The State Board of Medicine: A Review of Complaint Investigation and Adjudication

June 2001

Office of Performance Evaluations
Idaho State Legislature

Report 01-04

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Nancy Van Maren
Director

June 11, 2001

Members
Joint Legislative Oversight Committee
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At the direction of the Joint Legislative Oversight Committee, the Office of Performance Evaluations has completed an evaluation of the Board of Medicine's investigation and adjudication of complaints.

I respectfully submit this completed evaluation for your review and consideration. Consistent with national audit standards, I did not work on or direct this evaluation due to a personal conflict. The study was conducted entirely by a team of evaluators within the Office of Performance Evaluations under the direction of Ned Parrish, Principal Performance Evaluator. This team, consisting of Jim Henderson and Leslie Clement with assistance from Patty Burke, received the full cooperation of the members and staff of the Board of Medicine throughout the evaluation.

An executive summary is provided for a rapid review of the major findings and conclusions. Please do not hesitate to contact our office with questions.

Respectfully submitted,

Nancy Van Maren

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The State Board of Medicine: A Review of Complaint Investigation and Adjudication

Executive Summary

On January 18, 2001, the Joint Legislative Oversight Committee requested a performance evaluation of the Idaho Board of Medicine's investigation and adjudication of complaints against physicians. Concerns were raised that the board may, at times, have been arbitrary and capricious in its handling of complaints. In addition, questions arose regarding recent cases in which the board rejected the recommendations of its hearing officers and cases in which the board's disciplinary actions were overturned on appeal. Concerns were also raised regarding the board's use and oversight of its in-house and contract attorneys.

To conduct our evaluation, we asked:

- How has the board investigated complaints received against physicians? Have the investigative methods used varied from case to case and, if so, why?
- How often have complaints been filed by competing physicians, and how have these complaints been handled by the board?
- How often has the board used medical experts in investigating and prosecuting complaint cases? To what extent could these experts be considered competitors to the respondent physicians?
- How frequently, and on what grounds, has the board taken disciplinary action as a result of its investigation of complaints against physicians? Have the disciplinary actions taken been consistent from case to case? How often have discipline cases gone to hearing? Of these cases, how many were appealed to the courts, and with what result?

We addressed concerns about complaint investigations, disciplinary actions, and other issues.

- What statutory requirements govern membership on the Board of Medicine? What impact, if any, have issues related to board member terms of service and conflict of interest had on the board's handling of complaints? How do these requirements compare to national standards for state medical boards?

- What roles have the board's in-house and contract attorneys played in the investigation and adjudication of complaints? To what extent have these attorneys acted outside the scope of their authority? What oversight has the board provided to its attorneys?

To answer these questions, we reviewed Idaho Code and administrative rule, information in the board's discipline database, case files for a sample of complaint cases investigated by the board between 1996 and 2000, board records for contested cases, and court opinions for cases appealed to the courts. We also interviewed board members and board staff, representatives of medical and hospital associations in Idaho, and selected physicians. We gathered information from selected other states and the Federation of State Medical Boards.

COMPLAINT INVESTIGATION

Complaints have increased at a rate consistent with increases in the number of licensees.

The number of complaint cases opened by the board increased from 101 in 1996 to 132 in 2000. After taking into account a large number of complaints filed by a single physician from 1998 through 2000, it appears the increase in the number of complaints the board received was consistent with the growth in the number of licensees in the past five years. Most complaints were received from patients or their families, with 15 percent filed by other physicians or hospitals. Because complainants are not required to divulge conflict of interest or other motives for filing complaints, it was not possible to determine how many of these complaints were motivated by competitive interests. However, in most cases, the board provided respondent physicians with information about complaints filed against them (indicating the complainant) and an opportunity to respond to the concerns raised.

The Board of Medicine also received some complaints that board staff determined fell outside the board's jurisdiction. While the board's determination appeared reasonable in most cases, we identified 5 of 46 cases from 2000 that may have warranted additional investigation. We recommend that the board take steps

to ensure all complaints received are fully assessed to determine if further investigation or other follow-up is warranted.

Although the board generally followed a standardized process in investigating complaints, steps could be taken to strengthen investigations.

The Board of Medicine has generally followed a standardized process in its initial investigation of complaints lodged against physicians and physician assistants. This process includes review of the complaints received, the written responses of the respondent physicians, and patient medical records provided by those physicians. In two-thirds of the cases we looked at, the board's decision was based on the information gathered through this initial investigative work. In some of these cases, this work appeared to have been insufficient for the board to fairly decide whether cases should have been closed without disciplinary action or if disciplinary action was warranted. While board members we interviewed generally felt they had sufficient information to make decisions in complaint cases and requested further investigative work when they felt it was needed, we recommend that the board take steps to strengthen its investigation of complaints. We recommend the board routinely interview complainants, respondents, and other witnesses identified in investigative work. We also recommend the board gather additional information to assess the respondent physicians' overall performance.

The process for selecting medical consultants has been informal, and may not adequately ensured fair and impartial review.

We also found that the board's process for selecting medical consultants has been informal and may have been inadequate to ensure fair and impartial review. In our review of randomly selected sample of case files, we found that the medical consultants used to assess the standard of care were, in each case, from a different area of the state and did not appear to be in competition with the respondents. However, in one high profile case we looked at, the medical consultant used was from the same geographic area and could be considered a competitor. We recommend that the board establish criteria for selecting consultants, document how consultants are selected, and begin requiring consultants to sign independence statements.

COMPLAINT ADJUDICATION

From 1996–2000, the board took disciplinary action at a rate similar to other nearby states.

Information to compare Idaho's disciplinary actions with actions taken in other states was difficult to obtain because of differences in state requirements and inconsistencies in way states categorize and report the actions they take. However, based on information obtained from the Federation of State Medical Boards, it appears that the board's overall rate of disciplining physicians was similar

to boards in surrounding states from 1996 through 2000. During this period, the board closed nearly three-quarters of all cases with no disciplinary action. When disciplinary action was taken, it was often informal and confidential. The board settled about ten percent of all cases with voluntary settlements (consent agreements and license surrenders) and took more punitive disciplinary action (license suspensions and revocations) in two percent of cases closed during this period.

The terms of stipulations and orders generally appeared reasonable, but the liability release should be clarified.

The terms of consent agreements (stipulations and orders) entered into by the board from 1996 through 2000 generally appeared to be consistent and reasonable. Consent agreements are used to voluntarily settle complaint cases, and must be agreed to by the respondent physician as well as the board. Each agreement includes a liability release that restricts the respondent from taking further action against the board regarding the case at hand. We found the liability release form currently used by the board is complex and may be confusing to respondent physicians. We recommend that the form be modified to make it clear that the release applies only to the case at hand.

The board's process for resolving contested cases was consistent with due process

Respondent physicians contested 12 of the 575 complaint cases decided by the board from 1996 through 2000. The board's process for resolving these complaints, which included preparation of a formal complaint outlining charges and a hearing before an independent hearing officer, generally appears to have complied with due process requirements. In 9 of the 12 contested cases, the respondent appealed the board's post-hearing decision to the courts. In 4 of the 8 cases that have been decided by the courts so far, the board's disciplinary action was upheld. Of the remaining cases, 2 were overturned (1 of these is now under appeal to the Idaho Supreme Court) and 2 were affirmed in part, reversed in part, and remanded to the board for further proceedings. In these cases, the courts identified two types of deficiencies: (1) the board disciplined the respondent physician for acts not cited in the complaint; and (2) the board's findings were not supported by sufficient evidence. We recommend the board address these deficiencies by ensuring that all alleged violations of the Medical Practice Act are documented in the written complaints it issues and that its findings and conclusions are supported by sufficient and competent evidence.

The courts identified two primary deficiencies in cases which were reviewed.

BOARD MEMBER CONFLICT OF INTEREST AND MEMBERSHIP REQUIREMENTS

Board statutes could be modified to clarify conflict of interest requirements and bring board membership provisions in line with national standards.

We found that requirements for board member conflict of interest and disqualification in complaint cases are unclear. The board does not have a formal policy in this area and existing provisions in the Medical Practice Act do not apply to members of the Board of Medicine, which is now charged with making final decisions in disciplinary cases. We recommend that policymakers consider modifying the Medical Practice Act to clarify that recusal requirements apply to board members. We also recommend that the board establish a formal conflict of interest policy and review it at least annually.

We also found that, in several areas, statutes concerning board membership, selection, and terms of service are inconsistent with requirements recommended by the Federation of State Medical Boards. We recommend that policymakers consider several changes to bring the board's statutes in line with federation recommendations, including expanding the size of the board, extending the opportunity to nominate board members beyond the state medical associations, and limiting the length of time individuals may serve on the board.

BOARD LEGAL REPRESENTATION

The board appeared to have separated complaint case prosecution and adjudication, and provided direction and oversight to its legal counsel.

The board is authorized by statute to employ attorneys to assist it with its responsibilities. Until recently, the board relied primarily on a single contract attorney to prosecute contested cases, prepare consent agreements, and provide other general legal services (e.g., drafting rules and responding to public records requests). Based on our review from 1996 through 2000, it appears that the contract attorney acted within her scope of authority and received direction and oversight from the board. In addition, throughout the review period it appears the board has taken steps to separate attorney involvement in the prosecution and adjudication of complaints. While it is difficult to determine if the contract attorney advised the board informally, our interviews with board members and review of meeting minutes appeared to indicate the contract attorney had been excluded from the board's deliberation and decision-making in contested cases. In addition, the board established an in-house attorney in 2000 to help formalize the separation of the prosecutorial and adjudicative functions.

Summary of Report Findings and Recommendations

1. The number of complaint cases opened by the Board of Medicine from 1996 through 2000 increased 31 percent, with most cases alleging standard of care issues. *Page 9.*

2. Patients or their families filed most complaints, with relatively few filed by other practitioners. *Page 10.*

3. Some complaints that the Board of Medicine staff designated as outside the board's jurisdiction may have warranted further investigation. *Page 13.*

    - **We recommend that Board of Medicine staff routinely conduct preliminary investigations to ensure jurisdiction is completely and accurately assessed and monitor when there is the potential danger or threat to the public.** *Page 15.*

4. While the Board of Medicine generally followed the same basic process in its initial investigation of complaints, some inconsistencies were noted. *Page 16.*

    - **We recommend the Board of Medicine routinely notify respondents, within the standard ten-day timeframe, when it receives information regarding disciplinary actions from other states and regulatory agencies. We further recommend that the board provide complete complaint detail and/or copies of written complaints to all respondents.** *Page 18.*

5. Initial investigative work, which often served as the basis for the Board of Medicine's decisions, may have been insufficient in some cases for the board to decide whether disciplinary action was warranted. *Page 18.*

    - **We recommend the Board of Medicine take steps to strengthen its investigation of complaints against physicians and physician assistants.** *Page 20.*

6. The Board of Medicine's process for selecting medical consultants for standard of care cases has been informal, which could be inadequate to assure fair and impartial review. *Page 21.*

    - **We recommend the Board of Medicine formalize the process for selecting consultants to better assure that selection is conducted consistently and without conflict of interest.** *Page 22.*

7. The Board of Medicine's efforts to identify and prevent problems leading to complaints have been limited. *Page 23.*

    - **We recommend the Board of Medicine establish indicators of practice problems, develop monitoring systems, and use existing systems to limit and prevent medical practice violations.** *Page 23.*

8. During 1996 through 2000, Idaho physicians were disciplined at a rate similar to those in other nearby states. *Page 26.*

9. Most complaint cases were closed with no disciplinary action. *Page 27.*

10. When disciplinary action was taken during this period, it was often informal, non-punitive, and confidential. *Page 27.*

11. About ten percent of all cases closed during 1996 through 2000 were voluntarily settled. *Page 29.*

12. The Board of Medicine took punitive disciplinary action in about two percent of all cases closed during 1996 through 2000. *Page 29.*

13. Terms and conditions of stipulations and orders were consistent with the Idaho Rules of Administrative Procedure. *Page 31*.

