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BOARD OF MEDICAL EXAMINERS

Special Review

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Secretary of State — Audits Division

Auditing for a Better Oregon

The Honorable John Kitzhaber
Governor of Oregon
State Capitol
Salem, Oregon 97310

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This report encompasses our review of selected activities at the Oregon Board of Medical Examiners (BME). The objectives of our audit were to determine whether the BME: (1) has adequate complaint and investigative processes in place, (2) has complied with applicable statutes when disciplining licensees regulated under the Medical Practice Act, *Oregon Revised Statutes* (ORS) Chapter 677, and (3) has adequate accounting internal controls in place over cash and purchases.

We conducted our audit in accordance with generally accepted government auditing standards. In this regard, our audit procedures included inquiry of agency personnel, examination of accounting records, and examination of records and documentation related to complaints, investigations, and disciplinary actions. We limited our audit procedures to tests and procedures considered necessary in the circumstances.

OREGON AUDITS DIVISION

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Fieldwork Completion Date:
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SUMMARY

The Board of Medical Examiners for the State of Oregon (BME) is responsible for protecting the public by allowing only authorized and qualified people to practice medicine. The Medical Practice Act authorizes the BME to investigate and take action on complaints that allege a violation of the Act. Although the BME has recently made efforts to improve its investigative process, we found that the BME could further improve its complaint and investigative processes and improve its internal controls over cash and purchases.

Complaint Process: For calendar year 1995, the BME estimated that it received about 1,000 oral and written complaints directed toward licensees it oversees. These complaints include violations of the Act as well as issues that may not fall under BME's jurisdiction, such as a fee dispute between a licensee and a patient. Of the 1,000 complaints received, the BME opened case files on 300 complaints. The BME maintains specific detailed information on the complaints resulting in open cases. The BME was not able to provide detailed information on the remaining 700 complaints. The BME does maintain a correspondence file of written complaints that the BME determined did not warrant opening an investigation. The BME should establish formal policies and procedures that describe how complaints are accounted for and processed. The BME should consider maintaining a log that shows how it processes and disposes of each written complaint. Currently, the BME maintains a log of oral complaints but does not maintain a log of written complaints. In addition, the BME should consider establishing a procedure to follow up with complainants orally alleging a potential violation of the Medical Practice Act to submit their complaints to the BME in writing. Generally, the BME investigates written complaints that allege a potential violation of the Act and oral allegations that appear to be serious violations of the Act. Oral complaints not submitted to the BME as written complaints may result in violations not being investigated.

Investigative Process: We reviewed 25 case investigation files and found that the BME could improve (1) detail of documentation maintained in case files, and (2) supervisory review of investigations.

Cash and Purchases: The BME did not always have adequate internal controls in place to ensure that its cash accounts were reconciled in a timely manner and to prevent contract overpayments. The BME had not reconciled its revolving account since December 1994 and had overpaid a consultant $2,245. To ensure the integrity of its cash balances, the BME should reconcile all of its cash accounts on a periodic basis. To prevent contract overpayments, the BME should ensure that invoice amounts do not exceed contract amounts.

Other Matters: Prior to and during our review, we became aware of several additional areas that warrant discussion. These areas include the BME's (1) perceived lack of accountability, (2) public disclosure policy, (3) complaint and investigative practices, and (4) decisions pertaining to non-traditional medical practices.

The Board of Medical Examiner's response to our audit report is incorporated throughout the body of the report.

INTRODUCTION

ORGANIZATION AND FUNCTIONS

The Board of Medical Examiners for the state of Oregon (BME) was created by the Oregon Legislative Assembly in 1889 to regulate the practice of medicine. BME's purpose is to protect the public by allowing only authorized and qualified people to practice medicine and by taking action on complaints or reports of unprofessional conduct by licensed physicians.

The BME is responsible for establishing the rules and regulations pertaining to the practice of medicine in Oregon. The BME examines, licenses, and registers graduates of medical and osteopathic schools and is responsible for licensing podiatrists and registering or certifying physician assistants, acupuncturists, and respiratory care practitioners. In addition, the BME is responsible for investigating and disciplining licensees and for conducting a diversion program for chemically dependent licensees who are under its jurisdiction.

Composed of 11 board members (nine licensed physicians and two public members) appointed by the governor, the BME is supported by 29 staff positions. These employees are responsible for performing the day-to-day activities of the BME, which include licensing, investigating, and accounting activities. Board members perform much of their work by way of the following committees:

- *Investigative Committee,* which consists of five board members. This committee meets one day each month to consider investigative and disciplinary matters. This committee makes recommendations to the full board regarding disposition of investigations.

- *Administrative Affairs Committee,* which consists of five board members who meet quarterly to review applicants for licensure and to review administrative rules and procedures.

- *Legislation & Public Policy Committee*, which consists of three board members who develop and respond to legislative proposals. This committee is active primarily just before and after a legislative session.

In addition to the three main committees, there are several advisory committees for the different types of licensees regulated by the BME, such as the Committee on Acupuncture and the Advisory Council on Podiatrists. Most of these advisory committees include at least one board member. The 11 board members, referred to as the full board, meet quarterly to issue licenses and consider the activities of the committees.

As of March 1996, the BME was serving 12,456 licensees:

- 10,424 doctors of medicine and osteopathy;
- 1,070 respiratory care practitioners;
- 275 physician assistants;
- 266 acupuncturists;
- 263 licensees with limited licenses; and
- 158 podiatrists.

Of these licensees, 9,196 actively practice medicine in Oregon and the remaining 3,260 are either retired or are on inactive status because they live and practice outside the state of Oregon.

LAWS AND REGULATIONS

The BME is governed by *Oregon Revised Statutes* (ORS) Chapter 677, commonly referred to as the Medical Practice Act, and *Oregon Administrative Rule* (OAR) Chapter 847. To carry out its purpose of protecting the public, the Medical Practice Act (Act) authorizes the BME to follow up on complaints against licensees, investigate potential violations of the Act, and discipline violators of the Act. The Act allows the BME to perform investigative procedures and impose

disciplinary actions that it determines appropriate for a particular situation.

The Act grants the BME the authority to discipline violators of the Act. ORS 677.190 lists 27 separate grounds for which the BME may take disciplinary action against licensees. The BME must determine that a licensee has violated one of these grounds before it can discipline a licensee. Most grounds are specifically stated and range from gross negligence to conviction of a criminal offense. Unprofessional conduct is a separately listed ground and covers many areas not specifically addressed in the Act, such as sexual misconduct involving a patient.

