STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

A PERFORMANCE AUDIT
OF THE

BOARD OF MEDICAL EXAMINERS

OCTOBER 1981

A REPORT TO THE
ARIZONA STATE LEGISLATURE

REPORT 81-11

DOUGLAS R. NORTON, CPA
AUDITOR GENERAL

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

October 22, 1981

Members of the Arizona Legislature
The Honorable Bruce Babbitt, Governor
Mr. Douglas Cerf, Executive Director

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Board of Medical Examiners. This report is in response to a January 30, 1980, resolution of the Joint Legislative Oversight Committee. The performance audit was conducted as a part of the Sunset review set forth in A.R.S. §§41-2351 through 41-2379.

The blue pages present a summary of the report; a response from the Executive Director is found on the yellow pages preceding the appendices.

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

Respectfully submitted,

Douglas R. Norton

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SUMMARY

The Office of the Auditor General has conducted a performance audit of the Board of Medical Examiners in response to a January 30, 1980, resolution of the Joint Legislative Oversight Committee. This performance audit was conducted as a part of the Sunset review set forth in Arizona Revised Statutes (A.R.S.) §§41-2351 through 41-2379.

The Board of Medical Examiners, established in 1913, is responsible for examining and licensing medical doctors in Arizona and protecting the public from incompetent and harmful practitioners of medicine. Its membership consists of nine licensed physicians, two public members and the president of the Board of Nursing. All members, except the Nursing Board president, are appointed by the Governor to five-year terms.

Our review found that the quality and thoroughness of the Board's investigations of complaints have improved significantly since 1979. More complaints are now reviewed by staff physicians, Board members and the full Board. Despite improvements in the quality of Board investigations, we noted some deficiencies in its complaint review procedures. Board-member involvement in complaint investigations has overburdened some members with complaints and resulted in the appearance of partiality and unnecessary delays. We recommend that Board-member involvement in investigations be reduced since it is unnecessary. (page 17)

We also found that: 1) Board contact with complainants has been insufficient, 2) informal interviews have been used inappropriately, 3) proper notification was not given to all doctors involved in complaints prior to 1980, and 4) the Board has used disciplinary sanctions, letters of reprimand and concern not specifically authorized by law. We recommend that communication with complainants be improved, that formal hearings rather than informal interviews be held in serious cases or when doctors are uncooperative, and that the Board be authorized to issue letters of concern. According to the Board's assistant Attorney General, the Board also needs clearer statutory authority to enforce its own orders. (page 20)

We found that a few malpractice actions and settlements had not been reported to the Board by insurers as required by law. We recommend that BOMEX periodically audit compliance by insurers with malpractice reporting requirements and that penalty provisions be added to A.R.S. §32-1451.02. (page 36)

Although Board investigations of complaints appear to be thorough, our analysis of actions taken by the Board revealed that the Board has been excessively lenient in its disciplining of physicians with multiple complaints. As a result, the Board has not fully protected the public. We recommend that the Board adopt disciplinary guidelines or that the Legislature enact statutory penalties for specific violations. (page 38) In addition, the Board failed to properly report possible violations of State and Federal drug laws by a physician on probation with the Board. Failure to report such violations could subject members of the Board to removal from office. (page 45)

Since 1972, the Board has issued limited licenses to physicians who fail to pass the Board's licensing examination by a narrow margin. Limited licenses have been given to persons practicing in areas of medical need, usually rural regions of the State. We found that limited licenses are not necessary and have been subjected to abuses. Ten limited licensees were granted regular licenses improperly and three limited licensees were issued second limited licenses improperly. We recommend that limited licenses be eliminated from the statutes. (page 51)

Finally, we noted that confidential medical records on file at the Board are not adequately protected from unauthorized access and review. We recommend that the Board maintain better security over its confidential records. (page 63)

INTRODUCTION AND BACKGROUND

The Office of the Auditor General has conducted a performance audit of the Board of Medical Examiners (BOMEX), in response to a January 30, 1980, resolution of the Joint Legislative Oversight Committee. This performance audit was conducted as a part of the Sunset review process set forth in Arizona Revised Statutes (A.R.S.) §§41-2351 through 41-2379.

The Board of Medical Examiners, originally established by the Legislature in 1913, is responsible for examining and licensing medical doctors in Arizona, renewing medical licenses annually and protecting the public from incompetent and harmful practitioners of medicine. The Board is comprised of 12 members: nine licensed physicians, two lay members and the president of the Board of Nursing, who serves as an ex officio member. All members, except the Nursing Board president, are appointed by the Governor.

Board expenditures have increased from $293,752 in fiscal year 1976-77 to approximately $721,000 in fiscal year 1980-81. The BOMEX workload also has increased. For example, in calendar year 1976, 483 regular licenses were issued by the Board, 264 complaints were reviewed, 85 licensed doctors were investigated and 26 hearings were held. In calendar year 1980, 636 licenses were issued (32 percent increase from 1976), 311 complaints were reviewed (18 percent increase), 205 licensed doctors were investigated (141 percent increase), and 213 hearings were held (719 percent increase).

Table 1 contains detailed workload information for calendar years 1976 through 1980.

TABLE 1

BOMEX WORKLOAD MEASURES FROM
CALENDAR YEAR 1976 THROUGH 1980

	1976	1977	1978	1979	1980
Licenses Issued					
Regular	483	592	675	727	636
Temporary	46	53	62	34	45
Limited	12	14	8	9	8
Complaints reviewed	264	285	148	317	311
Malpractice actions reviewed		141	204	129	299
Investigational services					
Review of MDs	85	124	181	201	205
Pharmacies surveyed	166	217	576	499	386
Subpoena and record services	197	274	262	851	1,162
Other investigational services	102	146	163	144	177
Interviews	124	122	67	117	141
Hearings	26	100	163	124	213

As a result of legislation in 1976, the Board also is responsible for reviews of malpractice actions. In 1980, the Board reviewed 299 such actions.

The Board's full-time equivalent (FTE) employee staff of 23.5 in fiscal year 1980-81 includes four full-time investigators and three half-time physician consultants who investigate and review complaints and malpractice cases. Table 2 contains detailed expenditures and revenues data for fiscal years 1976-77 through 1980-81. Ninety percent of examination and licensing fees collected by the Board are deposited in a special Board fund to support its operation.

TABLE 2

BOMEX EXPENDITURES AND REVENUES
FOR FISCAL YEARS 1976-77 THROUGH 1979-80
AND ESTIMATES FOR FISCAL YEAR 1980-81

	Fiscal Year				
	1976-77	1977-78	1978-79	1979-80	1980-81 (Estimated)
Personal services	$177,808	$227,700	$297,100	$360,900	$457,200
Employee related expenditures	24,109	38,200	52,600	65,900	87,600
Professional and outside services	24,116	23,500	11,400	25,300	20,700
Travel:					
In-State	11,920	11,500	14,200	13,000	16,500
Out-of-State	1,440	4,000	3,200	4,700	4,500
Other operating expenses	51,055	66,700	66,900	94,100	132,100
Equipment	2,381	19,700	5,000	20,200	400
Refunds*	923		1,800	1,900	2,000
Total expenditures	$293,752	$391,300	$452,200	$586,000	$721,000
Total revenues	$484,461	$646,762	$599,473	$542,749	$712,722

The Auditor General expresses gratitude to the employees and members of the Board of Medical Examiners for their cooperation, assistance and consideration during the course of the audit.

* Refunds are generated upon withdrawal of license application, as established in A.R.S. §32-1431.

SUNSET FACTORS

Nine factors are considered to determine, in part, whether the Board of Medical Examiners should be continued or terminated, in accordance with A.R.S. §§41-2351 through 41-2379.

SUNSET FACTOR: THE OBJECTIVE AND PURPOSE IN ESTABLISHING THE BOARD

The purpose of the Board is not stated explicitly in Arizona law. According to a Board statement provided during our audit, the three purposes for the Board are:

> "1. To license and regulate doctors of medicine to assure that Arizona's physicians are current with the progress in medicine.
>
> "2. To assure that the public health, welfare, and safety is not endangered due to a licensed physician's medical incompetence or physical or mental incapacity, and
>
> "3. Through the use of discipline and rehabilitative programs, to assist licensed physicians to overcome impairments which affect (their) ability to safely practice medicine."

SUNSET FACTOR: THE DEGREE TO WHICH THE BOARD HAS BEEN ABLE TO RESPOND TO THE NEEDS OF THE PUBLIC AND THE EFFICIENCY WITH WHICH IT HAS OPERATED

Within the scope of our review, January 1, 1979, through June 30, 1980, the Board appears to have responded to all complaints and has initiated its own investigations of questionable activities or occurrences in the medical community. It also has increased its investigative resources by hiring physicians to investigate and review complaints. However, further improvements are needed. (page 9)

In addition, the Board appears to have operated efficiently. From 1976 to 1980, the number of complaints and malpractice actions received by the Board increased 131 percent, the scope of its investigations increased and its expenditures increased a comparable 145 percent.

SUNSET FACTOR: THE EXTENT TO WHICH THE BOARD HAS OPERATED WITHIN THE PUBLIC INTEREST

In most cases, the Board has operated within the public interest by adequately investigating and disposing of complaints and appropriate examination of physicians prior to licensing. However, some Board actions appear not to have been sufficiently stringent regarding doctors with a history of involvement in Board complaint and/or malpractice review. (page 37)

SUNSET FACTOR: THE EXTENT TO WHICH RULES AND REGULATIONS PROMULGATED BY THE BOARD ARE CONSISTENT WITH LEGISLATIVE MANDATE

Our audit did not reveal inconsistencies between Board rules and statutory mandate. A comprehensive review of Arizona regulatory boards' rules and regulations is being conducted by the Attorney General; however, no date has been set for its completion.

SUNSET FACTOR: THE EXTENT TO WHICH THE BOARD HAS ENCOURAGED INPUT FROM THE PUBLIC BEFORE PROMULGATING ITS RULES AND REGULATIONS AND THE EXTENT TO WHICH IT HAS INFORMED THE PUBLIC AS TO ITS ACTIONS AND THEIR EXPECTED IMPACT ON THE PUBLIC

Public awareness of the BOMEX is high. Seventy percent of respondents interviewed as part of a Statewide public opinion survey were aware of the Board although not all of these respondents could specifically name a function of the Board. Public awareness of BOMEX was the highest among Arizona health regulatory boards.

In addition, when compared with the efforts of other regulatory agencies, the Board appears to equal or exceed informing the public of its activities. The Board does not, however, notify individual complainants before holding hearings or taking disciplinary action. (page 21)

SUNSET FACTOR: THE EXTENT TO WHICH THE BOARD HAS BEEN ABLE TO INVESTIGATE AND RESOLVE COMPLAINTS THAT ARE WITHIN ITS JURISDICTION

Board investigations of patient and physician complaints generally are thorough and have improved markedly since January 1, 1979. (page 9)

SUNSET FACTOR: THE EXTENT TO WHICH THE ATTORNEY GENERAL OR ANY OTHER APPLICABLE AGENCY OF STATE GOVERNMENT HAS THE AUTHORITY TO PROSECUTE ACTIONS UNDER ENABLING LEGISLATION

The authority granted to the Attorney General to prosecute violations of Board statutes is adequate except that the current law is unclear as to whether violations of Board orders constitute grounds for disciplinary action. (page 34)

SUNSET FACTOR: THE EXTENT TO WHICH THE BOARD HAS ADDRESSED DEFICIENCIES IN ITS ENABLING STATUTES WHICH PREVENT IT FROM FULFILLING ITS STATUTORY MANDATE

Since 1978, Board legislative proposals have addressed the definition of advertising, continuing medical education requirements and use of hearing officers. SB1100 (Chapter 45) passed during the 1981 regular legislative session enacted these changes into law.

In May 1981 Board staff completed a draft legislative proposal which includes the following major legislative revisions:

- Change in licensure provisions,
- Elimination of limited licenses,
- Review of procedures and requirements concerning appointment of Board members,
- Authorization to hire special medical consultants and other investigative personnel,
- Increased Board member compensation,
- Provision for quarterly meetings,
- Increased flexibility of the Board's continuing education requirements,
- Increase in the range of disciplinary dispositions, and
- Change in insurer malpractice reporting requirements.

SUNSET FACTOR: THE EXTENT TO WHICH CHANGES ARE NECESSARY IN THE LAWS OF THE BOARD TO ADEQUATELY COMPLY WITH THE FACTORS LISTED IN THIS SUBSECTION

Our review determined statutory changes are needed for the Board to comply adequately with factors in this subsection. (pages 36, 50 and 61)

FINDING I

SINCE JANUARY 1, 1979, THE BOARD OF MEDICAL EXAMINERS HAS IMPROVED THE QUALITY AND THOROUGHNESS OF ITS COMPLAINT INVESTIGATIONS SIGNIFICANTLY. HOWEVER, SOME CHANGES IN THE COMPLAINT REVIEW PROCESS ARE NEEDED.

Arizona law authorizes the Board of Medical Examiners to review complaints against licensed physicians, requires doctors, hospitals and medical societies to report offending physicians to the Board, and mandates that insurers notify the Board of malpractice actions and settlements involving physicians.

Arizona appears to be superior to most other states with regard to statutory reporting requirements. In addition, the quality and thoroughness of the Board's review of complaints have improved significantly when efforts in the first six months of 1980 are compared to those in the first six months of 1979.

Our review of Board procedures, however, revealed the following deficiencies: 1) Board member involvement in the investigation of complaints has overburdened some members with complaints and resulted in the appearance of partiality and unnecessary delays, 2) Board contact with complainants has been insufficient, 3) informal interviews have been used inappropriately, 4) the Board did not notify all doctors involved in complaints prior to 1980, as required by law, 5) the Board has imposed disciplinary sanctions not specifically authorized in the statutes, 6) not all malpractice actions and settlements have been reported to the Board as required by law, and 7) the Board lacks authority in that violations of its orders are not clearly established in the statutes as cause for disciplinary action.

Authority to Investigate
Complaints and Malpractice Actions

A.R.S. §32-1451, subsection A, authorizes the Board to investigate complaints against doctors:

> "The board on its own motion may investigate any evidence which appears to show that a doctor of medicine is or may be medically incompetent or is or may be guilty of unprofessional conduct or is or may be mentally or physically unable safely to engage in the practice of medicine...."

Further, A.R.S. §32-1451, subsection A, requires doctors, hospitals and medical societies to report to the Board incompetent and unsafe doctors:

> "...any doctor of medicine, or the Arizona medical association, inc., or any component county society thereof or any health care institution as defined in §36-401 shall, and any other person may, report to the Board any information such doctor, health care institution, association, or individual may have which appears to show that a doctor of medicine is or may be medically incompetent or is or may be guilty of unprofessional conduct or is or may be mentally or physically unable safely to engage in the practice of medicine...."

"Medically incompetent" is defined in A.R.S. §32-1401, subsection 8, as follows:

> "'Medically incompetent' means lacking in sufficient medical knowledge or skills or both, in that field of practice in which the physician concerned engages, to a degree likely to endanger the health of his patients."

"Unprofessional conduct" is defined in A.R.S. §32-1401, subsection 10, as including any one of the following acts:

> "(a) Performing or procuring a criminal abortion or aiding or abetting in the performing or procuring of a criminal abortion.

"(b) Wilful betrayal of a professional secret or wilful violation of a privileged communication except as either of these may otherwise be required by law. This provision shall not be deemed to prevent members of the board from the full and free exchange of information with the licensing and disciplinary boards of other states, territories or districts of the United States or with foreign countries or with the Arizona medical association, inc., or any its component societies or with the medical societies of other states, counties, districts, territories or with those of foreign countries.

"(c) Advertising.*

"(d) Commission of a felony, whether or not involving moral turpitude, or a misdemeanor involving moral turpitude. In either case conviction by any court of competent jurisdiction shall be conclusive evidence thereof.

"(e) Habitual intemperance in the use of alcohol.

"(f) Habitual use of narcotic or hypnotic drugs or both.

"(g) Prescribing narcotic or hypnotic drugs or both for other than accepted therapeutic purposes.

"(h) Gross malpractice, repeated malpractice or any malpractice resulting in the death of a patient.

"(i) Impersonation of another doctor of medicine.

"(j) Acting or assuming to act as a member of the board when such is not the fact.

"(k) Procuring or attempting to procure [a basic science certificate or]** a license to practice medicine by fraud, misrepresentation or by knowingly taking advantage of the mistake of another.

"(l) Having professional connection with or lending one's name to an illegal practitioner of medicine or any of the other healing arts.

"(m) Representing that a manifestly incurable disease, injury, ailment or infirmity can be permanently cured, or that a curable disease, injury, ailment or infirmity can be cured within a stated time, if such is not the fact.

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* SB1100 (Chapter 45), enacted during the 1981 regular legislative session, amends subparagraph C to read as follows: "False, fraudulent, deceptive or misleading advertising or advertising the quality of medical services."

** This language was deleted from subparagraph K of SB1100 (Chapter 45) passed in 1981.

"(n) Offering, undertaking, or agreeing to cure or treat a disease, injury, ailment or infirmity by a secret means, method, device or instrumentality.

"(o) Refusing to divulge to the board upon demand the means, method, device or instrumentality used in the treatment of a disease, injury, ailment or infirmity.

"(p) Giving or receiving, or aiding or abetting the giving or receiving of rebates, either directly or indirectly.

"(q) Knowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine except as the same may be necessary for accepted therapeutic purposes.

"(r) Immorality or misconduct that tends to discredit the medical profession.

"(s) Refusal, revocation or suspension of license by any other state, territory, district or country, unless it can be shown that such was not occasioned by reasons which relate to the ability safely and skillfully to practice medicine or to any act of unprofessional conduct herein.