14. Stipulations and orders appropriately addressed issues raised in the complaint. *Page 31*.

15. The liability release form appended to some stipulations and orders is complex, and may be misinterpreted by respondents. *Page 33.*

    - **We recommend the Board of Medicine modify its liability release statement to clearly state that it only applies to the case being settled.** *Page 33.*

16. The Board of Medicine's process generally satisfies due process requirements. *Page 34.*

17. The Board of Medicine prevailed in most cases closed between 1996 and 2000 that were appealed, but the district and appellate court decisions indicate improvements are needed. *Page 36.*

    - **We recommend the Board of Medicine ensure its formal complaints include all acts arising from its investigation that might be a basis for disciplinary action.** *Page 38.*

    - **We recommend the Board of Medicine ensure that it only consider matters set out in formal complaints.** *Page 38.*

    - **We recommend the Board of Medicine discipline physicians based on substantial and competent evidence that appears in the record of hearing.** *Page 39.*

18. Conflict of interest provisions in the Medical Practice Act apply only to members of the Committee on Professional Discipline, and not to the Board of Medicine itself. *Page 41.*

    - **Should policymakers wish to require that Board of Medicine members disqualify themselves for conflicts of interest or bias, they could amend Idaho Code to include disqualification language as a part of the powers and duties of the Board of Medicine.** *Page 43.*

19. The Board of Medicine does not have a formal policy regarding conflicts of interest. *Page 43.*

    - **We recommend the Board of Medicine develop and adopt a conflict of interest policy and review the policy annually.** *Page 44.*

20. The present method of appointing members to the Board of Medicine appears to limit the consideration of physicians who are not members of the Idaho Medical Association or Idaho Osteopathic Medical Association. *Page 44.*

    - **Should policymakers wish to extend opportunities for Board of Medicine service to association non-members, they could amend Idaho Code to also permit nominations by any individual or organization.** *Page 45.*

21. The provision that the Director of the Idaho State Police serves as an *ex-officio* member of the Board of Medicine appears to be outdated. *Page 45.*

    - **Policymakers could increase public representation on the board by amending Idaho Code to replace the Director of the Idaho State Police with an additional public member.** *Page 46.*

22. The Board of Medicine has fewer total members than is called for in national standards. *Page 46.*

    - **Should policymakers wish to expand the Board of Medicine to be consistent with national standards, they could amend Idaho Code to increase board membership from 10 to 12 members.** *Page 46.*

23. Current statutes allow individuals to serve as members of the Board of Medicine and the Committee of Professional Discipline for a longer period of time than recommended nationally. *Page 47.*

    - **Legislators could consider amending Idaho Code to limit the length and number of terms an individual may serve on the Board of Medicine, and restrict total service on the board and Committee on Professional Discipline.** *Page 47.*

24. The Board of Medicine's use of private legal counsel and in-house counsel is consistent with statutes. *Page 49.*

25. The Board of Medicine appears to have properly separated investigative/prosecutorial and adjudicatory functions. *Page 50.*

26. During 1996 through 2000, the Board of Medicine's contract legal counsel initiated formal proceedings only when directed by the board. *Page 52.*

27. The Board of Medicine's contract legal counsel prepared stipulations and orders when directed by the board or when their preparation was otherwise within her discretion. *Page 52.*

Introduction
Chapter 1

On January 18, 2001, the Joint Legislative Oversight Committee requested a performance evaluation of the Idaho Board of Medicine's investigation and adjudication of complaints against physicians. Concerns were raised that the board may, at times, have been arbitrary and capricious in its handling of complaints. In addition, questions arose regarding recent cases in which the board rejected the recommendations of its hearing officers and cases in which the board's disciplinary actions were overturned on appeal. Concerns were also raised regarding the board's use and oversight of its in-house and contract attorneys.

Concerns were raised regarding the board's investigation and adjudication of complaints, and its use of attorneys.

To conduct our evaluation, we asked:

- How has the board investigated complaints received against physicians? Have the investigative methods used varied from case to case and, if so, why?

- How often have complaints been filed by competing physicians, and how have these complaints been handled by the board?

- How often has the board used medical experts in investigating and prosecuting complaint cases? To what extent could these experts be considered competitors to the respondent physicians?

- How frequently, and on what grounds, has the board taken disciplinary action as a result of its investigation of complaints against physicians? Have the disciplinary actions taken been consistent from case to case? How often have discipline cases gone to hearing? Of these cases, how many were appealed to the courts, and with what result?

- What statutory requirements govern membership on the Board of Medicine? What impact, if any, have issues related to board member terms of service and conflict of interest had on

the board's handling of complaints? How do these requirements compare to national standards for state medical boards?

- What roles have the board's in-house and contract attorneys played in the investigation and adjudication of complaints? To what extent have these attorneys acted outside the scope of their authority? What oversight has the board provided to its attorneys?

METHODS

To answer these questions, we:

We used a variety of research methods to examine these concerns.

- Reviewed Idaho Code and administrative rules concerning the Board of Medicine;
- Analyzed electronic case tracking data maintained by the board for both complaint cases opened and cases closed from 1996 through 2000;
- Reviewed case files for a randomly selected sample of 60 complaint cases closed by the board between 1996 through 2000 to assess the consistency with which the board followed its investigative process and to document the steps taken to investigate complaints. The sample represented approximately 10 percent of the cases closed during that period;
- Reviewed information concerning two high profile groups of complaints received by the board from 1996 through 2000;
- Reviewed meeting minutes for the Board/Committee on Professional Discipline for information concerning complaint cases closed from 1996 through 2000;
- Compared the terms of all stipulation and orders the board entered into with respondent physicians from 1996 through 2000;
- Reviewed court opinions for all complaint cases respondent physicians appealed to the courts between 1996 and 2000;
- Interviewed board members and board staff, representatives of medical and hospital associations in Idaho, and selected physicians; and

- Reviewed information about state medical board complaint investigation and adjudication processes, disciplinary rates, and model practices from the Federation of State Medical Boards and medical boards in selected other states.

Our review covered both the Board of Medicine, which has overall authority for the regulation of physicians, and the Committee on Professional Discipline, a body created by the board to conduct professional disciplinary enforcement investigations. Because of the concerns expressed, we focused our review on the handling of complaints about medical doctors, doctors of osteopathy, and physician assistants and did not review efforts to investigate and discipline other professions regulated by the board.[1] We did not consult with medical experts or otherwise attempt to evaluate whether the board appropriately resolved complaints regarding the standard of care and other issues.

We focused our review on the board's handling of complaints about physicians and physician assistants.

BACKGROUND

Board Responsibilities

The Board of Medicine's responsibilities are spelled out in the Idaho Medical Practice Act and the Disabled Physicians Act. As shown in Figure 1.1, the Medical Practice Act assigns the Board of Medicine responsibility for licensing physicians and physician assistants. Table 1.1 provides a breakdown of the total number of licenses issued by the board. From 1996 to 2000, the number of licensed physicians and physician assistants grew from 3,302 to 3,785, an increase of about 15 percent. This figure includes both active and inactive licenses as well as in-state and out-of-state licenses. In December 2000, the total number of physicians and physician assistants actively practicing in Idaho was 2,485.

Statutes assign the Board of Medicine responsibility for licensing and regulating these health professionals.

Statutes also authorize the board to investigate complaints about licensed physicians and physician assistants, and take disciplinary action when warranted. The Medical Practice Act requires the board to create a committee on professional discipline to conduct professional disciplinary enforcement investigations, and authorizes the board to subpoena evidence, depose witnesses, and

[1] Statutes also charge the Board of Medicine with regulating athletic trainers, dietitians, emergency medical technicians, occupational therapists, physical therapists, and respiratory therapists.

Figure 1.1: Statutory Responsibilities of the Board of Medicine

Medical Practice Act

- Operate, manage, superintend, and control the licensing of physicians and physician assistants.
- Establish rules for the administration of the act, including rules pursuant to the Administrative Procedures Act establishing procedures for the receipt, investigation, and disposition of complaints.
- Create a committee on professional discipline with authority, under the direct supervision and control of the board, to conduct professional disciplinary enforcement investigations.
- Take disciplinary action against physicians or physician assistants who have violated the act.
- Establish reasonable fees to cover administrative costs and enforcement activities.

Disabled Physician Act

- Establish examination committees to assess physicians' ability to practice with reasonable skill and safety.
- Restrict, suspend, or revoke the licenses of physicians found to suffer from mental illness, physical illness (including deterioration through the aging process), or excessive use or abuse of drugs or alcohol.

Source: Idaho Code §§ 54-1801-1808, 54-1831-1841 (2000).

Table 1.1: Number of Selected Board of Medicine Licensees, 1996–2000

	1996	1997	1998	1999	2000	Percent Change 1996–2000
Medical Doctor	3,062	3,177	3,341	3,361	3,374	10.19%
Doctor of Osteopathy	136	154	168	185	199	46.32
Physician Assistant	104	129	149	161	212	103.85
Total	3,302	3,460	3,658	3,707	3,785	14.63

Source: Board of Medicine's 2000 license report.

hold hearings in disciplinary cases. The Disabled Physician Act establishes a process for examining whether physicians' ability to practice medicine with reasonable skill and safety is impaired by mental illness, physical illness, or excessive use of drugs or alcohol. Both acts provide the board a range of disciplinary options including license restrictions, license suspension, and license revocation.

Board Membership

Idaho Code establishes membership requirements for the Board of Medicine.[2] Statutes specify that the Governor appoint nine of the ten board members, including seven licensed physicians (six medical doctors and one doctor of osteopathy) and two public members. Physicians serve six-year terms and public members serve three-year terms. The director of the Idaho State Police also serves on the board by law.

Statutes require the board to establish a Committee on Professional Discipline to conduct complaint

The Committee on Professional Discipline is comprised of five members appointed by the Board of Medicine: four licensed physicians and one public member.[3] Members serve three-year terms and may be reappointed once. Historically, the committee was comprised primarily of current members of the Board of Medicine. Recently, however, the board decided to have separate membership on the board and committee. According to the current board chairman, the committee's membership will now be comprised primarily of board members who have completed their service on the Board of Medicine.

Budget and Staffing

The Board of Medicine is funded from license and registration fees paid by regulated health professionals. Table 1.2 shows the board's appropriations each year since fiscal year 1996. During this period, funding appropriated to the board has increased 130 percent. This includes funding received through supplemental appropriations the board received in four of the seven years. The supplemental appropriations were requested to cover higher than anticipated legal costs associated with the discipline process.

Board appropriations increased 130 percent in the past 5 years due in part to increased discipline costs.

Table 1.2 also provides information on Board of Medicine staffing levels. From fiscal year 1996 through 2002, the board's

[2] IDAHO CODE § 54-1805 (2000).
[3] IDAHO CODE § 54-1806A(1) (2000).

Table 1.2: Board of Medicine Appropriations and Authorized Staffing, Fiscal Years 1996–2002

Fiscal Year	Total Approp.	Percent Change	FTPs Authorized	Percent Change
1996	$ 560,600		8	
1997	627,200[a]	11.88%	8	0.00%
1998	747,000[a]	19.10	9	12.50
1999	865,100[a]	15.81	10[b]	11.11
2000	1,187,900	37.31	12	20.00
2001	1,226,100[a]	3.22	12	0.00
2002	1,291,200	5.31	12.5	4.17
Overall Increase	$ 730,600	130.32%	4.5	56.25%

[a] Includes supplemental appropriation received.
[b] Includes position approved as part of a supplemental appropriation.

