Office of the Auditor General

REPORT OF THE

OFFICE OF THE AUDITOR GENERAL

236.1

DISCIPLINING OF PHYSICIANS BY THE BOARD OF MEDICAL EXAMINERS

AUGUST 1975

TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

MEMBERS

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Joint Legislative Audit Committee

GOVERNMENT CODE: SECTIONS 10500–10504

California Legislature

BOB WILSON
CHAIRMAN
ROOM 4126, STATE CAPITOL
SACRAMENTO, CALIFORNIA 95814
(916) 445-6161

August 11, 1975

The Honorable Speaker of the Assembly
The Honorable President pro Tempore of
the Senate
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members of the Legislature:

I am today releasing the report of the Auditor General on a review of the Board of Medical Examiners relating to the discipline of physicians violating the Medical Practice Act.

The Board of Medical Examiners is one of 34 boards and bureaus in the Department of Consumer Affairs empowered to license and monitor the practices of the businesses and professions they represent. The Board of Medical Examiners is responsible for the enforcement of the Medical Practice Act of the Business and Professions Code, which prescribes how physicians and other specified health professionals will be licensed. It gives the board authority to monitor its licensees to ensure that their professional conduct and the quality of their medical care meet the standards of the act.

The board consists of 11 members appointed by the Governor for four-year terms. The board's 43 employees are assisted in their investigation and enforcement activities by the Division of Investigation of the Department of Consumer Affairs, and by the Office of the Attorney General.

Of approximately 72,000 physicians licensed to practice medicine in California, an estimated 46,000 are currently practicing in the state. In 1974 the board took disciplinary actions against 50 physicians, or about one-tenth of one percent of those practicing in the state.

The Auditor General's report cites the following deficiencies:

- The Board of Medical Examiners has not promptly investigated and resolved alleged violations of the Medical Practice Act by physicians. In most cases the physicians had an unrestricted license to practice medicine until the effective date of the board's final order. The report includes numerous examples of lengthy delays in completing disciplinary actions.

- The board has not made full and prompt use of malpractice insurance reports to identify physicians who may be practicing in an incompetent or grossly negligent manner.

- The board has not issued regulations requiring reports from state-licensed hospitals on physicians whose hospital privileges have been limited or terminated.

Some of the reasons found for the problems noted above are:

- The time to complete a disciplinary action is typically the result of a series of delays in each of the offices involved: the Division of Investigation, the Office of the Attorney General, and the board itself.

- The Division of Investigation and the Office of the Attorney General cited workloads as reasons for their delays.

- In some instances investigations have not been pursued pending the outcome of a civil or criminal proceeding. Attorneys for physicians and patients involved in such actions often advise their clients not to provide records to the investigators, and subpoenas have been used on only a few occasions.

- The board does not have an adequate system to monitor pending investigations to locate cases that are lagging or to pinpoint reasons for these delays and to generate corrective action.

The Auditor General recommends that the Board of Medical Examiners:

- Put into effect a system that will enable it to monitor all pending cases and identify the reasons for any delays.

- More aggressively utilize existing resources to investigate and resolve alleged violations of the Medical Practice Act, and if existing resources prove to be inadequate, request funding from the Legislature for additional resources.

- Actively enforce requirements that insurance companies report malpractice settlements and judgments, and promptly open investigations on all cases selected for investigation and specifically on all malpractice claims in excess of $50,000.

- Adopt regulations requiring state-licensed hospitals to report to the board all physicians whose hospital privileges have been limited or terminated for unprofessional conduct, including incompetence and/or gross negligence.

It is further recommended that the Legislature enact legislation:

- To require insurance companies to report monthly all malpractice claims filed against California doctors and separately report all malpractice settlements and judgments.

- If adequate regulations are not adopted by the board, to require state-licensed hospitals to report to the board all physicians whose hospital privileges have been limited or terminated for unprofessional conduct, including incompetence and/or gross negligence.

If implemented these recommendations could result in the identification of additional physicians who may be practicing in an improper manner and also result in the more prompt disposition of disciplinary proceedings against physicians.

In a response contained in the report starting on page 21, the Director of the Department of Consumer Affairs stated that they agree with the findings and recommendations of the report and that they have proceeded to take several corrective steps within their jurisdiction to cut down on delays in the investigative process. The Executive Secretary of the Board of Medical Examiners, in a response attached to that of the Director, also stated that he agrees with the findings and supports the recommendations.

Respectfully submitted,

Bob Wilson

BOB WILSON, Chairman
Jt. Legislative Audit Committee

STATE OF CALIFORNIA

Office of the
Auditor General

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DEPUTIES

August 4, 1975

Honorable Bob Wilson
Chairman, and Members of the
Joint Legislative Audit Committee
Room 4126, State Capitol
Sacramento, California 95814

Dear Mr. Chairman and Members:

Transmitted herewith is our report on a review of the Board of Medical Examiners relating to the discipline of physicians violating the Medical Practice Act.

Respectfully submitted,

Glen H. Merritt
Chief Deputy Auditor General

Staff: John McConnell
Dore C. Tanner
Carla M. Duscha
Linda L. Huffman

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INTRODUCTION

In response to a legislative request, we have reviewed the activities of the Board of Medical Examiners relating to the discipline of physicians violating the Medical Practice Act.

The Board of Medical Examiners is one of 34 boards and bureaus in the Department of Consumer Affairs which are empowered to license and monitor the practices of the business and professions they represent.

In addition to licensing and regulating the activities of physicians, the Board of Medical Examiners is responsible for licensing and regulating the activities of physicians' assistants, physical therapists, psychologists, hearing aid dispensers, audiologists, speech pathologists, dispensing opticians and podiatrists.

The board consists of 11 members who are appointed by the Governor to staggered four-year terms. Ten of the board members are required by law to be physicians; the remaining member must be from outside the medical profession. At the beginning of June 1975, the terms of five board members expired; however, no reappointments or new appointments have been made. Incumbents may continue to serve for up to six months pending appointment of their successors.

The administration of the board's activities and the management of its 43 employees are the responsibilities of the board's Executive Secretary who is appointed by the board and serves at its pleasure. The current Executive Secretary has been with the board since November 15, 1972.

