also in near misses and the absence of good nursing care. We are interested in analyzing cases that involve a nurse who was associated with the practice breakdown, one or more identifiable patients, and some type of board action.

We have analyzed 861 cases. Eighty-three percent involved females, 17% involved males. The average age of the nurses was 46 years, ranging from 21-77. Sixty percent of the nurses held RN licenses, 37% held LPN/VN licenses, and 1% APRN. Practice breakdown occurred in all types of care settings; there was no one setting where breakdown was more likely to happen.

One of the significant findings is that sixty percent of the nurses in this database, who committed some type of practice error, had previously been disciplined or terminated by an employer. This shows that there is practice breakdown, the individual is disciplined and terminated, and he or she then goes on to a new employer and commits another error. Clearly, there is something wrong in the chain. Fifty-six percent of those nurses were terminated by their employers; 7 % resigned; only 28% of the nurses remained with their employer. There clearly needs to be some type of intervention at the time practice breakdown occurs, so the individual doesn't jump from institution to institution and continually commit the same error or a different one.

We found that 50% of the nurses committed practice breakdown when they worked at a location for two years or less. Seventy-three percent of those nurses had been licensed for two years or longer. Thirty-six percent of these nurses were previously disciplined; 38% were terminated by their employers.

When we looked at the nature of practice breakdown – whether medication errors, lack of intervention or clinical reasoning, or something else – there are multi-factor causes.

We feel these are very significant findings. There are cases that called for terminating or disciplining, and also cases that called for remediation. There has to be follow-up after

practice errors. Licensing boards can only address issues and problems and complaints they are aware of. There are many complaints, and issues, and errors that are never reported to boards of nursing. The individual is terminated; he or she goes on to work somewhere else and this is never brought to the attention of the licensing board. Many boards are adopting a Just Culture model that will be important in helping them direct nurses to remediation programs and I think these data make the case for remediation in addition to discipline.

Joey Ridenour, Executive Director, Arizona Board of Nursing

I will talk about a National Council of State Boards of Nursing (NCSBN) program called Commitment to Ongoing Regulatory Excellence (CORE). I will also talk about how information from this program is utilized in Arizona.

CORE has three purposes: 1) a national performance-measurement data system; 2) collection, aggregation, sharing and reporting of performance measurement; 3) an ongoing data highway for performance measurement, benchmarking, and identification of promising practices.

NCSBN has committed to the boards that CORE will be a source of high quality, accountable, comprehensible data, that it will be transparent and engender trust, that it will include a strategy for raising awareness of data availability and its benefits. CORE data is intended to be a useful source for improving public protection and fostering accountability among boards for continuous performance improvement. We need to be sure we select the right things to measure, without imposing a burdensome job on the boards. We will foster utilization of performance measurements, particularly evidence-based outcome measures related to high-impact public protection goals. We use standardized methods for gathering, validating and aggregating the data.

The framework? It is about the board's basic programs, processes and outputs and outcomes related to administration, practice, education approval, licensure, and discipline. The ultimate outcome is that patients receive safe, competent care from nurses.

During the last nine years, we have conducted four surveys of state boards and stakeholders directly affected by the functions of the boards – educational programs, employers and nurses. There were 20,984 respondents. Ninety-eight percent of boards of nursing participated in at least one survey.

The median number of complaints is 1,196, of which 978 fell within board jurisdiction and 16% were not considered for investigation. The average time from receipt of a complaint to resolution is seven months. Twenty-percent of cases were open for longer than a year. The average of cases completed in one year was about 66%.

Fifty-percent of employers surveyed said boards resolved cases in a timely manner. However, employers' expectation of how long it should take from opening a case to closure was one month. The average expenditure on administration is $4. There are an average of 11.5 FTEs directly involved in investigation and an average of two attorneys providing legal advice.

How do we use this information in Arizona? For the past ten years, the Arizona legislature has placed expectations on the board staff and members to be more explicit about the evidence that shows fulfillment of the public protection mandate. They ask us what outcomes we are accountable for, how we compare to other jurisdictions, and whether we have improved since the last CORE survey.

The CORE data has allowed us to document outcomes based on the data we receive. The data enables us to identify where our gaps are and what we need to do better. It informs our decisions about reallocating resources.

We have more than 80,000 licensees in Arizona, a huge increase during the last ten years. The cost per-licensee in Arizona is about $43, compared to a national average of $48. I use that information when considering raising the fee ceiling.

Some of the performance measures used in Arizona that may be used in future iterations of CORE surveys include the number of investigations completed per FTE and the number and type of disciplinary actions taken per 1,000 licensees.

CORE data does enable us to compare Arizona to national averages on the number of days it takes to resolve a case. The average is about 7 months. For Arizona, it ranges from 7.04-7.9, depending on the complexity of the cases. The average board commits about 28% of its resources to the investigative needs. In Arizona, we devote about 51%, simply because of the volume of cases.

We have changed triage criteria six times in the last five years to try to be sure we put more energy into the high-risk high-harm cases. A decade ago, 40% of every hundred cases resulted in discipline and 60% resulted in no discipline. These percentages are now reversed because we have been able to look at the risk factors.

During the last ten years, we have been able to verify the number of cases an experienced investigator should be able to handle in a year. It is about 10 a month, or 120 a year. It takes 24 months for an inexperienced investigator to develop that level of competence. In 2005, the average board took 9.13 months to resolve a case. This had dropped to 7.04 months in 2009.

How does this data affect our strategic thinking? It was said this morning, that boards need three things: the funds, the statutory authority and policies to guide the processes within the board. I use information from the CORE data to not only establish new staff positions, but also to defend against reductions in our budget and FTE numbers, and also a hiring freeze.

Another strategy is to delegate activities whenever possible, based on board policy and data. We look at how staff can close low-risk cases so the board can concentrate on the higher risk situations. We do not open cases in situations where past experience shows the board is not likely to take an action, such as a case where there has been an action in another state, but it is not a violation of Arizona's statute. Our goal for open cases per investigator is fewer than 90. We look for a mix of high priority cases and less serious ones.

Intake and triage are very important in enabling a board to get low priority cases out of the system as quickly as possible. We look at triaging of cases and the overall caseload by giving monthly reports to investigative staff highlighting the 100 oldest cases.