Source: Office of Performance Evaluations' analysis of 1995–2001 Idaho Session Laws.

Board staffing to investigate and adjudicate complaints has also increased.

authorized full-time positions increased by more than 50 percent. Much of this increase is attributable to increased staffing to investigate and adjudicate complaints. In fiscal year 1998, the board first established an investigator position. Subsequently, the board established another investigator position and a quality assurance manager position to oversee investigations. In the past year, the board replaced the quality assurance manager position with an in-house attorney responsible for advising the board and providing other legal services.

Previous Evaluation

The board has taken steps to address issues raised in our 1999 review of the complaint process.

The Office of Performance Evaluations previously reviewed the Board of Medicine in 1999. That report contained recommendations concerning the board's complaint resolution process and its efforts to inform and involve the public. In response to the evaluation, the board established written rules to govern the complaint investigation and resolution process. These rules were approved by the Legislature in the 2001 legislative session. The board also took steps to increase the accuracy of information in its discipline database, and to limit staff access to

this confidential information. Finally, the board increased the information provided to complainants in the investigative process. Complainants are now updated on the status of their complaint every four to six weeks and, in cases in which formal disciplinary action is not taken, are informed that the board may take informal, confidential action against license holders, when warranted.

Legislation passed in 2000 significantly changed the board's complaint handling process.

Legislative Changes

Since the 1999 evaluation, significant changes have been made to the Medical Practice Act. In the 2000 legislative session, House Bill 628 modifying the act was enacted as law. Among other things, the bill:

- Replaced the Board of Professional Discipline, which had previously been delegated the board's responsibility for investigating and adjudicating complaints, with a Committee on Professional Discipline, which was charged with the more limited responsibility of investigating complaints "under the direct supervision and control" of the Board of Medicine;

- Mandated that the Board of Medicine adopt rules pursuant to the Administrative Procedures Act regarding the receipt, investigation, and disposition of complaints;

- Required that the board notify respondent physicians when the board has authorized the committee on professional discipline to conduct an investigation; and

- Required that the board provide an opportunity for a person under investigation to meet with the committee or its staff before the initiation of formal disciplinary proceedings by the board.

These statutory changes were consistent with recommendations of the Federation of State Medical Boards.

These changes are consistent with recommendations of the Federation of State Medical Boards, an organization comprised of state boards like the Board of Medicine. The federation recommends that medical boards retain final authority for decision-making in complaint cases (rather than delegating that authority to a committee or subset of the board) and provide an opportunity for respondent physicians to have an informal conference with the board.

Review of Board's Investigation of Complaints
Chapter 2

Concerns were raised that the Board of Medicine was inconsistently investigating cases, allowing competitors to file complaints, and using competitors as medical consultants. To address these concerns, we reviewed applicable statutes and rules, examined the Board of Medicine's data on complaints opened from 1996 through 2000, and examined correspondence related to complaints that were received but not opened for investigation during that time. Additionally, we reviewed case files for a randomly selected sample of complaints investigated by the board during this period.

We found the Board of Medicine and its staff typically adhered to a standard process for investigating complaints, with some exceptions. Some complaints appeared to have warranted further investigation and may have been prematurely closed, while other similar cases were pursued. While investigations were generally conducted in a consistent manner, we found that, in some cases, more investigative work may have been needed to assure that sufficient evidence was available to support board decisions. Further, we concluded the board has relied on an informal system for selecting consultants when needed for case review, which may not have provided adequate assurance of fair and impartial review.

The Number of Complaints Has Increased in Recent Years

To determine how the number of complaint cases the board has opened about physicians and physician assistants has changed over time, and the general nature of those cases, we reviewed the Board of Medicine's complaint database. We found:

- **The number of complaint cases opened by the Board of Medicine from 1996 through 2000 increased 31 percent, with most cases alleging standard of care issues.**

The number of complaint cases opened by the board increased 31 percent over the past five years.

As shown in Table 2.1, the total number of complaint cases opened annually grew from 101 complaints in 1996 to 132 complaints in 2000, a 31 percent increase. Over this same period, the number of licensed physicians and physician assistants increased by 15 percent. However, after accounting for 22 complaints filed by a single physician since 1998, the complaint case growth rate over this time period was roughly equivalent to the growth rate in licensees.

The majority of opened complaints involved standard of care issues.

About 60 percent of all complaints opened involved alleged violations of the standard of care.[1] Allegations of improper conduct represented almost 17 percent of all complaints opened, followed by narcotic prescription violations at approximately 7 percent, and record violations at 4 percent. None of the other 11 categories of complaints individually represented more than 2.5 percent of all complaints.

To determine how often complaints were filed by potential competitors, we looked at the source of the complaint cases the board opened from 1996 through 2000. We found:

About two-thirds of opened complaints were filed by patients or their families, with just 15 percent filed by physicians and hospitals.

- **Patients or their families filed most complaints, with relatively few filed by other practitioners.**

Statutes require that licensed physicians inform the board of possible violations of the Medical Practice Act by their peers; failure to do so can result in disciplinary action.[2] Hospitals are also required to report adverse actions taken against physicians with hospital privileges.[3] Nonetheless, as shown in Table 2.2, patients or their family members filed 68 percent of all complaints opened by the board in the past five years. In contrast, physicians filed 13 percent of all complaints the board opened during this period.[4] However, this percentage may understate the relative number of complaints originating with physicians, as, at times,

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[1] According to Idaho Code § 54-1814 (7) (2000), standard of care is the provision of health care provided by other qualified physicians in the same community or similar communities, taking into account training, experience, and expertise.

[2] IDAHO CODE § 54-1818 (2000).

[3] Hospitals are required to report adverse actions, such as reductions in clinical privileges, under the *Health Care Quality Improvement Act of 1986*, 42 U.S.C. § 11101 (1998).

[4] Nearly one-third of these complaints were filed by a single physician in 1998 and 2000.

Table 2.1: Complaint Cases Opened by the Board of Medicine, by Complaint Grounds, Calendar Years 1996–2000

Grounds	1996	1997	1998	1999	2000	Total	Percentage of Total
Standard of care	65	43	61	78	97	344	60.6%
Improper conduct	15	34	20	12	15	96	16.9
Rx narcotics	4	8	5	14	8	39	6.9
Records	2	4	3	8	5	22	3.9
Improper sexual behavior	6	4	1	0	1	12	2.1
Alcohol impairment	1	3	2	2	1	9	1.6
Drug impairment	3	2	3	0	0	8	1.4
Ethics	0	0	2	2	4	8	1.4
Competency	1	1	2	1	0	5	0.9
Crime	0	0	2	3	0	5	0.9
Disability-impaired	1	1	1	1	0	4	0.7
Abandonment	2	0	0	0	1	3	0.5
Supervision	0	0	1	2	0	3	0.5
Denial of care	1	0	0	1	0	2	0.4
Other[a]	0	4	3	1	0	8	1.4
Total	101	104	106	125	132	568	100.0%[b]

[a] Includes Physician Recovery Network monitoring and unfounded grounds.
[b] Percentages do not sum due to rounding.

Source: Office of Performance Evaluations' analysis of Board of Medicine discipline database.

patient complaints may have been influenced by physicians. Furthermore, as Table 2.2 indicates, the board opened a number of complaints during this time that were received anonymously.[5]

It was difficult to determine how many complaints were filed or motivated by competing physicians.

To respond to committee concerns, we attempted to determine how many of the complaints originating with physicians were motivated by competitive interests and how many represented legitimate concerns. We were unable to do so because the complainant is not required to divulge conflict of interest or other

[5] In July 2000, the board adopted new rules for complaint investigation that requires all complaints be made in writing.

Table 2.2: Complaint Cases Opened by the Board of Medicine, by Complaint Source, Calendar Years 1996–2000

	1996	1997	1998	1999	2000	Five Year Total	Percent of Total
Patients/patient families	70	76	75	86	81	388	68%
Doctors	8	6	7	15	35	71	13
Other states	4	6	8	8	0	26	5
Government agencies[a]	2	2	6	3	5	18	3
Hospitals	4	3	2	2	2	13	2
Board of Pharmacy	4	1	0	2	3	10	2
Other[b]	9	10	8	9	6	42	7
Total	101	104	106	125	132	568	100%

[a] Except the Board of Pharmacy, listed separately.
[b] Includes the Physician Recovery Network, insurance companies, other medical professionals, and anonymous sources.

Source: Office of Performance Evaluations' analysis of Board of Medicine discipline database.

However, in most cases, respondent physicians were provided information about the complaint (identifying the complainant) and given an opportunity to respond.

motives for filing complaints. However, our review showed that, in most cases, the board's complaint notification process during the past five years provided respondents with specific complaint information and often included copies of the complaints made against them. In their responses to complaints, respondents were then able to indicate whether they felt the complaints were motivated by competitors. It was not clear whether this information influenced board determinations. Also, in July 2000, the board adopted rules that give respondents the opportunity, prior to initiation of formal disciplinary proceedings, to meet with the Committee on Professional Discipline or its staff.[6] Furthermore, we learned that during the period reviewed, the board had investigated complaints regardless of their source—common among medical boards operating under similar reporting requirements.

[6] IDAHO ADMIN. CODE, March 30, 2001, IDAPA 22.01.14.021.07.

Staff Determined Some Complaints Fell Outside the Board's Jurisdiction

As part of our review, we also looked at complaints that board staff determined fell outside the board's jurisdiction and statutory authority. We found:

- **Some complaints that the Board of Medicine staff designated as outside the board's jurisdiction may have warranted further investigation.**

Board staff determine if complaints fall within the statutory authority of the Board as defined in the medical practice act and rules relating to complaint investigation. Questions related to jurisdiction require referral to the executive director and/or board counsel. The board's authority to investigate complaints does not extend to cases involving fees, billing, insurance disputes, and other administrative practices. In addition, the board may only investigate complaints involving individuals it licenses and may not investigate complaints about health care facilities. When complaints are received that are outside the board's jurisdiction, administrative rules require that staff investigators respond, in writing, to the complainant and offer a referral, if indicated. The board must retain copies of these complaints for one year.[7]

In 2000, 46 complaints were received that board staff determined were outside the board's jurisdiction.

As shown in Table 2.3, in calendar year 2000, board staff determined that a total of 46 complaints fell outside the board's jurisdiction. From our review, most of these complaints appeared to fall outside of the board's authority. The majority of the complaints received combined multiple practice issues and services rendered by physicians and other non-licensed providers in medical group practices, hospitals, and other facilities. Other complaints addressed single issues such as the 14 complaints involving only billing and other administrative issues, and 8 complaints alleged non-licensed providers and health care facilities failed to provide adequate services. Additionally, 7 individuals requested the board to file their concerns for informational purposes only.

Many complaints fell outside the board's jurisdiction because they involved billing issues or did not name a licensed provider.

However, we identified 5 of the 46 cases that may have warranted further investigation because they: (1) identified physicians and

[7] IDAHO ADMIN. CODE, March 30, 2001, IDAPA 22.01.14.012.

Table 2.3: Complaints the Board of Medicine Determined Were Outside Its Jurisdiction, Calendar Year 2000

Complaint Type	Reviewed With No Action	Reviewed and Referred	Total
Allegations regarding multiple practice issues by multiple providers	9	8	17
Billing, charges, and other administrative issues	13	1	14
No physician named[a]	8	0	8
Information purposes only[b]	7	0	7
Total cases	**37**	**9**	**46**

[a] Allegations directed at other health care providers and facilities.
[b] Complainants asked the board to not open case unless contacted again.

Source: Office of Performance Evaluations' analysis of Board of Medicine's records.

physician assistants regulated by the board; (2) involved issues within the board's jurisdiction; or (3) involved serious allegations that required monitoring. Specifically:

However, several cases may have warranted further investigation or monitoring by the board.