The board is responsible for the enforcement of the Medical Practice Act of the Business and Professions Code. This act prescribes how physicians will be licensed and gives the board authority to monitor its licensees to ensure that their professional conduct and the quality of their medical care meet the standards of the act. The board will initiate an investigation of professional conduct of the quality of care for a variety of reasons, including: patient complaints, police arrest records, medical society referrals, news articles and information from other physicians.

Currently, there are approximately 72,000 physicians licensed to practice medicine in California. Of this number the board estimates that 46,000 are currently practicing in California.

In 1974, the board took disciplinary action against 58 licensees, including 50 physicians, for the following types of violations:

Type of Violation	Number Of Physicians Disciplined
Incompetence and Gross Negligence	1
Alcoholism	2
Criminal Medical Activities	3
Sex Offenses	3
Mental Incompetence	4
Fraudulent Billings	4
Theft, Bribery, Embezzlement and Tax Evasion	5
Narcotic Offenses	28
Totals	50

The 50 physicians disciplined during 1974 represent about one-tenth of one percent of the physicians practicing in the state. As shown in the above table only one physician was disciplined for incompetence and/or gross negligence during 1974.

This report contains recommendations which, if implemented, could result in the identification of additional physicians who may be practicing in an improper manner, and also in the more prompt disposition of disciplinary proceedings against physicians.

FINDINGS

ALLEGED VIOLATIONS OF THE MEDICAL PRACTICE ACT ARE NOT PROMPTLY INVESTIGATED AND RESOLVED.

The Board of Medical Examiners has not promptly investigated and resolved alleged violations of the Medical Practice Act by physicians. This situation persists because the board has not developed an adequate system to monitor pending investigations to identify those which are lagging and the causes for any delays.

Delays In Investigations

Of the 92 cases which resulted in disciplinary action by the Board of Medical Examiners during calendar year 1974 and the first four months of 1975, the time from the authorization of the investigation to final action by the board ranged from nine months to over seven years.* The median time of these cases was approximately two and one-half years.

The length of time to complete the disciplinary process is significant because in most cases the physician has an unrestricted license to practice medicine until the effective date of the board's final order.

* The case that took over seven years was an exception. It involved a physician who was in prison for three of those years for reasons not directly related to the practice of medicine.

The following table shows the elapsed time between the authorization for investigation and the final decision by the board for calendar year 1974 and the first four months of 1975.*

Number of Years from Authorization to Investigation Completion of Disciplinary Action	Number of Cases Decided By Board	
	Calendar Year 1974	First Four Months Of 1975
1 or less	2	0
1 to 2	13	19
2 to 3	25	8
3 to 4	3	6
4 or more	4	3
Unable to determine length of time to complete cases due to incomplete case files	3	6
Totals	50	42

The time to complete a disciplinary action cannot be attributed to any one step in the disciplinary process, but typically is the result of a series of delays in each of the offices involved: the Division of Investigation, the Office of the Attorney General, and the board itself.

Disciplinary actions of the board are based on investigations initiated by the board and conducted by the Division of Investigation, a separate division within the Department of Consumer Affairs which conducts investigations for boards and bureaus in the department. Following the completion of the investigation and a determination by members of the board's staff that disciplinary action is warranted, the evidence supporting the alleged violation is sent to the Attorney General for preparation of a formal accusation.

* Delays in implementation of the board's final decision because of appeals to the courts are in addition to the times in this table.

A public hearing is then held on the charges. This hearing is generally conducted either by an administrative hearing officer from the Department of General Services or a District Review Committee of the Board of Medical Examiners.

The proposed decision resulting from these hearings is sent to the board for consideration. The board has the choice of adopting, modifying or rejecting the proposed decision. Discipline imposed by the board ranges from revocation of the physician's license to a probationary term during which the physician must demonstrate to the board that he is correcting the problems that resulted in his discipline.

Examples of Lengthy Delays in Completing Disciplinary Actions

An example of a case taking approximately two and one-half years to complete involved a physician whose license was revoked in 1974 for excessive and improper prescribing of narcotics and dangerous drugs. The physician's practices were brought to the attention of the Board of Medical Examiners in April 1972 by a state parole officer whose client, a drug addict, was receiving many prescriptions for dangerous drugs from the physician. The board's staff authorized an investigation on April 10, 1972.

The parole agent was interviewed by an investigator from the Division of Investigation on April 14, 1972.* On September 15, 1972 the division reported that an undercover operator was sent to the doctor on September 7 and that the agent obtained prescriptions for dangerous drugs without a medical examination. Undercover operators were again used to obtain additional prescriptions without a medical examination in October, November and December 1972.

* The labels on prescription bottles and labels obtained by the investigator showed that prescriptions were issued by this physician to the parole officer's client on February 28, March 3, March 13, March 18, March 21 and March 23. During this 24 day period, ten prescriptions for narcotics, barbiturates and tranquilizers were issued by this physician to the parole agent's client, for a total of over 380 pills.

On February 26, 1973, the Division of Investigation recommended that disciplinary proceedings be started. On April 3, 1973 the board's staff authorized sending the evidence to the Attorney General's Office for preparation of an accusation. On May 4, 1973, the Division of Investigation sent the evidence to the Attorney General. The accusation was sent to the board's Executive Secretary for signature on July 25, 1973 with an explanation that the delay in preparing the accusation was due to certain legal uncertainties associated with the use of undercover operations.

On behalf of the board, the Attorney General attempted to arrange a stipulated settlement of the case with the physician on the basis of the prepared accusation. But in January 1974, the Division of Investigation learned that the physician had erroneously prescribed a dangerous drug for a three year old child. After this incident, the doctor signed an agreement with the board not to prescribe dangerous drugs or narcotics pending the disposition of the case. The hearing was held on August 7, 1974 and the hearing officer recommended revocation of the physician's license. The board ratified the hearing officer's recommendation on October 9, 1974.

This case had unnecessarily long time spans between actions, such as the five month span between the initial interview with the parole officer and the next investigative work, the two month span between the last investigative work and the date of the division report recommending to the board's staff that disciplinary proceedings be started, the one month span used by the board's staff to authorize the division to send the evidence to the Attorney General, the one month span after authorization before the case was transmitted to the Attorney General and the three and one-half month span between the hearing officer's recommendations and the board's action to adopt those recommendations.