"(t) Any conduct or practice contrary to recognized standards of ethics of the medical profession or any conduct or practice which does or might constitute a danger to the health, welfare or safety of the patient or the public, or any conduct, practice or condition which does or might impair the ability, safely and skillfully to practice medicine.

"(u) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any of the provisions of this chapter."

Finally, the Board is required to review records pertaining to malpractice actions filed and settlements made against physicians in accordance with A.R.S. §32-1451.02. Insurers must report every action filed and settlements revealed within 30 days of receipt.

Arizona's complaint and malpractice reporting procedures appear generally superior to those in most other states. According to an unpublished American Bar Foundation study, only 16 states require hospitals to report doctors who lose their privileges and only ten require insurers to report malpractice cases and settlements.

Quality and Thoroughness of Complaint Investigation Has Increased

The Board has established the following procedures for investigating complaints:

- A complaint may be received by the Board in writing or by telephone. Complaints received by telephone subsequently must be sent to the Board in writing.
- Medical records are obtained from the doctor or health care institution. In addition, the doctor is provided an opportunity to comment on the allegations.
- A staff physician reviews the medical records and writes a report on his findings.
- The staff physician's report is sent to a Board member, who recommends follow-up action, if any. Follow-up action may include an investigational interview with the doctor involved, an informal interview with the doctor by the full Board or a formal hearing.
- If the complaint involves drugs, Board investigators may conduct a pharmacy survey, which is an audit of the doctor's drug prescriptions on file at one or more pharmacies.
- Complaints are reviewed by the Board for final disposition.

We reviewed all complaints on file with BOMEX between January 1, 1979, and June 30, 1980. During this period, the quality and thoroughness of Board investigations has improved.* Table 3 summarizes percentages of complaints receiving staff, Board member and full Board reviews during the six-month periods ended June 30, 1979, December 31, 1979, and June 30, 1980.

As shown in Table 3, when the six-month period ended June 30, 1979, is compared to the six-month period ended June 30, 1980, the percentages of complaints reviewed by 1) Board staff (usually a physician), 2) at least one Board member, and 3) the full Board before final disposition increased significantly.

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* Hospitals and county medical societies were contacted to determine if the Board obtained all information on physicians under Board investigation. Results were inconclusive. (page 70)

TABLE 3

SUMMARY OF PERCENTAGES OF COMPLAINTS RECEIVING STAFF, BOARD-MEMBER AND FULL BOARD REVIEWS DURING THE SIX-MONTH PERIODS ENDED JUNE 30, 1979, DECEMBER 31, 1979, AND JUNE 30, 1980

	Period Complaint Was Received		
	1-1-79 to 6-30-79	7-1-79 to 12-31-79	1-1-80 to 6-30-80
Staff review (usually by physician)	50.9%	57.1%	75.8%
Board member review	77.6	88.7	90.3
Full board review	66.4	84.2	85.5

In addition, the quality of Board agendas has improved in that BOMEX staff members now prepare and include summaries of all complaints discussed. These summaries include the nature and results of any prior complaints and malpractice actions on file for the subject physician, as well as a statement of the current complaint before the Board.

Disposition Of Complaints

A.R.S. §32-1451, subsection C, authorizes the Board to render the following disciplinary action following an informal interview with a doctor: 1) issue a decree of censure, and 2) place the physician on probation under conditions, including temporary suspension or restriction of his license, best adapted to protect the public and rehabilitate the doctor. Following a formal hearing, the Board may impose the same penalties and, in addition, may suspend or revoke the doctor's license in accordance with A.R.S. §32-1451, subsection L.

Table 4 displays the disposition of complaints received for the period January 1, 1979, through June 30, 1980, for each type of complaint.

TABLE 4

DISPOSITION OF COMPLAINTS BY TYPE
JANUARY 1, 1979 - JUNE 30, 1980*

Complaint	Disciplinary Sanction Imposed by the Board					
	No Action**	Censure/ Reprimand***	Probation	Suspension	Other	Total
Fee dispute	68	0	0	0	10	78
Failure to diagnose	31	0	0	0	4	35
Quality of care (harm caused)	47	4	1	1	4	57
Quality of care (no harm)	40	0	0	0	3	43
Unnecessary services (e.g., surgery, testing)	8	1	0	1	0	10
Alcohol or drug abuse by doctor	7	0	4	0	1	12
Overprescribing narcotics/other drugs	31	3	8	0	6	48
Overprescribing for self and patient	7	0	1	0	0	8
Other physical or mental impairment of doctor	5	0	1	0	2	8
Failure to send or complete medical record	13	0	1	0	6	20
Privileges suspended by hospital	5	0	0	0	0	5
Unethical behavior	23	1	0	0	0	24
Advertising	5	0	0	0	0	5
Other	19	0	0	0	1	20
	309	9	16	2	37	373

* As of March 14, 1981.

** The complaint was dismissed or filed by the Board. Although no official disciplinary action was taken, 52 letters of advice or concern were sent to doctors involved in complaints.

*** Although the Board may issue a decree of censure, it is not specifically authorized to reprimand doctors. See page 31.

The Board dismissed or filed 309 (83 percent) of the 373 total complaints received, although 52 letters of advice or concern were sent to the doctors complained against. Nine doctors were reprimanded or censured, 16 were placed on probation and two were suspended. The Board imposed disciplinary sanctions most frequently in cases in which doctors were found to be overprescribing drugs for patients or were themselves involved in alcohol or drug abuse.

We identified 34 complaints which appeared to have merit in which the Board took no action following its investigation. Most of these were fee disputes or matters involving doctors with no prior history of complaints on file at the Board. In the case of fees, the Board is hesitant to act because its authority and jurisdiction is unclear. (page 69) In the case of physicians with no prior disciplinary problems on record, often all that is necessary, according to the Board's president, is for the doctor to be contacted by or called before the Board and the matter is solved. A few BOMEX dispositions, however, did not appear appropriate. These are described in Finding II. (see page 37)

Timeliness Of Review

As shown in Table 5, most complaints (67 percent) are acted on by the Board within six months of receipt. Final action on some (2.5 percent), however, took more than a year.

TABLE 5

PERCENTAGE OF COMPLAINTS
RESOLVED BY ACTUAL TIME

Complaint	90 Days or Fewer	4-6 Months	7-9 Months	10-12 Months	More Than One Year	Pending
Fee dispute	6.2%	7.8%	2.7%	1.3%	0.3%	2.7%
Quality/type of care	5.9	16.3	6.4	3.2	1.6	2.7
Drugs	5.6	7.0	2.4	0.8	0.3	2.1
Other	7.0	11.5	1.1	2.4	0.3	2.4
Total	24.7%	42.6%	12.6%	7.7%	2.5%	9.9%

See discussion of Board-member involvement and use of informal interviews (page 23) for causes of unnecessary delays in resolving complaints.

Board Member Involvement
in the Complaint Process

During the course of a Board investigation, complaints normally are sent to a Board member for review. The Board member may hold an investigational interview with the doctor who is the subject of the complaint, or he may recommend other Board action. The practice of using Board members as investigators appears to be a carry-over from prior years when the Board did not have a professional staff of investigators, resulting in some Board members being overburdened with complaints, the appearance of partiality and unnecessary complaint processing delays.

The Board's executive director assigns complaints to Board members. In making assignments, he considers: 1) Board member specialties (a complaint involving surgery would be referred to a surgeon), and 2) Board member abilities and thoroughness. This method of assignment has resulted in overburdening some Board members with complaints.

During the period January 1, 1979, to June 30, 1980, two physician members of the Board each investigated 47 complaints, while the remaining five investigated 38, 33, 32, 23 and 21 complaints respectively.* During that same period, the two public members investigated 22 complaints and 1 complaint respectively and the nurse member did not investigate a complaint.

It should be noted that complaint investigations are in addition to the Board's heavy meeting workload. For example, at its three-day quarterly meeting in March 1981, the Board interviewed 24 doctors, held three hearings, acted on 57 complaints and 67 malpractice actions, reviewed six license applications, approved 159 regular licenses and 14 temporary licenses and addressed several other matters. Despite member-workload differences, each member receives the same compensation, $30 per Board meeting day plus travel expenses.

* Excludes two Board members who were appointed after January 1, 1979.

Board member involvement in the investigation of complaints may compromise the appearance of BOMEX impartiality. According to the Legislative Council in an opinion dated May 14, 1981, individual Board members may be required to disqualify themselves from proceedings on a complaint if, as a result of serving as an investigator, they have a bias or prejudice:

> "Public officials are presumed to act in good faith, and it may be a heavy burden to show bias or prejudice....Nevertheless, it has been held that a public officer in a quasijudicial capacity is disqualified to sit in a proceedings in which there is a controverted issue as to which he has expressed a preconceived view, bias or prejudice. The officer must disqualify himself if he has prejudiced the case or has given a reasonable appearance of having prejudiced it....It is fundamental that a quasijudicial tribunal, similar to a court, must not only be fair, it must appear to be fair. Only thus can the proceeding meet the basic requirement of due process."*

Further, the Board's assistant Attorney General stated that Board members should not be involved in investigations of complaints at all:

> "Board members should not serve as complaint investigators. This adds very little to the review process. Cases are thoroughly reviewed by the staff physicians who could hold investigational interviews with the doctors involved prior to writing their final report....Using Board members as investigators can result in abuses...."

The following case examples show how Board member involvement in complaint investigations can taint the Board's appearance of impartiality or cause unnecessary delays in the complaint review process.

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* See Appendix I for opinion text.

CASE I

In February 1979 a BOMEX member filed a complaint with the Board alleging that substandard surgery had been performed on a four-year-old girl in a rural county hospital. The complaint was assigned to the same Board member for investigation. In March 1979, the doctor involved was called before the Board for an informal interview. At the interview, the Board member who had filed the complaint and had served as Board investigator also conducted the inquiry during the interview. Following the interview, and in accordance with the recommendation of the Board member who made the investigation, the Board voted to 1) dismiss the complaint, and 2) caution the doctor with regard to his handling of this and similar cases. The doctor who was the subject of the complaint stated that he has not been treated in a fair manner by the Board. Involvement of the Board member who filed the complaint as the complaint investigator gives the appearance of partiality in this case.

CASE II

In March 1980, a Board investigator conducting a pharmacy survey discovered that a doctor had prescribed large amounts of Quaaludes, an addictive sedative. The complaint was referred to two Board members for investigation, one of whom was a physician whose office was located in the same building as that of the physician who was the subject of the complaint. When the Board member contacted the physician against whom the complaint was filed to obtain information, the physician objected to the Board's entire investigation, claiming that the investigating Board member was biased against him because of a prior business deal involving the building in which their offices were located. Board action on the complaint was delayed until a second Board member was able to take over the investigation. The physician against whom the complaint was filed subsequently left the State. In September 1981, the doctor returned to Arizona for an informal interview before the Board. Following the interview, the Board dismissed the complaint with a letter of concern to the doctor.

CASE III

A Board investigator conducting pharmacy surveys in January and February 1980 discovered that a physician was prescribing large amounts of Demerol, an addictive pain killer, in violation of Federal drug regulations. Investigation revealed that the physician was addicted to Demerol, and the prescriptions were for his personal use. The case was assigned to a Board member, a nonphysician, for follow-up investigation. No Board action was taken until December 1980, when the personal physician for the doctor who was the subject of the pharmacy survey appeared before the Board and stated that his patient was in a drug rehabilitation program out-of-State and, therefore, was unable to appear. The personal physician for the doctor was a former member of BOMEX, and the Board member assigned to investigate the case admitted taking too long to bring the matter before the Board.

In an attempt to enhance the appearance of impartiality in medical board investigations, some states have removed board members from investigations. For example, medical board members in Michigan, California and Florida do not conduct complaint investigations.

Contact with Complainants Is Insufficient

Letters of acknowledgment and notice of Board decisions are sent to persons who file a complaint with the Board. Complainants are not contacted routinely, however, for clarification of their complaint or follow-up information. As a result, many complainants are dissatisfied with the Board's lack of communication.

The Office of the Auditor General surveyed doctors and the public at large who filed complaints with the Board during the period January 1, 1979 to June 30, 1980.

Approximately one-third of the public citizens who filed complaints and a few physician complainants surveyed criticized BOMEX for inadequate contact and communication with complainants. Lack of contact or knowledge of Board procedures, furthermore, appears to have resulted in a fairly widespread dissatisfaction with Board decisions. For example, the following statements were made by public complainants:

> "[I] filed complaint and all that was ever received was their decision based on the talk with the doctor."
>
> "[BOMEX] seemed reluctant to talk about decisions. Judgement had been made and that was that."
>
> "Other than to tell me the doctor was censured and educated and that an investigation was made, I was not advised of events."
>
> "...since I was given no chance to testify in my behalf, I state the review was unfair, and extremely partial. The final decision was biased and based on one-sided testimony. The explanation was simply a statement by [the executive director] dismissing my case with no explanation."
>
> "I was sent freshly typed form responses--essentially identical in two different cases. The Board merely took a look at the doctor's account in his medical file of the patient. Later, a lawyer found out that the matter was discussed in private session. The 'open' session was only a 'formal' vote to approve what had been decided in private."
>
> "Their answer 'no impropriety was found' indicated that they had addressed the complaint but merely dismissed it to get rid of it. I was asked for no information."

A few physicians who filed complaints also claimed they received little information concerning the investigation and decision-making process. For example, the following comments were made:

> "I do not recall ever hearing from them other than to acknowledge receipt of the letter."
>
> "These were referred complaints from which we received little feedback."

According to the Legislative Council, there is no statute or regulation requiring the Board to take specific investigative steps such as contacting complainants. However, the Council added that a proper investigation might include such contact:

> "With respect to medical doctors and in context of A.R.S. §§32-1451 and 32-1452, a 'proper' investigation by the Board of Medical Examiners might include the following steps: 1) investigate the source and nature of the evidence presented bringing the professional conduct, competence and ability to safely engage in medical practice of the medical doctor into question. To this end, the Board could access, for the purpose of examination, the books and records of the person being investigated, 2) interview patients of the medical doctor being investigated and examine their medical records not withstanding the confidential nature of the doctor patient relationship...3) issue subpoenas, as necessary, compelling the attendance and testimony of witnesses or the production of documents relating to the professional competence of any medical doctor under investigation...."*

Investigators in Florida interview complainants routinely. After a complaint is assigned to an investigator, he immediately schedules an interview with the complainant. During the interview, the investigator will obtain the pertinent facts of the case, a patient release and other evidence, documentation and names of witnesses the complainant may have to support the allegation.

According to the BOMEX executive director, the Board does not have sufficient staff to contact each complainant, as they do in Florida. It should be noted that the Board has improved its communication process in that currently complainants are advised more accurately of Board actions.

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* See Appendix II for the opinion text.

Use of Informal Interviews Has Been Inappropriate in Some Cases

Arizona statutes provide that the Board may hold either an informal interview or a formal hearing with doctors involved in complaints. Our review revealed that the Board holds informal interviews far more frequently than formal hearings in spite of the fact that: 1) several cases were of a serious enough nature to warrant a formal hearing, and 2) a physician who is the subject of the complaint may be uncooperative. By overutilizing the informal interview process the Board wastes time and resources, and delays the resolution of some complaints unnecessarily. A.R.S. §32-1451, subsection C, authorizes the Board to use informal interviews or formal hearings in resolving complaints:

> "C. If, in the opinion of the board, it appears such information is or may be true, the board may request an informal interview with the doctor concerned. If the doctor refuses such invitation or if he accepts the same and if the results of such interview indicate suspension or revocation of license might be in order, then a complaint shall be issued and a formal hearing shall be had in compliance with the subsequent subsections of this section. If, at such informal interview, together with such mental, physical or medical competence examination as the board deems necessary, the board finds the information provided under subsection A of this section to be true but not of sufficient seriousness to merit suspension or revocation of license, it may take either or both of the following actions:
>
> "1. Issue a decree of censure.
>
> "2. Fix such period and terms of probation best adapted to protect the public health and safety and rehabilitate or educate the doctor concerned. Such probation, if deemed necessary, may include temporary suspension or restriction of the doctor's license to practice medicine. Failure to comply with any such probation shall be cause for filing a summons, complaint and notice of hearing pursuant to subsection D of this section based upon the information considered by the board at the informal interview and any other acts or conduct alleged to be in violation of this chapter or rules and regulations adopted by the board pursuant to this chapter.

"D. If, in the opinion of the board, it appears such charge is or may be true, the board shall serve on such doctor a summons and complaint fully setting forth the conduct, inability or incompetence concerned and returnable at a hearing to be held before the board in not less than thirty days therefrom, stating the time and place of such hearing."*

According to the Legislative Council:

"A formal procedure is characterized by the availability of testimony of witnesses, stenographic records, briefs, arguments and findings of fact or opinion. On the other hand, the purpose of an informal administrative adjudication is to arrive at decisions based upon inspection or to dispose of complaints by consent or by correspondence...."

In most cases, the Board has chosen to hold informal interviews rather than formal hearings. During the period January 1, 1979, through June 30, 1980, the Board held 49 informal interviews and four formal hearings. According to BOMEX staff, informal interviews save the Board time and money. Preparing for and conducting formal hearings requires more work than is involved in conducting an informal interview. In addition, Board members generally prefer holding informal interviews, rather than formal proceedings.

According to a manual published by the National Attorney General Association, however, a formal hearing should be held rather than an informal proceeding if one or more of the following circumstances exist:

"(1) The Board believes that the complaint is sufficiently serious to require formal adjudication;

"(2) The licensee fails to respond to the Board's letter concerning a complaint and the Board believes there are sufficient grounds to justify further action;

* This section was amended in 1981 by SB1100 (Chapter 45) to allow the hearing to be held before the Board or a hearing officer.