We have information on our Web site about the complaint process so the public understands what we need. Documents can be downloaded from the Web site and we provide a response within 24-48 hours saying we have received the information and the complainant will be contacted.

We regularly enhance the competence of our investigators. We send them to CLEAR and many other conferences. The activity that leads to the most gain in competencies is bi-monthly peer review, including an Assistant AG, prior to placing cases on the board agenda. This enables the AG to follow the case through the entire process.

We provide clerical, administrative and legal support for investigators to help them manage their paperwork. The associate over compliance and I regularly audit the staff to make sure that high priority cases are being addressed in a timely way. We also look at the aging of cases. We delegate as much decision-making as we can to the staff, based on board policy, evidence and precedents.

We use a consent agenda at board meetings to allow time to debate the issues that are most controversial or complex. We standardize as much as we can. We have standard policies on criminal histories, DUIs, etc. This guides the investigative staff and helps new board members understand processes.

We have software systems to track cases. We are currently undergoing a sunset review and the auditor says we are doing a good job with the high priority and low priority cases, but we need to do better with the cases between the extremes. We will be able to track whether any cases have been untouched for two to four weeks and bring that to staff's attention.

It is important to gather investigative information as early as possible, so we send a questionnaire to complainants and respondents as soon as possible after a complaint has been received. Individuals remember the facts most accurately at this time and tend to be most helpful.

Improving the disciplinary process depends on the funding, staffing and authority the boards possess. In order to command additional resources, boards need to continue to document their performance and their needs. The CORE data has helped us understand the operational health of the board, where the gaps are, how we compare with others, and where to learn promising practices that might show us how to do things differently. One caution is to avoid getting so involved with metrics that one can't see the big picture.

Question: Did you design the software you are using in Arizona?

Ridenour: Yes, we developed it in 1996 and now Nevada and Louisiana also use it.

Question: Maryann, am I correct that 60% of the nurses in the database have previously either been disciplined or terminated by an employer? Does the National Council have a position on employer reporting requirements?

Alexander: The National Council does not have a position, but each state has its own requirements. Some have mandatory reporting; others do not.

Question: Do other boards have databases like CIN-BAD?

Liewer: Yes, the Federation of State Boards of Physical Therapy has one, as do the Association of Social Work Boards, the Federation of State Medical Boards, the National Association of Pharmacy Boards, the massage therapy association, the Association of State and Provincial Psychology Boards, the Association of Regulatory Boards of Optometry, and the National Council of State Boards of Nursing. Most organizations that have a federation or association of regulatory boards have a database.

Question: Is there any correlation between individuals who have been reported to TERCAP and malpractice cases?

Alexander: We do not collect data showing whether an individual was named in a malpractice case.

Question: Given the high percentage of nurses in the TERCAP database who have been terminated or disciplined, does the National Council do anything to help boards distinguish between those cases that should go to discipline and those where remediation is more appropriate?

Alexander: I think the Just Culture model sets a precedent for how this could be addressed. Cases where harm was intentional

or reckless cry out for discipline. But, there are many cases within TERCAP that involve unintentional errors, where there is definitely room for remediation.

Ridenour: I think that it is usually a red flag when we see nurses reported to TERCAP who have been terminated from many jobs over a period of time. This is something we need to investigate further.

Liewer: I serve on the National Practitioner Data Bank's Advisory Committee and we were recently made aware that the public use file has temporarily been withdrawn because a reporter was able to discern the identity of an individual doctor from what is supposed to be anonymous data.

Question: I have a question about TERCAP and the employment connection. Do you think this relationship is true across disciplines, or is it unique to nursing?

Alexander: I don't have any data, but if I were to guess, I think it is not isolated to nursing. The same trend probably exists in other disciplines, as well.

STAYING ON TOP OF DEVELOPMENTS IN THE LAW

Dale Atkinson, Executive Director, Federation of Associations of Regulatory Boards

It is inspiring to be surrounded by so many volunteers. Many thanks to board members, public and licensee, for the work you do in support of public protection. Public board members are especially inspiring. I can hear from some of your questions the difference between you and licensees who serve on regulatory boards because of the agendas they knowingly or unknowingly bring to the table. The first thing I tell new board members is that everyone is a public member. I try to get licensee members to take off that licensee hat and bring to the table public protection issues, using their knowledge of the profession itself.

I heard your earlier discussion about how to construct consent orders to protect the public, while being fair to the licensee. Let me caution you about being overly aggressive in consent orders. Among the trends I see is the fact that more and more lawyers are representing licensees. That is a good thing because it makes the process run more smoothly. However, when lawyers are involved, you get more push back and negotiations. For those of you who have time parameters within which you must resolve a complaint, get an extension if you are bumping up against the time limit rather than violate the statutory time limit.

Most of the cases I will talk about were decided in 2011. They may be subject to appeal where they could be reversed, affirmed or remanded in the future. I recommend you post cases on your Web site as soon as they are decided, even though there may be a pending appeal. Some boards say they don't want to post decisions until the appeal period is exhausted. It could take several years to resolve an appeal and the public needs to be aware of the original decision in the meantime.

That said, I start with a 2009 case, *Rose v. Board of Behavioral Sciences,* 2009 WL 2564997 (App. Ct. CA 2009) because it contains so many learning tools. The Appellate Court reversed the lower court and reinstated a 30-day suspension the board meted out against a social worker. The case involved three DUI convictions.

I get questions all the time about how moral character applications and DUI questions play out, especially if not directly related to the practice itself. In this case, the DUI convictions were over an 11-year period. One of these convictions occurred before the issuance of the license. This is key, because the board knew about a DUI conviction and still issued a license. The lawyer for the

licensee will say the first conviction is irrelevant for the future because the board chose to award a license anyway.

What the board could have done is to issue a license with some sort of probation attached to it stipulating that if there are future DUI violations, this first one will be relevant. The board could have decided to tag the license, as well.

The lower court thought the rehabilitation efforts undertaken by the licensee were adequate. The Appellate Court said it wanted to defer to the findings of the board. The Court also held that the suspension of the license was reasonable.