A second example, this one involving a case taking 17 months to complete, concerned a physician whose license was revoked in 1974 for using a prescription by a fictitious physician to a fictitious person to obtain narcotics for himself. The physician had been previously disciplined and placed on probation in February 1973 for administering narcotics to himself. The alleged violation was brought to the attention of the Division of Investigation by the police on February 2, 1973.

The investigation was opened by the board on March 21, 1973. The division completed its review of the case on June 4, 1973. The board staff authorized disciplinary action on June 28, 1973. The Attorney General received the case on August 10, 1973 and completed the accusation on October 4, 1973. An amended accusation was filed on January 22, 1974. The administrative hearing was held on March 21, 1974. The board adopted the hearing officer's recommendations to revoke the physician's license on July 9, 1974.

This 17 month case had unnecessarily long time spans between actions, such as the one and one-half month span between the date information from the police was received by the Division of Investigation and the authorization to open the case by the board's staff, a 24 day span between the date of the Division of Investigation report recommending to the board's staff that disciplinary proceedings be started and the date the board's staff authorized disciplinary action against the physician, and a three and one-half month span between the date of the hearing officer's recommendations to the board and the board's final action to revoke the physician's license.

Delays in Division of Investigation

Once division investigators are assigned a case, including those involving alleged incompetence and/or gross negligence, it often sits for long periods of time without being investigated. The required progress reports from

the investigators on these cases show that for periods of time -- in excess of 90 days -- no action has been taken and that the investigator has made little new headway in his work. As of March 31, 1975, investigations were pending on 315 cases involving alleged incompetence and/or gross negligence. Our review of these case files disclosed that 105 of these cases had delays of 90 days or more with no new progress. The appendix on page 21 contains 10 examples selected from among these 105 cases. The division cites workload as the reason for the delay in the processing of these cases.

An example of a case which remained uninvestigated for a long period of time involved a physician who sustained a malpractice settlement in excess of $200,000 for administering a drug which allegedly caused permanent mental damage to his patient. The investigation was opened in June 1974. The first progress report showed that it was not until five and one-half months after the case was opened that the investigator made the first contact with the plaintiff's attorney and the physician's insurance company. From these two contacts the investigator learned what drug the physician used and that the plaintiff's attorney had destroyed all his records pertinent to the case.

In some instances, the Division of Investigation has not pursued investigations pending the outcome of a civil or criminal proceeding. Attorneys for physicians and patients involved in such actions often advise their clients not to provide records to the investigators. The department could subpoena these records but has done so on only a few occasions.* The delay is particularly significant for its effects on cases of possible incompetence and/or gross negligence.

* We noted during our review that since about April 1975 the division has been making more frequent use of subpoenas. Also, in April 1975 procedural changes were made which the director estimates will reduce the time needed to prepare a subpoena by about two weeks.

By adding the length of time necessary to complete an investigation to the time a malpractice suit is in court, the length of time a possibly unfit physician is practicing with an unrestricted license is increased.

Another effect of delaying the investigation is the possibility that pertinent records and witnesses will be unavailable to investigators because of the long time span between the medical incident and board action.

An example of a case which remained uninvestigated for over 14 months involved a malpractice lawsuit against a physician. The investigation was opened in March 1973 after the board had received a news article announcing the suit had been filed. The first progress report, dated May 1973, showed that the investigator obtained the civil complaints and that the action had not been set for trial. The second, third, and fourth progress reports showed the investigator only checked to determine if the trial date had been set and stated that the investigation is pending the action of the court. The fifth progress report showed the lawsuit was settled out of court. The sixth progress report dated in May 1974 showed the investigator was beginning an attempt to obtain medical records. The case is still under investigation.

Delays in Office of the Attorney General

A case is referred to the Attorney General after the board's staff determines that there is sufficient evidence to impose administrative discipline on a physician. As the legal representative of the board in all proceedings, the Attorney General's responsibilities include preparing accusations against physicians and presenting the case before a hearing officer or the board's District Review Committees.

In some instances, the Attorney General's Office has not promptly concluded legal proceedings against physicians for alleged violations. This allows a possibly unfit physician to practice medicine for a longer period of

time with an unrestricted license. The Attorney General's Office explained that delays in bringing cases to hearing is due to workload and to delays in obtaining hearing dates from the Office of Administrative Hearings.

An example of a case delayed in the Attorney General's Office involved a physician convicted of involuntary manslaughter in 1974, as a result of the death of a patient where the physician didn't have any knowledge of how the surgical procedure he was performing was done. The case was referred to the Attorney General for preparation of an accusation in October 1974. However, the Attorney General has not yet prepared an accusation charging the physician with violations of the Medical Practice Act. A June 30, 1975 status report from the Division of Investigation stated that the Deputy Attorney General assigned to the case "has not drawn up (the) accusation on (the) subject yet due to (the) press of other business". We contacted the Deputy Attorney General assigned the case and he informed us that the case had been delayed due to his involvement in other cases.

Inadequate System to Monitor Pending Investigations

The board currently does not have a report which lists pending investigations according to their age and which shows the current status of each investigation and any reasons for delays. Such information is needed to direct attention to lagging investigations.

The board has a card file containing a card for each active investigation which identifies the licensee under investigation, the date the investigation was opened, whether the Division of Investigation or the Attorney General is now handling the case, and the date of the last progress report.

In addition the board maintains case files on all physicians currently under investigation. These files contain, among other things, copies of the original complaint, the letter from the board requesting the Division of Investigation to begin its work, progress reports from the Division of Investigation and correspondence with the Attorney General.

However, neither the card file nor the case files provide a feasible means of locating cases that are lagging, or to pinpoint reasons for these delays and to generate corrective action.

The card file does not show how much investigative work has been completed or at which stage the investigation currently is. The case files do contain such information; however, there are approximately 1,800 investigations in progress so it is not feasible for the board to use its case files directly to keep track of delayed investigations.

The Board's Responsibility

Although several agencies are involved in the disciplinary process, the Board of Medical Examiners is the agency charged by law with protecting the public against unfit physicians. As such, it has the right to demand that the Attorney General and the Division of Investigation, which act as the board's agents, perform the investigations and legal work for which they are retained promptly and in accordance with the board's instructions.

However, the board has seldom investigated the reason for lagging cases, does not have an organized approach to identify lagging cases, and in fact the board's own staff has delayed cases by not promptly authorizing investigations and disciplinary proceedings.