The Act lists disciplinary actions the BME may take and allows board members to use their discretion when making disciplinary decisions. As a result, two licensees who violate the same section of the Act may receive different disciplinary action. Each case is different and involves a unique set of circumstances; the statutes allow board members the flexibility to determine the most appropriate disciplinary action to take to protect the public and to discipline licensees.

FINANCIAL ACTIVITIES

The BME is completely self-supporting with most of its income being generated from examination, licensing, certification, and registration fees that it collects from its licensees. The BME's 1995-1997 biennial budget includes estimated revenues of approximately $6 million and expenditures of approximately $4.5 million. These operating expenses include $2.5 million for personal services and about $2 million for services and supplies, which include payments for consultants, legal fees, rent, and travel.

SCOPE AND METHODOLOGY

The BME's 1995-1997 budget contained a budget note requiring the BME to contract with an outside management consultant to review the management policies and practices of the BME, including a review

of staffing requirements, workload measures, and staff organization. At the beginning of our audit we were informed that this management review was in the completion phase and that our described audit scope would not duplicate the efforts of that review. However, a copy of the consultant's report, received in mid-April 1996, showed that we were auditing some areas similar to those reviewed by the consultant, since the consultant had increased its scope to include some complaint and investigative activities.[1] This report includes all areas in which we conducted audit work.

The objectives of this audit were to determine if the BME (1) has adequate complaint and investigative processes in place, (2) has complied with laws and regulations when disciplining licensees regulated under the Medical Practice Act, ORS Chapter 677, and (3) has adequate accounting controls in place over cash and purchases.

We reviewed statutes and administrative rules governing the BME's activities and performed tests of compliance with statutes that were significant to our audit objectives. We interviewed staff, reviewed policies and procedures, documented our understanding of internal controls and processes, and conducted tests of data related to our audit objectives.

We reviewed the process that the BME uses to handle written complaints to determine how and whether the BME accounts for all written complaints. We started to review the oral complaint process but curtailed audit work as the consultant sufficiently addressed this area.

During our review of the investigative process, we performed the following:

- reviewed applicable laws and regulations;
- interviewed BME staff, including the director, chief investigator, and medical director;

[1] Talbot, Korvola & Warwick,LLP, *Oregon Board of Medical Examiners Management and Operations Review April 1996*, (Portland, Oregon)

- reviewed the BME's quarterly reports to licensees;
- reviewed investigative policies and procedures of BME investigators and board members;
- reviewed the process the BME uses to discipline licensees who have violated the Act;
- reviewed statistics maintained on investigations and disciplinary actions;
- reviewed case files;
- observed part of an investigative committee meeting;
- reviewed various other documents; and
- reviewed documentation generated outside of the BME.

During our review, we obtained a basic understanding of how the BME screens complaints, investigates complaints it determines may be violations of the Medical Practice Act, and disciplines licensees that it has determined did violate the Act. Our understanding included observing a portion of the BME's April 4, 1996, Investigative Committee meeting. We observed board members interviewing and questioning licensees regarding potential Act violations and board members discussing courses of actions to take on current investigative cases.

We performed reviews of case files to determine whether the BME was complying with applicable laws, regulations, and its own policies and procedures. We reviewed case files to ascertain whether the files documented actions of board members and investigative staff and whether they included medical records, complaint correspondence, and various other documents. We also reviewed case files to determine how long the BME took to investigate and process cases and the extent and at what point in the process the board members were involved in the case reviews.

We conducted reviews of 25 case files. The BME opens a case file only when it intends to investigate a complaint that it has determined may be a violation of the Act. We reviewed 15 cases that the BME opened, investigated, and closed between July 1, 1993, to December 31, 1995. We judgmentally selected 10 cases that resulted in the BME taking disciplinary action and five cases that resulted in non-reportable actions by the BME. In addition, we judgmentally selected and reviewed five cases that are currently open and appear to be taking a long time to process.

During the audit, we became aware of staff turnover in the BME's investigative department. In October 1995 the BME employed a new chief investigator who has implemented and continues to implement changes to the BME's investigative policies and procedures. In March 1996 three BME investigators resigned. The BME employed two new investigators in May 1996 and one in June 1996. To review investigative procedures implemented by the new chief investigator, we judgmentally selected and reviewed four cases opened and investigated after December 1, 1995.

Recently, the Secretary of State received correspondence from citizens and from three licensees who had been disciplined by the BME. They raised concerns about BME operations and its decision-making process to discipline licensees. We intended to review two of these licensees' case files, but reviewed only one case file. We were unable to review the case file of the other licensee as the case was in litigation in the Court of Appeals.

We limited our audit procedures of the BME's investigative process to understanding and reviewing investigative activities and to determining if the board members complied with statutes when disciplining licensees. We did not question or evaluate the judgment of the board members.

During the course of the audit, we became aware of other issues of concern to licensees, citizens of Oregon, and the legislature. These concerns include (1) lack of accountability of the BME, (2) confidentiality of

complaints and board investigations, (3) investigative and complaint activities, and (4) traditional versus non-traditional practices of medicine. We address these issues in the OTHER MATTERS section of the audit report.

We performed the audit in accordance with generally accepted government auditing standards. Our conclusions are presented in the AUDIT RESULTS section of this report.

AUDIT RESULTS

OVERVIEW OF COMPLAINT PROCESS

The Board of Medical Examiners for the state of Oregon (BME) receives oral and written complaints against licensees and applicants seeking licensure by the BME. The complaints originate from a wide variety of sources including patients, relatives of patients, hospital peer reviews, other licensees, health care institutions, health insurance companies, pharmacies, and medical associations. About 50 percent of the complaints come from patients or their families. Many of these complaints are resolved quickly by BME staff who screen the complaints to determine if the allegations fall under BME's jurisdiction and are potential violations of the Medical Practice Act (Act).

To enable BME investigative staff to perform more investigative work and spend less time handling numerous phone calls, the BME recently created an ombudsman position. BME's ombudsman receives calls from both callers requesting information and callers making complaints against licensees. For callers seeking information, the ombudsman addresses their requests or refers them to a more appropriate entity. For callers with complaints, the ombudsman screens the calls to determine if the allegations fall under BME's jurisdiction. For oral complaints indicating a potential Act violation, BME's ombudsman asks the caller to submit a written complaint. If the oral allegation appears to be a serious violation of the Act, BME's ombudsman sends a memorandum detailing the complaint to BME's investigative staff, who may initiate an investigation on their own authority without the receipt of a written complaint. BME's ombudsman maintains a written log of oral complaints received.