"(3) The licensee's response to the Board's letter or investigative demand does not convince the Board that no action is necessary; [or]

"(4) An informal hearing or conference is held, but fails to resolve all of the issues."

Further, in an opinion dated May 21, 1981, the Legislative Council indicated that a formal hearing should be held if a doctor is uncooperative or if the complaint is of a serious nature:*

> "...If the doctor refuses the invitation to appear at the informal interview or if the doctor accepts the invitation and the results of the interview...indicate suspension or revocation of license may be in order, then a complaint shall be issued and a formal hearing shall be had...A.R.S. §32-1451, subsection C....
>
> "...Generally, the informal interview process would be acceptable if a complaint refers to conduct which would not appear to be sufficient to warrant suspension or revocation of a license but could be disposed of by consent or correspondence. Only in those cases where the harsh penalty of suspension or revocation of a license is possible would a formal hearing, with its procedures for attendance of witnesses, administration of dates and written findings of fact and opinion, be required."

It appears that the Board has held informal interviews inappropriately in some cases in which doctors were uncooperative, and the matters under review were serious in nature. We identified 19 complaints during our review which involved a serious quality-of-care matter and which appeared to have merit based on the Board's investigative findings. In nine cases, the doctor involved was called before the Board for an informal interview. In one case only was a formal hearing held.

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* See Appendix III for opinion text.

The following case examples demonstrate the inappropriate use of informal interviews:

CASE I

In December 1977, a doctor was admitted to a psychiatric facility suffering from an overdose of self-administered meprobamate (a tranquilizer). The doctor entered into a consent order with BOMEX which restricted the doctor from writing prescriptions for controlled substances and which required continued psychiatric care.

In October 1980, a Board investigator was informed by the Department of Public Safety that the doctor was prescribing large amounts of Talwin (a potentially addictive drug used for relief of pain) for a close relative. A survey of 13 pharmacies found that over an eight-month period, the doctor had prescribed 58 10cc vials of Talwin (30 mg) and 30 Talwin tablets (50 mg) for the relative, and 25 10cc vials of Talwin (30 mg) under the doctor's own name for "office use."

In December 1980, the Board scheduled the doctor for an informal interview rather than a formal hearing, despite the doctor's prior history of drug abuse.

At the interview the doctor refused to answer Board questions because counsel advised the doctor that the proceeding was informal and voluntary. Thus, the interview was terminated because the doctor was uncooperative.

The Board scheduled a formal hearing on the matter for March 1981. However, before the hearing was held and the Board could take action, the doctor was arrested by the Department of Public Safety and charged with obtaining dangerous drugs by fraud and deceit, issuing prescriptions without a Drug Enforcement Administration (DEA) registration number and unprofessional conduct while engaged in the practice of medicine. The Board suspended the doctor's license pending the outcome of the criminal case.

CASE II

In June 1980, Bomex initiated an investigation into the medical competence of a doctor who had failed to perform an indicated caesarian section during the course of an infant delivery. Although the mother's life was saved by a doctor who stepped in to assist, the child died shortly after birth. BOMEX's investigation substantiated that the care rendered by the doctor had been substandard; he was placed on probation after an informal interview. Terms of the probation included a requirement that the doctor take an oral competency exam and appear at the next Board meeting for a probationary interview. The doctor refused to submit to the exam, however, and failed to appear for the probationary interview. The Board suspended his license in March 1981.

The doctor had a prior record of complaints and noncooperation with the Board. In April 1978, a BOMEX investigative report established that the doctor had been prescribing large amounts of narcotics and addictive drugs to known drug addicts and traffickers. A pharmacy survey conducted in May 1978 confirmed that large amounts of drugs had been prescribed to at least 15 known drug offenders. In July 1978, the Board requested the doctor to appear for an informal interview. The doctor appeared for the interview two months later and apparently agreed to sign a stipulated agreement restricting him from writing prescriptions for narcotics and other addictive drugs.

An investigative report in November 1978 indicated, however, that the doctor refused to sign the stipulated agreement because he wished to continue writing prescriptions for some of the drugs. After failing to get his cooperation in signing the agreement, the Board requested the doctor to appear before the Board for another informal interview. The doctor claimed he was sick at the time of the interview, failed to appear and an interview was rescheduled for June 1979. That interview never was held. Instead the Board directed staff to draft a second, less restrictive agreement allowing the doctor to prescribe some drugs. The agreement was signed by the doctor and accepted by the Board in June 1979, nine months after the doctor's first appearance before the Board.

CASE III

In April 1980, the Board requested a doctor to appear before the Board on three separate matters: 1) the use of cardiovascular chemotherapy, 2) dispensing drugs at a naturopathic clinic, and 3) the care and treatment of an eight-year-old girl using vitamins and other drugs which allegedly had no benefit. The doctor, through his attorney in a letter to the Board dated May 7, 1980, refused the invitation to appear for an informal interview on the grounds that the second two matters had been added to the interview agenda without proper notification in accordance with A.R.S. §32-1451.* In a reply to the doctor's attorney, dated May 21, 1980, the Board's associate executive director wrote the following:

> "Please be advised that if, upon advice of counsel (the doctor) feels that he should not discuss the latter two matters in the context of an informal interview, the Board's only recourse would be to summon the doctor to a formal hearing."

Although the doctor had refused to agree to the informal interview, the Board requested him to appear for another informal interview at its September 1980 meeting. In reply, the doctor's attorney again refused on behalf of his client and challenged the Board to hold a formal hearing:

> "...If this is to be an informal hearing, you are again put on notice that we decline to have an informal hearing on these matters...in the event that the Arizona Board of Medical Examiners (wishes) to go any further, it would have to be done on a formal hearing basis...."

A formal hearing, however, never was held. In June 1981, the Board entered into a stipulation with the doctor, prohibiting his use of cardiovascular chemotherapy and dismissed the other two matters.

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* A.R.S. §32-1451 requires that doctors be notified of complaints against them within 120 days of receipt by the Board.

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* A.R.S. §32-1451 requires that doctors be notified of complaints against them within 120 days of receipt by the Board.

The previous cases appear to represent matters which should have been scheduled for formal hearings rather than informal interviews. According to Board members and staff, one obstacle to holding formal hearings is that the Board lacks time to hear cases and does not have hearing officers to whom this responsibility could be delegated.* In a 1980 annual report to the Governor, the two public members of the Board explained the problem:

> "Because of the complexities of the problems that come before the Board, substantial time of this Board is spent with detailed fact hearings. This, in our judgment, is a waste of the Board's time, effort and talents, and the work of the Board could be better facilitated by the use of hearing examiners. We enthusiastically endorse hearing examiners and would ask you as Governor to support that position with the Legislature."

In addition, it appears more hearings are not held because the Board's assistant Attorney General, whom the Board shares with several other agencies, does not have time to prepare and conduct many more hearings on behalf of the Board. Regardless of the reason, the Board's overutilization of informal interviews causes unnecessary delays in the resolution of some complaints and wastes Board time and resources.

Several Doctors Were Not Properly Notified of Complaints

A.R.S. §32-1451, subsection A, requires BOMEX to notify doctors when complaints against them are received:

> "The board shall notify the doctor about whom such information has been received as to the content of such information within one hundred twenty days of receipt of such information."

* SB1100 (Chapter 45), enacted in 1981, specifically authorizes the Board to use hearing officers.

During our review of complaints received during the period January 1, 1979, through June 30, 1980, we found ten cases in which the Board neglected to notify the doctors involved prior to the Board's final decision. All ten complaints were received in 1979.

According to the Legislative Council: 1) actions taken by the Board may be void if proper notification is not given, and 2) Board members could be held personally liable.

> "...The Board's duty to notify medical doctors regarding whose practice allegations have been made is mandatory and ministerial. There is no discretion for the Board to fail to notify all such doctors...
>
> "...Board investigation procedures relating to a doctor who has not been notified of the allegations are void. Whether or not the Board conducts an investigation, if it does not notify the doctor of the allegations against him, the members of the Board may be personally liable for injuries to the doctor caused by the Board's nonfeasance. Nonfeasance in public office is also a class 2 misdemeanor."*

A secondary effect of the Board's failure to notify doctors involved in complaints properly can cause ill-feelings between the Board and the physicians it regulates. For example, BOMEX received a letter in March 1980 from one of the doctors it failed to properly notify:

> "I have spoken to (a member of the Board) today about the gross lack of due process that has been afforded me in this matter by the Arizona Board of Medical Examiners and he agrees that there is absolutely no reason why I was not informed of this matter at the earliest possible time and that my opinion as to the merits of any complaint was not solicited."

According to the Board staff, this deficiency was recognized as a problem and corrective action was taken in 1980.

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* See Appendix IV for the opinion text. It should be noted that the Board's assistant Attorney General maintains that actions taken are not void in such cases.

Unauthorized Discipline
Used by the Board

As noted on pages 14 and 23, A.R.S. §32-1451, subsections C and L, authorize the Board to take four types of disciplinary action: 1) decree of censure, 2) probation under such terms which may involve temporary suspension of license, 3) suspension of license, and 4) revocation of license.

Our review indicates, however, that the Board has taken additional actions not specifically authorized by law. Dispositions of complaints received during the period January 1, 1979, through June 30, 1980, included five letters of reprimand and 52 letters of concern or advice. These dispositions, although not authorized by law, are matters of public record retained in doctors' files.

According to the Legislative Council, use of letters of reprimand and letters of concern are not in compliance with law:

> "There is no explicit or implicit statutory authority for the Board to take any disciplinary action against a medical doctor other than that specifically permitted by statute. If the Arizona Legislature had intended for the Board to have the authority to issue a letter of concern or a letter of reprimand to a medical doctor instead of issuing a decree of censure or fixing the term or conditions of probation, or both, it must be assumed that it would have so provided...."

According to the Legislative Council, however, it is not clear whether the Board may be liable for taking such actions:

> "Without knowing the context in which the Board issues a letter of concern or letter of reprimand and what effect, if any, such disciplinary actions have on the professional practice of a medical doctor, it is impossible to determine whether the Board would be liable for taking either disciplinary action...."*

* See Appendix V for the opinion text.

Every Malpractice Action Has
Not Been Reported to BOMEX

Insurance companies which offer malpractice coverage are required by law to report to the Board within 30 days all claims and settlements filed against insured physicians. Not all malpractice actions, however, have been reported.

A.R.S. §32-1451.02, subsections A and C, state:

> "A. Any insurer providing professional liability insurance to a doctor of medicine licensed by the board of medical examiners pursuant to this chapter shall report to the board, within thirty days of its receipt, any written or oral claim or action for damages for personal injuries claimed to have been caused by an error, omission or negligence in the performance of such insured's professional services, or based on a claimed performance of professional services without consent or based upon breach of contract for professional services by a doctor of medicine.
>
> . . . . . .
>
> "C. Every insurer required to report to the board pursuant to this section shall also be required to advise the board of any settlements or judgments against a doctor of medicine within thirty days after such settlement or judgment of any trial court."

The Board is required to review all malpractice reports filed by insurers; it may take disciplinary action against the doctors involved in accordance with A.R.S. §32-1451.02, subsection E:

> "E. The board shall institute procedures for an annual review of all records kept in accordance with this chapter in order to determine whether it shall be necessary for the board to take rehabilitative or disciplinary measures prior to the renewal of a medical doctor's license to practice."

We conducted a review of malpractice suits filed in Arizona courts since January 1, 1979, to determine if insurers are reporting to the Board in compliance with law. Results of the review, which was limited primarily to doctors with multiple complaints on file at BOMEX,* revealed that four malpractice actions and one settlement of $1.75 million against a doctor had not been reported to the Board. Further review disclosed that one of the doctors apparently had no insurance coverage and one suit was dropped before the defendant was served with the suit.

In addition, one case appeared to have been reported late, more than a year after the suit was filed in court. However, late reporting in this case apparently was a result of the Rules of Civil Procedure in Arizona, which permit a plaintiff up to one year to serve a summons on the defendant doctor. Rule 6(f) states the following:

> "Summons and Service, Abatement of Action. An action shall abate if the summons is not issued and served, or the service by publication commenced within one year from the filing of the complaint."

Thus, the insurer may not become aware of a suit until the doctor has been served with the complaint,** up to one year after the suit is filed.

In two cases we reviewed, it appears the insurance company failed to report malpractice actions. According to the Legislative Council, insurers who fail to report actions filed or settlements, or report late, are not in compliance with the law. However, the law lacks enforcement provisions:***

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* Twenty-eight doctors who had complaints recorded during the period January 1, 1979, through June 30, 1980, had a history of at least three complaints on file at the Board.

** Adding to the delay is a statute of limitation which permits the plaintiff to wait up to three years before filing suit.

*** See Appendix VI for the opinion text.

> "With respect to all claims or settlements or judgments entered against medical doctors from and after the effective date of A.R.S. §32-1451.02 [February 27, 1976], the burden on the professional liability insurer is clear. The insurer must report the statutorily required information in a timely fashion to BOMEX...."
>
> "The basic problem in enforcing provisions of A.R.S. §32-1451.02 is that the statutes do not prescribe any consequences for the failure to report. Failure to report in a timely fashion is not even declared to be unlawful and an offense...."

As a result of noncompliance by insurers with reporting requirements, the Board is not in possession of timely important information pertaining to the physicians it regulates. According to the Legislative Council:

> "Failure of professional liability insurers to report claims filed or settlements on judgments entered pursuant to A.R.S. §32-1451.02 will hinder the ability of BOMEX to regulate the medical profession as intended by the Legislature...."

To address this problem, BOMEX staff suggested amending current law to require insurers to report malpractice actions to the Department of Insurance, which regulates the insurers, rather than to the Board. The Department of Insurance then could report the actions to BOMEX.

Board Lacks Enforcement Authority

According to the Assistant Attorney General assigned to BOMEX, the Board lacks clear authority to enforce its own orders. Violation of Board orders is not specifically established in statute as grounds for disciplinary action. As a result, the Board is unable to fully protect the public by enforcing Board-ordered restrictions and limitations on doctors disciplined by the Board.

For example, in March 1981, the Board summarily suspended a physician who failed to appear at a probationary interview. The doctor had broken all terms of his probation order, including the requirement that he take an oral competency examination. The Board apparently waited until the doctor failed to appear for his interview before acting on the original violation because its authority to take immediate action on violations of probation orders is unclear.

CONCLUSION

The Board of Medical Examiners has improved the quality and thoroughness of its complaint review process. However, the following deficiencies need to be addressed: 1) Board member involvement in complaint investigations has resulted in uneven workloads, conflicts and unnecessary delays, 2) contact with complainants is insufficient, 3) use of informal interviews has been inappropriate in some cases, 4) unauthorized discipline has been used by the Board, 5) not all malpractice actions have been reported to the Board, and 6) the Board lacks clear authority to enforce its own orders.

RECOMMENDATIONS

Consideration should be given to the following recommendations:

1. Board member involvement in investigation of complaints be reduced and that investigations be conducted increasingly by Board staff.

2. Contact and communication with complainants be improved and that physician and nonphysician complainants be better informed of BOMEX investigative procedures.

3. Formal hearings be held in all cases in which doctors are uncooperative with the Board, request formal hearings or are involved in serious matters which could result in suspension or revocation of license.

4. Board disciplinary authority be expanded to include letters of concern.

5. The Board periodically audit compliance by insurers with malpractice reporting requirements and report noncompliance to the Department of Insurance.

6. Penalties for noncompliance be added to the provisions of A.R.S. §32-1451.02.

7. Board statutes be amended to specifically establish violations of Board orders as grounds for disciplinary action.

FINDING II

THE BOARD OF MEDICAL EXAMINERS HAS BEEN LENIENT IN ITS DISCIPLINING OF PHYSICIANS WHO ARE THE SUBJECTS OF MULTIPLE COMPLAINTS.

Arizona statutes confer broad discretionary power on BOMEX with regard to disciplining physicians guilty of violating State law or Board rules. However, the Board has not adopted informal guidelines or formal rules to aid in exercising its discretionary authority. As a result, the Board has not fulfilled its statutory responsibility to protect the public. Between January 1979 and June 1980 complaints were filed against 314 individual physicians licensed by the Board, of whom 28 had at least three complaints filed against them.

Our review of the disciplinary sanctions imposed by the Board against these doctors revealed that the Board was lenient in comparison to disciplinary guidelines in effect in California and statutory penalties established in Michigan's public health code. In addition, the Board was lax in its disciplining of a drug-addicted physician and did not officially report to the proper authorities the physician's possible violation of State and Federal drug laws.

Board Authority to Investigate Complaints

As noted on page 10, A.R.S. §32-1451, subsection A, authorizes the Board to investigate complaints against the doctors it licenses.

> "The board on its own motion may investigate any evidence which appears to show that a doctor of medicine is or may be medically incompetent or is or may be guilty of unprofessional conduct or is or may be mentally or physically unable safely to engage in the practice of medicine...."

Board Discipline of Physicians with Multiple Complaints Has Been Lenient

From January 1979 to June 1980 the Board received complaints against 314 individual physicians, of whom 28 had at least three complaints on file at BOMEX, and 17 of whom had at least one substantiated complaint. We compared the disciplinary action taken by the Board for substantiated complaints to minimum actions prescribed by two separate criteria:

1. Minimum and maximum penalties for specific violations based on disciplinary guidelines in effect in California.*

2. Statutory penalties in effect in Michigan - Michigan's Public Health code enacted in 1978 contains penalties which must be applied to specific violations.**

Results of the analysis, shown in Table 6, indicate that the disciplinary sanctions imposed by the Board for 12 of the 17 physicians with substantiated complaints was excessively lenient in comparison to minimum actions prescribed in California guidelines or Michigan statutes.