Although workload has been cited as a reason for delays, we believe that the need for additional staff, if any, cannot be proven until the board more aggressively utilizes its existing resources. Such resources include 43 board employees plus assistance from the Division of Investigation and the Attorney General's Office.

CONCLUSION

In our judgment, investigations of alleged violations of the Medical Practice Act are not promptly investigated and resolved. As a result, the public's health and safety is not adequately protected.

This situation is contributed to in part because the Board of Medical Examiners does not have a system enabling it to locate delayed investigations and to initiate action to speed up these investigations.

RECOMMENDATIONS

We recommend that the Board of Medical Examiners put into effect a system that will enable it to monitor all pending cases and identify the reasons for any delays.

We further recommend that the Board of Medical Examiners more aggressively utilize its existing resources to investigate and resolve cases of alleged violations of the Medical Practice Act. If existing resources then prove to be inadequate, we recommend that funding for additional resources be requested from the Legislature.

BENEFITS

Implementation of these recommendations will protect the public's health and safety by reducing the time a possibly unfit physician is practicing with an unrestricted license.

FULL AND PROMPT USE IS NOT MADE OF MALPRACTICE INSURANCE REPORTS TO IDENTIFY PHYSICIANS WHO MAY BE PRACTICING IN AN INCOMPETENT AND/OR GROSSLY NEGLIGENT MANNER.

The Board of Medical Examiners has not actively enforced the statutory requirement that it be notified of all malpractice judgments and settlements in excess of $3,000. In addition, the board has not promptly followed its own policy of opening investigations on all physicians involved in malpractice judgments and settlements in excess of $50,000. Furthermore, existing law only requires annual notification after the case has been settled or judgment entered which may be a considerable period of time after the incident occurred and after the case was filed.

Insurance companies are required by Section 800 of the Business and Professions Code to report annually to the Board of Medical Examiners all malpractice claims payments in excess of $3,000. The board, however, has not actively enforced this law. Our review disclosed that in 1974, the board did not receive reports from every insurance company making malpractice claims payments. Efforts by the board to enforce Section 800 of the Business and Professions Code are hindered because it has not compiled a list of all companies that have offered malpractice insurance in California in recent years.

The board has a policy of investigating all malpractice judgments and settlements over $50,000 and 10 percent of those under $50,000 for possible incompetence and/or gross negligence. This policy was designed to assist the board in locating physicians who could be practicing medicine in an incompetent and/or grossly negligent manner. Our review disclosed that the board did not open investigations of physicians with malpractice judgments and settlements over $50,000 for extended periods of time after receiving notifications from the insurance companies.

Of the 111, 1973 judgments and settlements over $50,000 resulting from malpractice lawsuits, the board did not open investigations into possible incompetence and/or gross negligence on 53 physicians involved in these judgments and settlements for at least five months after receipt of the insurance company reports. In addition, 12 cases had not been opened for investigation as of May 31, 1975.

For judgments and settlements over $50,000 received by the board for the year 1974, 97 cases involving possible incompetent and/or grossly negligent physicians were not opened as of May 31, 1975. Seventeen of the 97 cases were received by the board over nine months before that date, and the remaining 76 cases had been in the board's office for over five months before May 31, 1975.

The following table shows for 1973 and 1974 insurance company reports, the length of time it took the board to open investigations of physicians involved in malpractice insurance judgments or settlements in excess of $50,000.

	Physicians Reported by Insurance Companies	
	1973	1974
Investigations not opened as of May 31, 1975*	12	97
Investigations opened five or more months after receipt of insurance company reports	53	2
Investigations opened between one month and five months after receipt of insurance company reports	0	2
Investigations opened within one month after receipt of insurance company reports	22	0
Investigations opened as the result of other sources prior to receipt of insurance company reports	5	23
Status not known because board staff unable to locate case files at the time of our review	19	17
Malpractice judgments and settlements over $50,000 received by the board	111	141

*The board's staff has informed us that these cases have now been opened.

Of the 65 cases in 1973 opened after one month or left unopened, 13 or 20 percent, involved malpractice settlements or judgments of $200,000 or more. For 1974, 17 or 17 percent, of the 101 cases opened after one month or left unopened, involved malpractice settlements or judgments in excess of $200,000.

In addition to the delays by the board in opening cases, existing law only requires that the board be notified once a year and only after the case has been settled or judgment entered. This may be a considerable time after the case was filed. Delays of up to 12 months are created because reports are required only annually. Additional delays occur between the time a case is filed and the time a judgment or settlement is entered.

CONCLUSION

The Board of Medical Examiners does not require insurance companies to comply with the existing law requiring them to notify the board once a year of malpractice settlements and judgments paid in excess of $3,000 and does not promptly open investigations into claims payments in excess of $50,000. Furthermore, in our opinion, the fact that existing law only requires annual reporting and only requires reporting of judgments and settlements and not claims filed makes it less effective than it could be if more frequent reporting were required and if claims were also required to be reported.

Failure to open investigations immediately after receipt of insurance company reports could permit incompetent and/or grossly negligent physicians to practice medicine for a longer periods of

time. It could also create investigative problems of locating records and witnesses due to the passage of time.

RECOMMENDATIONS

We recommend that the Board of Medical Examiners:

- Actively enforce the requirement that insurance companies report malpractice settlements and judgments and that it promptly open investigation on those cases selected for investigation

- Promptly open investigations on all malpractice claims in excess of $50,000.

We further recommend that legislation be enacted to require insurance companies to report monthly all malpractice claims filed against California doctors and separately all malpractice settlements and judgments.

BENEFITS

Implementation of these recommendations will facilitate the identification of cases where a physician may be practicing in an improper manner.

THE BOARD OF MEDICAL EXAMINERS HAS NOT ISSUED REGULATIONS REQUIRING REPORTS FROM STATE LICENSED HOSPITALS ON PHYSICIANS WHOSE HOSPITAL PRIVILEGES HAVE BEEN LIMITED OR TERMINATED.

Hospitals represent one of the few places where physicians practice their profession under the scrutiny of their peers and with routine internal reviews of medical practices. These reviews can include internal audits of diagnosis and treatment, pathological reviews of tissues removed in surgery, and review of emergency room care and treatment. A pattern of irregular practices or unprofessional conduct by a physician, or an individual instance of grossly improper treatment, can result in termination of hospital staff privileges.