I am a supporter of suspensions, which I believe can be more effective than revocation, because if the revocation is not carefully worded, someone can ask for reinstatement of a revoked license. Also, with revocation, the board loses jurisdiction over the individual. With suspension, the board determines the length of time and specifies the conditions for lifting the suspension, subject to approval by the board.

In this case, the court ruled that the board does not need to establish harm to patients as a prerequisite to administrative action. This is good because it overcomes the defense by licensees that they weren't intoxicated on the job; no one was ever hurt; it is not related to practice; and so on.

The next case is *Lankheim v. Board of Registration in Nursing*, Docket SJC-10684, 458 Mass.1022, 941 N.E. 2nd 18, 2011 WL 6895 (Supreme Judicial CT. MA 2011). This case involved multiple licenses and multiple jurisdictions. The nurse in this case was licensed in Florida, where she was accused of fabricating educational achievements. She was investigated and came before the board. The Florida board accepted what the court referred to as a "voluntary surrender." In my world, there is no such thing as a voluntary surrender. If someone is under investigation and wants to turn in his or her license, the board should produce a consent order, or settlement agreement, or stipulation agreement that both parties sign. If the licensee refuses to sign, the case should go to hearing.

In this case there actually was a consent order with the Florida board, but it did not contain findings of fact. The nurse was also licensed in Massachusetts. The Massachusetts board initiated an administrative action based on the Florida action and meted out a 5-year suspension. The nurse appealed, contending she didn't know the Florida consent order was *discipline*. The Massachusetts Supreme Court eventually upheld the Massachusetts board's action. In the meantime, the board faced legal fees, publicity, staff time, and all the other expenses involved in pursuing the case.

The nurse also alleged that she had been told by a member of the Massachusetts nursing board that it was unlikely that the Florida action would lead to discipline in Massachusetts. This shows that board members need to be careful about what they say. Boards need communication protocols.

The next case is *Dakanay v. Georgia State Board of Physical Therapy and the Federation of State Boards of Physical Therapy (FSBPT)*, Civil Action File No. 2010 CV 192875 (Sup. Ct. GA 2011). In short, the physical therapy boards have had an issue involving breach of security of their exam. An exam breach in one state affects all other states.

This particular case involved review courses in foreign countries, adding to the complexity of the copyright issues. There were accusations of item harvesting used to build review courses that provided candidates from these countries with an unfair advantage because they had access to exam materials. The Federation of State Boards of Physical Therapy (FSBPT), which owns the exam, said that candidates educated in one of the four countries where the breach occurred would

have to take a new, different exam because FSBPT could not be sure of the validity of the results from the original exam. Because it would take time to develop the new exam, the affected candidates would have to wait to be tested.

Georgia adopted the FSBPT policy and made candidates from the named countries wait to take the exam. Four candidates filed a lawsuit in Georgia claiming unfairness, violation of equal protection, and other Constitutional principles. The court held in favor of the candidates, finding that the restrictive policy was really a rule, so the board should have followed rulemaking procedures. The court enjoined the board, saying it could not enforce the policy until it promulgated a rule, so the candidates were allowed to take the test.

The FSBPT's reaction to this decision was to change its testing arrangements. Starting in 2012, they will eliminate continuous testing and have four test dates each year.

The next case is *Love v. Scott, Chairman, Tennessee Board of Professional Responsibility, in his official capacity,* 2011 WL 113624 (Bankruptcy Ct. TN 2011). In this case, a lawyer was disciplined and assessed costs. He filed for bankruptcy and when he applied to get his license back, the board said he hadn't paid his costs, so they would not reissue his license. He argued the bankruptcy discharged the costs and got a court ruling to that effect. Fines, on the other hand cannot be discharged in bankruptcy.

The next case, *Cabret-Carlotti v. Arizona Medical Board*, 2011 WL 540285 (App. Ct. AZ 2011), involves a letter of reprimand. The court ruled that even though the letter is public and on the board's Web site, it is not appealable because it is not disciplinary and does not affect the licensee's legal rights or privileges.

I represent jurisdictions that are trying to convince me they can issue what are called "non-disciplinary revocations." I am concerned about that because the boards do not want to post the revocation on the Web site or report to databanks because it is "non-disciplinary."

In The Matter of the Suspension or Revocation of the License of Azam, 2011 WL 347035 (Supr. Ct. NJ 2011) shows that there is a difference between the burden of proof in criminal cases and administrative cases. In this case, a psychiatrist was disciplined with a 5-year suspension. His defense was that he was exonerated criminally. The court ruled against the licensee on the grounds that the burden of proof in a criminal case is "beyond a reasonable doubt," but in an administrative case, the burden of proof is "preponderance of clear and convincing evidence."

Several years ago, some medical boards moved from preponderance to beyond a reasonable doubt, but this did not start a trend.

Boards occasionally get sued. In *Vuyyuru v. Jadhov,* 2011 U.S. Dist LEXIS 42254 *Dict. Ct. VA 2011) United States District Court, a physician filed several lawsuits against the board, all of which were dismissed. The court assessed costs back against the physician for frivolous lawsuits against the board. The court imposed a pre-filing injunction on the doctor, so he would have to get permission to file a lawsuit in the future.

In *North Carolina State Board of Dental Examiners v. Federal Trade Commission*, No. 5-11-CV-49- FL, 2011 U.S. Dist. LEXIS 48296 and 2011 U.S. Dist. LEXIS 12696 (U.S. Dist. Ct.) United States District Court for the Eastern Division of North Carolina, the FTC is pursuing administrative action against the North Carolina State Board of Dental Examiners. The board issued an opinion saying that whitening teeth is within the scope of practice of dentists and enforced the opinion by sending cease and desist orders against other professions engaged in teeth whitening in the state. This case is important because it involves states' rights. The FTC is

saying it can invoke anti-trust law to review a board's determination of scope of practice. The FTC said the board's opinion was anti-competitive and harms consumers by denying access to certain teeth-whitening services.

A few months ago, the hearing examiner ruled that the NC Board of Dentistry violated anti-trust laws. It also ruled that because the board is independent, and collects and disperses its own fees, the immunity principles do not apply. Another thing involved in the North Carolina Case is the way board members are appointed. The public members are appointed, but licensee members are elected by the profession. The FTC is saying this is economic protectionism.