BME's investigative staff receive and screen all written complaints. If they determine the complaint does not fall under BME's jurisdiction, they send the complainant pertinent sections of the Medical Practice Act and a letter stating that the allegation as written is not a violation of the Act. In the letter they ask the

complainant to reevaluate their complaint pursuant to the Act and resubmit a written complaint that specifically states which section of the Act they believe was violated. BME investigative staff "open" a case file for each complaint that appears to be a potential violation of the Act. The BME sends the complainant a letter acknowledging the complaint and stating that a case has been opened and that the complaint is under investigation. The BME maintains a correspondence file of written complaints received but does not maintain a log of all written complaints received and their disposition by BME.

COMPLAINT PROCESS COULD BE IMPROVED

The BME could improve both its oral and written complaint processes. For calendar year 1995, the BME estimated that it received about 1,000 oral and written complaints directed toward licensees it oversees. These complaints include violations of the Act as well as issues that may not fall under BME's jurisdiction, such as a fee dispute between a licensee and a patient. Of the 1,000 complaints received, the BME opened case files on 300 complaints. The BME maintains data on the 300 complaints resulting in open cases. The BME was not able to provide detailed information on the remaining 700 complaints that BME determined did not warrant an investigation. The BME does maintain a correspondence file of written complaints that the BME determined did not warrant opening an investigation.

For oral complaints received that may be violations of the Act, the ombudsman requests the caller to submit a written complaint to the BME. With the exception of complaints that appear to be serious violations of the Act, the BME generally will not open a case and conduct an investigation until a written complaint is received. The BME does not follow up to ensure that complainants orally alleging a potential Act violation submit their complaint to the BME in writing. Therefore, the lack of a written complaint may result in potentially serious violations not being investigated.

When the BME receives a written complaint, it is forwarded to investigative staff who either send the complainant a letter stating that (1) a case file has been opened and the complaint is under investigation, (2) as written, the allegation is not a violation of the Act and the complainant should reevaluate the complaint and resubmit it if necessary, or (3) the complaint does not fall under the BME's jurisdiction.

The BME could also improve the documentation that it maintains on written complaints. The BME does not have formal policies and procedures that describe how written complaints should be accounted for and processed. The BME either opens a case or corresponds with a complainant stating the reason(s) why the BME will not investigate a complaint. The BME maintains the complaints resulting in open cases in case files and maintains the other complaints in a correspondence file. The BME does not maintain a log of written complaints received that shows types and sources of complaints received, when they were received, how and when BME staff processed the complaints, and whether BME staff performed any necessary follow-up on complaints requiring the complainant to submit more detail before BME staff could initiate an investigation.

We recommend the BME establish policies and procedures to track data on oral complaints received, including whether callers subsequently submit a written complaint alleging a violation of the Medical Practice Act. The procedures should include follow-up phone calls to complainants who have not submitted their complaint in writing within 30 days of the oral complaint. In addition, we recommend the BME establish policies and procedures that enable it to account for the receipt and disposition of all written complaints received.

AGENCY RESPONSE:

Part of the difficulty with the recommendation for the oral complaint process is that the Board treats every inquiry under the terminology of "complaint." The chief investigator and ombudsman are developing a set of protocols for telephone triage.

When appropriate, persons are referred to the appropriate agency or association. If the ombudsman, who triages telephone calls, receives a verbal complaint against a licensee of the Board that falls within the jurisdiction of the Board and presents danger to the public, he confers with the chief investigator, who can begin an investigation immediately. To follow up with complainants who choose not to send in a written complaint involves additional time and staff resources which may be better spent handling existing cases. It also does not recognize the responsibility the complainants have in following through.

Policies and procedures can be found in the desk manual for the chief investigator that ensure accountability for the receipt and disposition of all written complaints, via the correspondence files that are maintained. Currently, the chief of the investigative section maintains a correspondence file with each written complaint and his response in the event that the complaint does not fall within the jurisdiction of the Board of Medical Examiners. We will explore the feasibility of maintaining a log with the chief investigator who began with the Board on October 1, 1996. All written complaints that fall within the Board's jurisdiction and are investigated are tracked on a summary sheet.

AUDITOR COMMENTS:

Currently, the BME follows up on oral complaints that may be serious violations of the Act and written complaints. Some of the oral complaints not submitted to the BME in writing that allege a potential Act violation may not appear to be "serious" violations of the Act; however, they may be violations of the Act that warrant investigating. We continue to recommend that the BME perform follow-up procedures to ensure that oral complaints that may be violations of the Act are submitted to the BME in writing.

We continue to recommend that the BME establish formal policies and procedures that describe how complaints are accounted for and processed. Although the chief investigator's desk reference manual provides instruction on complaint correspondence, it does not include policies and procedures regarding the accountability of complaints received and their disposition by BME. We recommend that they implement procedures to account for the receipt and disposition of all complaints received, not just the opened complaints.

OVERVIEW OF INVESTIGATIVE PROCESS

When a complaint is received alleging a violation of the Medical Practice Act, a case file is "opened." There are basically four steps to the investigative process for each open case: (1) fact-finding and information gathering by BME investigators, (2) medical review of the allegation by BME's medical director, (3) case file review by BME's Investigative Committee, and (4) disciplinary review by the full board. The following describes the BME's investigative process, which is also illustrated in a flowchart on page 20.

INVESTIGATOR RESPONSIBILITIES

Investigators gather and report facts after a complaint has been made. Investigative staff are responsible for receiving and following up on complaints against licensees to determine if there has been a violation of the Act or *Oregon Administrative Rules*. Investigative staff also investigate certain applicants for licensure or certification to help the board members determine whether a past criminal record, a history of addiction, or other problems warrant denial or restriction of licensure or certification. BME investigators are also responsible for monitoring licensees against whom the BME has taken disciplinary action. The investigative staff includes a chief investigator, three investigators (two full-time and one part-time), an ombudsman, and three office staff members (two full-time and one part-time), for a total of 7.1 full-time equivalents.