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* These criteria are the basis for proposed disciplinary guidelines drafted by the Board's Assistant Attorney General for BOMEX review. The Board did not adopt them.

** Michigan is the only state which has established in law specific penalties for each type of violation.

TABLE 6

COMPARISON OF ACTUAL BOARD DISCIPLINE
TO PROPOSED CRITERIA

Doctor	Nature of Substantiated Complaints*	Actual Board Action Taken (As of March 1981)	Minimum Action Suggested By: California Guidelines	Minimum Action Suggested By: Michigan Code	Results of Comparison
1	Prescribing to drug abusers and medical incompetence	A stipulated agreement was signed. Later the doctor was placed on probation. License was suspended when the doctor broke the terms of his probation.	Probation and suspension of license	Fine or probation and limitation on suspension of license	Board action was appropriate
2	Overprescribing drugs	The doctor was placed on probation and his license temporarily suspended for 60 days.	Probation	Fine or probation	Board action was appropriate
3	Inappropriate use of a drug	A letter of advice was written to the doctor.	No action	No action	Board action was appropriate
4	Overprescribing drugs and unnecessary surgery (2) (see Case III, page 44)	The doctor was censured by the Board.	Probation (two separate terms)	Fine or probation, reprimand or fine and suspension of license	Board action was lenient compared to California guidelines and Michigan code
5	Improper prescribing to drug addicts, income tax evasion and overprescribing drugs (3 separate complaints)	The doctor was placed on probation for improperly prescribing to drug addicts, censured for income tax evasion, and reprimanded for overprescribing drugs.	A separate term of probation for each of the three violations	A fine or probation for prescribing to drug addicts and overprescribing drugs. Michigan code does not specifically address income tax evasion	Board action was lenient compared to California guidelines
6	Sexual misconduct with a minor	The doctor was reprimanded.	Probation	**	Board action was lenient compared to California guidelines
7	Overprescribing drugs (3)	The doctor was placed on probation.	Probation and suspension of license	Fine or probation and suspension of license	Board action was lenient compared to California guidelines and Michigan code
8	Overprescribing drugs and medical incompetence (see Case II, page 43)	The doctor was placed on probation for overprescribing drugs. No action was taken on complaint involving medical incompetence.	Probation (two separate terms)	Probation and limitation or suspension of license	Board action was lenient compared to California guidelines and Michigan code

* Number of complaints are in parenthesis if more than one of same type.
** Michigan code contains no specific reference to these types of violations.

Doctor	Nature of Substantiated Complaints*	Actual Board Action Taken (As of March 1981)	Minimum Action Suggested By: California Guidelines	Minimum Action Suggested By: Michigan Code	Results of Comparison
9	Unprofessional and unethical behavior (2) excessive fees, unnecessary testing, unnecessary surgery and medical incompetence (see Case I, page 41)	The doctor was placed on probation once, censured and his major surgery privileges were suspended.	Two terms of probation, suspension of license	Fine or probation, reprimand and suspension of license	Board action was lenient compared to California guidelines and Michigan code
10	Medical incompetence (3)	The doctor was ordered to discontinue major abdominal surgery and to seek consultation prior to other surgery.	Probation and limitation of privileges	Limitation of license followed by suspension	Board action was lenient compared to Michigan code
11	Improperly prescribing amphetamines, unprofessional conduct and overprescribing drugs	The doctor was placed on probation twice and censured.	Probation (three separate terms)	Fine or probation (twice) and reprimand	Board action was appropriate
12	Overprescribing drugs	The doctor was sent a letter of concern.	Probation	Fine or probation	Board action was lenient compared to California guidelines and Michigan code
13	Overprescribing drugs	The doctor was placed on probation.	Probation	Fine or probation	Board action was appropriate
14	Overprescribing drugs and unethical behavior	The doctor was censured.	Probation	Fine or probation	Board action was lenient compared to California guidelines and Michigan code
15	Excessive fees	The doctor was reprimanded.	Probation***	**	Board action was lenient compared to Board guidelines
16	Charging for transfer of records (3)	Three letters of concern were written to the doctor.	Probation and suspension of license***	**	Board action was lenient compared to Board guidelines
17	Unprofessional conduct, failure to provide test results (2), failure to complete insurance forms, failure to provide records(2) and over-prescribing amphetamines	The doctor was censured four times and placed on probation.	Suspension of license***	**	Board action was lenient compared to Board guidelines

* Number of complaints are in parenthesis if more than one of same type.

** Michigan code contains no specific reference to these types of violations.

*** California guidelines do not specifically address all violations in these cases. Minimum action is based on proposed Board guidelines, which were modeled after California's and drafted by the Board's assistant Attorney General. As of October 1, 1981, these guidelines had not been adopted by the Board.

Several Board members, staff and others who have been involved with BOMEX agreed that in some cases the Board has been too lax in its discipline and has not taken appropriate action. For example, the following statement was made by a physician and former member of the Board:

> "I believe the board has too often been too lenient and too forgiving of proven incompetent or unethical physicians....The board has too often been reluctant to act against bad doctors - and if the allegedly bad doctor shows up at BOMEX with a forceful lawyer, the Board often rolls over and foregoes any meaningful discipline."

The following are examples of cases in which the Board appears to have been too lenient.

Case I

The doctor was the subject of numerous complaints on file at the Board and many of the facts surrounding his early involvement with the Board are unavailable. Between April 1958 and August 1980, 22 complaints about him were received by the Board. In October 1966 the doctor was accused of unprofessional acts involving three female patients. In 1967, the doctor was accused of lying, charging excessive fees and double-billing patients. In 1968, the doctor was censured by the Arizona Medical Association for unprofessional and unethical behavior and double-billing procedures involving Medicare.

Board Action

The Board placed the doctor on probation following his censure by the Arizona Medical Association in 1968. Two investigations by the Board in 1969 and 1970 suggested poor patient care by the doctor.

Between 1970 and 1976, the doctor was accused of violating the terms of his probation, and was charged with substandard patient care and unprofessional conduct.

Board Action

There is no evidence that the allegations were substantiated and no action was taken by BOMEX.

In 1977, the doctor was accused of unethical conduct involving anonymous notes sent to patients of other doctors. The notes criticized the quality of care the doctors were providing and suggested that malpractice suits be filed against them. The notes were traced to a typewriter which had been in the doctor's office.

Board Action

Following its investigation of the matter, the Board censured the doctor.

In 1979 the doctor again was accused of medical incompetence and charging excessive fees. Board investigators documented cases of unnecessary laboratory work and surgery, including several unnecessary appendectomies.

Board Action

In 1980 the Board restricted the doctor from performing major surgery, issued a formal complaint and charged the doctor with unprofessional conduct and medical incompetence. In June 1981, the Board amended its formal complaint against the doctor to include additional matters, and in September 1981 the Board ordered a summary suspension of the doctor's license and scheduled a formal hearing. Final Board action was pending as of October 1, 1981.

Comment

The Board failed to take appropriate disciplinary action against the doctor despite numerous substantiated violations. Minimum action suggested by the California guidelines and Michigan code would be suspension of license much sooner than September 1981.

CASE II

In April 1980, the Board received a complaint against a doctor who already was on probation for over-prescribing drugs. The complaint alleged that he was medically incompetent.

Investigative Findings

A BOMEX staff physician reviewed ten of the doctor's cases, including one which resulted in the death of a newborn infant. The doctor was called in to assist in the delivery of the baby, who had developed a prolapsed umbilical cord. According to a BOMEX investigative report, the baby was listed as nonviable (incapable of independent existence) on the mother's chart. However, statements from several nurses indicated that the baby had a 60 beat-per-minute heartbeat which later rose to 140 beats-per-minute. The doctor placed an oxygen tube directly into the baby's endotracheal tube leading into the lungs, causing the baby's lungs to "blow up" and explode. The staff physician who reviewed the case noted that none of the efforts to resuscitate the child had been recorded in the hospital record, indicating the possibility of a cover-up,* and that the doctor's direct use of oxygen was "a severe error in judgment with a fatal result." Following a review of all ten cases, the staff physician concluded that there was sufficient evidence suggesting medical incompetence and unprofessional conduct.

Board Action

In September 1980, the Board voted to file the complaint and took no action against the doctor.

* The alleged cover-up was reported to the county sheriff's department after questions were raised by audit staff as to whether the alleged cover-up had been reported to appropriate authorities.

Comment

The Board failed to take disciplinary action on the doctor despite: 1) a medical investigation's findings that the doctor made a severe error in judgment, and 2) the doctor was already on probation for other violations.

CASE III

On December 5, 1979, a hospital reported that a doctor had been placed on probation by the hospital.* It was alleged that the doctor had performed unnecessary and risky diagnostic procedures (cardiac catheterizations), had provided incompetent care, was deficient in medical knowledge, maintained inadequate medical records and cared for too many patients at the same time. Several of the doctor's patients had died. The same doctor had been the subject of five prior complaints filed with the Board.

Investigative Findings

After an extensive review of patient records, a BOMEX medical consultant reported the following conclusions:

> "(1) The indications for cardiac catheterizations are frequently marginal, and it would appear there is an over use of the invasive diagnostic procedures.
>
> "(2) There are too many right heart catheterizations.
>
> "(3) There is no indication that the information obtained [from the catheterization procedure] is put to use for the care of the patient.
>
> "(4) There is no documentation of the complications which occurred during the catheterization procedures.
>
> "(5) There is a definite lack of sophistication of the cardiac evaluation of the patients, evaluations are often superficial, brief and incomplete, and there is a very real question as to how much cardiology (the doctor) really knows...."

* The hospital eventually revoked the doctor's hospital privileges.

Board Action

In March 1980, the Board required the doctor to submit to an oral competency examination, which he passed. He also entered a training program to correct his deficiencies. In December 1980 the doctor was censured after the Board found him: 1) guilty of poor judgment in patient management and selection of patients for catheterizations, and 2) deficient in maintaining adequate records.

Comment

The doctor is free to apply for privileges and to practice medicine in other Arizona hospitals, despite the fact that he was found to be a dangerous practitioner. Minimum action suggested by the California guidelines and the Michigan code would have been a term of probation.

Board Failed to Discipline Drug Abuser Properly

In April 1979 a physician reported to the Board that a doctor was self-administering and abusing the drugs Demerol (an addictive pain killer) and Talwin. At an investigational interview, the doctor admitted his drug usage and, in September 1979, was placed on probation. Terms of probation required the doctor to: 1) discontinue self-administering drugs, 2) surrender his drug enforcement certification authorizing him to obtain or prescribe certain controlled substances, and 3) continue under the care and treatment of a psychiatrist.

In December 1980 it was found that the doctor again was abusing drugs, including amphetamines, Valium,* Librium (a sedative) and Talwin. The Board continued his probation since the doctor had admitted himself to an institution for treatment, but further restricted his prescription-writing privileges. A check by a BOMEX investigator in January 1981 confirmed that the doctor had surrendered his certificate of registration for Federally classified drugs.

* A drug used in the treatment of anxiety and tension which has potential for physical and psychological dependence.

In March 1981, BOMEX discovered that the doctor was obtaining controlled substances from various drug salesmen who had visited his office. It was determined that in February 1981 the doctor had obtained 48 half-ounce bottles of tussend expectorant cough syrup and 60 Darvocet-N 100 mg. tablets, both Federally classified substances. A subsequent investigation established that the doctor had obtained drugs on seven different occasions after he had lost his drug privileges.

At the Board's meeting in March 1981 the doctor admitted obtaining the 48 bottles of tussend expectorant and that he took some of the cough syrup for an alleged sinus condition. When questioned further by a Board member, the doctor also admitted taking Darvon. The doctor agreed that he had slipped in his rehabilitaton program, but claimed he still was making progress in his attempt to stop using drugs. However, another Board member accused the doctor of being devious:

> "It looks like you were trying to outwit us or maybe you're just trying to confront us. I heard you in here three months ago making great protestations about how you had religion and how you had no more problems and then I hear about you getting...48 bottles of a substance well known to be sought after by addicts."

However, the Board took no further disciplinary action other than to require continued treatment of his drug problem and daily biological fluid testing.

It appears the doctor may have violated Federal and State law by obtaining controlled substances in February 1981 without proper authorization. In an opinion dated May 21, 1981, the Legislative Council stated the following:

> "Title 21, United States Code section 801 et seq. relates to the prevention and control of drug abuse. 21 U.S.C. section 812 lists several drugs or other substances, listed under the heading of scheduled drugs, which are defined as controlled substances and subject to federal law.

"Federal law provides that every person who manufactures, distributes or dispenses any controlled substance or who proposes to engage in the manufacture, distribution or dispensing of any controlled substance shall annually register with the United States attorney general according to rules and regulations promulgated by him. 21 U.S.C. section 822. Pursuant to 21 U.S.C. section 824, the United States attorney general may revoke or suspend the registration of a person upon certain findings. Federal law prohibits a person from knowingly or intentionally acquiring or obtaining possession of a controlled substance by misrepresentation, fraud, forgery, deception or subterfuge. 21 U.S.C. section 843. In addition, it is a federal violation for any person to knowingly or intentionally possess a controlled substance except if obtained with a valid prescription or if the person possesses a valid registration statement. 21 U.S.C. section 844. Knowledge of the presence of a narcotic, control over it and power to produce or dispose of the narcotic constitutes elements of this offense. Amaya v. U.S., 373 F.2d 197 (1967).

"Under Arizona law, a person who knowingly possesses a narcotic drug except upon a written prescription by an authorized person is guilty of a class 4 felony. To be found guilty of such a crime, a person must have physical or constructive possession of a narcotic with actual knowledge of the presence of the narcotic substance. State v. Donovan, 116 Ariz. 209, 568 P.2d 1107 (App. 1977)."*

According to Legislative Council, the Board should have reported officially** this possible violation of State and Federal laws to an appropriate law enforcement agency:

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* See Appendix VII for opinion text.

** Although a Board investigator informally mentioned the case to a DEA agent, it was not reported officially to the State Attorney General, the county attorney or the county sheriff.

"One purpose of establishing a board of medical examiners is to protect the public against those doctors who are medically incompetent, guilty of unprofessional conduct or mentally or physically unable to safely engage in the practice of medicine. Arizona Revised Statutes (A.R.S.) section 32-1451. Thus, there is a duty upon members of the board to inform law enforcement agencies if they have a good faith belief that a medical doctor may have violated federal or state law relating to illegally obtaining a narcotic. This view is further reinforced since the action in question has a direct bearing upon the qualifications of a person to practice medicine in this state."

According to Legislative Council, failure of the Board to report violations of law may be grounds for removal of Board members:

"A.R.S. section 32-1402, subsection C, paragraph 1 states:

"A member of the board, after notice and a hearing before the governor, may be removed upon a finding by the governor of continued neglect of duty, incompetence, or unprofessional or dishonorable conduct, in which event such member's term shall end upon such finding.

"This section prescribes statutory authority for removal of a member of the board for continued neglect of duty, incompetence or unprofessional or dishonorable conduct. Arguably a failure by the members of the board from informing law enforcement officials about a possible violation of state or federal law is grounds for removal from office. However, this determination could only occur upon a finding, after notice and a hearing, by the governor.

"In addition, it is a class 2 misdemeanor for a public officer to knowingly fail to perform a duty to the public. A.R.S. section 38-443."

Finally, the Board appears to have been remiss in: 1) failing to hold a formal hearing on the matter, and 2) failing to take further disciplinary action against the doctor at its March 1981 meeting. According to Legislative Council, the Board is required to hold a hearing and take appropriate disciplinary action if a doctor on probation violates the conditions of his probation:*

> "Under A.R.S. section 32-1451, subsection C, paragraph 2, the board may place a doctor on probation and:
>
> > "Failure [of a doctor] to comply with any such probation shall be cause for filing a summons, complaint and notice of hearing pursuant to subsection D of this section based upon the information considered by the board at the informal interview and any other acts or conduct alleged to be in violation of this chapter or rules and regulations adopted by the board pursuant to this chapter.
>
> "A.R.S. section 32-1451, subsection D requires the board to conduct a complete hearing if the board believes that a charge of medical incompetence, inability to perform or unprofessional conduct by a doctor is or may be true. Therefore, according to the provisions of A.R.S. section 32-1451, subsection C, paragraph 2, failure to comply with probation requirements imposed by the board is grounds for triggering the hearing procedure mandated by A.R.S. section 32-1451, subsection D."

In the cases cited above, the Board apparently has not taken appropriate disciplinary action. In some cases the Board gave a doctor multiple opportunities to reform. As noted on page 5, the Board views rehabilitation of impaired physicians as one of its purposes. In other cases, the Board appears to have exercised leniency on advice of its assistant Attorney General and in response to the possibility of legal challenge by the doctor involved.**

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* The Board's assistant Attorney General maintains that these matters are within the Board's discretionary powers.

** Despite the Board's reluctance to impose strict discipline, there are no recent cases of Board disciplinary action overturned by the courts.

CONCLUSION

Current laws confer on the Board of Medical Examiners broad discretionary power with regard to discipline, and the Board has no informal guidelines or formal rules to aid it in making disciplinary decisions. In the case of 12 doctors with multiple complaints on file at BOMEX, the Board appears to have been excessively lenient in imposing its discipline when compared to disciplinary guidelines in effect in California and statutory penalties contained in Michigan's public health code. In addition, the Board did not officially report possible violations of State and Federal drug laws by a physician who has been abusing drugs, and it did not appear to take appropriate disciplinary action following the doctor's violation of probation. As a result, the Board has not fulfilled its statutory responsibility to protect the public.