The same anti-trust issue was disputed in Alabama, where the state supreme court said the board of dentistry has the right to impose such a restriction. A district court recently ruled that the funeral directors' and embalmers' statute in Louisiana amounts to economic protectionism on the grounds that board members protect and promote their own profession.

In *Dakshinamoorthy v. National Association of Boards of Pharmacy (NAPB) and Catizone, 2011* U.S. Dist. LEXIS 40034 (U.S. 2011), there were exam score anomalies, so the applicant had to take the test more than once. The third time he took it, he earned the highest score received in several years. It turned out an imposter has taken the exam. The NABP invalidated the score and turned information over to the Michigan board, which summarily removed the license, but reinstated it a few days later. The licensee sued NABP for defamation. The court held in favor of NABP, ruling they acted in good faith in turning over information to the board. The immunity protections of the board stretched to NABP.

Comment: CAC is enthusiastic about what the FTC is doing *vis a vis* scope of practice. For thirty years, the FTC has been intervening as it did in North Carolina, not as a matter of states' rights, but as a matter of the potential for licensing boards to violate anti-trust laws.

DEALING WITH ERRORS USING THE "JUST CULTURE" APPROACH

Julie George, Executive Director, North Carolina Board of Nursing

The North Carolina Board of Nursing began adopting a Just Culture model in 2001 when David Marx published a white paper describing Just Culture. About the same time, CAC was promoting its PreP 4 Patient Safety program. We began a PreP program at the same time we were integrating Just Culture concepts in our handling of practice breakdown incidents that were reported to the board.

Since 2001, we have had 516 referrals to our PreP program, which is an early intervention program for things that are very minor violation or an antecedent to practice breakdown. Of those, 462 met our eligibility criteria. Of those 462 participants, we had only one reported to our board for subsequent discipline.

The cornerstone of Just Culture is the belief that protecting the public depends on learning from mistakes, whether they are near misses or mistakes that actually cause harm. The Just Culture framework looks at errors or an outcome and the choices individuals make.

David Marx divides things into three categories. One category is human error, that is, honest mistakes. A second is at-risk behavior, which is the largest category. The third is reckless behavior.

We feel we have the most impact as a regulatory entity when we intervene in at-risk behavior. With human error, our belief is that if it is truly error and not a pattern of behavior of an incompetent practitioner, taking a

punitive action will not prevent errors. We really should spend our resources on reckless behavior, where immediate action is appropriate and people should be removed from practice.

An example of at-risk behavior is exceeding the speed limit. All of us take risks, sometimes based on assumptions that may or may not be accurate. There are various levels of rule breaking.

Traditional regulation looks at the complaints that come in, the outcomes that occur, and the individual(s) involved. In order to move away from that, we had to look a bit more broadly and that is what we have done with Just Culture. This really began with some Institute of Regulatory Excellence projects sponsored by the National Council of State Boards of Nursing. We developed an evaluation tool for evaluating incidents reported to the board.

One of the first things we had to do was train ourselves to understand Just Culture. As we developed the complaint evaluation form, it was our hope we could work in tandem with the hospitals in North Carolina that had already formed a collaborative committed to the use of Just Culture.

Our complaint evaluation tool aligned with the Just Culture algorithm. Any time we made changes based on our experience, we sent the changes to David Marx's staff to be sure we were still aligned with that algorithm. One of the things the tool does is help employers know that they are meeting their obligation to report to the board. It assures them that if they go through the process, they are reporting appropriately. Some cases go into the PreP program. Some are handled by the facility. The feedback we got from the employers is that they appreciate the clarity about what they need to report.

We developed tools for education because later we included hospitals, long-term care facilities, and education programs that had not had the benefit of the Just Culture formal training. The education programs have been very interested, so we have begun to introduce Just Culture concepts to the students who intern in hospitals.

We started with five hospitals; we now have more than ten hospitals and a few long-term care facilities. As of the end of 2010, we had 63 reports. Examples of reports are errors, inadequate documentation, and failure to follow procedures.

For the program to have integrity, there have to be exclusionary criteria. A Just Culture does not mean the regulator is soft and fuzzy. It says people are held accountable in a way that is dependent on their intentional choices and the level of risk they take. So, things such as drug diversion, impairment, sexual misconduct, and patient abuse are immediately reported to the board.

We are gearing up for statewide implementation in January 2012. We will be educating major employers, large hospital systems, and our own office so we will be able to answer questions and help employers distinguish between things that are immediately reportable and things they can handle.

I feel that Just Culture is the right model for regulation because it recognizes that individuals do not necessarily control everything. There are systems implications. Regulatory boards have a finite amount of resources and I see this as a way for us to use our investigators' time for things that really matter. I believe patient safety is enhanced as a result of the collaborative relationships we have established with employers who are not afraid to contact the board. We submit our regulatory cases to TERCAP. It is useful to get the feedback and see the demographics of practice breakdown. We are trying to bring that information to the attention of our licensees.

Betsy Houchen, Executive Director, Ohio Board of Nursing

Ohio's patient safety initiative is a collaborative project between the board and employers. We believe the board is contributing to the creation of a culture of patient safety and accountability by focusing on a comprehensive approach to practice complaints. We believe the time is ripe for organizations, employers and regulators to work together.

Our mission is to actively safeguard the health of the public through effective regulation of nursing care, a major part of which is investigating complaints and adjudicating violations. Ohio is a mandatory reporting state. The Nurse Practice Act requires employers to report to the board those licensees and certificate holders who they have reason to believe may have violated the Nurse Practice Act.

We now regulate more than 250,000 licensees and certificates. We receive over 6,000 complaints annually. Approximately 19% are cases of nursing practice breakdown, such as medication errors. The board takes disciplinary action in over 2,000 cases each year.

Our patient safety initiative has many dimensions, including our Practice Intervention and Improvement Program (PIIP), collaboration with employers, employer remediation plans, TERCAP data, and Just Culture. The goal of the initiative is to increase patient safety through effective reporting, remediation, modification of systems, and accountability.