Reports of disciplinary action limiting or terminating a physician's hospital privileges can be a valuable source of information on possible improper medical practices.

Currently the board receives reports from hospital medical staffs on the practices of their members sporadically and solely at the discretion of the individual hospitals.

During the course of our review, we found cases under investigation which had been sent to the board by concerned hospital officials. These cases represented less than three percent* of the cases the board referred to investigation in the first five months of 1975.

The Board of Medical Examiners has the authority under the Business and Professions Code to issue regulations requiring state licensed hospitals to report to the board cases involving the discipline of a licensed physician for "unprofessionalism or incompetence".

* The only available statistics kept by the board combine referrals from hospitals and pharmacies and show that both together account for less than three percent of the cases referred by the board to the Division of Investigation.

To date the board has not issued such regulations despite the fact such action could result in further action against incompetence and/or gross negligence by physicians. We were informed by the board's staff that they were unaware authority existed for such regulations.

Hospital officials interviewed during our review said they were reluctant to report their disciplinary actions against their member physicians because of the potential legal liability for the hospital and its staff. They said the question of legal liability would be resolved if the Board of Medical Examiners specifically required hospitals to report all instances of discipline by the hospital for improper medical practices.

CONCLUSION

The Board of Medical Examiners has not used its authority under the Business and Professions Code to issue regulations requiring hospitals to report cases where a physician's hospital privileges have been limited or terminated although such information would aid it in locating physicians who may be practicing medicine in an improper manner.

RECOMMENDATIONS

We recommend that the Board of Medical Examiners adopt regulations requiring state licensed hospitals to report to the board all physicians whose hospital privileges have been limited or terminated for unprofessional conduct, including incompetence and/or gross negligence.

We further recommend that if such regulations are not adopted by the board that legislation be enacted to require such reporting.

BENEFITS

Implementation of these recommendations will facilitate the identification of cases where a physician may be practicing in an improper manner.

State of California

Memorandum

To : Jack Merritt
Chief Deputy Auditor General
Office of the Auditor General
925 L Street, Room 750
Sacramento, CA 95814

Date : July 23, 1975

Subject: BOARD OF MEDICAL EXAMINERS

From : **Department of Consumer Affairs**
Executive Offices

Thank you for the briefing last week on the Auditor General's report of the Board of Medical Examiners. We welcomed the review and the report documented many of the problems that our staff had previously identified. I hope that the report can be used as an impetus for bringing about the long overdue reforms needed in the Board of Medical Examiners.

I am enclosing a copy of our response and the response of the Board of Medical Examiners.

TAKETSUGU TAKEI
Director

TT:jt
Enclosures

cc: Raymond Reid
Executive Secretary
Board of Medical Examiners

RESPONSE OF THE
DEPARTMENT OF CONSUMER AFFAIRS
TO THE AUDITOR GENERAL'S REPORT - BOARD OF MEDICAL EXAMINERS

July 23, 1975

The Department of Consumer Affairs agrees with the findings and recommendations of the Auditor General and we have proceeded to take several corrective steps within our jurisdiction to cut down on delays in the investigative process.

For example, the new Chief of the Division of Investigation has assigned one of his top-level assistants to monitor Medical Board cases involving gross negligence and incompetence; authority to issue administrative subpoenas has been delegated to the Division staff, thereby cutting down delays in gathering information; and we have directed our Management Systems staff to develop new procedures in the Board's investigative unit.

However, there are many problems with the Board of Medical Examiners not addressed in the Auditor General's report, some of which will require legislation and others requiring fundamental changes in the Board's disciplinary policy. Rather than focus exclusively on investigations of individual complaints, the Board and its staff should make a greater effort to analyze trends and patterns of complaints and propose remedies to address those key problem areas. Further, some consideration should be given to on-going evaluation of physician competence, such as mandatory reexamination as a condition for renewal, office audits and close coordination with PSRO's (Professional Standard Review Organization) being established throughout the state.

DEPARTMENT OF Consumer Affairs

BOARD OF MEDICAL EXAMINERS
1020 N STREET, SACRAMENTO, CALIFORNIA 95814
TELEPHONES:
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Complaints and Licensure Records (916) 322-5030
Corporations (916) 322-5043

July 24, 1975

Jack Merritt
Chief Deputy Auditor General
Office of the Auditor General
925 L Street, Room 750
Sacramento CA 95814

Dear Mr. Merritt:

Overall, the Board of Medical Examiners' staff is in agreement with the findings and supports the recommendations made by the Auditor General's report.

Some background regarding the situation in the Board during the last two years may be helpful to further evaluate the findings and recommendations. There has been a dramatic increase in the past two years in the number of consumer complaints and inquiries reaching this office and a dramatic increase in the number of final settlements and judgements reported requiring investigation which sharply increased the pressures on all offices involved in handling disciplinary actions for the Board. The resulting delays in completing investigations by the Division of Investigation, filing Accusations by the Attorney General's Office, and the scheduling of hearings by the Office of Administrative Hearings are a reflection of this increase.

Although the Board does not have a specific monitoring system for the Division of Investigation or the Attorney General's Office, it does not mean that attempts were not made to push cases to conclusion whether they were at the Division of Investigation or the Attorney General's Office. The investigations staff has been in daily contact with investigators and supervisors from the Division of Investigation as well as individual Deputy Attorney General's handling cases for the Board of Medical Examiners. Approximately two years ago, a representative from the Department of Finance and a representative from the Division of Investigation interviewed staff of the Board of Medical Examiners as well as other boards in the Department.* At that time the Board staff indicated, and their report will bear this out, that investigations opened with the Division of Investigation were not handled

*_Management Review of the Division of Investigation_, Department of Finance, page 33.

promptly and that many cases had no initial reports within 60 days after a case was opened, which is the Division of Investigation's internal policy. As a contractor for the services of the Division of Investigation, we expected closer supervision and control of Board of Medical Examiners' investigations by the supervisors in the Division of Investigation. Even if monitoring procedures had been established, we still doubt whether the majority of delays could have been avoided. In addition to the recommendations by the Auditor General, the Board would recommend that the Division of Investigation establish a procedure of monitoring investigations to meet the policy they have established, hire investigative personnel with medical background, and give the Board of Medical Examiners control over the handling of these cases by having a supervisor in each Division of Investigation office responsible for Medical Board cases only.