- One complainant alleged a standard of care violation by a board-licensed physician working within the Department of Correction. In subsequent conversations with board staff, we were told the case was not opened because staff believed the allegation was directed toward Correctional Medical Services staff, rather than the individual physician. At a minimum, this case should have been referred to the department for additional investigation and follow-up.

- One complainant raised a number of concerns, ranging from billing to improper conduct, and inadequate standard of care. Board staff determined the complaint related to billing and did not open a case for investigation. Staff might have considered addressing the professional conduct issue and conducted further follow-up to rule out standard of care violations.

- Two complainants alleged improper sexual behavior. Staff did not open an investigation in one case because it was under criminal investigation. However, the case alleged child sexual exploitation and warranted monitoring. In the other case, a

medical professional alleged a physician exploited her when she was an inpatient and recuperating from her hospital stay. This case was not opened because the Medical Practice Act only addresses improper sexual conduct and exploitation when it occurs in a physician- patient relationship. However, the allegation appeared serious enough to have conducted additional investigation.

- In another case, the patient was an elderly woman who alleged that she was pressured to undergo diagnostic testing she did not request or want. The patient claimed the bill was not justified under these circumstances. Staff assessed the complaint as a billing issue, although it might have conducted further investigative steps to rule out a standard of care violation.

It was not clear, from the correspondence in the file, how staff determined jurisdiction in some cases. Furthermore, we were not able to identify other investigative actions staff might have conducted because the file only includes correspondence and does not include any documentation of other types of contacts or review. Nonetheless, all complaints received should be adequately investigated to determine the board's jurisdiction.

The rationale for jurisdiction determinations was not documented in the board's files.

Therefore:

We recommend that Board of Medicine staff routinely conduct preliminary investigations to ensure jurisdiction is completely and accurately assessed and monitor when there is the potential danger or threat to the public.

Specifically, preliminary investigative actions should include:

- Conducting interviews with complainants and patients to clarify complaints when multiple issues are raised;

- Documenting actions taken on complaints received, but not opened, including staff's preliminary investigative actions and rationale for not opening a case.

In addition, board staff should monitor licensed providers in all cases involving potential risks to public safety.

The Board Generally Adhered to a Standard Investigative Process

To examine the board's efforts to investigate complaints we reviewed a sample of 60 cases in depth.

To examine how the board investigated complaints, we conducted an in-depth review of 60 complaint cases *closed* in the past five years.[8] This represents about 10 percent of the 575 complaints resolved from 1996 through 2000. We selected cases representing the full range of alleged medical violations. We looked at 30 cases that were closed with no action and 30 others in which the board took some type of disciplinary action to examine whether investigative actions were applied consistently in all types of cases. We also interviewed board members and board staff, and contacted other state medical boards to determine their review processes.

We found:

- **While the Board of Medicine generally followed the same basic process in its initial investigation of complaints, some inconsistencies were noted.**

The board's initial investigation of complaints included review of the complaint received and information provided by the respondent

Under 2000 House Bill 628, the board was required to adopt rules detailing its process for investigating complaints. Effective July 2000, the Board of Medicine adopted rules that generally reflect the process the board had used to investigate complaints throughout the period we reviewed (1996–2000). Steps in the initial case investigation process included:

1. Board staff sent the complainant a letter acknowledging the complaint within ten business days, when possible;

2. Board staff notified the respondent within ten business days that a complaint had been received and requested a response to the allegations including copies of pertinent medical records, when possible;

3. Board staff prepared a summary report for the Committee/ Board of Professional Discipline, including descriptions of the complaint, the response, and prior complaint history.

[8] We over-selected cases that resulted in disciplinary actions (e.g., letter of reprimand, stipulation and order, and revocation) in order to determine whether the board and staff investigated these cases using the same procedures as in the cases that did not result in disciplinary action.

Board staff followed this basic process for investigating complaints in most of the cases we reviewed. In 43 of the 60 cases we reviewed (72 percent), board staff sent a letter acknowledging receipt of the complaint to the complainant. In 56 of the cases we reviewed (93 percent), the respondent physician was sent a letter notifying him or her of the complaint. A copy of the complaint generally accompanied these letters. Staff summarized the complaint and physician response in 57 of the 60 cases (95 percent) in its report to the Committee/Board on Professional Discipline.

In most cases, the board followed this standardized process in its initial investigation of complaints.

Deviations from the basic process appeared reasonable in most cases. For example, it is not necessary to acknowledge reports of disciplinary actions taken by other states or reports submitted by other boards, such as the Board of Pharmacy.

However, some respondents did not receive timely notification of complaints or were provided with incomplete information. Specifically:

- Respondents in reciprocal action cases were not notified when the staff initially learned of other states actions. Instead, respondents learned of the board's consideration of reciprocal action when they received the proposed stipulation and order. Additionally, because of time needed to have the board's attorney draft the order and obtain authorizing signatures, respondents received this information well beyond the standard ten-day notification timeframe.

- One respondent was not made aware of a complaint against him until four months after the initial complaint receipt. The board staff may have delayed notification in this case because the respondent had other complaints under investigation. However, each complainant identified different issues. When eventually notified, this respondent did not receive a copy of the complaint and was only told that the board had "additional concerns."

- In two anonymous complaints, respondents were not provided with specific complaint information.[9]

However, in a few cases, respondent physicians did not receive timely notification of complaints or complete information about the concerns raised.

[9] Under the new complaint investigation rules, anonymous complaints are no longer accepted.

Failure to provide some respondents with adequate and timely complaint notification prior to rendering formal disciplinary actions may be inadequate to assure a fair and impartial review. The board should take steps to ensure all case investigations are handled consistently. Therefore:

We recommend the Board of Medicine routinely notify respondents, within the standard 10-day timeframe, when it receives information regarding disciplinary actions from other states and regulatory agencies. We further recommend that the board provide complete complaint detail and/or copies of written complaints to all respondents.

We also found:

- **Initial investigative work, which often served as the basis for the Board of Medicine's decisions, may have been insufficient in some cases for the board to decide whether disciplinary action was warranted.**

Investigative report summaries generally include board staff's summary of the complainant's concerns, a summary of the respondent's personal response, copies of medical records, and information about respondents' prior complaint histories. Other investigative data, such as Physician Recovery Network background information and prescription profiles, were provided in half of the report summaries we reviewed. None of the summaries we reviewed included staff analysis or recommendations. Interviews or additional research were not conducted at this time.[10] Additionally, when further action was noted, documentation was often incomplete. For example, staff generally did not record dates of telephone contacts nor the content of those discussions.

In two-thirds of the cases we reviewed, the board's decision was based solely on the staff's initial investigative

In 40 of the 60 cases we reviewed (67 percent), the board's decision was based solely on this limited, initial investigative work by staff. Further, after reviewing the initial summary report, the Committee/Board of Professional Discipline seldom directed staff to conduct further investigation. In just 14 of the 20 remaining cases the board asked staff to conduct additional investigation, including further records review and obtaining

[10] Staff told us their role is to accumulate information and not to advise the board in any of its medical determinations.

consultants. In the remaining 6 cases, decisions about further investigation were delayed pending the receipt of records from sources including the Physician Recovery Network, hospitals, and other states. Additionally, although the board's contracted attorney told us it is important to establish patterns of practice violations, the board expanded its investigative scope beyond a single complaint in just 7 of the 60 cases we reviewed. Two of these cases involved standard of care issues, 2 narcotic prescription violations, and 3 improper conduct complaints.

Board staff seldom interviewed parties involved in complaint cases, or expanded the scope of their initial investigation to look at overall performance.

Committee and board members we spoke with told us they generally felt they had enough information to make case determinations.

Nonetheless, additional investigative steps may be warranted to ensure that case investigations are conducted completely and fairly. We identified several cases in which further investigation might have substantiated complainant allegations or alternatively, given further evidence to support the respondent. For example:

- In one case, a patient alleged that her medical problem was only properly diagnosed and treated after leaving the care of the respondent and seeing another physician. She alleged that the respondent failed to provide an adequate standard of care. Our review of the case file found no evidence of a request for medical records from the physician who subsequently treated the patient or any documented contact to confirm or refute the allegation.

- In another case, a patient alleged that the respondent failed to provide needed medical services after agreeing to assume his care from a referring physician. We found no documentation of staff contacting the referring physician, or requesting a copy of the referring physician's records that might have clarified the agreed upon scope of care.

Medical consultants were used in 5 of 29 standard of care cases we reviewed.

The Federation of State Medical Boards recommends medical boards broaden investigative efforts beyond single incidents to identify patterns of care and conduct interviews with peers and patients. Consultants were used infrequently. In just 5 of 29 standard of care cases (17 percent), the board requested consultants review of respondents' medical records. One consultant was obtained to assess a potential disability. Other state medical boards we contacted required a medical review in all quality of care cases. Additionally, other states have found

that, by taking additional investigative steps, they have improved the quality of their complaint investigations. For example:

Some other states routinely interview those involved in complaint cases and/or use medical consultants to review all standard of care cases.

- Nebraska's Board of Medicine staff routinely interviews complainants, respondents, and patients prior to the board's consideration of the complaint. Its chief investigator told us they use medical consultants in all standard of care cases.

- Nevada's Board of Medical Examiners uses a staff physician to review all standard of care complaints after staff investigators have compiled a case. The physician then makes recommendations to the board. If the staff physician lacks specific knowledge of the specialty standards, the case may be referred to an outside consultant.

- The Board of Medical Examiners in Arizona has five full-time medical consultants on staff. Once the staff investigator completes the initial stage of the investigation, the investigator forwards the quality of care information onto the assigned medical consultant. Outside consultants are obtained when internal staff lack the required expertise. Like Idaho, consultants provide the board with an assessment in quality of care cases. Staff also routinely interviews complainants, respondents, and patients.

- The Ohio State Medical Board's investigative actions includes a review of a respondent's malpractice claim history, hospital privilege actions, and other pertinent records. The board forwards these materials onto physician experts in all standard of care cases, as Ohio case law requires the board to obtain expert opinion in each quality of care case that has a potential for formal disciplinary action.

The board could take several steps to strengthen the investigation of complaints.

Therefore:

We recommend the Board of Medicine take steps to strengthen its investigation of complaints against physicians and physician assistants.

[11] With the adoption of new complaint investigation rules in July 2000, respondents now have the opportunity to meet with the board prior to the initiation of formal action. While this occurs late in the investigative process staff and respondents told us that this will provide additional information to the board and improve overall communication between respondents and the board.

Specifically, the board staff should*:*

- Routinely interview the complainant, respondent, and witnesses in complaint cases;[11]
- Consider increasing the use of medical consultants to review standard of care cases;
- Routinely gather additional records and data to determine practice patterns; and
- Completely document all investigative actions, including telephone conversations and interviews.

Informal Selection of Medical Consultants Risks Negatively Impacting Review

We also reviewed those case files in our sample related to standard of care to address concerns that the board has used respondents' competitors as consultants. We examined how the board selected consultants. We found:

- **The Board of Medicine's process for selecting medical consultants for standard of care cases has been informal, which could be inadequate to assure fair and impartial review.**

Consultants are not required to sign statements regarding conflicts of interest.

Our file review showed the board generally followed an informal process for selecting consultants. Additionally, we spoke with some board members and staff. While some board members said they offered recommendations regarding consultant selection, staff told us it selected consultants. According to staff, they excluded physicians who had prior complaint histories with the Board of Medicine, and selected consultants who came from similar, but geographically different, communities, and had the same or similar medical specialty as the respondent. Consultants are not required to sign statements regarding conflicts of interest. Additionally, Idaho's Board of Medicine does not pay its medical consultants.

Criteria for selecting consultants have not been clearly defined.