Just Culture is one component of the system. It promotes recognition and modification of system flaws and holds individuals accountable for reckless behavior or repeated behavior that poses increased risks to patients. Just Culture strikes a balance; it is neither highly punitive nor blame-free. It is a culture that holds organizations accountable for their systems and staff accountable for the quality of their choices.

Facilities implement the culture within their organizations by providing training, establishing systems and methods to report practice complaints, and providing remediation and resolve issues contributing to practice breakdown. The board incorporates Just Culture analysis in its review of practice complaints.

Another component of our initiative is TERCAP. We believe this data will assist in the development of new approaches to patient safety. Another component is our PIIP program, which is similar to PreP in North Carolina. It is a confidential alternative to discipline program for practice cases. It includes structured remedial education and monitoring. Participants must have a documented correction of their practice deficiency.

Putting all the components together, the board developed these objectives for the patient safety initiative: increase employer reporting of practice breakdown, increase employer-sponsored practice remediation, incorporate Just Culture for the review of practice complaints, create a statewide patient safety database, and increased the use of the PIIP program.

We recognize that facilities are responsible for choosing to establish this culture within their organizations. The board can work collaboratively with employers to promote the principles and incorporate the Just Culture analysis. The essential link between the board and employers is the reporting of complaints.

If complaints are not reported, the risk to public safety is high. If employer A makes a complaint and employer B reports a complaint about the same nurse, a pattern may emerge. If that second employer is not reporting the information, it is unlikely the board can identify a pattern of behavior.

We have a variety of remedies when we are notified of practice breakdown, from non-disciplinary advisory letters to remediation through PIIP, or discipline. Reports to the board provide information, which the board submits to the National Council for TERCAP analysis of practice breakdown. Using the Just Culture analysis of complaints brings consistency to the complaint review.

If employers are in doubt about whether to complain to the board, we encourage them to complain. We may have additional information about the nurse that they don't know about. We will evaluate complaints on a case-by-case basis. A board attorney reviews complaints before they go out for investigation, using the Just Culture analysis to gather information. The supervising board member for discipline reviews cases with the staff.

To implement the initiative, we amended the administrative rules for PIIP. We needed authority for employers to provide remediation. We contacted interested facilities and found that some had already incorporated Just Culture into their system. We designed it as a pilot program before going statewide. The Ohio Patient Safety Institute that is part of the hospital association is interested in Just Culture, so we are working with them in developing the statewide initiative. Legislators took an interest in the initiative. More information about the patient safety initiative is available at http://www.nursing.ohio.gov.

Question: Is Just Culture appropriate for other professions?

Houchen: Yes, it is appropriate for any profession.

Question: When CAC developed PreP, we realized that it couldn't work without cooperation from hospitals. We had some success with boards of nursing, but were unable to get medical boards to incorporate the concept, in part because hospitals were unwilling to cooperate. Hospitals tend to resist mandatory reporting. Do you think you would have had any success with your programs if hospitals had not been willing to work with you? Have you attempted to get other boards in your states to do what you are doing?

George: We needed cooperation from hospitals. We did in North Carolina. When David Marx visited us, we invited other boards to attend, but very little developed. I think you have to have a commitment from the leadership within professional associations, the board, and hospitals.

Houchen: In Ohio, we invited other boards and agencies to learn about Just Culture. It generated interest, but I am not sure any other professions have formally adopted it.

HANDLING MINOR COMPLAINTS USING NON-PUBLIC INTERVENTIONS

Katherine Thomas, Executive Director, Texas Board of Nursing

I am going to talk about a couple of provisions of the Texas Nursing Practice Act that took effect in 2009. These ideas did not originate with the nursing board, but we developed them through a rulemaking process into something I think we can live with.

Texas is very large geographically and is adding about a million people each year in population. We have one of the lowest nursing / population ratios in the country. Our legislature has funded most of the nursing education for the last four sessions to help address the nursing shortage. The complaint load is increasing, in part because of criminal background checks for both initial licensure and renewals.

We have almost 330,000 nurses in Texas. We had about 16,000 complaints last year and took about 2500 disciplinary actions. We

have a backlog of about 3,000 over the last five years. We are at the point now where we can resolve almost as many complaints as we receive a year, and we are working on reducing the backlog.

We are experiencing less cooperation from the profession with resolving complaints through negotiation. Everything has become very public; lawyers are soliciting business. For several years, our board orders have been posted on the Web site. Criminal background checks have exposed many cases.

In the context of talk about making regulation less punitive, we started to look at what we could do to assure competence and safety in practice. We looked at alternative disciplinary methods that might help us get a little more cooperation from the profession.

Legislation passed in 2009 created two alternatives for the board. The first is a corrective action program. Corrective actions are essentially warnings that are not disciplinary and are not reported to the federal data banks. The only kinds of violations corrective action can address are things such as, practicing under a delinquent license, failure to complete required CE, failure to disclose a criminal history that would not result in discipline, a pattern of documentation errors, and so on. The sanctions we may impose are remedial education or fines. The nurse has to agree with the corrective action plan or regular discipline will apply.

The law gives the Executive Director authority to offer a corrective action agreement. The Executive Director reports quarterly to the board the nature and type of corrective action agreements that have been entered into.

The second alternative legislated in 2009 is deferred discipline. We decided to test this with a pilot program. The legislation authorizes the board to dismiss a complaint if the respondent successfully completes all conditions of a deferred action. This is similar to deferred adjudication in criminal law. The violations and sanctions are limited. They include remedial education for practice violations and warnings. Non-serious violations would qualify for this option. The deferred action is public until dismissed.

The law required the board to appoint an advisory committee to oversee the pilot. The committee consists of members of the profession, various organizations with an interest, and consumer advocates. We were required to do a feasibility study, which will conclude no later than January 2014.

For the feasibility study, we surveyed other boards of nursing. We found that a small number of states have expungement or confidential authority. Expungement authority is usually limited to less serious violations, situations where a certain period of time has elapsed, completion of the terms of an order, and/or no prior disciplinary history. None of the boards reported using deferred action authority.