In the last two years budget and personnel requests have been turned down which the Board felt were necessary to increase its ability to handle additional workload. Also, every attempt was made to convince the administration to move the Board out of its cramped, noisy quarters. These conditions resulted in poor morale and above average turnover of trained technical staff which hindered the Board's operation.

The Board staff, recognizing room for improvement in its operations, last year requested for and received the assistance of the Consumer Affairs Management Analysts Office. Since July, 1974 a Management Analyst has been in the process of reviewing procedures, making recommendations for changes, and assisting in implementing those changes.

The other section of this report concerns the handling of investigation of malpractice settlements and judgements reporting to the Board. In 1973 at the request of the Executive Secretary, the Department of Insurance was requested and did send a letter to all insurance companies reminding them of the reporting requirements in Section 800. The law itself simply requires the Board to maintain statistics on final settlements and judgements. The Board of its own volition decided that it would investigate these settlements and judgements to see if it would result in weeding out incompetent physicians. Another section of the law requires that legislative recommendations, if any, should be made at each session of the Legislature. These recommendations were made and a narrative copy is attached listing the recommendations that have been made over the past two years, with some of the recommendations resulting in legislation introduced by former Assemblyman Waxman, who was then Chairman of the Assembly Select Committee on Medical Malpractice and in whose public hearings the Board participated along with the Attorney General's Office.

The recommendation of the Auditor General to have the Board issue regulations requiring reports from hospitals is an excellent one. This suggestion was partially incorporated by Assemblyman Waxman in his AB 3633 of the last legislative session which gave immunity to persons reporting information on

a physician to the Board of Medical Examiners. As mentioned earlier, this legislation was partially the result of the work of the Board, in conjunction with the Attorney General's Office in suggesting changes in the law which would broaden the ability of the Board to obtain information as well as to take disciplinary action against a physician. The Board has met with Assemblyman Duffy and has discussed with him specific legislation which would require hospitals to report any physicians whose staff privileges were revoked.

Sincerely,

RAYMOND REID
Executive Secretary

RR:sue

Memorandum [Attachment to Board of Medical Examiners written response to this report.]

To : Mr. Frank Reynolds
Chief Deputy Director
Executive Offices

Date : February 5, 1974

File No.:

From : Board of Medical Examiners

Subject:

Pursuant to Article II, Section 802 of Division II of the Business and Professions Code, the attached statistical report is hereby submitted.

The legislature in enacting this statute requested that the Board include recommendations for corrective legislation. At the time of filing the 1972 report, the Board had unsufficient experience with this area to make any recommendations. After two years of operation the Board respectfully recommends the following corrective legislation.

The first group of recommendations relate to the reporting requirement of Section 800. The data presented by the carriers cannot be interpreted uniformly and is of little value to the Board without a great deal of unnecessary investigation. The Board respectfully requests that legislation be enacted clarifying the nature of the report as follows:

1. Full name and license number of licensee.
2. Specific amount for which judgement or settlement is rendered.
3. If a formal suit was filed, the court of record and the case number assigned by that court.
4. A brief written statement outlining the facts on which the claim was based.
5. A requirement that the reporting be done quarterly, thus eliminating the end of year flood of reports that create an administrative backlog, detremental to the Board's investigatory process.
6. A penalty clause that would insure compliance with the requirements of this section.

This second group of legislative recommendations would allow the Board to better pursue its disciplinary function by providing additional information to the present system of reporting settlements or judgements. Suggested provisions would include:

1. A requirement that any attorney, or individual functioning in a like capacity, when filing with any court of record in this state, any pleading or other document having legal effect

relating to a claim or action for damages for personal injuries caused by an error, omission, or negligence in the performance of professional services by any individual licensed under the provisions of Division II of the Business and Professions Code, also file a copy of same pleading or document with the agency which issued the license, certificate or similar authority.

2. Any attorney or individual functioning in a like capacity who files any pleading or document with the licensing agency (the Board) shall be immune from any civil liability arising out such a reporting.
3. Any information contained in any pleading or document filed with the Board that is not of public record shall be considered confidential.
4. This reporting responsibility is to extend to any pleading or document relating to the final disposition of the claim or action including a settlement, negotiated settlement, or judgement and and dismissal whether voluntary or not.
5. An appropriate penalty clause should be included to insure compliance.
6. The Board should be empowered to adopt rules and regulations implementing the above legislation.

RAYMOND REED
Executive Secretary

RR:vjm

Enclosure

written response to this report.]

To : Mr. Timothy Comstock
Deputy Director
Department of Consumer Affairs

Date : February 21, 1975

File No.:

From : Board of Medical Examiners

Subject: MALPRACTICE REPORT SUBMITTED PURSUANT TO ARTICLE II, SECTION 802 OF DIVISION II OF THE BUSINESS AND PROFESSIONS CODE

Background

This report is the fourth report by the Board of Medical Examiners to the Legislature. The first and second report contained no recommendations since our experience with the investigations of malpractice settlements and judgements had just begun and not enough data, based on our investigations of physicians and surgeons reported under Section 802 could be used with any reliability.

The third report, dated February 5, 1974, contained recommendations relating to reporting requirements of insurance companies, which would allow the Board, without undue preliminary investigation, to determine the specifics of the malpractice settlements and judgements reported. The basic recommendations of the third report are contained in Assembly Bill 36 introduced this session by Assemblyman Howard Berman.

In December 1973 and November 1974 representatives of the Board of Medical Examiners testified at the hearings of the Assembly Select Committee on Medical Malpractice. The Board's testimony contributed to some of the legislative recommendations contained in the Select Committee's Preliminary Report of June 1974.

Since the transcript of the November 1974 hearing has not been published, we have included, as Attachment I of this report, the testimony presented at the hearing by Doctor Harold E. Wilkins, a Board member. We have also included a letter to Assemblyman Henry Waxman from Doctor Wilkins which indicates the lack of close correlation between successful malpractice settlements and judgements and incompetence. Questions asked of Board representatives at these hearings primarily concerned discipline and any findings of the Board which resulted from its investigation of malpractice settlements and judgements reported annually.

Attachment II outlines a five-year statistical table of the Board's increasing investigations and disciplinary actions.