Although the legal definition of a standard of care case provides some guidance as to the needed qualifications of case consultants (i.e., consultants should be from the same or similar geographic communities), the selection criteria are not otherwise formalized. In one high profile case we reviewed, the selection criteria staff

listed were not used. Competitors initiated the complaints and staff obtained consultants who were physicians living in the same geographic area as the respondent and conducting the same medical practice. This compromised the respondent's assurance of impartial review.

Some other states have established written criteria for selecting consultants.

Other boards have established written criteria for the selection of consultants. The State Medical Board of Ohio, like Idaho, requires its consultants practice in the same specialty as the respondent. However, Ohio also requires the consultant to be:

- Board certified;
- Currently in clinical practice for the same type of disorders as the physician under review;
- Free from disqualifying information on file with the medical board (such as no open complaints); and
- Free from conflicting or disqualifying interest with the physician under review (such as personally knowing the physician or being identified as "the competition").

Ohio's consultants also must respond to a questionnaire confirming their review experience (e.g., peer review, medical malpractice, hospital committee, workers compensation, insurance), practice situation, and percentage of time spent in clinical practice.

Some of these selection criteria could help to ensure the quality of consultants obtained. Also, there appeared to be some confusion between the staff and board regarding who has been responsible for consultant selection.

Therefore:

We recommend the Board of Medicine formalize the process for selecting consultants to better assure that selection is conducted consistently and without conflict of interest.

Specifically, the board should:

- Establish written criteria for selecting consultants;
- Document staff's rationale for selecting individual consultants;
- Require consultants to sign written independence statements.

The Board Can Take Steps to Limit and Prevent Practice Violations

In our review of complaints that were received but not opened, the 60 case files, and two high profile cases, we noted that, in most cases, the board and staff relied on complaints to drive its investigation process.
We found:

- **The Board of Medicine's efforts to identify and prevent problems leading to complaints have been limited.**

The board could strength its investigation process by monitoring several key indicators of potential practice problems.

The Board of Medicine's current investigative process is primarily complaint-driven, with few exceptions. In most cases, the board became aware of practice and conduct problems only after receiving a complaint. Staff also learned of potential problems through the use of the National Practitioner Data Bank to verify medical credentials, and from other boards, medical associations, and governmental agencies.[12] The board also routinely monitors licensees who have stipulations and orders that define practice limitations and other requirements.

However, the Federation of State Medical Boards recommends state boards be more proactive and less reactive. It suggests a number of steps that state medical boards can take to identify potential practice problems rather than waiting until a complaint is filed. It suggests that boards develop indicators of practice problems and monitor those case characteristics listed in Figure 2.1.

Therefore:

We recommend the Board of Medicine establish indicators of practice problems, develop monitoring systems, and use existing systems to limit and prevent medical practice violations.

[12] The data bank contains information on malpractice payments and adverse licensure, clinical privileges, and professional association activities.

Figure 2.1: Indicators of Physician Performance and Practice Problems

- Frequency of changes in practice location
- Number of inactive licenses in other states
- Number of malpractice claims, including judgements and settlements
- Number of complaints
- Failure to receive specialty board certification
- Changes in area of practice without formal retraining
- Health status
- Age
- Prescribing practices
- Physicians without hospital privileges or medical practice affiliation who are not routinely subject to peer review
- Physician performance and outcome data received from sources such as Professional Review Organizations
- Disciplinary reports by managed care organizations
- Disciplinary reports by other government agencies

Source: The Federation of State Medical Boards, *Evaluation of Quality of Care and Maintenance of*

Assessment of Complaint Resolution and Disciplinary Actions Taken
Chapter 3

Concerns were raised that the board's disciplinary actions were unfairly applied, that settlements imposed unrealistic terms and conditions and unfairly deprived physicians of certain rights. To address these concerns, we reviewed the actions taken on all cases closed during 1996 through 2000; and spoke with board members, staff, and legal counsel. We also reviewed Idaho Code and administrative rules, surveyed other states, and obtained data from the Federation of State Medical Boards.

Overall we found that Board of Medicine imposed disciplinary actions at a rate that is generally consistent with several nearby states; most cases were closed without any disciplinary action at all. When disciplinary action was taken, it was usually informal and non-punitive in nature. Further, we found that stipulations and orders settling cases contain terms and conditions that appropriately address the concerns raised in the complaint. We also found that the board's disciplinary process provides constitutional due process protections. Finally we conclude that although the board's decisions are usually upheld on cases appealed to the courts, some improvements are needed.

We compared information about the number of disciplinary actions taken by the Board of Medicine and similar boards in surrounding states.

Idaho's Rate of Discipline Was Comparable With Nearby States

To address concerns about the number of disciplinary actions taken by the board, we reviewed data for other nearby states and compared those with the disciplinary rate in Idaho. Because it was difficult to compare different types of disciplinary actions due to different medical practice statutes and different reporting categories among the states, we focused on the total number of disciplinary actions taken.

We found:

- **During 1996 through 2000, Idaho physicians were disciplined at a rate similar to those in other nearby states.**

The Federation of State Medical Boards computes several indices that take into account differing severity of disciplinary actions, the total number of licensed physicians, and the number of licensed physicians that actually practice in that state. Because the number of disciplinary actions tends to be very small when compared to the number of licensees, indices are expressed in the number of disciplinary actions per 1,000 physicians. The composite of these indices, called a Composite Action Index, represents the state board's overall rate of discipline.

The board averaged 4.08 disciplinary actions per 1,000 physicians over the past 5 years.

Table 3.1 shows the Composite Action Index for Idaho and five nearby states. As the table shows, rates varied from year to year, particularly in states with relatively few physicians.[1] This occurs because a small increase or decrease in the total number of actions can affect the overall index. To "smooth" these annual fluctuations, we calculated a five-year average of the annual indices. As shown, Idaho's average rate of 4.08 actions per 1,000

[1] We excluded Wyoming from this table because that state has less than 1,000 practicing physicians and the annual fluctuations are much greater than in the states shown. Additionally, the federation has reported that the Composite Action Index for such states is of limited validity.

Table 3.1: Composite Action Index of Discipline Actions by Selected State Medical Boards, 1996–2000

	1996	1997	1998	1999	2000	Five Year Avg.
Washington	2.82	3.65	3.19	4.33	3.16	3.43
Montana	4.45	4.69	2.94	4.01	2.17	3.65
Idaho	**5.02**	**3.14**	**4.60**	**6.22**	**1.43**	**4.08**
Oregon	4.57	4.58	4.21	3.78	4.44	4.32
Nevada	5.10	4.32	4.99	3.97	4.16	4.50
Utah	5.66	3.61	5.23	3.19	6.05	4.75

Source: Federation of State Medical Boards, *Summary of 2000 Board Actions*, April 6, 2001.

physicians is higher than that of two nearby states and lower than three others. Therefore in terms of total disciplinary actions, the Idaho State Board of Medicine disciplined physicians during 1996 through 2000, at a rate consistent with that of nearby state medical licensing authorities.

The board's disciplinary rate was comparable to those of surrounding states.

A Large Majority of Cases Were Closed Without Discipline or With Informal Actions

To determine how frequently the board has taken disciplinary action and the different types of disciplinary actions that the board has taken, we reviewed the board's discipline database and reviewed a sample of case files.

We found:

- **Most complaint cases were closed with no disciplinary action.**

Nearly three-quarters of all complaint cases were closed with no disciplinary action.

Table 3.2 shows that in 425 cases, or nearly three-quarters of those closed during 1996 through 2000, the board determined that disciplinary action was not warranted and closed them without further action. We also noted that complaints alleging standard of care violations were more likely to be closed without action than those alleging improper sexual conduct or physician substance abuse problems.

We also found:

- **When disciplinary action was taken during this period, it was often informal, non-punitive, and confidential.**

In the majority of cases in which disciplinary action was taken, the board used informal, confidential letters to express their

Statutes provide the board with a range of disciplinary actions including, confidential admonition or reprimand, probation, suspension of license, or revocation of license. In addition to or in conjunction with the forgoing, the board may impose of fine of up to $10,000 and require the respondent to pay the board's costs of investigation and prosecution.[2]

Table 3.2 also shows that about 14 percent of cases (or more than half of those that resulted in some disciplinary action) were closed with a confidential admonition or reprimand. We have termed

[2] IDAHO CODE § 54-1806A(6)(d) and (9), (2000).

Table 3.2: Board Action on Cases Closed, 1996–2000

Board Actions	1996	1997	1998	1999	2000	Five Year Total	Percent
Closed with no action	67	85	41	112	120	425	74%
Non-punitive							
Admonishment	10	12	12	23	9	66	
Reprimand	2	2	5	2	2	13	
Total non-punitive	12	14	17	25	11	79	14
Settlements							
Stipulation and order	8	6	12	11	8	45	
License surrender	3	1	5	2	1	12	
Total settlements	11	7	17	13	9	57	10
Punitive							
Suspension	0	2	1	2	3	8	
Revocation	0	3	0	2	1	6	
Total punitive	0	5	1	4	4	14	2
Total	90	111	76	154	144	575	100%

Source: Office of Performance Evaluations' analysis of Board of Medicine data.

these actions as "non-punitive" as they placed no restrictions on the respondent's practice of medicine, are not released to the public, nor reported to any other agency.[3] According to board members with whom we spoke, these types of actions are intended to be educational in nature and to correct isolated and minor departures from the Medical Practice Act.

[3] However, included in the number of cases resolved with a reprimand was a formal proceeding in which the hearing officer recommended and the Board of Professional Discipline agreed, that the physician be reprimanded. Since it resulted from a formal proceeding, the reprimand is a public record.

A Small Number of Cases Resulted in Restriction or Loss of License Privileges

We reviewed the board's discipline database and discipline files to identify cases that resulted in restrictions or loss of licensed privileges. We found:

- **About ten percent of all cases closed during 1996 through 2000 were voluntarily settled.**

Ten percent of all cases closed from 1996–2000 were resolved with a stipulation and order or voluntary license surrender.

Idaho code encourages informal settlement of contested cases through negotiation, stipulation, agreed settlement, or consent order.[4] As Table 3.2 shows, 45 complaints closed during 1996 through 2000 were resolved with a stipulation and order and 12 physicians agreed to surrender their license rather than exercising their right to a contested case hearing.

The most punitive of the disciplinary actions available to the board involve the loss of respondents' ability to practice medicine, either temporarily or permanently.

We found:

- **The Board of Medicine took punitive disciplinary action in about two percent of all cases closed during 1996 through 2000.**

The board suspended or revoked practitioner licenses in 14 of 575 cases closed during the past five years.

Table 3.2 shows that licenses were suspended or revoked in 14 of the 575 cases closed during 1996 through 2000. As shown, licenses were temporarily suspended in eight cases and permanently revoked in six others.

Figure 3.1 provides more detailed information about these cases, including the allegations and board determinations. In about one third of these cases (5 of 14), the board took disciplinary action against licensees in response to disciplinary actions in other states. In two other cases the board took disciplinary actions after licensees violated the terms of a stipulation and order they had voluntarily entered into with the board. As shown, all of the other complaints alleged multiple grounds for discipline or standard of care issues involving multiple patients. Thus, the board appeared to resort to punitive discipline when a pattern of standard of care violations or other misconduct was involved.

[4] IDAHO CODE § 67-5241(c), (1995).