RECOMMENDATIONS

Consideration should be given to the following recommendations:

1. The Board develop and adopt disciplinary guidelines setting out appropriate dispositions for specific violations.

2. If the Board fails to develop such guidelines, then the Legislature should consider reducing the Board's broad discretionary power in disciplinary matters by prescribing specific statutory penalties.

FINDING III

THE GRANTING OF LIMITED LICENSES HAS BEEN SUBJECTED TO ABUSES AND APPEARS TO BE UNNECESSARY.

Arizona law permits BOMEX to issue limited licenses to practice medicine to applicants who fail the Board's examination by a margin of five percentage points or less. Limited licensees must serve areas in medical need, usually rural regions of the State. However, because areas of need are not defined in statute or regulation, assignment of limited licensees has at times been arbitrary. Since 1972, the Board has granted 94 limited licenses. Our review found that: 1) ten limited licensees were granted regular licenses improperly, based on a supplemental oral examination, and 2) three limited licensees were issued a second limited license in apparent violation of law. Furthermore, some limited licensees have questionable records and may be endangering public health, welfare and safety. The granting of limited licenses appears unnecessary in that most other states do not grant limited licenses and Arizona's county medical societies object to them.

Authority to Grant Limited Licenses

A.R.S. §32-1425.02, subsection B, authorizes the Board to grant limited licenses to applicants who lack one or more of four requirements for a regular license:

> "B. A limited license may be granted by the board to an applicant otherwise qualified for regular licensure except for one or more of the following:
>
> "1. If he is a foreign graduate and does not hold the standard permanent certificate of the educational council for foreign medical graduates or its equivalent.
>
> "2. If he has not completed the required approved internship or post graduate training.

"3. If he has not obtained citizenship in the United States but is taking every action provided by law to become a citizen. The board immediately shall revoke his license to practice medicine in the event the physician's final petition for naturalization is denied, and, after hearing, shall revoke such license if it appears after a reasonable time that such physician has not secured or is not diligently attempting to secure his certificate of citizenship.

"4. If he has failed the written examination of the board with a weighted grade average of not less than seventy percent."* (Emphasis added)

The Board may assign limited licensees to areas in need of health practitioners, in accordance with A.R.S. §32-1425.02, subsection C.

"C. The board shall at least annually review all information made available to it to determine the greatest need for location of health practitioners in this state and shall assign limited licentiates in the order of the greater need for the greater number of possible recipients of health care." (Emphasis added)

Between June 1972 and August 1980, the Board has issued 94 limited licenses. Table 7 summarizes the number of limited licenses by county as of August 15, 1980.

* A.R.S. §32-1428, subsection F, requires an average score of 75 percent and not less than 50 percent in any one subject to pass the licensing exam.

TABLE 7

SUMMARY OF THE NUMBER OF LIMITED LICENSES
AS OF AUGUST 15, 1980

County	Number
Apache	3
Cochise	3
Coconino	2
Gila	8
Graham	0
Greenlee	5
Maricopa	30
Mohave	5
Navajo	8
Pima	5
Pinal	14
Santa Cruz	3
Yavapai	1
Yuma	7
Total	94

As shown in Table 7, a high proportion of the limited licenses has been assigned to nonmetropolitan counties.

Areas of need are not defined in law or regulation. The Board has identified areas of need by contacting Arizona's county medical societies and by determining, through review of the medical directory published annually by the Board, which areas lacked licensed physicians. This process has resulted in determinations of areas of need that have been at times arbitrary. For example, 30 limited licenses have been issued in Maricopa County to provide doctors for such facilities as Maricopa County General Hospital, Arizona State Hospital and the Veterans Administration Hospital; and three limited licenses were issued for Peoria, one for Mesa and one for a specialist in spinal cord injury at Good Samaritan Hospital in Phoenix.

Regular Licenses Improperly
Granted to Limited Licensees

A.R.S. §32-1425.02, subsections D and E, provide that the holder of a limited license may be issued a regular license upon passing the Board's written examination with a grade of 75 percent or more:

> "D. A limited license shall be issued for a period of not less than three years nor more than five years during which period the licentiate shall obtain United States citizenship or complete the written examinations of the board with a grade average of seventy-five percent or more." (Emphasis added)

We identified ten limited licensees who took the Board's written examination and failed it, but were issued regular licenses on the basis of an oral examination administered by the Board. The oral examination, taken on a pass-fail basis before a panel of two physicians, was used to supplement the licensee's score on the written examination. Of the ten doctors granted a license in this manner, one had failed the Board's written examination three times, and two oral examinations, before finally being granted a regular license. According to Legislative Council, the practice of offering limited license holders oral examinations to supplement written examinations is not in compliance with A.R.S. §32-1425.02.

> "...if statutory language is plain and unambiguous, it must be given effect...applying this rule of statutory construction to A.R.S. §32-1425.02, subsection D, it is clear that the method for a limited licensee to obtain a regular license to practice medicine in this state is to take a written examination from the board and receive a score of 75 percent or more.
>
> "...no provision is made in this subsection for the Board to give a limited licensee an oral examination. If the Legislature intended to give the Board this option, they would have specifically stated so in the statutes...."* (Emphasis added)

* See Appendix VIII for opinion text.

According to Legislative Council, the validity of the regular licenses issued on the basis of supplemental oral examinations could be questioned:

> "Some courts hold that vested rights may preclude revocation of a license in this situation. If a valid license is issued and a person makes expenditures upon such license, some courts hold that the licensee has a vested right in such license and the state cannot revoke it unless the licensee commits an act which subjects him to revocation pursuant to statute.
>
> "However, other courts hold that a permit issued under a mistake of fact or in violation of law confers no vested right or privilege on the person to whom the license has been issued even if the person acts upon it and makes expenditures in reliance on the license. B&H Investments Inc. v. City of Coralville, 209 N. W. 2d 115 (Iowa 1973).
>
> "We cannot predict how a court would act if the license of a person issued under the facts as presented to us was subject to question because of the improper manner in which it was issued. Certainly, the acts of the board in violation of the statute raise grave questions about the validity of such licenses." (Emphasis added)

Use of supplemental oral exams for limited licensees was first recommended to the Board by its former executive director in February 1975, citing four doctors who had been given oral examinations as a precedent. However, it should be noted that none of these four had been limited license holders and all had applied for regular licensure under separate provisions of the statutes which are governed by different requirements than those applicable to limited licensees.

The Issuance of More Than One Limited License Is Not in Compliance with Law

Limited licenses may be issued for a period not less than three years nor more than five years, in accordance with A.R.S. §32-1425.02, subsection D. However, we identified three limited licensees who were granted new limited licenses by the Board because their original limited licenses were scheduled to expire. However, according to the Legislative Council in an opinion dated May 21, 1981, the Board does not have the authority to issue new limited licenses to doctors whose original limited licenses have expired:

"There is no authority in the statutes for the board to issue a new limited license to a medical doctor whose original limited license has expired. Clearly the intent of the legislature in enacting A.R.S. §32-1425.02 was to allow the board to temporarily authorize certain persons who show a minimal level of medical competence but lack certain other requirements to practice medicine in this state and thereby relieve the shortage of doctors in medically underserved areas. Under the legislative scheme, the person is allowed to practice medicine under close observation and evaluation while he attempts to fulfill those requirements which he lacks in order to achieve full status as a medical doctor. Furthermore, the legislature has afforded the person an adequate period of time, from three to five years, in which to attain these requirements. A.R.S. §32-1425.02 subsection D and F.

"Therefore, based upon this legislative plan, the legislature did not intend that the board issue a new limited license to those individuals who could not meet the statutory requirements to be licensed as a medical doctor during the period of time in which they had a limited license. However, you may wish to recommend that the legislature clarify this area to specifically state whether or not they intend that the board issue a renewable limited license."* (Emphasis added)

It should be noted that the Board's assistant Attorney General has advised the Board that the statutory language in question permits successive limited licenses.

The Board, in its most recent limited license action of March 1981, granted a new limited license to a doctor in a small Northern Arizona community.

A review of records on file at BOMEX raises questions about the competency of this and another doctor whose limited licenses were renewed by the Board. The following cases summarize complaints and Board action involving these two doctors.

* See Appendix IX for opinion text.

CASE I

From April 1977 to January 1981 BOMEX received eight complaints and reviewed three malpractice suits involving one of the doctors, a specialist in obstetrics and gynecology (OB/GYN). In 1977 the hospital in which the doctor practiced placed him on probation due to substandard patient care. In May 1978, following a staff investigation, a formal complaint was issued by the Board, charging the doctor with medical incompetence and unprofessional conduct. The doctor was accused of: 1) performing five unnecessary caesarian sections, 2) improperly performing two amniotomies, 3) failing to monitor fetal heart tones, 4) failure to detect a pelvic abnormality, 5) wrongly refusing to transfer an infected hospital patient to an isolated area, 6) improperly prescribing antibiotics on multiple occasions, 7) performing two unsuccessful vasectomy operations, and 8) failing to document patient medical records properly. Following a formal hearing by the Board, the doctor was ordered to undergo 20 hours of training in the use of antibiotics and to improve his record keeping.

In December 1980, the doctor again was brought before the Board to discuss two other matters. Board investigators found that the doctor had committed a "significant judgmental error" in failing to diagnose an ectopic (tubal) pregnancy and had repaired an inguinal hernia in a medically incompetent manner. The doctor was reprimanded by the Board and ordered to discontinue performing hernia operations.

In January 1981, a physician at the hospital in which the doctor practiced submitted to the Board several of his obstetrical cases covering the first six months of 1980. The cases, according to the complaining physician, exhibited "a consistent lack of good medical judgment." However, the doctor, who was not eligible for a regular license because he failed the Board's licensing exam on three occasions, and whose limited license was due to expire, was issued a new limited license by the Board in March 1981.

CASE II

In June 1979 the chief of staff of a regional medical center wrote to the Board questioning the medical competence of a limited licensee who had been working at the facility. Shortly after his arrival at the facility, according to the letter of complaint, the doctor's management of pediatric cases was found to be "totally unacceptable," and his pediatric privileges were removed. Although initially permitted to perform D and Cs (dilation and curetage) under supervision, his supervisors decided he was incapable of performing the procedure and removed those privileges. According to the chief of staff, the doctor was the subject of several special meetings of the intensive care, the medical records and the medical practices committees of the hospital. The doctor had admitted patients to the intensive care unit with myocardial infarctions (heart attacks) and had not attended to them for several days, although medical records allegedly were altered to make it appear the patients had been seen. The complaint added that the doctor was deficient in his understanding of physiology and pathology.

In August 1979 the doctor was given an oral competency examination by the Board and passed on a conditional basis. The examiners reported that the doctor could handle the vast majority of nonemergency routine office problems, but was deficient in the knowledge of basic sciences and the ability to handle critical care matters. It was recommended that the doctor undertake an educational program to address his deficiencies. The Board did not follow up on the recommendation of the examiners, but issued a second limited license to the doctor in September 1980.

In addition to possibly endangering the public health, the issuing of new licenses to the doctors in both cases described also resulted in strained relations between the Board and the physicians and medical facilities in the counties affected.

Two Other Limited Licensees Have Presented Problems

Two other physicians issued limited licenses by BOMEX also appear to have been problem practitioners. Unlike the previous two cases, neither of these doctors has yet come before the Board for a license renewal. One of the two physicians was reported in July 1976 for performing risky and unnecessary cardiovascular testing and surgery. A second complaint in September 1976 alleged that the doctor had improperly performed an operation, stripping the veins from the legs of a 76-year-old patient. The operation left the patient half-crippled. In December 1976 the Board placed the doctor on probation and required him to seek independent medical consultation before performing invasive diagnostic procedures (such as angiograms and arteriograms), hiatal hernia repairs and cardiovascular or vascular surgery. The doctor also was required to undergo retraining in vascular and gastrointestinal surgery.

Another limited licensee was reported to the Board in May 1980 by a nurse who alleged that the doctor was guilty of extensive financial impropriety, that he had deserted his practice and abandoned his patients. According to the complaint, the doctor owed money to several creditors, including professional associates, wrote thousands of dollars in bad checks and double-billed for services. The doctor's hospital privileges had been restricted, based on concerns over his performing unnecessary surgery and his diagnostic and surgical skills. The Board's investigation of the matter was pending as of October 1, 1981. According to the Board, the investigation still is pending because the doctor did not leave an easy trail to follow. He has been in California, Ohio, Texas and now appears to be in Europe. The doctor's flight has made it difficult to serve a summons and complaint, which is necessary for a hearing.

Most States Do Not Offer Limited Licenses

A review of the medical statutes of other states revealed that only two states have a specific limited license provision similar to Arizona's. Arkansas issues temporary licenses in "areas of critical medical shortage," and Georgia offers a provisional license restricted to specific geographic localities.

Several states, including Washington, Oregon and Illinois, offer limited or temporary licenses to permit doctors to practice in institutions such as prisons and state mental hospitals. According to an official of the American Medical Association, the practice of issuing limited licenses fosters a dual standard of medical care. Even in those states which restrict limited licenses to state institutions, the limited license generally is granted only when the institution is unable to recruit a physician with an unrestricted license to fill the position.

County Medical Societies Claim
Limited Licenses Are Unnecessary

In November 1980 BOMEX wrote to all county medical societies in Arizona to solicit their opinions regarding the need for limited licenses in their areas. Eight of the ten counties responding to the survey claimed there is no need for new limited licenses in their jurisdictions at this time. Five societies, moreover, specifically questioned the need for such licenses at all. For example, the following comments were made:

> "We do not feel that in the (foreseeable) future considering the increasing output of this country's medical schools and the increasing saturation of medical practitioners in the cities of Arizona that a limited licensure provision need necessarily be continued for any areas of the state."
>
> "...the concept of limited licensed practitioners should be abandoned since an abundance of physicians in general are now available to serve our county...."
>
> "...it is our belief that issuing limited licenses could foster second class medical care and we question the need for limited licensing in the state."

Thus, most county societies either expressed no current need for limited licenses or specifically recommended their elimination from the statutes. The Board supports elimination of limited licenses and has included this change into proposed statutory changes for the next regular legislative session.

CONCLUSION

Our review found that ten limited licensees were improperly issued regular licenses based on a supplemental oral examination and that three licensees were issued a second limited license in apparent violation of State law. Some limited licensees appear to have been problem practitioners.

Most other states do not offer limited licenses and most Arizona county medical societies do not feel there is a need for limited license holders in their jurisdictions.

RECOMMENDATION

It is recommended that no new limited licenses be granted, and provisions for a limited license be eliminated from the statutes. Under this recommendation, current limited licenses would be valid until their expiration or until the license holder is properly granted a regular license.

FINDING IV

CONFIDENTIAL BOMEX RECORDS ARE NOT ADEQUATELY PROTECTED FROM UNAUTHORIZED ACCESS AND REVIEW.

The Board of Medical Examiners is required by law to maintain the confidentiality of patient names, patient records, hospital records and other files pertaining to cases investigated by the Board. Currently, such records are kept in file cabinets which lack locking mechanisms. In addition, during the course of our audit we observed confidential files which apparently had been left on desks overnight. As a result, unauthorized persons have access to the Board's records. Other institutions and agencies also required to maintain confidential records use locked files and tighter security measures.

BOMEX Records Are Confidential

A.R.S. §32-1451.01 requires BOMEX to maintain confidentiality of patient names, patient records, hospital records and other documents used during the course of an investigation:

> "C. Patient records, including clinical records, medical reports, laboratory statements and reports, any file, film, any other report or oral statement relating to diagnostic findings or treatment of patients, any information from which a patient or his family might be identified or information received and records kept by the board as a result of the investigation procedure outlined in this chapter shall not be available to the public.
>
> "D. Nothing in this section or any other provision of law making communications between a physician and his patient a privileged communication shall apply to investigations or proceedings conducted pursuant to this chapter. The board and its employees, agents and representatives shall keep in confidence the names of any patients whose records are reviewed during the course of investigations and proceedings pursuant to this chapter.

> "E. Hospital records, medical staff records, medical staff review, committee records, testimony concerning such records and proceedings related to the creation of such records shall not be available to the public, shall be kept confidential by the board and shall be subject to the same provisions concerning discovery and use in legal actions as are the original records in the possession and control of hospitals, their medical staffs and their medical staff review committees. The board shall use such records and testimony during the course of investigations and proceedings pursuant to this chapter." (Emphasis added)

During the course of our audit, it was noted that most file cabinets which contain confidential records lack locking mechanisms. In addition, files containing confidential information apparently have been left on desks overnight. The Board believes tighter security is unnecessary. However, unauthorized persons have access to BOMEX records.

Other agencies which maintain confidential records have developed tighter security measures. For example, at a hospital contacted by audit staff, patient records are kept in a separate room. At the end of the day, the room is locked and the key is handed to security guards. Access to the room is restricted to authorized employees only. Confidential criminal records maintained by a county Superior Court in Arizona are locked in file cabinets. A check-out procedure is used for individual files. Interviewed employees did not find the security measures burdensome or difficult to use.

The cost of installing improved security measures at BOMEX does not appear to be prohibitive. The Department of Administration, State Purchasing Office, has a contract with a private vendor to purchase and install cabinet key locks at a cost of about $34 each.

CONCLUSION

Although the Board is required to maintain patient names and medical records as confidential, files containing such information are kept in unlocked cabinets, thus subjecting confidential records to unauthorized access. Other institutions and agencies maintaining confidential records use tighter security measures.

RECOMMENDATION

It is recommended that the Board of Medical Examiners maintain better security over its confidential records.