Statistical Summary

Attachment III is a statistical table showing the number of malpractice settlements reported to the Board at the end of each calendar year.

Summary

The Board of Medical Examiners has cooperated with and contributed to the efforts of the Assembly Select Committee on Medical Malpractice. In cooperation with the Attorney General's Office, recommendations were made to and accepted by the Legislature for improving the reporting of errant physicians to the Board for disciplinary action as well as changing the Medical Practice Act to allow the Board to take action against physicians who have been incompetent. The effect of some of these changes is reflected in the Board's summary of disciplinary actions in Attachment II.

In order to better fulfill its role as a disciplinary body, the Board requested additional budget allocations for investigating and disciplining physicians. Budget requests have been submitted for additional st ff in the Board's investigations section and for an additional Medical Consultant. In addition, the Board will recommend the introduction of legislation in this session to increase the number and membership of District Review Committees so that p ompt disciplinary action can be taken against a physician who is negligent or incompetent or who, in any other way, represents a danger to the public.

Further analyses of previous reports and of this year's reports are being made. If additional recommendations result, they will be forwarded to the Legislature as required by Section 802.

BOARD OF MEDICAL EXAMINERS

RR:lb

State of California

Department of Justice

Memorandum

To : John H. McConnell, C.P.A.
Office of the Auditor General
925 L Street, Suite 750
Sacramento, CA 95814

Date : July 24, 1975

File No.:

From : Office of the Attorney General - Los Angeles

Subject: AUDITOR GENERAL'S REPORT ON THE MEDICAL BOARD

In response to your inquiry of Tuesday last, I am enclosing two documents which support my statements to you, circling the pertinent information thereon.1/

You will notice that in the Governor's Budget for 1975/76 he recommended an increase of 28 attorneys in the Professional and Vocational Licensing Administrative Law Section of this office, which section serves the Department of Consumer Affairs. You will note in the Legislative Analysis they referred to 20 attorneys, but indicate they have not been able to verify whether the Department of Consumer Affairs had budgeted sufficient funds to allow the Attorney General to establish the proposed positions. I assure you that I know of my own knowledge that the Department did not.

Lynn Henry Johnson

LYNN HENRY JOHNSON
Assistant Attorney General

LHJ:lam
Encl.

1/ The two documents referred to are Page 51 of the 1975-76 printed budget and Page 31 of the Legislative Analyst's analysis of the 1975-76 budget. The printed budget includes 28 additional attorney positions for the Professional and Vocational License Unit in the Attorney General's Office which handles the work of the Department of Consumer Affairs and other licensing and regulating agencies. The Legislative Analyst's report recommends that 8 of the 28 positions proposed for work other than that of the Department of Consumer Affairs be deleted and withholds recommendation on the 20 proposed for Department of Consumer Affairs work on the basis that he had "not been able to verify whether [the boards and bureaus in the Department of Consumer Affairs] have budgeted sufficient funds" and went on to state that the Attorney General's Office "failed to clear the establishment of these positions with the client agencies and submitted its budget to the Department of Finance too late to permit the latter to screen their positions adequately".

APPENDIX

This appendix contains summaries of 10 of the 315 Division of Investigation case files that were open for investigation into possible incompetence and/or negligence as of March 31, 1975. We identified 105 of these cases as not being promptly investigated. The specific criteria we used to identify delayed investigations were: (1) the passage of more than 90 days before medical records of a malpractice settlement or judgment were obtained or subpoenaed; (2) the passage of more than 90 days before a newly referred case was initially investigated; and (3) lapses of more than 90 days in the investigative process without additional progress. We selected the 10 cases as typical examples of these 105 cases.

In addition to being examples of delayed investigations, these cases show the elapsed time between the date of the incident, the date of the judgment or settlement the notice is received from the insurance company, and the date the case was opened for investigation.

Case Number: 1

Description: Case Involved Malpractice Judgement of $652,000 for Alleged Improper Surgery

Date of Incident: September 25, 1968

Date of Court Judgment: February 8, 1971

Date Notice of Court Judgment
Sent to Board of Medical Examiners: June 23, 1973

Case Opened for Investigation: July 19, 1973

Date and Progress Made on Investigation

First Report: Report of September 21, 1973 showed investigator interviewed plaintiff's attorney and learned that plaintiff was unwilling to cooperate until appeal to higher court was completed.

Second Report: Report of December 11, 1973 showed investigator had made no new progress.

Third Report: Report of July 9, 1974 showed investigator had learned that the appeal was over. Investigator stated he had contacted plaintiff and obtained his release of medical records.

Fourth Report: Report of August 7, 1974 showed investigator had interviewed plaintiff and had not received his medical records from him.

Fifth Report: Report of December 27, 1974 showed investigator unsuccessfully tried to obtain patient's medical records from hospital.

Sixth Report: Report of April 7, 1975 showed investigator still had not obtained medical records from hospital.

Seventh Report: Report of May 29, 1975 showed the board's medical consultant had reviewed the medical records on May 23, 1975. The report also showed the investigator on May 28, 1975 interviewed the physician. The case was recommended for closure for insufficient evidence.

Case Number: 2

Description: Case Involved Malpractice Settlement of $150,000

Date of Incident: August 1, 1966

Date Notice of Settlement Sent to
Board of Medical Examiners: January 3, 1974

Case Opened for Investigation: June 20, 1974

Date and Progress Made on Investigation

First Report: Report of December 17, 1974 showed investigator had obtained plaintiff's name and amount of settlement from insurance company on December 11, 1974. Investigator said case should be transferred to another district office of the Division of Investigation.

Second Report: Report of March 6, 1975 indicated investigator had asked plaintiff's attorney for pertinent medical records.

Third Report: Report of May 23, 1975 indicated investigator had again asked for medical records on May 8, 1975. Lawyer responded that he would check his files for the records.

Case Number: 3

Description: Case Involved $1.3 Million Malpractice Settlement for Permanent Brain Damage to Young Child

Date of Incident: September 28, 1968

Date of Insurance Settlement: July 7, 1973

Date Notice of Settlement Sent to Board of Medical Examiners: January 15, 1975

Case Opened for Investigation: November 19, 1973 (opening date preceeded settlement notice due to prior newspaper report of case)

Date and Progress Made on Investigation

First Report: Report of March 20, 1974 showed investigator requested another division office to obtain legal records and interview all parties involved in suit.