Figure 3.1: Medical Licenses Revoked or Suspended for Cases Closed 1996–2000

Reciprocal	Complaint by Case	Disciplinary Action[a]
Yes (WY)	Disability-alcohol	Suspension
Yes (CA)	Disability-drugs	Suspension
Yes (WA)	Improper sexual behavior	Suspension
No	Failure to comply with stipulation and order	Suspension
No	Failure to comply with stipulation and order	Suspension
No	Improper sexual behavior; violation of standard of care–2 patients; providing false information to board	Suspension (stayed)[b]
No	Improper sexual behavior; violation of standard of care–1 patient	Suspension (stayed)[b]
No	Improper sexual behavior; improper prescribing practices; violation of standard of care–1 patient	Suspension
Yes (CO)	Disability-impaired	Revocation
Yes (WA)	Crime	Revocation
No	Violation of standard of care–12 patients; improper sexual behavior–1 patient	Revocation
No	Violation of standard of care–12 patients	Revocation
No	Competency; violation of standard of care–9 patients	Revocation
No	Improper prescribing practices and violation of standard of care–4 patients; felony conviction of possession of a controlled substance; falsification of medical records and violation of standard of care–1 patient; prescribing controlled substances to self; disability-drugs	Revocation

[a] Reflects the board's action, which may have been modified by district or appellate courts on appeal.
[b] The board's final order provided that the suspension be stayed (not made effective) for five years conditioned on there being no violations during that period.

Source: Office of Performance Evaluations' analysis of Board of Medicine disciplinary files.

Terms and Conditions Imposed in Stipulations and Orders Appeared Consistent and Appropriate

In requesting this evaluation, the committee raised concerns that the board's stipulations and orders imposed inappropriate terms and conditions on physicians. To address these concerns, we spoke with board members, staff, and legal counsel and reviewed

Idaho Code and administrative rules. We also reviewed all 42 of the stipulations and orders that closed 45 complaints during 1996 through 2000.

We found:

- **Terms and conditions of stipulations and orders were consistent with the Idaho Rules of Administrative Procedure.**

The Idaho Rules of Administrative Procedure specify that consent agreements must recite the parties to the agreement and the conduct "…proscribed or prescribed by the consent agreement." Additionally, consent agreements may: (1) recite the consequences of failure to abide by the agreement; (2) provide for payment of civil or administrative penalties authorized by law; (3) provide for loss of rights, licenses, awards, or authority; (4) provide for other consequences as agreed to by the parties; and (5) provide that the parties waive all further procedural rights with regard to enforcement of the agreement.[5]

Elements common to all stipulations and orders entered into by the board and respondents during 1996 through 2000, included:

Stipulations and orders issued by the board were consistent in form and content.

- The parties to the agreement (e.g. respondent and the board);
- A statement that the respondent knowingly and voluntarily waived any right to a formal hearing and other rights accorded under the Administrative Procedures Act and the Medical Practice Act;
- What specifically the respondent must do or refrain from doing; and
- The consequences of failure to abide by the order.

Further, we found:

- **Stipulations and orders appropriately addressed issues raised in the complaint.**

[5] IDAHO ADMIN. CODE, July 1, 1993, Vol. 1, IDAPA 04.11.01.280. The board's stipulations and orders are "consent agreements" as defined in this rule.

Board members and staff told us that the board's objective has been to correct substance abuse, standard of care, and other issues through rehabilitation and education whenever practical. Stipulations and orders are intended to achieve that objective. In entering into a stipulation and order, the board agrees not to pursue disciplinary actions beyond that specified in the order and the respondent waives his or her right to a formal hearing.

The terms of the agreements appeared reasonable and appropriate to the issues at hand.

The terms concerning what the respondent must do or refrain from doing varied somewhat depending on the type of stipulation and order. For example, conditions of stipulations and orders that addressed substance abuse were related to rehabilitation and treatment including abstinence, random drug and alcohol screening, and participation in the Physicians Recovery Network.[6] Because they responded to a broader range of issues, stipulations and orders addressing standard of care violations were more varied. These terms included restricted practice, monitoring physicians, review of patient records, and additional training. In each case, the conditions imposed appear to appropriately address the issues raised in the complaint and to further the board's stated rehabilitation and educational objectives.

In 9 of the 42 cases, stipulations and orders were used to take reciprocal discipline when license holders were disciplined in other states.

Further, nine of the stipulations and orders were orders for reciprocal discipline adopting agreements executed between the respondent and another state's licensing authority. These reciprocal orders were in a somewhat different form but imposed essentially the same terms and conditions as those initiated by the Idaho State Board of Medicine. The board adopted the other state licensing authority's terms and conditions without modification in each case.

Most stipulations and orders also included an agreement to release the board, staff, attorneys, consultants, witnesses, and others from any liability arising from their involvement in the case. Concerns were raised that this release unfairly required respondents to waive their right to take action against the board even for future actions. To address these concerns, we reviewed Idaho Code, the liability release form and spoke with the board's prosecuting attorney.

[6] Physicians Recovery Network is a substance abuse rehabilitation program for physicians operated by the Idaho Medical Association under contract with the Board of Medicine.

We found:

- **The liability release form appended to some stipulations and orders is complex, and may be misinterpreted by respondents.**

Idaho Code protects any member of the board, its Committee on Professional Discipline, its staff, and any person providing information or testimony to the board from liability or damages for their actions as long as the actions are taken without malice and with reasonable belief that they are warranted.[7] However, this statutory protection does not extend to federal cases of action. Our review revealed that the 19 stipulations and orders signed prior to May 1998 contained a liability release paragraph that was fairly short and straightforward and appropriately notified respondents of the statutory protection from liability. The 12 orders signed subsequently contained a separate form attached and required a separate signature.[8] The form begins with a statement that the release is "…for the sole consideration of the informal resolution of the pending disciplinary action." This and other language on the form clearly limits it to the case being settled. However, another part of the form sets out that "… damages sustained are or may be permanent and progressive and that recovery therefor is uncertain and indefinite…." This and other language in the form could be misinterpreted as a blanket release from liability for past and future board actions.

The board requires respondent physicians to sign a liability release when voluntarily settling cases with stipulations and orders.

The release form could be misinterpreted as requiring the respondent to release the board from liability in the present case and any future board actions.

The board's prosecuting attorney told us that a separate liability release was suggested by a respondent's attorney. The board's prosecuting attorney also stated that defense counsels have not expressed any concerns about advising their clients to sign it. Further, it is intended to apply only to the board's actions associated with the stipulation and order to which it is attached. However, the release could be amended to clearly limit it to the case being settled. Therefore:

We recommend the Board of Medicine modify its liability release statement to clearly state that it only applies to the case being settled.

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[7] IDAHO CODE § 54-1806A(12), (2000).

[8] Nine reciprocal and two other stipulations and orders did not contain a release form.

The Board of Medicine's Disciplinary Process Provides Constitutional Due Process Protections

Due process protections include (1) the right to be notified of all charges; and (2) the right to answer the allegations made.

Concerns were raised that the board, at times, violated licensees' due process rights. Due process originates in the United States and Idaho Constitutions. The safeguard reads in pertinent part, "No person shall be…deprived of life, liberty or property without due process of law."[9] Although not defined in either the United States or Idaho Constitutions, courts have determined due process to mean the right to be fairly notified of the specific allegations charged and the right to a full opportunity to answer the allegations, including the right to compel witnesses, to cross-examine witnesses, and to present evidence.

We reviewed the board's disciplinary procedures to determine if those procedures afforded respondents due process protections requiring fair notice of the allegations and the opportunity to be heard. We found:

- **The Board of Medicine's process generally satisfies due process requirements.**

In initially investigating complaints, the board generally notified respondents of complaints received and provided them an opportunity to respond.

The Idaho Supreme Court has held that the right to practice ones profession is a valuable property right and consequently, the State (the board) cannot exclude a person from the practice of his or her profession without having provided due process safeguards.[10] The U.S. Supreme Court has held that due process protections do not apply to the investigative phase of an administrative proceeding.[11] However, since July 1, 2000, statutes and rules specific to the Board of Medicine provide certain protections in its investigative process that go beyond due process requirements. Specifically, statutes and rules concerning the board's investigations require that:

- When a complaint is received, the respondent is generally notified of the nature of the complaint;
- The respondent is provided an opportunity to respond to the complaint in writing; and

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[9] IDAHO CONST., Art. I, § 13. Further, the U.S. Constitution reads in pertinent part, "Nor shall any state deprive any person of life, liberty, or property, without due process of law." U.S. CONST., amend. XIV.

[10] Tuma v. Board of Nursing, 100 Idaho 74, (1979).

[11] Hannah v. Larche, 363 U.S. 420, (1960).

- The respondent is provided an opportunity to meet with the Committee on Professional Discipline or its staff before the initiation of formal disciplinary proceedings.[12]

The board prepared a formal complaint, specifying the charges alleged, for each case that went to

Respondents were provided notice of the specific charges against them. In each case closed during 1996 through 2000, that went to a hearing, the Board staff prepared a formal complaint that specified the alleged facts, which, if proven at hearing, would constitute grounds for disciplinary action under the Medical Practice Act. The complaints were generally organized into one or more counts with each count representing the care of one patient, although some complaints alleged conduct that was not specific to any patient but also represented grounds for discipline.

Respondents were provided an opportunity to have their cases heard before an independent hearing officer.

In addition, in each case, respondents were provided an opportunity to answer the charges against them. Unless a respondent voluntarily surrendered his or her license or otherwise waived his or her right to a hearing, each license suspension or revocation was imposed only after a hearing. Hearings were conducted in accordance with the Idaho Administrative Procedures Act and the Idaho Rules of Procedure before an independent hearing officer. Respondents were afforded the opportunity to disqualify any appointed hearing officer for bias or substantial prior involvement and were allowed one disqualification without cause. At the hearings, respondents, most of whom were represented by legal counsel, presented evidence, cross-examined the board's witnesses, and called their own witnesses.

Final Disciplinary Decisions in Contested Cases Involved Review of the Evidence and Consideration of Recommendations

Upon completion of a hearing, the hearing officer reviewed the record of the hearing, including documentary evidence, testimony of witnesses, depositions, transcriptions of testimony, and closing briefs by both parties. He or she then prepared findings of fact and conclusions of law and a recommended order on whether disciplinary action should be imposed.

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[12] IDAHO CODE § 54-1806(2), (2000) and IDAHO ADMIN. CODE. March 30, 2001, IDAPA 22.01.14.000-022.

The board rejected or modified the hearing officers findings and conclusions in 5 of 12 cases that went to hearing from 1996–2000.

Since the Board of Medicine is the ultimate decision-maker on disciplinary matters, it need not accept the hearing officer's findings. The board may use the experience, technical competence, and specialized knowledge of its members to evaluate the evidence, to decide whether to accept or reject the hearing officer's findings, and what disciplinary action to impose, if any.[13] However, when it rejects the hearing officer's factual determinations, it must articulate a basis for doing so and state findings of fact and conclusions of law that support its decision.[14]

As shown in Figure 3.2, of twelve contested cases closed between 1996 and 2000, the board rejected the hearing officer's findings of fact and conclusions of law 2 times in whole, 3 times in part, and accepted the hearing officer's findings without modification in 7 other cases.

Most Board of Medicine Contested Cases Were Reviewed by the Courts

The Idaho Administrative Procedures Act provides respondents the right to petition for judicial review of the board's determinations on contested cases.[15] We reviewed hearing officers' and the board's determinations and the decisions of district and appellate courts concerning the twelve cases that went to hearing and were closed during 1996 through 2000.

We found:

In 9 of the 12 cases that went to hearing, respondents appealed the board's decision to the courts.

- **The Board of Medicine prevailed in most cases closed between 1996 and 2000 that were appealed, but the district and appellate court decisions indicate improvements are needed.**

In 9 of the 12 cases that went to a hearing, respondents appealed the board's decision to the district court. As also shown in Figure 3.2, district courts affirmed the board's action in six of these, reversed the board's action in one, and remanded another to the

[13] IDAHO CODE § 67-5251(5) (1995). Before July 1, 2000 this review and decision process was conducted by the Board of Professional Discipline.
[14] Woodfield v. Board of Professional Discipline, 127 Idaho 738 (Ct. App. 1995)
[15] IDAHO CODE §§ 67-5270–67-5279 (1995 and Supp. 2000).