We looked at the nurse licensure compact. Compact states must report any disciplinary action to the National Council's database. The deferred action pilot allows the TX board to share information with any nursing board in the country. The board decided that nurses practicing on a privilege in Texas under the compact would not be eligible for deferred discipline. Deferred actions reported to the federal data banks cannot be removed, even after becoming confidential under Texas law.

The advisory committee looked at the feasibility study and made recommendations to the board. They recommended that deferred actions should only be available to those with no prior criminal history; that they would only include discipline that could be resolved through remedial education or a warning with stipulations; that they would only be available if remediation could address the situation; that they would be public for five years; and that they would not include

intentional acts, such as falsification, deception and chemical dependency or substance abuse.

The board made additional recommendations. They recommended that deferred discipline be available only as a condition of settlement and not available for sexual or criminal misconduct. They recommended that deferred discipline be treated as prior discipline if there are subsequent violations, and that it should no longer be treated as deferred if there is a violation of the order or a failure to meet one of the conditions.

The deferred discipline rule gives the Executive Director discretion to offer deferred discipline, but only for less serious violations with low risk of public harm. Respondents must agree to comply with the order. It is not available for initial licensure or for nurses practicing under a nurse compact privilege. Also, the board evaluates the outcome and effectiveness of the pilot on a regular basis.

Many deferred discipline cases involve practice violations that cause concern, often because there is a pattern, but there is a low risk of harm to a patient. These include medication and documentation errors, repeated violations in single shift, and so on.

This has not been controversial. So far, licensees want to see more violations put into the deferred program. Public advocacy groups cautioned the board to be very careful in implementing the program, but they didn't oppose it. Generally, they object if disciplinary information becomes non-public. We will be monitoring to determine the recidivism rate. We have not determined what will happen to licensees in deferral if the legislature terminates the program in 2014.

In conclusion, I do think there is a place for non-public actions. All boards will have to grapple with how long disciplinary action remains public.

Question: My board uses corrective action orders more for education that remediation. I'm surprised to see things in your list of corrective actions that are more behavioral, such as criminal conduct. Would you speak to that?

Thomas: The sanction we would issue would be a jurisprudence course.

Question: I speak as a public member of a social work board and I sincerely disagree with non-disciplinary discipline. In five years, that nurse could be in my state and we would have no way of knowing the nurse had been disciplined. It is a public disservice to deny us the right to learn about a disciplinary history.

Thomas: I should clarify that another nursing board will see the information about non-disciplinary orders in Texas. It would be in the National Council's database. I don't know whether other professions can access that data.

Question: You said deferred discipline could involve documentation errors and medication errors. Do you do addiction evaluations of those nurses?

Thomas: If the offense involves controlled substances or other issues at work that raise questions about the possibility of diversion, there would be an evaluation and if diversion or substance abuse were found, the nurse would not be eligible for deferred discipline.

Question: With the exception of addiction, how do your actions differ from a consent agreement?

Thomas: Deferred discipline is an agreed order. The only thing that changes is that after five years, if the board dismisses the discipline, it will not appear on the board's public Web site. The board can still use it as history, if needed.

Question: Could it become public in the future if other action is taken?

Thomas: The deferred decision is made up front. The licensee is not eligible to ask for it

later. Licensees with prior disciplinary history are not eligible for deferred discipline.

SUMMARY SUSPENSION: IS THIS AUTHORITY USED AS OFTEN AS IT SHOULD BE?

Karen Matthew, Director of Investigations and Inspections, North Carolina Board of Pharmacy

I'm going to talk about what the North Carolina Board of Pharmacy does for summary suspensions. I have been with the board for five years after a 25-year career in law enforcement.

Our board has five pharmacists elected by licensees and one public member. We permit licensed pharmacists, pharmacies, durable medical equipment, and businesses that sell prescribed medical equipment, and we register pharmacy technicians. We also register doctors, nurse practitioners and physician assistants who dispense prescriptions from their offices.

If we get a complaint dealing with a threat to public health, safety or welfare, our Executive Director can order an investigation. We probably suspend 4-5 pharmacists per year and may 8-10 pharmacy technicians. Most of the technicians are disciplined for diversion and selling.

An example of a summary suspension case involved a pharmacist who was trading a non-controlled pain medication for sexual favors. We debated whether to make it a priority case, because it did not involve a controlled substance, but we summarily suspended him because of the sexual aspect. Under due process, he had the right to challenge the summary suspension. We held a hearing on the merits. One piece of evidence was a tape recording of a phone conversation in which the pharmacist said he thought the board would rescind the summary suspension because a controlled drug was not involved. When the board heard this, it decided to uphold the summary suspension.

Most of the suspensions we issue have to do with impairment. About one-third of our investigations involve errors. If we learn that a pharmacist has had several DUIs we investigate immediately. Drug distribution can be a federal or state charge.

A case where we decided not to use summary suspension began when the board received an anonymous call alleging an elderly pharmacist had dementia. One of our senior investigators concluded the pharmacist did have dementia. We worked with him and persuaded him to surrender his license.

Another case involved a pharmacist who was not impaired. He had no prior history with the board. We discovered he was selling prescriptions online. We received several complaints, some from out of state. The board issued a summary suspension, which the pharmacist challenged. The pharmacist got his license back, but it was subsequently suspended again and the pharmacist is in prison currently for several felonies.

An advantage of summary suspension is that it enables a board to swiftly address cases involving impairment, sexual misconduct and take these practitioners out of practice. Summary suspension also may prevent the individual from overdosing, and it may be the catalyst that convinces them need treatment. We offer the right to voluntarily surrender instead of summary suspension.

There can be disadvantages to summary suspension in a state like North Carolina, which has many rural areas. If the board deprives a rural area of its only pharmacist, we deprive patients of health care. It can also cause personal hardship for the pharmacist's family.

The board discusses summary suspensions in closed session. The board receives the initial facts or allegations and past history. The board members can ask questions of the

investigator who is presenting the summary. The board engages in discussion, which is not recorded.

Bruce McIntyre, Acting CEO, Rhode Island Board of Medical Licensure and Discipline

The question before us today is "Are we under-utilizing the tool of summary suspension?" I believe that we are. Several years ago, at a Federation of State Medical Boards meeting, a former U.S. Surgeon General and Commissioner of Health for the State of New York gave the keynote speech. The key point of this address was the use of summary suspension in the state of New York. She made no apologies for the liberal use of summary suspensions in New York State. She believed this was the most efficient way to protect the public.