When a complaint is opened as a case file, it is assigned to a BME investigator. Each investigator is working at one time on several cases that are at various stages in the investigative process. During the preliminary stages of an investigation, a licensee is contacted by an investigator. Initial contact is frequently by correspondence in order to identify the nature of the complaint and to request pertinent records and a summary of treatment or events from the licensee. All information and records provided to the investigators are privileged and can be used only for BME purposes. The BME has the statutory authority to subpoena

records. During this same time period, the investigator will usually meet with and personally interview the complainant to determine whether or not the allegation is within the grounds for disciplinary action as defined in the Act and consistent with the initial complaint submitted to the BME.

Investigative staff may perform the following during investigations of alleged violations of the Medical Practice Act or *Oregon Administrative Rules*:

- Interview complainant and licensee;
- Locate and interview witnesses, physicians, nurses, and other professional persons;
- Examine all available records that may have a bearing on the complaint;
- Collect evidence in oral, written or physical form to be used in BME hearings or court procedures;
- Arrange for laboratory analyses of materials collected as evidence;
- Prepare detailed and comprehensive reports of field investigations;
- Attend Investigative Committee and full board meetings and present information as needed; and
- Testify at administrative hearings or in court as required.

BME investigators do not draw conclusions nor make disciplinary recommendations; their purpose is to present as much documentation and verification of facts as are possible and reasonable. During the investigation, they maintain a case diary, which is a chronology of investigative efforts performed on a case. When the investigators have completed their investigation, they assemble the documentation obtained into a case file and prepare a case summary, which is a comprehensive summary highlighting the important facts of the case.

Case files are organized in chronological or date order with the face sheet, referred to as the "Investigative Committee Report," in the front of the file. The BME maintains a database on all opened cases and uses the database to generate face sheets, which summarize key information pertaining to a complaint against a licensee. In addition to the face sheet, case files include board orders, written complaints, correspondence between the BME and licensee, medical records, investigative staff memos and case summaries, transcriptions and excerpts from Investigative Committee meetings, and consultant reports.

The time frame of an investigation varies due to the complexity of the complaint, as well as the number and geographic locations of people with knowledge relevant to the allegation. According to BME staff, the average length of an investigation is about 90 days, but it may take much longer to complete investigations on more complex cases. Completed case files are presented to the BME's medical director and Investigative Committee for review. There are occasions when case files are sent back to investigative staff by the Investigative Committee because the committee members want the investigators to ascertain additional facts or acquire supplemental records.

Medical Director Responsibilities

The medical director, who is a physician, is responsible for reviewing complaints and providing medical expertise to the investigative process. The medical director serves as an information resource to the public, licensees, and the BME staff. Depending on the case, the medical director's review is done simultaneously and/or subsequent to the investigation performed by investigative staff. Specific to the investigative process, the medical director:

- Supplies medical knowledge as needed on a day-to-day basis by the BME staff;

- Reviews complaints made against licensees for evidence of medical incompetence, impairment, negligence, or unprofessional conduct. The

medical director reviews the investigative work done by BME's investigative staff and, depending on the allegation, may review patient records of licensees;

- Compiles medical case summaries for presentation to the Investigative Committee and the full board;

- Makes a recommendation to the Investigative Committee as to which open cases should be closed with no further investigation because the allegation is not substantiated or is clearly not a violation of the Act; and

- Participates in all meetings of the Investigative Committee and the full board.

Once the medical director has completed review of an open case, the medical director schedules the case to be reviewed at the next Investigative Committee meeting. The medical director assigns cases to each Investigative Committee board member to review.

Investigative Committee Responsibilities

All complaints received by the BME that result in a case file being opened are investigated and the results are reported to the BME's Investigative Committee (IC), which consists of five board members. The IC meets on a monthly basis to review and discuss newly opened and continuing cases, to discuss and address requests from licensees on probation, and to interview licensees to ascertain the events surrounding an allegation. Prior to the monthly meetings, BME staff send to each IC member the agenda for the meeting and case file documentation on the member's assigned cases. The members review their assigned cases prior to the IC meetings and during the meetings the member assigned to a specific case leads the discussion on that case. If members determine that they do not have the medical expertise necessary to adequately review a particular case, the BME contracts with a medical consultant who has expertise in that medical specialty

to review the case and patient records of the licensee. The IC may ask the medical consultant to submit a written report documenting any findings and/or attend an IC meeting to participate in an interview of the licensee.

Basically, the IC case reviews result in the case being closed with no action taken, the case being closed with no formal disciplinary action taken, or the case remaining open for further IC review. Some IC case discussions are relatively short because the IC concludes that the allegation is not substantiated and there is clearly no violation of the Act and directs BME staff to close the case. Some cases require in-depth discussion, even if the IC determines there is no violation of the Act, because the IC believes the allegation is serious enough to warrant non-disciplinary action by the BME, such as a letter of concern to the licensee regarding the licensee's practice or behavior. For cases in which there is a possibility of a violation of the Act, the licensee is invited to appear before the IC to discuss the allegation. After interviewing the licensee, the IC reviews the evidence and may determine that (1) more investigative work must be done before it can proceed with the case, (2) the allegation does not result in a violation of the Act and warrants either no action or non-disciplinary action, or (3) the allegation and evidence obtained warrant ordering the licensee to appear before the full board at its next quarterly meeting.

Full Board Responsibilities

All potential violations of the Act are reviewed by the full board. After a licensee appears before the full board, it votes on whether or not to file formal charges which may result in disciplinary action. To file charges, the board issues a "Complaint and Notice of Disciplinary Action." Up to this point, all case file documentation has been confidential; the BME must publicly disclose this notice and any subsequent board orders. A licensee has a right to a hearing before any disciplinary action is taken unless the board has cause to believe that the licensee may be an immediate danger

to patients. In such a case, the full board can immediately suspend the licensee. ORS 677.240 (5) authorizes the board to meet on an ad hoc basis. A suspended licensee is entitled to a hearing but cannot practice medicine until the suspension is lifted by the BME. A licensee may waive the right to a hearing and consent to a board order or may contest the case and request a hearing.