Figure 3.2: Board Actions on Hearing Cases and Appeals to District and Appellate Courts, 1996–2000

Board Action on Hearing Officers Findings	Board Action	District Court	Supreme Court or Court of Appeals Decision	Current Status
Not Appealed				
Accepted	Suspension	Not appealed		Suspension
Accepted	Stipulation and order	Not appealed		Stipulation and order
Accepted	No discipline	Not appealed		No discipline
Appealed to District Court Only				
Accepted	Revocation	Pending		Pending
Accepted	Reciprocal suspension	Affirmed	Not further appealed	Reciprocal suspension
Accepted	Suspension	Affirmed	Not further appealed	Suspension
Appealed to Appellate Courts				
Rejected	Reprimand	Affirmed	Pending	Pending
Rejected	Revocation	Reversed	Pending	Pending
Accepted	Suspension (stayed)	Affirmed	Reversed	No discipline
Accepted in part	Suspension (stayed)	Affirmed	Reversed on one count	Suspension
Accepted in part	Revocation	Remanded	Affirmed in part, reversed in part, and remanded	Revoked on remand
Accepted in part	Revocation	Affirmed	Affirmed in part, reversed in part, and remanded	Revoked on remand

Source: Office of Performance Evaluations' analysis of Board of Medicine discipline files and court decisions.

board for additional findings and conclusions. One case, filed in December 2000, is still pending before the district court.

Of the 8 cases reviewed by the courts so far, the board's action was upheld in 4, partially affirmed in 2, and overturned in 2.

Six of the eight district court decisions were appealed further, four of which had been decided as of May 18, 2001.[16] One case was reversed completely, and another reversed as to one count but affirmed as to two other counts. Additionally, in two cases the board's actions were partially affirmed, partially reversed, and the cases were remanded to the board for further proceedings. In both of these cases, the board again reviewed the record, entered new findings of fact, conclusions of law, and again revoked respondents' licenses. In one of these cases, the respondent again filed a petition for judicial review but did not timely file an appeal brief resulting in its dismissal. The other respondent did not appeal.

In cases overturned or remanded to the board, the courts have identified two primary deficiencies.

In reversing board actions or remanding cases for further proceedings, district and appellate courts have cited two deficiencies:

- The respondent was disciplined for acts not charged in the complaint; and
- Findings were not supported by sufficient evidence.

To ensure the board does not discipline physicians for acts not set out in its formal complaints:

We recommend the Board of Medicine ensure its formal complaints include all acts arising from its investigation that might be a basis for disciplinary action.

Broadening formal complaints would reduce the likelihood that evidence and testimony at hearing would relate to conduct not charged in the complaint.

Additionally:

We recommend the Board of Medicine ensure that it only consider matters set out in formal complaints.

[16] Two appeals were filed by the board, four by respondents.

This would further reduce the likelihood that the board will violate respondents' due process rights by disciplining them for acts for which they were not charged.

To ensure that disciplinary actions are based on sufficient evidence:

We recommend the Board of Medicine discipline physicians based on substantial and competent evidence that appears in the record of hearing.

Assessment of Conflict of Interest and Board Membership Requirements
Chapter 4

In the early stages of this evaluation, concerns were raised about the potential for board member conflicts of interest in the discipline process and the length of time individuals have served on the Board of Medicine and Committee on Professional Discipline. To examine these concerns, we reviewed applicable statutes and rules, reviewed meeting minutes for the Board of Medicine and Committee on Professional Discipline and interviewed board members and staff to determine how the board meetings are conducted, focusing on disciplinary proceedings. We also compared requirements concerning board membership, composition, and terms of service with national standards.

Conflict of Interest Requirements for Board Members Are Unclear

We found:

- **Conflict of interest provisions in the Medical Practice Act apply only to members of the Committee on Professional Discipline, and not to the Board of Medicine itself.**

The Medical Practice Act contains a provision requiring members of the Committee on Professional Discipline to disqualify themselves if they have a conflict of interest or bias in complaint cases brought to them. Additionally, a respondent may move to disqualify a member of the committee from any proceeding if the respondent can show there is a conflict or bias that would interfere with the member's impartial consideration of the case.[1]

Statutes require Committee on Professional Discipline members to disqualify themselves when they have a conflict of interest or bias in complaint

[1] IDAHO CODE § 54-1806A(5) (2000).

Board members have recused themselves from participating in disciplinary deliberations and decisions on a number of occasions. We looked at Board/Committee on Professional Discipline meeting minutes for all 575 complaints cases closed from 1996 through 2000 and determined that at least one member recused themselves from disciplinary deliberations and decisions in 15 cases.[2]

Prior to passage of House Bill 628 in 2000, the Board of Medicine delegated its full authority for disciplining physicians and physician assistants to the Board of Professional Discipline. The Idaho Code provisions regarding board member conflict of interest and disqualification, discussed above, applied specifically to the Board of Professional Discipline and not to the Board of Medicine as a whole.

These requirements do not apply to members of the Board of Medicine, which is now charged with taking disciplinary action in complaint

As discussed previously, House Bill 628 limited the authority of the Committee on Professional Discipline and placed responsibility for decisions about physician and physician assistant discipline with the Board of Medicine. Yet Idaho Code provisions regarding conflict of interest and board member disqualification were not amended to reflect the changes in the Board of Medicine's responsibilities. Consequently, these provisions have not applied to the individuals charged with making medical disciplinary enforcement decisions since July 1, 2000.

The Idaho Ethics in Government Act, which is intended to prevent public offices from being used for personal gain and assure impartiality of public officials in governmental functions, applies to the Board of Medicine. However, it is limited to financial conflicts of interest and does not address bias or substantial prior involvement in a case.[3] Also, the Idaho Rules of Administrative Procedure prohibit contacts between board members and respondents and prosecutors while proceedings are pending, but do not address bias or prior involvement arising prior to the proceedings.[4]

As a result, current statutes do not clearly spell out requirements for handling of conflict of interest situations among members of

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[2] Additionally, at least one board member abstained from voting on 32 different disciplinary decisions.

[3] IDAHO CODE §§ 59-701 through 59-705 (1994 and Supp. 2000).

[4] IDAHO ADMIN. CODE, January 1, 1995, Vol. 1, IDAPA 04.11.01.423.

the Board of Medicine in cases of medical disciplinary enforcement. Therefore:

Should policymakers wish to require that Board of Medicine members disqualify themselves for conflicts of interest or bias, they could amend Idaho Code to include disqualification language as a part of the powers and duties of the Board of Medicine.

We also found:

- **The Board of Medicine does not have a formal policy regarding conflicts of interest.**

The Board of Medicine has not adopted a written policy to further define conflict of interest requirements in the Medical Practice Act and specify the process for recusal board members should follow. In addition, board members indicated that the board has not regularly reviewed conflict of interest requirements.

The Board of Medicine has not adopted a written conflict of interest policy as recommended by the Federation of State Medical Boards.

In its *Elements of a Modern State Medical Board,* the Federation of State Medical Boards recommends that boards, with the advice of legal counsel, adopt a conflict of interest policy and review the policy annually.[5] According to a 1998 federation report, 34 boards have adopted a formal policy.[6] The federation recommends that conflict of interest policies require, at a minimum, board members to make any potential conflict of interest in a given proceeding known, in advance, to their colleagues on the board. The federation also recommends that the policy specify that actual recusal is left to the discretion of the individual member.

Adopting such a policy could help board members decide when disqualification is appropriate and emphasize the importance of an impartial consideration of discipline cases.

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[5] Federation of State Medical Boards, *Elements of a Modern State Medical Board* (Euless, TX: 1998), 6.

[6] Federation of State Medical Boards, *Maintaining State-Based Medical Licensure and Discipline: A Blueprint for Uniform and Effective Regulation of the Medical Profession* (1998), (visited 5 June 2001) <http://www.fsmb.org/uniform.htm>, 7–8

Therefore:

We recommend the Board of Medicine develop and adopt a conflict of interest policy and review the policy annually.

Statutes Concerning Board Membership Are Inconsistent With National Standards

During our review we also found:

- **The present method of appointing members to the Board of Medicine appears to limit the consideration of physicians who are not members of the Idaho Medical Association or Idaho Osteopathic Medical Association.**

Statutes specify that state medical associations are to provide lists of board nominees for the Governor's consideration.

In Idaho, board nominations are made by the Idaho Medical Association (or the Idaho Osteopathic Medical Association, when the doctor of osteopathy position is vacant), which is to provide three names for each vacancy.[7] According to an official with the Idaho Medical Association, nominees come, by and large, from among its association members.[8] The Governor then appoints members from the list of nominees.

However, some physicians practicing in Idaho are not members of these associations. For example, in December 2000 there were 2,162 medical doctors actively practicing in Idaho. The Idaho Medical Association reports that its membership includes approximately 1,500 actively practicing medical doctors, or about 69 percent of all actively practicing medical doctors in the state.[9] Thus, nearly 700 practicing physicians have been generally excluded from consideration for board membership.

Nearly 700 actively practicing medical doctors do not belong to the medical association, limiting their ability to serve

The Federation of State Medical Boards recommends that nominations for positions on state medical boards not be limited to the medical association in the state. Instead, the federation recommends that any individual, organization, or group have the

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[7] IDAHO CODE § 54-1805(1)(b) (2000).

[8] The Idaho Medical Association has typically requested nominations from local medical societies to ensure nominees are drawn from the same general area of the state as the board member being replaced.

[9] The Idaho Medical Association reported that its membership includes several hundred other medical doctors that are not actively practicing in Idaho.

opportunity to suggest nominees to the Governor. The Federation further recommends that medical societies or organizations be specifically requested to nominate two or more potential appointees for each position.[10]

The Federation of State Medical Boards recommends that nominations for board membership not be limited to medical associations.

Therefore:

Should policymakers wish to extend opportunities for Board of Medicine service to association non-members, they could amend Idaho Code to also permit nominations by any individual or organization.

We also found:

- **The provision that the Director of the Idaho State Police serves as an *ex-officio* member of the Board of Medicine appears to be outdated.**

As noted in Chapter 1, the director of the Idaho State Police serves as an *ex-officio* member of the Board of Medicine. The director's membership appears to date from 1949 when the board was established within the (then) Department of Law Enforcement.

However, our review of the board's meeting minutes shows that the director of the Idaho State Police typically does not attend meetings. In discussions with him regarding his membership on the board, he said he felt it was not necessary for his agency to be represented on the board. He also indicated his agency would provide any assistance needed by the board, regardless of his membership on the board.

Statutes regarding board membership could be changed to replace the director of the Idaho State Police with an additional public member

Board members we spoke with told us it would be beneficial to increase the range of medical specialties represented on the board to assist in deliberations and decisions about complaint cases. They also felt that it would be beneficial to increase public membership on the board. The Federation of State Medical Board's recommends that 25 percent of all members on state medical board be public members. Currently, 2 of the 10 members of the Board of Medicine (20 percent) are public members.

[10] Federation of State Medical Boards, *Elements of a Modern State Medical Board (Euless, TX: 1998)*, 2.

Therefore:

Policymakers could increase public representation on the board by amending Idaho Code to replace the Director of the Idaho State Police with an additional public member.

Additionally, we found:

- **The Board of Medicine has fewer total members than is called for in national standards.**

The size of the Board of Medicine could be increased to increase both physician and public membership.

The Federation of State Medical Boards recommends that state medical boards consist of 12 to 24 members.[11] According to the Federation, the actual size of the board should be determined on the basis of the size of the state's physician population, the composition of the board, and other work of the board.