OTHER PERTINENT INFORMATION

BOARD APPOINTMENTS

A.R.S. §32-1402, subsection A, provides for the appointment of Board members by the Governor:

> "A. This chapter shall be administered by a board of medical examiners consisting of twelve members, two of whom shall represent the public, one of whom shall be the president of the state board of nursing who shall serve as an ex officio member and nine of whom shall be actively practicing medicine and be from at least three different counties of the state, except that no more than five of the board members shall be from any one county. Members of the board shall be appointed by the governor. Appointments of members who are doctors of medicine to the board may be made by the governor from a list submitted by the Arizona medical association, inc., containing at least two names for each vacancy to be filled. The governor may require the Arizona medical association, inc., to submit such additional list or lists as he may deem expedient. All appointments shall be made promptly and, in the case of the vacancy of a professional member or members, appointment shall in no event be later than ninety days after receipt by the governor of a satisfactory list of nominees as provided in this section. (Emphasis added)

A number of physician and nonphysician Board members surveyed commented that the quality of Board appointments was disappointing. According to at least one Board member, appointments occasionally have been based on political considerations. According to a BOMEX staff member, appointees need to be well-known, competent physicians who are respected by their peers and willing to participate in disciplinary actions when necessary.

Several Board members were critical of the nurse-member appointment. This has been the president of the Board of Nursing and, therefore, subject to change each year. The criticism was leveled that the president of the Board of Nursing does not have time to serve on the Board as an active, fully functioning member. Our complaint review confirmed that the nurse member had not been involved in the complaint review process. The latest, Board-proposed statutory changes provide that a member of the Board of Nursing, who is a licensed nurse but not necessarily its president, be appointed for a multi-year term.

SURVEYS OF COMPLAINANTS AND LICENSED PHYSICIANS

Surveys were sent to all patient* complainants, physician or other health practitioner complainants, and doctors against whom complaints were filed from January 1, 1979, through June 30, 1980. In addition, a random sample of licensed physicians was surveyed to determine general opinions of the medical community towards BOMEX.

Table 8 summarizes the opinions of various survey respondents regarding the quality of Board complaint investigations.

TABLE 8

PATIENT AND PHYSICIAN RATINGS OF THE QUALITY OF BOMEX COMPLAINT INVESTIGATIONS

	Percentage Responding					
	Very Good	Good	Poor	Very Poor	No Opinion	No Response
Patient complainants	16%	10%	16%	21%	25%	12%
Physician complainants	16	37	3	7	30	7
Physicians against whom complaints were filed	45	24	7	7	10	7

* Occasionally patient complaints were lodged by parents, spouses or surviving relatives of patients.

As shown in Table 8, opinions of the Board's complaint review process were mixed. Patients who complained, however, were more dissatisfied with the Board's actions than those physicians who complained. Only 26 percent of the patients rated the quality of the Board's current investigations as "good" or "very good" compared to 53 percent of the physician complainants. Physicians against whom complaints were filed also were generally satisfied with the quality of the Board's investigations and the manner in which the complaints against them were handled in that 69 percent rated the quality of investigations as "good" or "very good." Survey respondents suggested improving the Board's complaint review process by increasing contact with complainants, providing increased feedback during the course of a complaint investigation and offering explanations of Board decisions.

Based on results of the survey of medical doctors practicing in Arizona, physicians generally are satisfied with the quality of the Board's investigations and disciplinary decisions. Approximately one-fourth (26 percent) of the physicians surveyed, however, indicated that, in their opinion, the Board does not adequately protect the public from harmful or incompetent physicians. In addition, 46 percent of physicians responding to the survey believed the medical community was only partially complying or not complying at all with Arizona law, which requires doctors to report incompetent colleagues. According to doctors surveyed, fear of law suits and a reluctance to become involved prevents physicians from reporting all suspected or known instances of incompetency.

BOARD JURISDICTION OVER FEE DISPUTES

From January 1, 1979, through June 30, 1980, 78 complaints involving physician fees were received by the Board; however, no formal disciplinary action was taken in any of these cases.* The Board's authority to act in matters involving fees is unclear in that charging excessive fees is not specifically included in the definition of "unprofessional conduct" (A.R.S. §32-1401) as grounds for disciplinary action.

* See page 15 for a listing of all complaints received and their disposition.

Some Board members and staff, however, expressed the opinion that the Board's jurisdiction over excessive fees should be clearly established, and that the Board should take action in disciplining physicians who charge excessive fees. Others interviewed during the audit, as well as some survey respondents expressed a contrary opinion, arguing that fee disputes are matters of private enterprise which should not be subject to Board regulation. California's guidelines and Michigan's code do not include excessive fee-charging as a violation subject to discipline. In addition, a model health professions regulatory act developed by Aruthur Young and Company for the Federal Drug Enforcement Administration does not recommend including excessive fee-charging as grounds for disciplinary action.

SURVEY OF HOSPITALS AND MEDICAL SOCIETIES

As part of our audit, we asked seven hospitals and four county medical societies in Arizona to assess their relationship with BOMEX and to express their opinions of the Board's performance.* All hospitals and medical societies responding to our survey were aware of the Board and maintained some contact with it. Such contact ranged from weekly communication by two hospitals to verify licenses, to only yearly contact by two other hospitals and one medical society.

* In most cases, audit staff conducted face-to-face interviews and left a written survey form for the hospital or society to complete.

All hospitals and medical societies said they maintain their own internal grievance or disciplinary procedures. A few had reported physicians to the Board. However, some disciplinary matters which resulted in action by the hospitals (a reprimand or probation) apparently were not reported to the Board. In addition, it appeared that some physicians who had been the subjects of complaints received at BOMEX from January 1, 1979, through June 30, 1980, had also been involved in disciplinary proceedings with a hospital or medical society. It appears that hospital or medical society proceedings and Board investigations regarding the same physicians may have been occurring simultaneously. It is generally the policy of the hospitals to report physicians who may be incompetent to the Board only after final action has been taken, such as limiting or suspending a physician's privileges. Discipline short of privilege limitation or suspension or voluntary resignations from a hospital's staff in lieu of formal action usually are not reported to the Board. Thus, the Board may not be aware of these proceedings at the time of its own investigations. It should be noted that one criteria the Board uses in determining whether a physician is incompetent includes whether an infraction is an isolated incident or part of a pattern of medical errors.

A few of the hospitals and medical societies surveyed expressed some concern over current law (A.R.S. §32-1451, subsection A) which requires hospitals and medical societies to report offending physicians. According to these survey respondents, the law is vague and does not clearly define when or under what circumstances a physician should be reported to the Board.

RELATIONSHIP TO ASSOCIATION

Prior to the initiation of our audit, the Board appeared to maintain a close relationship to the Arizona Medical Association (ARMA), a private association of Arizona's physicians affliated with the Americal Medical Association (AMA). Prior to April 1980, BOMEX offices were located in the same private office building with ARMA. In April 1980, the Board moved to a new office location at the urging of one of the public members of the Board because a Sunset audit report was critical of an overly close relationship between another regulatory board and a professional association. In addition, the Board's executive director, who had been an employee of the Association, has retired and the current director has no official relationship with ARMA.

INVESTIGATIVE FINDINGS TERMINOLOGY

The Board may take disciplinary action against doctors if investigation finds them to be guilty of medical incompetence or unprofessional conduct. During the course of our review, it was noted that staff physician reports to the Board regarding incompetence and unprofessional conduct frequently use terminology such as "judgmental error" and "technical error". These terms are not defined in law, Board rule or administrative directives.

According to staff physicians interviewed, "judgmental errors" are lesser errors, such as prescribing the wrong medication, while medical incompetence implies a doctor is significantly deficient in knowledge of the needed actions in a given medical situation. "Technical errors" normally refer to manual skills.

The Board's assistant Attorney General stated that in preparing formal complaints against doctors he translates the investigative terminology used by staff physicians into language comparable with statutory provisions.

PUBLIC INFORMATION EFFORTS AND PUBLIC AWARENESS OF BOMEX

The Auditor General commissioned the Public Opinion Research Program at Arizona State University to conduct a Statewide statistical survey concerning general public awareness of six* of the State's health regulatory boards. More than 700 telephone interviews were conducted with randomly selected Arizona citizens.

Results of the survey indicate that public awareness of BOMEX is significant. Seventy percent of the respondents interviewed stated that they were aware of the Board. Awareness of the Board was even higher (79 percent) among those respondents who had actually received medical care by a licensed medical doctor and among those who had been hospitalized (80 percent) within the past two years. Respondents were more aware of the Board than any of the other five health regulatory boards.

Respondents were less certain as to Board functions. Only 19 percent knew the Board heard complaints, 16 percent were aware of the Board's responsibility to license physicians and one percent mistakenly stated that the Board conducts autopsies.

Of the 403 citizens surveyed who received health care within the past two years, 12 percent were dissatisfied with their care. Of these dissatisfied citizens, 69 percent were dissatisfied with a medical doctor's care as opposed to care by another type of health practitioner. The most frequent source of dissatisfaction with a medical doctor's care was with the type or quality of care provided. However, only six percent of those dissatisfied with their care claimed to have filed a complaint with the appropriate licensing board in spite of the fact that 40 percent of those responding to the question were aware that the Board handled complaints.

* Board of Medical Examiners, Board of Chiropractic Examiners, Board of Osteopathic Examiners in Medicine and Surgery, the Naturopathic Board of Examiners and the Boards of Nursing and of Podiatry Examiners.

Most of those dissatisfied with a medical doctor did not take action, although approximately one-fourth of those dissatisfied complained directly to their doctors.

Table 9 compares the efforts the Board has made to encourage public input and increase public awareness to those efforts of other Arizona regulatory boards surveyed by the Auditor General.

TABLE 9

METHODS USED BY ARIZONA REGULATORY AGENCIES
TO ENCOURAGE PUBLIC INPUT AND PUBLIC PARTICIPATION
IN ACTIVITIES CONCERNING REGULATORY DUTIES

	Used by Other Regulatory Agencies		Used by the Board of Medical Examiners
	Number	Percentage	
NOTIFICATION REQUIRED STATUTORILY			
- Post regular meeting notices at officially designated locations	26	89.6%	X
- Post formal hearing notices at officially designated locations	20	69.0	X
- Post notices of hearings regarding adoption of rules and regulations at officially designated locations	27	90.0	X
NOTIFICATION BEYOND THAT WHICH IS REQUIRED STATUTORILY			
- Notify individual complainants by mail of formal hearings	21	72.4	
- Notify by mail consumers who request information regarding:			
1) Regular meetings	18	60.0	X
2) Formal hearings	17	58.6	X
3) Hearings on adoption of rules and regulations	25	83.3	X
- Notify by mail affected licensees/registrants of:			
1) Regular meetings	15	50.0	X
2) Formal hearings	26	89.7	X
3) Hearings on adoption of rules and regulations	19	63.3	X
- Notify by mail professional associations of hearings regarding adoption of rules and regulations	21	70.0	X
- Notify news media by mail of hearings regarding adoption of rules and regulations	17	58.6	X

As shown in Table 9, BOMEX appears to equal or exceed the level of effort of most other regulatory agencies to inform the public of its activities. Records of meetings and hearings are maintained and written transcripts not subject to confidentially restrictions are available to the public. Meeting agendas and minutes of meetings are distributed to some State agencies, medical facilities, the State medical association and representatives of the news media.

Unlike several other boards and agencies, however, the Board does not notify individual complainants before holding hearings or taking disciplinary action. This deficiency involving lack of adequate communication with complainants was addressed on page 20.

During the course of the audit, we noted that pharmacists appeared not to be aware of disciplinary actions taken by the Board. As a result, some pharmacists did not know that a physician had been restricted from prescribing certain controlled substances. After audit staff discussed the information with the Board it contacted the Board of Pharmacy, which has agreed to publicize in its quarterly newsletter, sent to all licensed pharmacists, information regarding those doctors with restricted prescription-writing privileges. It also was suggested by one hospital administrator interviewed during our audit that the Board forward similar information to each hospital in the State.

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THE ARIZONA BOARD OF MEDICAL EXAMINERS
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"Advice is seldom welcome.
Those who need it most,
like it least." Johnson

Although it has been said that advice is seldom welcome, the Board of Medical Examiners is indeed, appreciative of the comments and recommendations embodied in the Auditor General's Performance Audit. While the Board does not fully agree with all the comments and recommendations, they do recognize the benefits to be gained from periodic review of the process. Such review can serve as a positive basis for discussion and hopefully improvement.

It is for this very reason that the Board views as unfortunate that the timetable established for Sunset Review did not allow the Auditor General's staff an opportunity to review the full spectrum of the Board's statutory activities. Not included in the Auditor General's review is the entire process of licensure, the question of how to deal with proliferation of foreign medical schools, the value of continuing medical education, and the need for temporary as well as locum tenens licensure. While recognizing the obvious time constraints, the Board believes that all of these areas could have benefited from Sunset Audit Review. Nevertheless, those areas that were examined are addressed below in the order presented in the performance audit.

FINDING I

SINCE JANUARY 1, 1979, THE BOARD OF MEDICAL EXAMINERS HAS IMPROVED THE QUALITY AND THOROUGHNESS OF ITS COMPLAINT INVESTIGATIONS SIGNIFICANTLY. HOWEVER, SOME CHANGES IN THE COMPLAINT REVIEW PROCESS ARE NEEDED.

1. Authority To Investigate Complaints and Malpractice Actions.

The Auditor General finds Arizona's complaint and malpractice reporting procedures to be generally superior to those in most other states. Much to the credit of the legislature, this has enabled the Board to become a recognized leader in the regulation of physicians.

2. Quality and Thoroughness of Complaint Investigation.

The Auditor General also recognizes that the Board performs a thorough investigation of complaints and continually strives to better its procedures. This process is ongoing and the quality of the Board's work continues to mature.

PLEASE ADDRESS ALL COMMUNICATIONS TO THE EXECUTIVE DIRECTOR FOR THE BOARD

3. Disposition of Complaints.

The Auditor General further acknowledges that the Board has been decisive in its disposition of complaints with the exception of those involving fee disputes. On this point, the Board solicits the assistance of the legislature in defining whether and to what extent it should exercise authority in such matters.

4. Timeliness of Review.

The Auditor General, likewise, notes that the Board has acted with dispatch on complaints and that most are decided within six months of receipt. Of this, the Board is quite proud, particularly in light of the sensitive and complicated nature of its work.

5. Board Member Involvement of the Complaint Process.

The Board agrees with the auditor's recommendation "that Board member involvement in investigation of complaints be reduced and that investigations be conducted increasingly by the Board Staff." The Board and its staff have been working toward this end for some time and are reviewing a procedure which would eliminate Board member involvement in all phases of the investigative process.

6. Contact with Complainants is Insufficient.

The Board agrees with a portion of the auditor's recommendation... "that physician and non-physician complainants be better informed of BOMEX investigative procedures." The Board seriously questions the benefits to be derived from the auditor's recommendation that there b routine interviewing of all complainants for clarification of their complaints or follow-up information. The Board plans to include a brief description of its review process along with the letter to the complainant acknowledging receipt of the complaint. This proposed narrative will provide the public and physicians with a better understanding of the Board's methods and timetables involved in investigating allegations against physicians. Of course, this is not to say complainants have not or will not be interviewed. Obviously, this is a necessary part of some investigations, but not all.

7. Use of Informal Interviews Has Been Inappropriate.

The Auditor General recommends that the Board not use informal interviews as frequently as it does, but, instead, suggests increasing resort to the formal hearing. The Board strongly disagrees with the auditor's position for the very reason that the Auditor General made this recommendation, that is "by over utilizing the (Formal Hearing) process the Board wastes time and resources, and delays the resolution of some complaints unnecessarily." As the legislature correctly recognized, when it authorized the Board to exact discipline in the context of an informal interview, often

a trial type hearing is either too cumbersome or too expensive or both and yet some procedural protection is desirable. Therefore, a good procedure is simply to let the party know the nature of the evidence against him and to listen to what he has to say and this is the very purpose of the Board's informal interview. Nevertheless, with the advent of hearing officers, which the legislature endorsed just this past session, the Board has channeled an increasing number of cases to formal hearing setting. This, in turn is sure to foster a more balanced approach to disciplinary matters.

8. Several Doctors Were Not Properly Notified of Complaints.

This is a moot issue since BOMEX Staff recognized this problem and instituted routine notification procedures in January of 1980, a fact which is demonstrated in the Auditor General's report which states "during our review of complaints...we found ten cases in which the Board neglected to notify the doctors involved prior to the Board's final decision. All ten complaints were received in 1979."

9. Unauthorized Discipline Used by the Board.

The Board agrees with the Auditor General's recommendation that "Board disciplinary authority be expanded to include letters of reprimand or concern." The Board's proposed draft legislation includes such a provision. However, the problem as addressed by the auditors may simply be imagined. A "letter of concern" does not, nor was it meant to constitute discipline. It represents only an expression of interest and warning, by the Board, in cases where there was insufficient evidence to warrant statutory discipline. In other words, although the facts of the particular case may not be enough in and of themselves to justify disciplinary action, the Board, through a letter of concern, draws the doctor's attention to a specific problem and he is advised that if the course or pattern of practice continues, disciplinary action will be recommended.

10. Every Malpractice Action Has Not Been Reported to BOMEX.

The Auditor General found that insurance companies have not, as required by law, reported every malpractice claim or lawsuit to the Board. The auditor's recommendation was that penalties be added to the provisions of ARS §32-1451.02, for non-compliance with this requirement. While the Board has no disagreement with the Auditor General's recommendation, the Board very strongly urges a review of the intent and purpose of this entire section of law. Specifically, the Board believes that the auditing of insurance company reporting practices as well as sanctions for non-compliance with reporting requirements properly falls within the jurisdiction of the Insurance Department - not the Board of Medical Examiners.