Hearings afforded licensees facing disciplinary charges, referred to as contested case hearings, are conducted before a hearings officer who is an attorney in private practice. The licensee is entitled to be represented by legal counsel. The BME is represented by its legal counsel, an assistant attorney general. After the evidence is presented, the hearings officer submits a proposed order to the full board, which either accepts, rejects, or amends the order. If the full board finds that the licensee has violated the Act, it determines what disciplinary action it wants to impose and issues a final order. ORS 677.205 provides the board with a wide array of actions from which to select when disciplining a licensee. If the violation is quite serious and rehabilitation is not a likely recourse, the full board may revoke the license; this action automatically bars the licensee from reapplying for licensure for two years. If the violation does not warrant revocation, the board may place the licensee on probation for a period of time under specific conditions designed both to protect the public and assist in rehabilitating the licensee. The full board may also reprimand the licensee, issue a fine up to $5,000, suspend the licensee for a fixed period, place limitations and restrictions on licensee's practice, or take other such actions it deems appropriate.

When the final orders are issued, the BME notifies the complainant of the final resolution and that the case is closed. If a licensee disagrees with the action taken by the board, the decision may be appealed to the Oregon Court of Appeals and the Oregon Supreme Court. The BME performs ongoing monitoring of licensees placed on probation and licensees with restrictions or limitations placed on their medical practice. Based on statistics maintained by the board for calendar year 1995, the BME opened 300 cases and closed 236 cases.

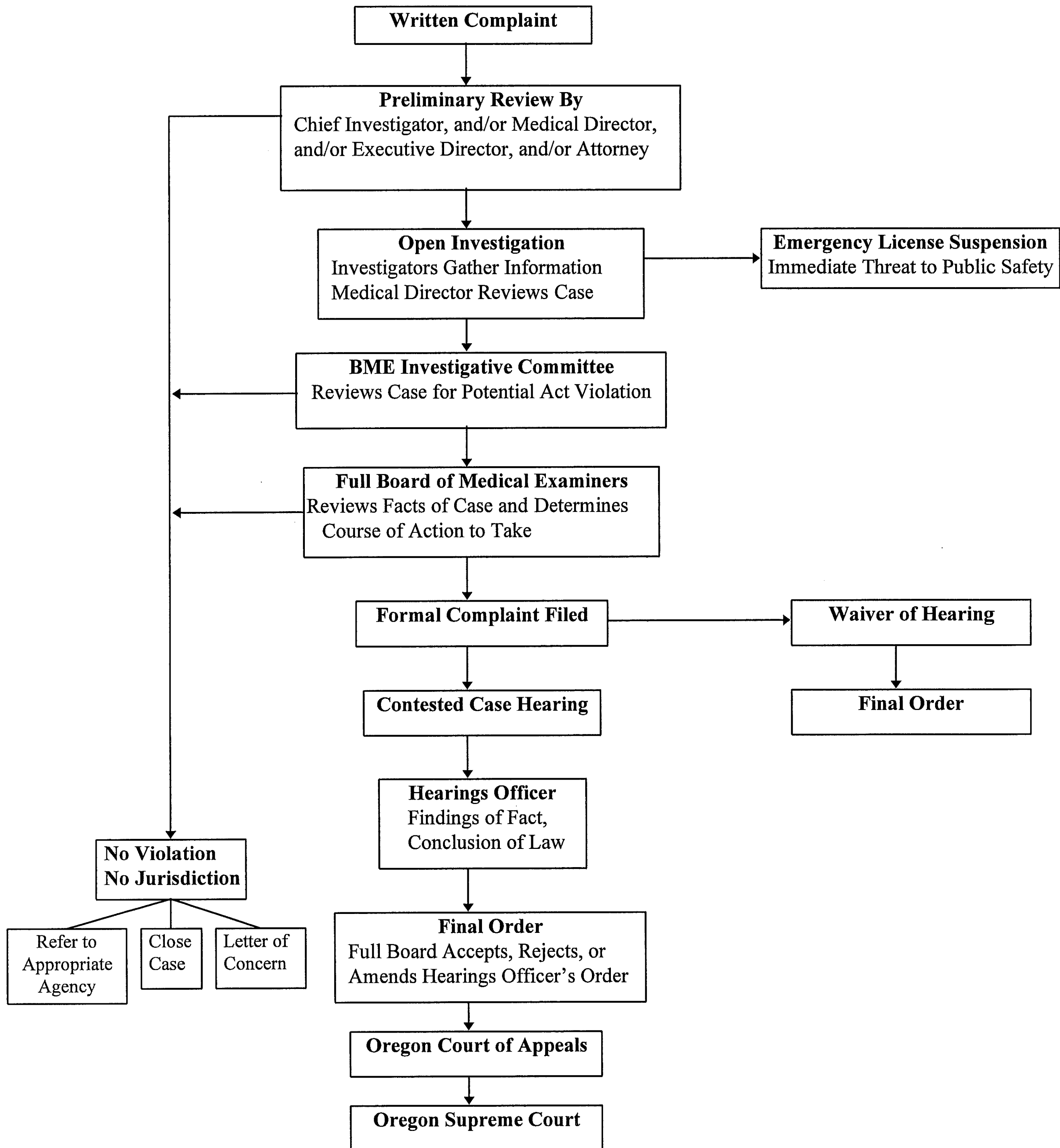
Of the cases closed, about 13 percent resulted in disciplinary action, 28 percent resulted in non-disciplinary action, and 59 percent resulted no action being taken.

Although the board members perform the same review process on most cases, the length of the review process varies by type of complaint and complexity of the allegation. During our observation of the IC meeting, we noted that some case discussions were relatively short while others took longer.

BME staff stated that it usually takes board members longer to discuss and make decisions on cases involving unprofessional conduct, because each case involves a unique set of circumstances that board members need to review to determine if a licensee poses a danger to the public. In ***Spray v. Board of Medical Examiners***, the Oregon Appellate Court concluded that board decisions can be made on a case by case basis.[2]

[2] ***Spray v. Board of Medical Examiners***, 50 Or. App. 311, 319-320, 624 p.2d. 125, 132 (1981), *Mod. on other grounds* 51 Or. App. 73, 627 p.2d. 25 (1981).

BME INVESTIGATIVE PROCESS



INVESTIGATIVE PROCESS COULD BE IMPROVED

During the past year the BME has initiated various actions to improve its investigative process; however, several areas of the process could be improved to make it more efficient.