Is summary suspension before a hearing an abuse of power? Under the Constitution, licensees have a right to a hearing before the government can take away their property. Your board may use the administrative procedures act, or it may have independent authority to summarily suspend. Either way, you must offer a hearing pretty quickly. There are a lot of issues there. Does the hearing have to be begun within a certain number of days? Does it need to be concluded within ten days? What does ten days really mean?

Let's say there is a case of sexual misconduct, but the victim did not have the courage to bring a complaint to the board until years later. We had such a case in Rhode Island, *El Gabri v. Board of Medical Licensure.* The doctor had been asked to leave the University of Chicago Medical School under a non-disclosure agreement. When we got the case, he was notorious in medical circles. We did a summary suspension. We called him in to discuss settlement terms.

He took the case to superior court. The decision in this case was basically a treatise on the administrative law of summary suspension. He raised every possible defense: inadequate investigation, unconstitutional hearing process, bias on the part of board members, and so on. The evidentiary record is very important in summary judgment cases. We made sure we had every piece of evidence in order and at the court's disposal. The ruling in the board's favor gave the board the confidence to take on these kinds of cases.

What kinds of cases lead to summary suspension? Most are situations in which a licensee knows what he or she is doing is wrong, but does it anyway. They act intentionally. Such people should not be practicing medicine.

What are the thought processes that go into making a decision about whether to summarily suspend a license? In 2011, we have done more summary suspensions in Rhode Island than we have in the entire history of the board. Most of our cases right now are summary suspensions.

If your board has not done a summary suspension, consult your attorneys and once you do one, it sends a shock wave through the profession. Licensees will know forevermore that you are serious about protecting the public. And, the public will know also. It has a huge effect.

Our department of health has a vaccination program that gives free childhood vaccines to pediatricians who are serving immigrant and other underserved populations. *Matter of Wallace Gonsalves, D.O.* involved a surgeon who was receiving free pediatric vaccines. Our investigator asked him why and he concocted an answer. As far as we could tell, he wasn't treating children. We consulted the board of pharmacy and ultimately developed a case against the doctor involving immigration fraud, drugs, personal injury and workers' compensation fraud. He was repackaging the samples and selling to a pharmacist who repackaged them again and sold them to adults. The court authorized the

board to do a warrantless search of this doctor's office and confiscate items.

In the Matter of Russell Aubin, D.O., the surgeon was doing a meniscus repair on a college coed. According to the patient, during the surgery, he was rubbing her breasts and whispering in her ear, etc. He said, "Don't tell anyone I did this because I will be in a lot of trouble." She came to the board to complain. She sounded very credible. But there were others in the operation room, so we asked how it could be possible. We brought Dr. Aubin in and he claimed he gave her Propofol, which causes sexual hallucinations and fantasies.

I happened to be talking to a friend at the Massachusetts medical board and mentioned this case. My friend said the same thing was alleged at a hospital in western Massachusetts. So, we drove to the town and interviewed a different girl who told the same story. We went to the hospital and spoke to the president of the hospital who told us "I've been waiting for you." The Propofol defense was used in this instance also. So, we summarily suspended Dr. Aubin, which was upheld in superior court.

We had the hospital recreate the scene in the operating room. The surgeon was under a tent during the surgery, which is why he was able to abuse the patient without being noticed by the others in the operating theater.

Quality of care cases are more complicated that cases of intentional wrongdoing. We have to ask ourselves whether the licensee can be saved. Board interviews with licensees enable them to see what is not in the chart. You can ask questions and discern whether the licensee made an uncharacteristic error, or just "doesn't get it." Interviews do sometimes lead to a summary suspension.

Boards are often criticized for being too lenient, but almost never criticized for being too tough. We have a District Judge (Bruce Selya) who said the following in one of our cases:

> It is difficult to conjure up a state interest more compelling than oversight of the professional conduct of local health care providers, nor a subject in which (the) citizenry would have a more legitimate stake.

How that stake is honored is up to you, but I would urge you to consider using summary suspension more often.

Question: You indicated that you are doing more summary suspensions. To what do you attribute this?

McIntyre: We have a health director whose philosophy is to suspend now and let them earn the license back. The other reason is that these are serious cases.

Question: Who has control over substance registration numbers, the board of medicine or the board of pharmacy?

McIntyre: It used to be the board of pharmacy. But because we work together, it really doesn't matter. It's just an administrative thing.

Question: When you need expert witnesses, do you go outside the board to find people in the same specialty as the doctor in question, or can any board member serve as that expert for summary suspension?

McIntyre: As a matter of administrative law, anyone with a license can serve as an expert because we don't license by specialty. The case law says it is not necessary to have an expert with the same specialty as the respondent.

Matthew: In North Carolina controlled substance registration numbers are under the drug control unit of the Department of Health and Human Services. Our boards talk to each other, so we know when various professionals are under investigation.

MEMBERSHIP INFORMATION

CAC offers memberships to state health professional licensing boards and other organizations and individuals interested in our work. We invite your agency to become a **CAC** member, and request that you put this invitation on your board agenda at the earliest possible date.

CAC is a not-for-profit, 501(c)(3) tax-exempt service organization dedicated to supporting public members serving on healthcare regulatory and oversight boards. Over the years, it has become apparent that our programs, publications, meetings and services are of as much value **to the boards themselves** as they are to the public members. Therefore, the **CAC** board has decided to offer memberships to health regulatory and oversight boards in order to allow the boards to take full advantage of our offerings.

We provide the following services to boards that become members:

1) **Free** copies of all **CAC** publications that are available to download from our website for **all** of your board members and **all** of your staff.
1) A **10% discount** for **CAC** meetings, including our fall annual meeting, for **all** of your board members and **all** of your staff;
2) A **$20.00 discount** for **CAC** webinars.
3) If requested, a **free** review of your board's website in terms of its consumer-friendliness, with suggestions for improvements;
4) **Discounted rates** for **CAC's on-site training** of your board on how to most effectively utilize your public members, and on how to connect with citizen and community groups to obtain their input into your board rule-making and other activities;
5) Assistance in **identifying qualified individuals** for service as public members.