11. Board Lacks Enforcement Authority.

The Board agrees with the Auditor General's recommendation that "Board Statutes be amended to specifically establish violations of Board orders as grounds for disciplinary action." The Board's proposed draft legislation contains such a provision.

FINDING II

THE BOARD OF MEDICAL EXAMINERS HAS BEEN LENIENT IN ITS DISCIPLINE OF PHYSICIANS WHO ARE THE SUBJECTS OF MULTIPLE COMPLAINTS.

The Auditor General has concluded that the Board was lenient - not in dealing with physicians generally, but only with a few physicians found guilty of multiple offenses. On the basis of this finding, the Auditor General recommended that either the Board develop disciplinary guidelines or in the alternative, that the legislature prescribe specific statutory penalties. The Board disagrees with the auditor's assessment of the Board's leniency on the following grounds.

First, the judgment of what constitutes lenient disciplinary action is a highly subjective one. What may be "lenient" to the Auditor General is "cruel and unusual punishment" to the physician in question.

Second, and a far greater concern to the Board is the yardstick used by the Auditor General in making their determination. They used guidelines established by California and Michigan. As far as can be determined by the Arizona Board these are the only two states who have set guidelines for such circumstances. We are unaware if the Auditor General or any other entity has made studies to determine the effectiveness of these guidelines on disciplinary action within these two states. A phone call to these two states by the Arizona Board elicited the fact that the guidelines are not an absolute standard and a great deal of discretionary authority is still vested with both boards. The result is that the Arizona Board seriously questions how two states' guidelines can constitute what the Auditor General apparently considers is a universal standard for appropriate discipline.

Finally, the Arizona Board has a real concern with the Auditor General's apparent tunnel vision approach to this Board's disciplinary activity. The Board believes that discipline serves many and sometimes competing interests, including the public's protection and rehabilitation of the offender. Depending on the facts and circumstances of a given case, different people may weigh these interests differently in striking a balance. The Board feels its statutory responsibility is to weigh the preservation of public health and safety with the potential for rehabilitation of the

physician. No arbitary set of standards could better serve this end, as, ultimately the public's trust must lie in the collective judgment of the Board made up of both lay people and physician members.

FINDING III

THE GRANTING OF LIMITED LICENSES HAS BEEN SUBJECTED TO ABUSES AND APPEARS TO BE UNNECESSARY.

The Board is in complete agreement with the Auditor General's recommendation that "provisions for Limited Licenses be eliminated from the statutes." The Board's proposed draft legislation repeals the section authorizing the issuance of Limited Licenses.

FINDING IV

CONFIDENTIAL BOMEX RECORDS ARE NOT ADEQUATELY PROTECTED FROM UNAUTHORIZED ACCESS AND REVIEW.

The Board disagrees with the Auditor General's recommendation "that the Board of Medical Examiners maintain better security over its confidential records." Since there have been no security breaches or other problems with the Board's records since 1913, the Board believes that the current security measures provides sufficient protection for confidential records and that the potential cost will not justify whatever potential increased security might be achieved. However, the Board is sensitive to the Auditor General's worries and will accept a twenty-four hour security guard should the Auditor General's office fund such a position out of their appropriation.

CONCLUSION

This concludes the Board's response to the formal findings by the Auditor General. However, there is one more matter which the Board feels it must address.

While the Board does not believe it would serve any worthwhile purpose to discuss the specific cases used as illustration by the Auditor General in its formal report, the Auditor General in one particular case entitled Board Failure To Discipline Drug Abusers Properly (page 45) raises a serious allegation which must be addressed. While it may just be an issue of semantics, the Auditor General, through a legislative council opinion, suggests that the Board's failure to "officially" notify the appropriate law enforcement agency of possible violations of State and Federal Narcotics Law could result in the members of the Board of Medical Examiners being removed as provided in Statute for "continued neglect of duty, incompetence, or unprofessional or dishonorable conduct."

The Board takes great exception to this implication. While the Auditor General is correct that no bureaucratic memorandums exchanged hands between law enforcement agencies and this office, the Auditor General is also aware that there exists a specific group established to provide for a sharing of potential drug abuse problems among law enforcement agencies.

This group, which is entitled the Intra-Agency Compliance Detail, is made up of representatives from:

Department of Public Safety
Scottsdale Police Department
Mesa Police Department
Glendale Police Department
Tempe Police Department
Adult Probation Office of Maricopa County
Maricopa County Attorneys Office
Federal Drug Enforcement Administration
Board of Dental Examiners
Board of Nursing
Board of Pharmacy
Board of Medical Examiners
Board of Osteopathic Examiners

This group meets on the first Tuesday of each month at the Board of Medical Examiners offices to exchange information regarding ongoing drug investigations and matters pertinent to both law enforcement and the member regulatory agencies. In March 1981, the Board of Medical Examiners' Chief Investigator discussed with the members of the Intra-Agency Compliance Detail the above-referenced case. As in the past, had any of the member agencies voiced an interest in pursuing the physician in question from a criminal point of view, a formal directive would have been drafted by the Executive Director of the Board of Medical Examiners to that law enforcement agency. No agency requested an "official" memo regarding this matter.

As an additional comment on this subject, BOMEX is more than a little concerned with the almost complete lack of interest among prosecutorial agencies of cases involving unlicensed practitioners which have been forwarded to those agencies by this Board. The catch phrase seems to be that these cases lack "jury appeal" and, therefore, go unprosecuted. The Board believes that this creates somewhat of a double standard where the Board acts aggressively against physicians who are licensed and who appear to be in violation and is totally inactive against non-licensed practitioners.

In conclusion, the Board of Medical Examiners feels that the Sunset Audit was a very positive activity for all the parties involved. The Board will modify its procedures to reach desired results of many of the auditor's findings. In addition, those issues which

may require legislative responses are addressed in proposed draft legislation that will be available for legislative review.

PHILLIP Z. SABA, M.D.
Chairman

DOUGLAS N. CERF
Executive Director

APPENDIX I

LEGISLATIVE COUNCIL OPINION 0-81-16

May 14, 1981

ARIZONA LEGISLATIVE COUNCIL

MEMO

May 14, 1981

TO: Douglas R. Norton
Auditor General

FROM: Arizona Legislative Council

RE: Request for Research and Statutory Interpretation (O-81-16)

This is in reponse to a request submitted on your behalf by Gerald A. Silva in a memo dated May 14, 1981. No input was received from the attorney general concerning this request.

FACT SITUATION:

In accordance with Arizona Revised Statutes (A.R.S.) section 32-1451, the board of medical examiners (board) investigates and resolves complaints against licensed medical doctors. The complaint investigation process typically involves the following steps:

1. A staff review of the written complaint, pertinent medical records and the doctor's rebuttal.

2. A review of the complaint by a board member who makes a recommendation as to what further steps should be taken.

3. An informal interview by the full board or an investigational interview by the investigating board member.

4. A formal hearing by the board.

5. A final review and decision by the board.

Actions 3 and 4 are taken only in select cases.

QUESTIONS PRESENTED:

1. Is it proper for a board member who initiates an investigation by filing a complaint with the board to also serve as the investigating board member, conduct the informal interview with the doctor involved, recommend action by the board and vote on matters relating to disciplinary action?

2. Should a board member who has been involved in an investigation of a complaint also participate in a formal hearing on the same matter and vote on final disciplinary action?

DISCUSSION:

Our response to both questions presented is the same, involve similar considerations and will be discussed together.

Initially, it must be recognized that all medical doctors, including board members, are obligated to report to the board information they may have reflecting on the

competency, professional conduct or mental or physical capacity of other doctors. The failure to report this information is itself unprofessional conduct. A.R.S. section 32-1451, subsection A.

In performing his duties, a board member must be conscientious and display good faith, honesty and integrity. He must exercise reason and avoid capricious or arbitrary action. These qualities are particularly important since individual rights could be jeopardized by their neglect. 67 C.J.S. Officers section 201 (1978).

Public officials are presumed to act in good faith, and it may be a heavy burden to show bias or prejudice. Chequinn Corporation v. Mullen, 193 A.2d 432 (Me. 1963). Nevertheless, it has been held that a public officer in a quasi-judicial capacity is disqualified to sit in a proceeding in which there is a controverted issue as to which he has expressed a preconceived view, bias or prejudice. The officer must disqualify himself if he has prejudiced the case or has given a reasonable appearance of having prejudiced it. Kennecott Copper Corp. v. F.T.C., 467 F.2d 67 (10th Cir. 1972); Acierno v. Folsom, 337 A.2d 309 (Del. 1975). It is fundamental that a quasi-judicial tribunal, similar to a court, must not only be fair, it must appear to be fair. Only thus can the proceeding meet the basic requirement of due process. Amos Treat & Co. v. S.E.C., 306 F.2d 260 (D.C. Cir. 1962); American Cyanamid Company v. F.T.C., 363 F.2d 757 (6th Cir. 1966). The due process considerations were expressed as follows in N.L.R.B. v. Phelps, 136 F.2d 562, 563 (5th Cir. 1943):

> /A/ fair trial by an unbiased and non-partisan trier of the facts is of the essence of the adjudicatory process as well when the judging is done in an administrative proceeding by an administrative functionary as well as when it is done in a court by a judge. Indeed, if there is any difference, the rigidity of the requirement that the trier be impartial and unconcerned in the result applies more strictly to an administrative adjudication where many of the safeguards which have been thrown around court proceedings have, in the interest of expedition and a supposed administrative efficiency been relaxed. Nor will the fact that an examination of the record shows that there was evidence which would support the judgment, at all save a trial from the charge of unfairness, for when the fault of bias and prejudice in a judge first rears its ugly head, its effect remains throughout the whole proceedings. Once partiality appears, and particularly when, though challenged, it is unrelieved against, it taints and vitiates all of the proceedings, and no judgment based upon them may stand.

Specific facts in each case determine whether a board member should recuse himself from voting on disciplinary action. Relevant considerations include:

(a) The substance of the complaint.

(b) Whether and at what point the board member forms and expresses conclusory opinions.

(c) The nature and substance of his opinions. A generalized conviction or point of view on policy or law is not sufficient to disqualify a member of the board from voting. There must be an actual bias focusing on the facts and doctor in the particular case under investigation before the board member is disqualified. American Cyanamid Company v. F.T.C., supra; Davis, Administrative Law Text section 12.02 (1972).

(d) Whether the board member's personal interests, including pecuniary and familial, could be affected by a particular result. These extraneous circumstances are unrelated to the merits of the issues and cannot be modified by persuasive evidence in the investigation or hearing. Tumey v. Ohio, 273 U.S. 510 (1927). Arizona's conflict of interest laws would specifically apply if a pecuniary interest is involved. A.R.S. Title 38, chapter 3, article 8.

(e) The board member's prior relationship, if any, with the doctor. The same considerations as stated in (d) supra may apply here to disqualify a board member.

(f) The extent and nature of the board member's participation in the investigation and review process. In each case an inquiry must be whether a board member has been so involved in the process that any bias, prejudice or conflict of interest he has taints the entire effort. Obviously, the less he takes part in the preliminary aspects of the process, the less likely will any of his biases and prejudices intrude into the formal hearing.

Prejudgment, in a manner of speaking, may be a built-in consequence of any administrative agency's having multiple duties such as investigative and judicial functions. It is not, however, a violation of due process per se. Pangburn v. C.A.B., 311 F.2d 349 (1st Cir. 1962). It is simply one more factor to consider in addition to the other circumstances surrounding each case.

It should be noted in passing that the administrative law doctrine of necessity does not apply to the questions presented. That doctrine would hold that if the entire board were disqualified, it could nevertheless act because there is no alternative tribunal provided by law. An unsatisfactory ruling in that case could be reviewed on appeal. Under the questions presented, we have only the situation where perhaps one board member may be disqualified, leaving the remainder of the board free to act.

CONCLUSION:

Applying legal standards to the facts of an individual case or cases is beyond the scope of this memorandum. However, due process considerations indicate that it may not be proper for a board member to function as stated in the questions presented in particular instances. In all cases, a board member should be scrupulous in avoiding the appearance of bias, prejudice or conflict of interest, even if it means abstaining from voting in formal hearings on matters with respect to which he has been involved in preliminary stages.

RECOMMENDATION:

It may appear bizarre for a single person to act in the several capacities of plaintiff, investigator, prosecutor and judge in the same case. You may wish to recommend a self-imposed separation of the functions with the board's staff assuming full responsibility for conducting investigations and informal interviews as well as administrative standards to determine qualification for voting in disciplinary actions.

cc: Gerald A. Silva
Performance Audit Manager

ARIZONA LEGISLATIVE COUNCIL

MEMO

May 15, 1981

TO: Douglas R. Norton
Auditor General

FROM: Arizona Legislative Council

RE: Request for Research and Statutory Interpretation (O-81-13)

This is in response to a request submitted on your behalf by Gerald A. Silva in a memo dated May 14, 1981. No input was received from the Attorney General concerning this request.

FACT SITUATION:

Arizona Revised Statutes (A.R.S.) section 32-1451, subsection A states that:

> A. The board on its own motion may investigate any evidence which appears to show that a doctor of medicine is or may be medically incompetent or is or may be guilty of unprofessional conduct or is or may be mentally or physically unable safely to engage in the practice of medicine.

QUESTION:

What steps and procedures would constitute a proper investigation conducted pursuant to A.R.S. section 32-1451, subsection A?

ANSWERS:

The operative language in A.R.S. section 32-1451, subsection A, relating to the authority of the board of medical examiners (board) to investigate any evidence which appears to question the professional competence of a medical doctor, is not accompanied by any precise statutory or regulatory road map for the board to follow in conducting a "proper" investigation. Within certain general statutory guidelines, the board has administrative discretion to conduct the investigation in such manner as it sees fit.

Administrative agencies are creatures of legislation without inherent or common law powers. The general rule applied to statutes granting powers to administrative agencies is that they have only those powers that are conferred either expressly or by necessary implication. Sutherland, Statutory Construction section 65.02 (4th ed., Sands, 1972); Corporation Commission v. Consolidated Stage Company, 63 Ariz. 257, 161 P.2d 110 (1945); Garvey v. Trew, 64 Ariz. 342, 170 P.2d 845 (1946). The board of medical examiners must follow the dictates of the Arizona Revised Statutes in exercising its administrative powers and duties relating to investigations as well as every other matter.

In that the statutes do not prescribe the precise components of a proper investigation for the board, reference must be made to the meaning of the operative term in the enabling statute. It is an elementary principle of statutory construction that each word in a statute will be given effect. Sutherland, section 46.06; State v. Superior Court for Maricopa County, 113 Ariz. 248, 550 P.2d 626 (1976). The words of a statute are to be

given their common meaning unless it appears from the context or otherwise that a different meaning is intended. Ross v. Industrial Commission, 112 Ariz. 253, 540 P.2d 1234 (1975). According to Blacks Law Dictionary, 5th Edition (1979), the word "investigate" means:

> To follow up step by step by patient inquiry or observation. To trace or to track; to search into; to examine and inquire into with care and accuracy; to find out by careful investigation; examination; the taking of evidence; a legal inquiry.

There is general agreement that investigations by government officials, which may be held in private, are informal proceedings to obtain information to govern future actions, have no parties and are not proceedings in which action is taken against anyone. Bowles v. Baer, 142 F.2d 787, 788 (1944).

A.R.S. sections 32-1451 and 32-1451.01 prescribe certain guidelines which condition any investigation by the board into the competence of a medical doctor. In the exercise of its investigative authority, A.R.S. section 32-1451.01, subsection A provides that the board and its employees shall have access to, for the purpose of examination, any documents or records held by relevant parties if the documents or records relate to medical competence, unprofessional conduct or the mental or physical ability of a doctor of medicine to safely practice medicine.

Since persons involved in matters relating to the professional competence of a licensed medical doctor may be reluctant to provide all necessary information, A.R.S. section 32-1451.01, subsection B provides that the board on its own initiative or upon the application of any person involved in the investigation may issue subpoenas compelling the attendance and testimony of relevant witnesses or demanding the production of relevant documents. Subpoenas issued by the board are subject to enforcement by the superior court.

A.R.S. section 32-1451.01, subsections C, D and E prescribes certain other procedural requirements to which the board must adhere in the exercise of its investigative responsibilities. Subsection C provides in substance that patient records obtained by the board as the result of any investigation procedure not be made available to the public if the records could be used to identify the patient or his family. Subsection E of A.R.S. section 32-1451.01 provides that, while hospital records, medical staff records, medical staff review committee records and related sources of information are to be available to the board as necessary during each professional competence examination, the board is required to take such steps as are necessary to ensure that such information remains confidential. A.R.S. section 32-1451.01, subsection D even provides a general exemption to the board from the otherwise applicable doctor-patient shield of privileged communications in the exercise of its investigatory responsibilities. Subsection D further provides that the board and its employees, representatives and agents are required to keep in confidence the names of any patients whose records are reviewed during the course of an investigation.

The investigation relating to professional competence authorized by A.R.S. section 32-1451, subsection A is basically the first step in instituting a disciplinary proceeding against a medical doctor. A.R.S. section 32-1451, subsection C provides that, if, in the opinion of the board, the information presented questioning the professional competence of a medical doctor is or may be true, the board may request an informal interview with

the doctor concerned. If the doctor refuses the informal interview invitation or if the results of the interview indicate that a license suspension or revocation might be in order, the statutorily prescribed formal complaint and hearing process applies. On the other hand, if the informal interview, together with such competence examination reports as are deemed necessary by the board, indicate that the information relating to medical incompetency or guilt of unprofessional conduct or the physical or mental inability to safely engage in the practice of medicine is true but not of sufficient seriousness to merit license suspension or revocation, the board may issue a decree of censure or fix a term and conditions for probation, or both.