ACKNOWLEDGMENT OF IMPROVEMENTS TO INVESTIGATIVE PROCESS

In recent changes to improve its investigative process, the BME (1) created an ombudsman position to help relieve investigative staff from handling numerous calls, thus, allowing them to concentrate efforts on investigative caseloads, (2) implemented, and continues to implement, policies and procedures that better document investigative performance and that hold investigators more accountable for the content and time frame of their investigations, and (3) improved the content and completeness of medical reviews performed by the medical director. The BME is in the process of hiring a compliance officer who would be responsible for monitoring licensees on probation and licensees who have restricted or limited medical practices. Currently, the BME has its investigative staff perform monitoring as time permits.

CASE REVIEW RESULTS

While reviewing 25 case files, we found that the BME's investigative process was documented in the case files and that the BME appeared to be in compliance with laws and regulations significant to our audit objectives. However, the BME could improve the documentation maintained in case files and the supervisory review of investigations.

We reviewed 15 case files that were opened and closed between July 1, 1993, to December 31, 1995. We also reviewed nine case files that are currently open, five that appear to be taking a long time to investigate and four that were opened since the employment of the new chief investigator in October 1995. Additionally, we reviewed the case file of a licensee who was concerned about the decision-making activities of the board members. We found that the BME appeared to perform adequate investigative procedures on this case. The board members revoked the licensee's license, which was within their legal authority.

(1) Need for Better Documentation in Case Files. In most instances, it was difficult to ascertain the investigative activities the BME performed on a case unless the entire case file was reviewed. The file organization made it difficult to determine when and what investigative activities were performed. It was also difficult to determine when the first and subsequent IC and full board reviews occurred. This was especially difficult for complex cases as the files contained numerous documents.

We found little evidence in the case files of the investigative activities performed by the IC and the full board. In all cases presented to the IC, we did find evidence in the file that the IC reviewed the case. However, in several instances the evidence was a sentence or two on the face sheet and/or a short memo in the file stating that IC reviewed the status of the case on a certain date. The purpose of the face sheet is to summarize in a standard format similar information on each opened case. Basically, face sheets are to include a summary of the current allegation, a summary of prior cases opened against the licensee, the type and source of complaint, the results of the medical director's review, and a summary of IC and full board actions on the current allegation.

The BME could improve the content of its face sheets. Some face sheets contained the medical director's review and some did not, some were very comprehensive and contained IC and board actions, while others were vague and contained little detail of such actions. Information included on the face sheet and in the case file memos sometimes did not include how often a case was reviewed, the documentation reviewed, and the decisions made.

Based on our review of the information provided to IC members prior to the monthly IC meetings and from observation of the April 4, 1996, IC meeting, the IC deliberates extensively on most cases. BME investigative staff stated that they are trying to improve the information on the face sheet and in the case files so that it more comprehensively documents the investigative activities and decisions made regarding cases. They stated that many of the activities of the IC and board members are documented in separately maintained meeting minutes and board transcriptions.

The BME could also improve its documentation of investigative case summaries and case diaries. BME's current investigative manual states that investigators are to summarize the investigative activities performed on each case by preparing a case summary and case diary. Most of the reviewed case files did not contain case summaries and case diaries. Case summaries were to be prepared during the period covered by our review while the preparation of case diaries is a recent requirement implemented by the new chief investigator. Some of the more recently opened case files contained these documents and we found that they made the case review more efficient because it was easier to understand the allegation and the investigative activities performed and when they were performed.

We recommend the BME ensure case files contain case summaries and case diaries. In addition, we recommend the BME implement procedures to ensure the face sheet more clearly states who performed what action and when, when the investigation was started and completed, when the medical director reviewed the case and the results of the review, when the IC reviewed the case and the result, when the full board reviewed the case and the result, the final action taken, and the date the case was closed.

AGENCY RESPONSE:

The bulk of the cases that were reviewed were between July 1, 1993, - December 31, 1995, the time period when personnel changes were taking place in the medical director and chief investigator positions. The current medical director joined the staff in July 1995 and the chief investigator position changed recently. Case files have had their investigative committee report face sheets updated with full reports from the medical director; investigation files have full documentation of the investigative activities that have been performed in each case. It had been the policy of the prior executive director, medical director, chief investigator and investigators not to maintain case summaries and diaries. This has been changed to reflect the improved documentation.

(2) Supervisory Review of Investigative Activities Could Be Improved. The case files show little, if any, evidence of supervisory review of activities performed by investigators. The BME chief investigator uses a weekly investigative flow sheet to supervise the BME's investigative activities. The investigative flow sheet shows the status of all open cases, the

investigators assigned to each case, the date each case was opened, the licensees being investigated, the type and source of complaint, and the next supervisory review date. The chief investigator uses this report to determine how many cases each investigator is working on, the timeliness of the investigations, and the status of the investigations. He agreed that this report is an effective supervisory tool only if used properly.

We reviewed five currently open cases that appear to be taking a long time to investigate and found that two of the cases had reasonable explanations for lengthy investigations. The case files of the other three cases lacked evidence of investigative activities that would explain the delays. In one case, the file contained little evidence that investigative activities had occurred during a nine-month period. The case was opened in September 1993 and was not submitted to the IC for review until December 1994. The other two cases, which pertained to the same licensee, were opened for investigation in 1994. The BME investigator assigned to these cases did not perform any activities on the cases because he was waiting for another state agency to complete its investigation of the licensee. During a February 1996 supervisory review using the weekly investigative status report, the new chief investigator noted the status of these cases and the BME is currently performing investigative activities on these cases.

The BME does not maintain information on the appropriate caseload for an investigator. The chief investigator reviews the weekly investigative flow sheet, which is available in summary form and by individual investigator, and assigns cases to investigators based on their current caseloads. The BME does not maintain data on the length of time it takes to complete an investigation. Some investigators may be taking longer than other investigators to investigate similar cases. BME staff stated that an investigation averages less than 90 days, but they were unable to specify how many hours investigators actually spent investigating a case during those 90 days.

We recommend the BME document supervisory reviews of case files. This could be achieved by documenting the review on the face sheet or by including a procedures checklist in the case file. The supervisory review should include explanations of why cases took longer or shorter than the average to investigate. We also recommend the BME maintain data on

the length of time it takes to investigate a case so that it can determine the appropriate caseload to assign to investigators.

AGENCY RESPONSE:

Supervisory review is done daily, on an informal basis, by the chief investigator. All active cases are logged and reviewed on a periodic basis through investigative section's staff meetings. The chief investigator is responsible for supervisory review on a regular basis.