We have set the annual membership fees as follows:

Individual Regulatory Board	$275.00
"Umbrella" Governmental Agency plus regulatory boards	$275.00 for the umbrella agency, plus $225.00 for each participating board
Non-Governmental organization	$375.00
Association of regulatory agencies or organizations	$450.00
Consumer Advocates and Other Individuals (NOT associated with any state licensing board, credentialing organization, government organization, or professional organization)	$100.00

MEMBERSHIP ENROLLMENT FORM

TO BECOME A CAC MEMBER ORGANIZATION, PLEASE COMPLETE THIS FORM AND SEND IT TO:

CAC

1400 16th Street NW ● Suite 101
Washington, D.C. 20036
Voice (202) 462-1174 ● FAX: (202) 354-5372

Name:		
Title:		
Name of Organization or Board:		
Address:		
City:	State:	Zip:
Telephone:		
Email:		

Payment Options:

6) Mail us a check payable to CAC for the appropriate amount;
7) Provide us with your email address, so that we can send you a payment link that will allow you to pay using PayPal or any major credit card;
8) Provide us with a purchase order number so that we can bill you;

Purchase Order Number:

or

9) Provide the following information to pay by credit card:

Name on credit card:	
Credit card number:	
Expiration date and security code:	
Billing Address:	

Signature Date

Our Federal Identification Number is 52-1856543.

WE WANT YOU EITHER WAY!

We hope your board or agency decides to become a member of **CAC**. Membership includes a subscription to our newsletter for **all** of your board members and **all** of your staff, as well as many other benefits. But if you decide **not** to join **CAC**, we encourage you to subscribe to **CAC *News & Views*** by completing and returning this form by mail or fax.

NEWSLETTER SUBSCRIPTION FORM

Downloaded from our website: **Calendar year 2012 and back-issues for $240.00.**

Name of Agency:	
Name of Contact Person:	
Title:	
Mailing Address:	
City, State, Zip:	
Direct Telephone Number:	
Email Address:	

Payment Options:

1) Mail us a check payable to **CAC** for the appropriate amount;
2) Provide us with your email address, so that we can send you a payment link that will allow you to pay using PayPal or any major credit card;
2) Provide us with a purchase order number so that we can bill you;

Purchase Order Number:

or

3) Provide the following information to pay by credit card:

Name on credit card:	
Credit card number:	
Expiration date and security code:	
Billing Address:	

Signature Date

Our Federal Identification Number is 52-1856543.

CAC CONSULTANT SERVICES

We know licensure boards and the environments in which they function. We know the many operational activities they carry out to protect the public. We know the resource and other constraints they confront. We know the skepticism they often face from licensees and the general public. We know the disruptions and added distrust that emerge when media reports reveal how board shortcomings failed to protect the public.

And we know that we can help boards to improve their performance and to shore up public confidence. We know the intricacies of professional regulation and we know how to carry out rapid feedback evaluations that can be of practical use to decision-makers.

What Do We Offer?

We provide quick turnaround reviews, identify best practices worthy of emulation, develop practical solutions geared to real-world environments, and present crisp, action-oriented reports and/or briefings. Among the questions we can help boards address are these:

- How can alternative-to-discipline programs for impaired practitioners be made more accountable for performance?
- How can board websites be made more informative and helpful to the public?
- How can efficiencies be incorporated into licensure and discipline processes?
- How can training programs for board members be enhanced?
- How can boards tie in more effectively with the movement to reduce medical errors?

How Do We Work?

We emphasize close collaboration with you, the client. We start by working with you to narrow down our scope of services to the discrete issues and approaches warranting attention. Once we agree on the review's focus and methods, we assemble a small team that conducts interviews, reviews and develops data, and presents findings and recommendations. Throughout the process, we consult with you and offer feedback on an as-needed basis. Our aim is to provide you with information, ideas, and recommendations that you can readily adapt.

Who Are We?

CAC is a nonprofit organization focused on the improved accountability and performance of health professional oversight boards. Since its establishment in 1987, it has produced scores of reports aimed at enhancing the public protection mission of the boards; conducted annual meetings intended to sharpen the skills and insight of public members on the boards; convened policy-focused conferences on key issues of concern to boards (most recently on competency assessment); served as a resource for board members, executives, and staff seeking guidance on policy and operational matters; and, not least of all, fostered greater attention to proactive error-prevention and quality improvement initiatives through its Practitioner Remediation and Enhancement Partnership (PREP). For more information on PREP see http://www.4patientsafety.net.

CAC's Consultant Services Division, established in 2008, draws on this background to provide services specifically for heath care licensure boards. The three principals are David Swankin, Rebecca LeBuhn, and Mark Yessian. For more than a quarter of a century, each has had considerable exposure to boards, from the ground up. Swankin, co-founder, president, and CEO of CAC has been on the forefront of licensure and discipline issues as a speaker, trainer, writer, and advisor. LeBuhn, co-founder and CAC chair, has been an integral part of all CAC operations and has served as a public member on boards herself. Yessian, CAC board member and recently retired from the Office of Inspector General of the U.S. Department of Health and Human Services, has led numerous high profile studies of boards.

Our consultant services, however, draw on far more than the three individuals noted above. One of our unique advantages is that we can draw on a vast network of individuals with whom we have associated with over the years and who can be deployed on individual studies. A first step once we have delineated the scope of services with a client is to assemble a study team well suited for that particular engagement. This approach enables us to tailor the expertise needed for each project.

Why Retain CAC Consulting Services?

Boards can turn to many consultant organizations to help them with management and operational issues. Three factors help to distinguish us:

1) Our expertise in the substance of professional regulation;
2) Our capacity to conduct rapid feedback, high-quality assessments;
3) Our track record and reputation for ensuring that licensure boards are publicly accountable.

When you contract with us to examine some aspect of your board's operation, you can have confidence that you will gain timely, useful, and credible insights that can enhance your public protection mission.

For inquiries, contact David Swankin at DavidSwankin@cacenter.org.