According to data collected by the Federation of State Medical Boards, the total number of physicians practicing in each state in 2000 ranged from less than 1,000 in Alaska to nearly 83,000 in California. In 2000, Idaho had approximately 2,300 licensed medical doctors and doctors of osteopathy actively practicing in the state, near the low end of this nationwide range. Consequently, a membership of 12 members would be consistent with federation recommendations. As noted, current membership on the Board of Medicine is limited to 10 members.

Therefore:

Increasing the number of physician members could help increase the range of medical specialties represented on the board.

Should policymakers wish to expand the Board of Medicine to be consistent with national standards, they could amend Idaho Code to increase board membership from 10 to 12 members.

Board membership could be distributed as follows: 8 medical doctors, 1 doctor of osteopathy, and three public members. Increasing the number of medical doctors on the board from 6 to 8 could help increase the range of medical specialties represented on the board. In addition, increasing the total number of public members on the board to 3 would bring total public membership on the board to 25 percent, as recommended by the Federation of State Medical Boards. Finally, increasing the size of the board would help minimize the risk of critical decisions being left to a

[11] *Ibid*., 1.

small number of board members when recusals and absences occur.

We also found:

- **Current statutes allow individuals to serve as members of the Board of Medicine and the Committee of Professional Discipline for a longer period of time than recommended nationally.**

Since July 2000, membership on the Committee on Professional Discipline has been limited to two three-year terms. However, membership on the Board of Medicine is not restricted. The Medical Practice Act provides for physicians to hold six-year appointments to the Board of Medicine. Statutes do not preclude reappointment to the board for subsequent terms, nor do they limit the number of times a member may be appointed.

Statutes do not limit the number of terms an individual may serve on the Board of Medicine.

In contrast, the Federation of State Medical Boards recommends that consecutive service on state medical board membership be limited to a maximum of two, four-year terms. The federation suggests that terms be long enough to permit development of effective skill and experience by members, but that the number of consecutive terms be restricted.

The Federation of State Medical Boards recommends consecutive service on state medical boards be limited to 8 years.

Although we did not find any instances in which board members were reappointed, some Board of Medicine members have continued to serve on the Board/Committee of Professional Discipline after completing their terms on the board. One individual is scheduled to complete his service on June 30, 2001 at which time he will have served on the Board of Medicine and the Board/Committee on Professional Discipline for twelve consecutive years.

Therefore:

Legislators could consider amending Idaho Code to limit the length and number of terms an individual may serve on the Board of Medicine, and restrict total service on the board and Committee on Professional Discipline.

Assessment of the Board of Medicine's Legal Representation
Chapter 5

In requesting this evaluation, concerns were voiced that the board's contract legal counsel had, at times, acted outside the scope of her authority, and that the counsel improperly influenced the board in making decisions on disciplinary cases. To address these concerns, we reviewed Idaho Code, Administrative Rule, minutes of the Board of Professional Discipline, Committee on Professional Discipline, and Board of Medicine meetings, and the Idaho Rules of Professional Conduct. We also spoke with the board's legal counsel, board members and staff, respondents, and representatives of the Idaho Hospital Association and the Idaho Medical Association.

In representing clients, attorneys are required to perform with professional competence and diligence. Further they are required to abide by clients' decisions, keep clients informed, and to keep attorney-client information confidential. Attorneys function as both counselors to and advocates of their clients.[1] The Board of Medicine, as a client, exercises oversight over its counsel through the approval of settlements and disciplinary actions.

The Board Is Authorized to Employ Contract and In-House Attorneys

To determine if the board's use of a contract attorney as well as in-house counsel is consistent with statutes, we reviewed Idaho Code and spoke with an official in the Attorney General's Office.

We found:

- **The Board of Medicine's use of private legal counsel and in-house counsel is consistent with statutes.**

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[1] IDAHO RULES OF PROFESSIONAL CONDUCT, Rules 1.1–1.16, 2.1–2.3, 3.1–3.9, (1986, amend. 1997).

Statutes authorize the Board of Medicine and similar agencies to obtain legal representation from the Attorney General or employ other attorneys.

Statutes allow certain agencies, including the Board of Medicine, to employ private counsel or to contract with the Office of the Attorney General for legal representation.[2] According to an official in the Attorney General's office, of 13 professional and occupational licensing agencies authorized to employ private counsel, 7 contract with the Attorney General for legal representation and 5 (including the Board of Medicine) rely solely on legal counsel other than the Attorney General. The other agency receives some legal services from the Attorney General and some legal services through private counsel. Additionally, the Medical Practice Act specifically authorizes the hiring of in-house counsel. The board may "hire or appoint employees, including an Executive Director, investigators, *attorneys*, consultants and independent hearing examiners."[3]

The Board Has Taken Steps to Separate Attorney Involvement in Complaint Case Prosecution and Adjudication

We also found:

- **The Board of Medicine appears to have properly separated investigative/prosecutorial and adjudicatory functions.**

With respect to disciplinary actions, administrative rules distinguish between an agency's investigative/prosecutorial function and its adjudicatory function.[4] The investigative function involves gathering evidence leading to a formal hearing and the prosecutorial function involves the presentation of evidence, argument, and briefs at the hearing. The adjudicatory function involves consideration of the hearing record and the decision whether to impose disciplinary action and with what specific actions.

Statutes require the separation of complaint prosecution and

As relates to the Board of Medicine, the negotiation of stipulations and orders is a prosecutional function while determining the acceptance of these orders is an adjudicatory function. These functions must be kept separate because, if negotiations are unsuccessful, the cases can become formal

[2] IDAHO CODE § 67-1406 (1995).
[3] IDAHO CODE § 54-1806(1), (2000).
[4] IDAHO ADMIN. CODE , January 1, 1995, IDAPA 04.11.01.420–429.

proceedings. Rules prohibit an attorney involved in the investigative/prosecutorial functions from advising the board when performing its adjudicatory function.

Board members told us that the board's contract attorney, who prosecuted each of the 12 contested cases addressed by the board from 1996 through 2000, did not advise the board when it deliberated and decided these cases. While it is difficult to determine the extent to which this attorney may have informally advised the board, we interviewed board members and reviewed board minutes to assess the attorney's involvement in these cases and found no indication that the attorney improperly advised the board in these cases. Board minutes for 1996 though 2000 revealed that whenever the board was considering contested cases, the prosecuting attorney was absent, and, accordingly, did not participate in the board's adjudication of those cases.

Based on board minutes, the board's contract attorney, who prosecuted contested cases, was absent when the board deliberated and made decisions regarding those cases.

The hiring of multiple attorneys assists the board in keeping these functions separate. The board employs:

- A contract attorney who has represented the board for many years, originally as a deputy Attorney General. This attorney has prosecuted disciplinary cases, negotiated stipulations and orders. She has also assisted with non-disciplinary and paraprofessional matters;
- An in-house attorney who is a state employee. This attorney, who is also a registered nurse, was initially hired in April 1999 as a Quality Assurance Specialist to investigate cases.[5] In August 2000, this employee was designated as "Attorney for the Board" and assigned general legal counsel duties involving non-disciplinary matters or disciplinary cases involving paraprofessionals.
- Other contract attorneys on a case by case basis to advise it in its adjudication function.

The board has used the services of multiple attorneys to help separate the prosecution and adjudication

Board Attorneys Were Given Both Specific Direction and Discretionary Authority

As noted, concerns were raised concerning the scope of authority of the board's legal counsel. To address these concerns, we

[5] The board requires that its quality assurance specialists be registered nurses.

reviewed minutes of board and committee meetings, the board's discipline files, and spoke with respondents, board members, attorneys, and staff. We compared the disciplinary cases described in Chapter 3 with minutes of the Committee/Board of Professional Discipline and Board of Medicine meetings.

We found:

- **During 1996 through 2000, the Board of Medicine's contract legal counsel initiated formal proceedings when directed by the board.**

In each case that went to hearing from 1996–2000, the board directed the contract attorney to initiate formal proceedings.

In each of the cases described in Chapter 3, in which formal proceedings were conducted, those proceedings were initiated after a vote of the Board of Professional Discipline to initiate proceedings. During this period, the board acted to initiate formal proceedings 22 times.

We also found:

- **The Board of Medicine's contract legal counsel prepared stipulations and orders when directed by the board or when their preparation was otherwise within her discretion.**

The board's contract attorney generally prepared stipulations and orders when requested to do

Our review of board minutes revealed that the Board of Professional Discipline or Board of Medicine had generally previously voted to offer a stipulation and order.[6] With respect to cases closed during 1996 through 2000, the board acted to offer stipulations and orders 44 times.

One respondent alleged that the board's contract counsel, "has the authority to offer a stipulation and order and the authority to take it away." However, the board's discipline file and meeting minutes reflect that, in this respondent's case, the board acted to offer a stipulation and order, then later acted to close the case with informal discipline.

We also identified two instances where a stipulation and order was drafted at the request of a respondent's attorney. In both

[6] In cases where the board receives notice of a stipulation and order in another state, staff prepared an order of reciprocal discipline without waiting for direction from the board.

instances, this was a step to come to agreement without formal action, as formal proceedings had commenced and a hearing was scheduled. Because the stipulations and orders were requested between board meetings, the attorney drafted them without specific direction to do so. And, according to correspondence in the files, respondents' attorneys were informed that the board had final approval authority.

Both of these cases appear to be a reasonable exercise of professional judgment because:

- Board members told us the attorney has authority to attempt to settle cases (with stipulations and orders) even when the board has directed the case to move to formal proceedings;
- The attempt to settle the cases was consistent with the board's objective of resolving disciplinary actions through education and rehabilitation as well as statutory provisions encouraging informal resolution of contested cases;[7]
- The only available alternatives were to refuse to settle the cases or to delay the hearings until the board could act to authorize the negotiation of stipulations and orders; and
- The board retained the authority to approve the stipulation and order.

Board approval was required before stipulations and orders negotiated by the contract attorney became effective.

[7] IDAHO CODE § 67-5241(1)(c) (Supp. 2000).

Response to the Evaluation

Idaho State Board of Medicine

PO Box 83720 Boise, ID 83720-0058

June 7, 2001

Nancy Van Maren, Director
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Boise, Idaho 83720-0055

Dear Ms. Van Maren,

On behalf of the Board of Medicine, we would like to thank you for the opportunity to comment on the report *The State Board of Medicine, A Review of Complaint Investigation and Adjudication* for the Joint Legislative Oversight Committee.

The performance evaluation and its findings have provided the Board with a framework for consideration of the Board's investigative and adjudication process.

The Board endorses the findings of this report that physicians are afforded due process in the complaint and adjudication process with our dual notification during the initial complaint investigation process and again with the initiation of formal proceedings. The evaluation report affirms that both Board attorneys act under the direction and guidance of the Board of Medicine.

The Board is in total agreement with the concept that more aggressive investigation including collateral investigations, and investigations unrelated to patient complaints could be accomplished. With legislative support, the Board of Medicine will seek to change the rules enacted by HB 628 to accomplish this recommendation. As the sole state agency required to have rules for investigation, the Board will look to the legislature for support in accomplishing this recommendation.

The Board agrees with the report that most state boards of medicine are required to investigate the allegations of violation of their respective medical practice acts regardless of the source. The violations of the medical practice act will continue to be the focus of any investigation and/or action by the agency.

The Board affirms that there exists a statutory requirement that standard of care cases are defined as care provided by physicians in the *same* or similar community.

The Board endorses the concept of conflict of interest disqualification guidelines and since the Board of Medicine is not the only state agency involved in contested case hearings we support legislative changes that require conflict of interest disqualification in all administrative hearing procedures conducted in the state.

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The Board supports the concept that the Governor not be limited in his ability to appoint any qualified candidate to serve on any board or commission and that membership in any organization not be required for public service.

The Board of Medicine continues to evaluate and improve its processes and will continue to seek out opportunities to improve.

Sincerely,

Bruce Honsinger
Chairman

Nancy M. Kerr
Executive Director

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