Caseload information is available. The medical director has done periodic audits on the time it takes to complete a case. In the last four years it has been 102 days on the average to investigate a case for the Board. Caseload assignments are based on monthly and as needed section meetings. There are idiosyncratic differences between cases. The Board may have a case that involves simply a retrieval of records. On the other hand, a case can involved several consultants, some from outside the state, and in-depth medical and surgical information.

ACCOUNTING CONTROLS

To determine whether the BME has established adequate internal controls over cash and purchases, we reviewed the BME's cash reconciliation process and judgmentally selected for review five cash receipts and eight disbursements. The BME did not always have adequate controls in place to ensure that its cash accounts were reconciled in a timely manner and to prevent contract overpayments. The BME had not reconciled its revolving account since December 1994 and had overpaid a consultant $2,245.

During the course of the audit, we discussed these deficiencies with BME staff. BME staff reconciled its revolving account prior to the conclusion of the audit. In addition, BME staff promptly researched the overpayment and the consultant fully reimbursed the BME.

CASH RECEIPTS AND RECONCILIATIONS

The BME is self-supporting with all revenues derived from license, examination, certification, and registration fees. Most of the BME's cash receipts are from registration fees charged to physicians. The amount and timing of receipts are predictable since fee amounts and renewal dates are established by the BME. Physicians, who account for about 86 percent of the licensees under the BME's jurisdiction, are required to pay a $330 biennial license renewal fee by December 31 of odd-numbered years. As a result, the BME receives most of its revenue during odd-numbered years. For example, it received about $567,000 for the 12 months ended June 30, 1995, but received about $2.9 million for the six months from July 1995 to December 1995, which encompassed the license renewal date for physicians.

Because the BME receives a large portion of its cash receipts at the end of odd-numbered years, we judgmentally selected and reviewed five cash receipts received between November 1995 and February 1996. Four test items represented receipts of license renewal fees and one item was for an initial application fee. All five receipts were made in the form of checks, were properly recorded by the board through its check validation process, and were deposited timely and intact.

In addition to reviewing cash receipts, we reviewed the BME's cash account reconciliations to determine if they were prepared properly and timely. The BME prepares cash reconciliations for its revolving fund, its petty cash fund, and its cash maintained in the State Treasury. ORS 677.290 states that all moneys received by the BME shall be deposited into its account in the General Fund of the State Treasury; this ORS section also allows the BME to maintain a revolving account not to exceed $50,000. ORS 677.305 authorizes the BME to maintain a petty cash fund not to exceed $5,000.

The petty cash and General Fund reconciliations were adequate and timely. However, the revolving account had not reconciled since December 1994. As a result, BME staff were not aware that $3,583 was improperly deposited to its revolving account in October and November 1995. We discussed this matter with BME staff and they immediately initiated action and made corrections to the revolving account. BME staff stated that they are now reconciling all accounts on a monthly basis.

The BME uses its revolving account moneys to administer educational and rehabilitation programs. BME fiscal staff incorrectly recorded the $3,583 in BME's accounting records and incorrectly instructed the Oregon Department of Administrative Services Control Accounting Unit to deposit these moneys in BME's revolving account instead of its State Treasury account. State agencies are accountable for their cash balances and are responsible for verifying the integrity of those amounts on a periodic basis by preparing a reconciliation of the control accounting cash balances to the agency's cash balances.

We recommend the BME continue to prepare cash reconciliations on a monthly basis to ensure that cash balances are accounted for properly.

Agency Response:

This is currently being done daily based on the conversion to SFMS. The business manager oversees this function.

CASH DISBURSEMENTS AND PURCHASES

The BME's expenditures for the six months ended December 31, 1995, totaled about $1.2 million. The board incurred about $640,000 in personal service costs for its 29 employees and $543,000 in services and supplies costs, including rent, travel, legal fees, and consultant fees. A small amount of these expenditures were cash disbursements from the revolving and petty cash accounts; the majority were vouchers and warrants processed through control accounting at the Oregon Department of Administrative Services.

We judgmentally selected and reviewed eight expenditures, including one capital outlay expenditure, four services and supplies expenditures, and three petty cash disbursements. With one exception, the expenditures appeared reasonable and were properly processed and recorded by the BME.

The exception transaction occurred when the BME overpaid a consultant $245 on a December 1995 invoice. For 49 hours charged by the consultant, the BME paid $5 more per hour than stated in its contract with the consultant. Upon further review of related invoices, we determined the BME overpaid the consultant a total of $2,245. According to board staff, they mistakenly recorded $65 per hour instead of the contract rate of $60 per hour on forms provided to the consultant for billing purposes. Based on our audit, the board informed the consultant of the mistake and the consultant repaid the board $2,245 on April 17, 1996.

We recommend the BME, when making payments to consultants, verify invoice amounts to contract amounts to ensure billing accuracy.

AGENCY RESPONSE:

This is done on a regular basis, particularly in view of the new accounting system.

OTHER MATTERS

During the course of our audit work, we became aware that some individuals and entities were concerned about activities of the Board of Medical Examiners for the State of Oregon (BME). Three licensees, previously disciplined by the BME, and two citizens contacted the Joint Legislative Audit Committee sharing their concerns about the BME's (1) perceived lack of accountability, (2) public disclosure policy, (3) complaint and investigative processes, and (4) decisions made pertaining to non-traditional medical practices. The legislature included a budget note in the BME's 1995-1997 biennial budget requiring the BME to contract with an outside management consultant to review the management policies and practices of the BME. In addition, the Oregon Medical Association performed a study of the BME and issued a report in April 1996 that included several recommendations pertaining to its activities. Moreover, four bills were presented during the 1995 legislative session that proposed changes to the BME's activities. House Bill 3340 pertained to alternative medicine and was passed by the legislature during the 1995 special legislative session. House Bill 2493 and Senate Bills 811 and 1111 proposed changes to the statutes governing the BME; these three bills were not passed. In the following section, we present information pertaining to the above issues.

ACCOUNTABILITY

The BME's statutes, biennial budget, and fees must be approved by the legislature. The BME's operations are subject to oversight and audit by the Joint Legislative Audit Committee and the Secretary of State. In addition, as a state agency, the BME is required to comply with the policies and procedures established by the Oregon Department of Administrative Services for its budget and accounting activities. Besides state government oversight, the BME operates under the scrutiny of the Oregon Medical Association, the Osteopathic Physicians and Surgeons of Oregon, the Organization for Fairness in Medical Practice, health professionals under its jurisdiction, medical facilities and health organizations, and citizens of Oregon.