Second Report: Report of August 19, 1974 showed second investigator had gathered court records and had contacted physician's hospital on August 16, 1974 and learned physician was practicing in another area of the state.

Third Report: Report of November 25, 1974 showed second investigator had interviewed patient's parents and found them uncooperative.

Fourth Report: Report of February 3, 1975 showed second investigator had unsuccessfully tried to interview plaintiff's attorney. Investigator had also received patient's hospital records on January 28, 1975. Case referred to Board of Medical Examiners' medical consultant.

Fifth Report: Report of May 2, 1975 shows that consultant requested interview with physician.

Case Number: 4

Description: Case Involved Malpractice Settlement of $5,000 for Physician's Alleged Failure to Sufficiently Inform Patient of Risk of Treatment

Date of Incident: Not Available

Date of Insurance Settlement: Not Available

Note Notice of Settlement Sent to Board of Medical Examiners: Not Available

Case Opened for Investigation: June 18, 1974

Date and Progress Made on Investigation

First Report: Report of January 6, 1975 showed investigator had received information regarding amount of settlement from insurance company. Report also showed investigator had obtained court record of plaintiff's complaint. Investigator also requested medical records from plaintiff's attorney on October 15, 1974 and, upon receiving no cooperation, said he would prepare necessary subpoena.

Second Report: Report of May 29, 1975 showed investigator had interviewed physician on May 29, 1975. Report also showed medical records were reviewed by the board's medical consultant and case was recommended for closure for insufficient evidence.

Case Number: 5

Description: Case Involved Malpractice Settlement of $61,500

Date of Incident: Not Available

Date of Insurance Settlement: Not Available

Date Notice of Settlement Sent
to Board of Medical Examiners: June 26, 1973

Case Opened for Investigation: July 19, 1973

Date and Progress Made on Investigation

First Report: Report of January 9, 1974 showed investigator had received court records on January 9, 1974. Also he had requested medical and legal records from plaintiff's attorney.

Second Report: Report of June 7, 1974 showed investigator was told that attorney no longer had records on case. Investigator contacted superior court in an unsuccessful attempt to obtain court exhibits.

Third Report: Report of December 30, 1974 showed investigator again contacted superior court without success. Investigator said he would now try to locate plaintiff in order to obtain medical records release.

Fourth Report: Report of February 28, 1975 showed investigator had sent subpoena to Attorney General on February 25, 1975 for approval to obtain hospital medical records.

Fifth Report: Report of April 8, 1975 showed investigator served subpoena on hospital and was told the records were no longer available. Investigator said the physician had agreed to make his records available.

Sixth Report: Report of May 15, 1975 showed the board's medical consultant reviewed all materials on May 14, 1975 and the investigator recommended the case be closed for no evidence of violation.

Case Number: 6

Description: Case Involved Patient's Complaint of Alleged Gross Incompetence

Date of Incident: Not Available

Date Complaint Received by
Board of Medical Examiners: Not Available

Case Opened for Investigation: March 25, 1974

Date and Progress Made on Investigation

First Report: Report of December 20, 1974 showed investigator had obtained a portion of necessary medical records and was trying to obtain remaining medical records.

Case Number: 7

Description: Case Involved Malpractice Settlement of $3,800 for Death of Patient

Date of Incident: February 20, 1971

Date of Insurance Settlement: November 29, 1973

Date Notice of Settlement Sent to Board of Medical Examiners: January 3, 1974

Case Opened for Investigation: June 20, 1974

Date and Progress Made on Investigation

First Report: Report of December 20, 1974 showed investigator had interviewed insurance company representative on December 10, 1974 and learned name of plaintiff and amount of settlement. Report also showed investigator had interviewed physician and obtained his medical records on December 12, 1974. Report showed investigator had obtained court records on December 16, 1974.

Second Report: Report of April 7, 1975 showed investigator was attempting to obtain hospital medical records and medical release from plaintiff.

Case Number: 8

Description: Case Involved Malpractice Judgment of $100,000 for Alleged Improper Surgery

Date of Incident: June 23, 1970

Date of Court Judgment: Not Available

Date Notice of Court Judgment
Sent to Board of Medical Examiners: January 17, 1974

Case Opened for Investigation: June 19, 1974

Date and Progress Made on Investigation

First Report: Report of December 31, 1974 showed investigator contacted insurance company and learned the amount of judgment. Report showed investigator also obtained court records from which he learned the allegation of the plaintiff. Report showed on September 24, 1974 investigator unsuccessfully tried to obtain medical records from plaintiff's attorney. Investigator stated would prepare necessary subpoena.

Second Report: Report of May 28, 1975 showed the board's medical consultant reviewed the medical records on May 23, 1975. The report also showed the investigator interviewed physician on May 28, 1975. Case was recommended for closure for insufficient evidence.

Case Number: 9

Description: Case Involved Malpractice Settlement in Excess of $100,000 for Death of Patient

Date of Incident: May 12, 1967

Date of Insurance Settlement: March 30, 1973

Date Notice of Settlement Sent to Board of Medical Examiners: January 3, 1974

Case Opened for Investigation: June 20, 1974

Date and Progress Made on Investigation

First Report: Report of October 16, 1974 showed investigator was attempting to collect medical records.

Second Report: Report of January 24, 1975 shows investigator was still attempting to collect medical records.

Third Report: Report of March 28, 1975 shows investigator had obtained medical records and was holding them for review of Board of Medical Examiners' medical consultant.

Case Number: 10

Description: Case Involved $85,000 Malpractice Settlement for Alleged Improper Surgery

Date of Incident: November, 1969

Date of Insurance Settlement: Not Available

Date Notice of Settlement Sent to Board of Medical Examiners: January 17, 1974

Case Opened for Investigation: June 19, 1974

Date and Progress Made on Investigation

First Report: Report of January 6, 1975 showed investigator had obtained court records and had requested plaintiff's attorney to send pertinent medical records. Investigator noted on report that attorney's response showed he was "willing to cooperate" but had made "no reference to medical records" needed by investigator.

Second Report: Report of May 29, 1975 showed the board's medical consultant reviewed medical records on May 23, 1975. The report also showed the investigator interviewed the physician. The case was recommended for closure for insufficient evidence.