The BME board mainly consists of individuals recommended by private entities, the Oregon Medical Association and the Osteopathic Physicians and Surgeons of Oregon. When board member vacancies occur, these entities nominate potential replacement members. The governor considers these nominees in appointing new board members. Management from the Oregon Medical Association stated that historically, the

governor appoints new board members from the nominees the association recommends. All appointments are subject to confirmation by the senate.

CONFIDENTIALITY

ORS 677.425 specifically states that information provided to the BME is confidential, not subject to public disclosure, and not admissible as evidence in any judicial proceeding. Generally, investigative and complaint documents on all cases are confidential documents that only board members, hearings officers, and certain BME staff can access. Licensees under investigation do not have access to complaint and investigative documentation. Currently, only cases upon which the BME intends to take disciplinary action are a matter of public record. The only documents disclosed to the public are the BME's official notice to pursue disciplinary action and its final order, which states the violation and the disciplinary action imposed by the board members.

The issue of confidentiality is not a new issue. During the last three legislative sessions, legislation has been introduced that would make available to the public all complaint and investigative information involving health professionals under the BME's jurisdiction. During the 1995 legislative session, Senate Bill 1111 and House Bill 2493 proposed changes to the BME's confidentiality statutes that would have required public disclosure of complaint and investigative documentation. Although these bills were not passed, a strong interest in revising the BME's confidentiality statute continued after the session. As a result, a confidentiality law task force was organized in the fall of 1995 to review the BME's public disclosure statute. The task force consisted of representatives from the legislature, the Oregon Medical Association, the Osteopathic Physicians and Surgeons of Oregon, and the board. The purpose of the task force was to recommend what, when, and how complaint and investigative information should be released by the BME. In April 1996 the task force concluded that the current public disclosure process of the BME should continue as is.

COMPLAINT AND INVESTIGATIVE PROCESSES

The BME is responsible for establishing rules and regulations pertaining to the practice of medicine in Oregon and for disciplining violators of the Medical Practice Act. In its role as a regulatory agency, the BME makes decisions that often result in strong emotional responses from the public and licensees. During the 1995 legislative session, changes to the complaint and investigative processes of the BME were proposed in House Bill 2493 and Senate Bill 1111.

House Bill 2493, which encompassed professional licensing boards, including the BME, would have established uniform procedures for investigation of complaints by professional licensing boards and would have required that certain disciplinary proceedings of professional licensing boards be public, including related records. Senate Bill 1111 proposed substantive changes to how the BME investigates and disciplines licensees. According to legislative documentation, the legislature was not able to thoroughly review these bills to enable it to make solid policy recommendations. These bills were not passed during the legislative session. At the legislature's direction, the Department of Administrative Services is currently performing a study of licensing boards with the goal being to review the operations of licensing boards and provide recommendations to the 1997 legislature.

Earlier this year, the Oregon Medical Association organized a task force to review and make recommendations regarding the operations and policies of the BME. The Oregon Medical Association is a private organization that represents the doctors of medicine and osteopathy licensed by the BME. The association has about 5,400 physician members, which represents about 52 percent of the licensed physicians. In April 1996 the association issued its task force report which included 15 recommendations: eight recommendations stating that the Medical Practice Act be amended, six recommendations stating that the association itself should perform certain tasks, and one recommendation stating that the BME should adopt

policies pertaining to actions by board members and staff toward licensees. Association management stated that it intends to develop, prior to the 1997 legislative session, legislation that addresses several of its task force recommendations.

ALTERNATIVE MEDICINE

Traditional versus non-traditional practices of medicine was an issue addressed during the 1995 legislative session. House Bill 3340, relating to alternative medicine, amended ORS 677.190 to include a definition of alternative medical treatment and to establish that alternative medicine by itself does not constitute unprofessional conduct. This bill was passed by the legislature during the regular session, vetoed by the governor, and then passed again by the legislature during the 1995 special session. According to the governor, he vetoed the bill because he believed it would give medical doctors far too much latitude to perform unproven or risky procedures. As amended, ORS 677.190 allows the use of alternative medical treatment "even if the treatment is outside recognized scientific guidelines, is unproven, is no longer used as a generally recognized or standard treatment or lacks the approval of the United States Food and Drug Administration."

Senate Bill 811, which was not passed during the 1995 legislative session, proposed changes to the composition of the BME board to require the inclusion of one physician who had a medical practice emphasizing alternative medical care.

AGENCY RESPONSE:

Accountability: The extensive accountability noted is governed by specific statutes.

Confidentiality: Following the legislative session, the Board convened a task force to examine the issue of confidentiality of records. The Task Force included BME board members, State Senators and Representatives, and representatives from the Oregon Medical Association. The task force recommended that the public disclosure of records, which is based on attorney general advice, be codified and that the Board

increase public awareness of information available on licensees. This is currently in process.

Complaint and Investigative Processes: The Board of Medical Examiners is considered one of the top medical boards in the country. In a Federation of State Medical Boards survey, the Oregon Board's percentage of complaints that led to an action exceeded the national average. The Board also produces almost twice the average number of actions per investigator. The executive director and the medical director met extensively with the Oregon Medical Association Task Force and collaborated on many of the recommendations of the Task Force.

Alternative Medicine: The Oregon Board of Medical Examiners did not oppose House Bill 3340. Cases involving questions of quality of care or fraud sometimes involve practitioners who use alternative or complementary medical treatments. The Board does not oppose the use of alternative or complementary medicine by medical doctors. However, every physician's practice must be competent and professional regardless of modality. Any lower standards would not protect and serve the public.

AUDITOR COMMENTS:

We did not review the basis for ranking medical boards in the country. We did not review data compiled by other states as it is difficult to draw comparisons when complaint and investigative processes may differ greatly. Moreover, the definition of a "complaint" and "action" may differ between medical boards. Drawing comparisons from data that may not be comparable could result in misleading information.

REPORT DISTRIBUTION

This report is a public record and is intended for the information of the Oregon Board of Medical Examiners, the governor of the state of Oregon, the Oregon Legislative Assembly, and all other interested parties.

COMMENDATION

The courtesies and cooperation extended by the officials and employees of the Oregon Board of Medical Examiners were commendable and much appreciated.

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