A.R.S. section 32-1451, subsection C, does not prescribe any grounds for determining the seriousness of the information received concerning the competency of a licentiate. Application of a rule of reason suggests that seriousness should be determined by an assessment of potential harm to patients, not by a balancing of the M.D.'s societal value.

There is, unquestionably, a conflict with respect to permitted investigation procedures under A.R.S. section 32-1451, subsections C and D. In contrast to A.R.S. section 32-1451, subsection C, subsection D provides that if, in the opinion of the board, the charge is or may be true, the board is required to serve on the doctor a summons and complaint requiring a hearing before the board. Under subsection D, the only requirement for advancement of a charge to the complaint stage is that it is or may be true. Unlike the case under subsection C, there is no reference under subsection D to an informal hearing at which time the board may issue a decree of censure or fix a term of probation in response to a less serious charge. To clarify the inconsistency between A.R.S. section 32-1451, subsections C and D, your office may wish to recommend corrective legislation to the Legislature.*

Once a professional competence investigation against a medical doctor has reached the formal complaint and hearing stage, the board is required to secure from the medical doctor being investigated, pursuant to A.R.S. section 32-1451, subsection E, such mental, physical and medical competence examinations as are required to fully inform itself with respect to the complaint. A.R.S. section 32-1451, subsection H prescribes the same subpoena authority for the board in the adjudication of complaints and formal hearings as is the case in the investigation stage. Once a professional competence investigation against a medical doctor reaches the formal complaint and hearing stage, the medical doctor has certain due process procedural guarantees pursuant to A.R.S. section 32-1451, subsections F, G, I and K. Subsection G provides, for example, that the doctor may be present at the hearing in person together with such counsel and witnesses, if any, as he or she may select.

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* This inconsistency developed following the passage of omnibus medical malpractice legislation in 1976.

CONCLUSION:

There is no statute or regulation in Arizona which prescribes specific investigative procedures for the board of medical examiners. Review of laws governing other professional or occupational licensing boards failed to indicate any statutes which specifically prescribe investigative procedures. The legislative intent in Arizona seems clearly to leave investigative procedures at the administrative discretion of each particular licensing board.

With respect to medical doctors and in the context of A.R.S. sections 32-1451 and 32-1452, a "proper" investigation by the board of medical examiners might include the following steps:

1. Investigate the source and nature of the evidence presented bringing the professional conduct, competence and ability to safely engage in medical practice of the medical doctor into question. To this end, the board could access, for the purpose of examination, the books and records of the person being investigated.

2. Interview patients of the medical doctor being investigated and examine their medical records notwithstanding the confidential nature of the doctor-patient relationship.

3. Review hospital records, medical staff records and medical staff review committee records relating to the medical doctor being investigated.

4. Issue subpoenas, as necessary, compelling the attendance and testimony of witnesses or the production of documents relating to the professional competence of any medical doctor under investigation.

5. Require that the medical doctor being investigated submit to such medical, physical and mental competence examinations as are required to review the nature of the evidence concerning the professional competence of the medical doctor.

6. After assembling and assessing all of the evidence developed pursuant to the preliminary investigation against the generally accepted competence standards for the profession, the board should determine whether an informal interview with the medical doctor is necessary. If it appears at this stage that the evidence presented is of sufficient gravity that license suspension or revocation might be in order, the board is required to issue a formal complaint and provide for a hearing. There is an inconsistency here in that the operative statute also provides that if the information presented relating to professional competence is or may be true, with no assessment as to relative seriousness, the board may move directly to the complaint and formal hearing stage.

The board has similar investigative authority following the filing of a complaint to develop necessary evidence concerning the matter in question. If the evidence presented at the informal interview is not of sufficient gravity to warrant license suspension or revocation, the board may proceed to issue a decree of censure or fix a term of probation, or both. The major problem in this regard is that there are no specific statutory standards by which the board may evaluate the seriousness of the information received concerning the licentiate's activities.

Application of a rule of reason suggests that seriousness should be determined by an assessment of potential harm to patients, not by a balancing of the M.D.'s societal value.

If the board of medical examiners has failed to investigate allegations concerning the professional competence of a medical doctor brought pursuant to A.R.S. section 32-1451, subsection A with sufficient vigor on the grounds that the relevant statutes are unnecessarily vague, appropriate corrective legislation could be recommended to the Legislature. However, given the general complexity in questions of professional conduct, competence and ability to safely engage in medical practice relating to medical doctors as well as every other profession, any attempt to prescribe specific investigative procedures could be counterproductive and artificially limit the board in certain disciplinary circumstances.

Your office may also wish to recommend corrective legislation to the Legislature with respect to the use of informal interview by the board.

cc: Gerald A. Silva
Performance Audit Manager

ARIZONA LEGISLATIVE COUNCIL

MEMO

May 21, 1981

TO: Douglas R. Norton
Auditor General

FROM: Arizona Legislative Council

RE: Request for Research and Statutory Interpretation (O-81-14)

This is in response to a formal request submitted on your behalf by Gerald A. Silva in a memo dated May 14, 1981. No input has been received from the Attorney General concerning this request.

FACT SITUATION:

Arizona Revised Statutes (A.R.S.) section 32-1451, subsections C and D allows the board of medical examiners (board) to hold informal interviews or formal hearings if, in the opinion of the board, it appears a doctor is or may be medically incompetent, guilty of unprofessional conduct or otherwise unable to safely engage in the practice of medicine.

During the course of its review of complaints and malpractice reports, the board has, for the most part, elected to initially conduct informal interviews, pursuant to A.R.S. section 32-1451, subsection C, rather than formal hearings. As a result, in some cases, lengthy delays of 90 days or more have occurred because doctors called before the board were unable to appear at the time of the board's quarterly meeting, failed to appear at the time scheduled, or refused to respond to questions of the board at the informal interview.

QUESTIONS PRESENTED:

1. Under what legal and other circumstances should a formal hearing be held in lieu of or in addition to an informal interview?

2. What are the ramifications, if any, when the board is unable to take disciplinary action against a doctor because of lengthy delays, and the doctor is involved in subsequent violations of the medical practices act?

ANSWERS:

1. The full text of A.R.S. section 32-1451, subsections C and D states that:

C. If, in the opinion of the board, it appears such information is or may be true, the board may request an informal interview with the doctor concerned. If the doctor refuses such invitation or if he accepts the same and if the results of such interview indicate suspension or revocation of license might be in order, then a complaint shall be issued and a formal hearing shall be had in compliance with the subsequent subsections of this section. If, at such informal interview, together with such mental, physical or medical competence examination as the board deems necessary, the board finds the information provided under subsection A of this section to be

true but not of sufficient seriousness to merit suspension or revocation of license, it may take either or both of the following actions:

1. Issue a decree of censure.

2. Fix such period and terms of probation best adapted to protect the public health and safety and rehabilitate or educate the doctor concerned. Such probation, if deemed necessary, may include temporary suspension or restriction of the doctor's license to practice medicine. Failure to comply with any such probation shall be cause for filing a summons, complaint and notice of hearing pursuant to subsection D of this section based upon the information considered by the board at the informal interview and any other acts or conduct alleged to be in violation of this chapter or rules and regulations adopted by the board pursuant to this chapter.

D. If, in the opinion of the board, it appears such charge is or may be true, the board shall serve on such doctor a summons and complaint fully setting forth the conduct, inability or incompetence concerned and returnable at a hearing to be held before the board in not less than thirty days therefrom, stating the time and place of such hearing.

Therefore, as prescribed by statute, if a doctor is accused of being medically incompetent, guilty of unprofessional conduct or mentally or physically unable to safely engage in the practice of medicine, the board may request an informal interview with the doctor. If the doctor refuses the invitation to appear at the informal interview or if the doctor accepts the invitation and the results of the interview" . . . indicate suspension or revocation of (sic) license might be in order, then a complaint shall be issued and a formal hearing shall be had . . . ." A.R.S. section 32-1451, subsection C. If, at the informal interview, the board finds the accusations against the doctor are true, but not of sufficient seriousness to merit suspension or revocation of his license, the board could impose sanctions on the doctor less burdensome than suspension or revocation of his license.

Informality is a hallmark of an administrative proceeding. 2 Am. Jur. 2d Administrative Law section 342; A.R.S. section 41-1010, subsection A; Fitzpatrick v. Board of Medical Examiners', 96 Ariz. 309, 394 P.2d 423 (1964). A formal procedure is characterized by the availability of testimony of witnesses, stenographic records, briefs, arguments and findings of fact or opinion. On the other hand, the purpose of an informal administrative adjudication is to arrive at decisions based upon inspection or to dispose of complaints by consent or by correspondence. 2 Am. Jur. 2d Administrative Law section 342.

Generally, the informal interview process would be acceptable if a complaint refers to conduct which would not appear to be sufficient to warrant suspension or revocation of a license but could be disposed of by consent or correspondence. Only in those cases where the harsh penalty of suspension or revocation of a license is possible would a formal hearing, with its procedures for attendance of witnesses, administration of oaths and written findings of fact and opinion, be required.

2. There is no statutory provision or any case law which provides for increased punishment against a doctor who is under suspicion for a violation of the medical practices act who subsequently is involved in another violation of the act. In such a case, the board could proceed pursuant to A.R.S. section 32-1451 and, if the charge is found to be true, censure or place the doctor on probation or suspend or revoke the license of the doctor.

Generally, an administrative body is liable for nonfeasance when the duty is ministerial and the failure to perform is the proximate cause of the injury sustained.

Industrial Commission v. Superior Court 5 Ariz. App. 100, 423 P.2d 375 (1967); 73 C.J.S. Public Administrative Bodies and Procedure section 15. Additionally, Arizona law provides that a state officer is not personally liable for an injury resulting from his act or ommission in a public capacity where the act or omission was the result of the exercise of discretion vested in him if the exercise of the discretion was done in good faith without wanton disregard of his statutory duties. A.R.S. section 41-621, subsection G.

Thus, depending on the facts of each case, the board could be potentially liable if disciplinary action against a doctor is delayed and subsequent violations are committed by the doctor.

CONCLUSIONS:

1. A formal hearing should be held against a doctor accused of a violation of the medical practices act if the doctor refuses a request for an informal interview with the board or if, in the opinion of the board or after an informal interview, the board believes that suspension or revocation of the license of the doctor may be warranted.

2. The statutes and case law are silent as to the ramifications in the case of a doctor who is under suspicion for a violation of the medical practices act who subsequently is involved in another violation of the act.

cc: Gerald A. Silva
Performance Audit Manager

ARIZONA LEGISLATIVE COUNCIL

MEMO

May 14, 1981

TO: Douglas R. Norton
Auditor General

FROM: Arizona Legislative Council

RE: Request for Research and Statutory Interpretation (O-81-12)

This is in response to a request submitted on your behalf by Gerald A. Silva in a memo dated May 14, 1981. No input was received from the attorney general concerning this request.

FACT SITUATION:

Arizona Revised Statutes (A.R.S.) section 32-1451, subsection A requires that the board of medical examiners (board) notify a doctor when information is received indicating that the doctor is or may be guilty of medical incompetence, unprofessional conduct, or is otherwise unable safely to engage in the practice of medicine:

* * *

> The board shall notify the doctor about whom such information has been received as to the content of such information within one hundred twenty days of receipt of such information.

* * *

It appears that in several cases, the board has not notified the doctor involved that a complaint alleging misconduct was received by the board.

QUESTIONS PRESENTED:

1. Is the board required to notify the doctor involved in all cases when a complaint is received?

2. If not, what are the circumstances in which the board is not required to notify the doctor involved?

3. What are the legal and other ramifications of failing to notify the doctor in cases where such notification is required?

ANSWERS:

1. Yes.

2. Not applicable.

3. See discussion.

DISCUSSION:

1. The principal issue is whether the cited passage of statute is directory or mandatory. The word "directory" is defined as a statutory provision which is a mere direction or instruction having no obligatory force. Black's Law Dictionary 414 (5th ed. 1979). "Mandatory" is defined as imperative or a command. Id. at 867.

Although language may appear to be mandatory in an absolute sense, it may be deemed directory in effect when the purpose of the legislature in enacting the statute can best be carried out by such a construction. Valley Bank v. Malcolm, 23 Ariz. 395 (1922); Department of Revenue v. Southern Union Gas Co., 119 Ariz. 512 (1978). The words "the board shall notify the doctor" appear to allow the board no option. It is necessary, however, to determine whether a mandatory construction is indeed required. No formalistic rule of grammar or word form should stand in the way of carrying out the legislative intent.

The relevant provision was enacted as a minor part of the medical malpractice bill from the thirty-second legislature, first special session. Laws 1976, first special session, chapter 1, section 9. It was added as a Senate amendment, but there is no legislative history, either in the legislative journals or committee minutes, to indicate a legislative intent in enacting this particular provision. In the absence of a direct statement of legislative intent, one must look to the consequences of placing a mandatory or directory effect to determine whether either is more reasonable than the other. In addition, some special guidelines are recognizable. Sutherland, Statutes and Statutory Construction, section 25.04 (4th ed., Sands, 1972).

The use of the word "shall" normally indicates a mandatory intent, especially when the duty is for the benefit of a private individual. Brooke v. Moore, 60 Ariz. 551 (1943); Boyden v. Commissioner of Patents, 441 F.2d 1041 (App. D.C. 1971). If a time is stated within which to perform an official duty, and if the time limit is essential to the purpose of the statute, the statute may be deemed to be mandatory. John C. Winston Co. v. Vaughan, 11 F. Supp. 954 (1935), affd. 83 F.2d 370. Likewise, if a statute prescribes an act to be performed and the time, manner and occasion of its performance with no provision for discretion, it is considered a ministerial or mandatory act. Magma Copper Co. v. Arizona State Tax Commission, 67 Ariz. 77 (1948); State v. Airesearch Mfg. Co., 68 Ariz. 342 (1949). If a persons's rights may be jeopardized by an official's failure to comply with the statute, the statute will be deemed mandatory. State ex rel. Werlein v. Elamore, 147 N.W.2d 252 (Wis. 1967). Finally, some judicial statements imply a presumption in favor of a mandatory construction unless the directory nature of the statute is clear. Woodmansee v. Cockerill, 185 N.E.2d 439 (Ohio 1961).

A.R.S. section 32-1451 establishes a comprehensive procedure for receiving and investigating complaints against medical doctors. The board is to receive all complaints and, from them and from other information it may have or obtain, determine whether to proceed with an investigation of the doctor. The statute also contemplates informing the doctor that allegations have been made regarding his practice. This information is vital to the doctor, not only in his own defensive interest, but in the interest of his practice and relationship with his patients and professional colleagues.

From the foregoing analysis, it is our conclusion that the doctor must be informed in all cases in order to avoid jeopardizing his rights and interests. There is no allowance or standards by which the board may elect not to inform some doctors. In this case the requirement for notification is mandatory.

2. Since the answer to question number 1 is affirmative, this question does not apply.

3. The important distinction between directory and mandatory provisions of statutes is that the violation of the former causes no legal consequences while the failure to comply with the requirements of the latter may invalidate official acts and subject the noncomplier to affirmative legal liabilities.

The invalidity of proceedings is one of the prime characteristics of a mandatory provision of law. Department of Revenue v. Southern Union Gas Co., supra. Therefore, if the board proceeded to investigate a doctor whom it had not notified within 120 days, the investigation and any consequent action by the board would be void. Of course, if the board dropped the investigation, the question of its invalidity would be moot.

Since notification of doctors is a ministerial duty of the board, i.e., one with respect to which there is no discretion, the members of the board may be personally liable for damages to one to whom the duty is owing to the extent of any injury proximately caused by the nonperformance. Industrial Commission v. Superior Court In and For Pima County, 5 Ariz. App. 100 (1967); State v. Superior Court of Maricopa County, 123 Ariz. 324 (1979). Moreover, a mistake as to the nature of the duty does not excuse the offense. 63 Am. Jur. 2d Public Officers and Employees section 292 (1972). A.R.S. section 32-1402, subsection F would shield board members from personal liability if the failure to notify was "in good faith and in furtherance of this chapter." It is questionable whether the failure to perform a ministerial act specifically prescribed by statute could be deemed to qualify for the immunity.

Finally, in cases where the officer's duty is to the public, A.R.S. section 38-443 provides that nonfeasance of the duty is a class 2 misdemeanor.

CONCLUSION:

1. The board's duty to notify medical doctors regarding whose practice allegations have been made is mandatory and ministerial. There is no discretion for the board to fail to notify all such doctors.

2. Not applicable.

3. Board investigatory proceedings relating to a doctor who has not been notified of the allegations are void. Whether or not the board conducts an investigation, if it does not notify the doctor of the allegations against him, the members of the board may be personally liable for injuries to the doctor caused by the board's nonfeasance. Nonfeasance in public office is also a class 2 misdemeanor.

cc: Gerald A. Silva
Performance Audit Manager

ARIZONA LEGISLATIVE COUNCIL

MEMO

May 15, 1981

TO: Douglas R. Norton
Auditor General

FROM: Arizona Legislative Council

RE: Request for Research and Statutory Interpretation (O-81-25)

This is in response to a request submitted on your behalf by Gerald A. Silva in a memo dated May 14, 1981. No input was received from the Attorney General concerning this request.

FACT SITUATION:

Arizona Revised Statutes (A.R.S.) section 32-1451, subsection C, paragraph 1 allows the board of medical examiners (board) to issue a decree of censure if a medical doctor is found to be medically incompetent, guilty of unprofessional conduct, or physically or mentally unable to safely engage in the practice of medicine and if the offense was not of sufficient seriousness to merit suspension or revocation of license.

On occasion the board has written a "letter of reprimand" or a "letter of concern" to a doctor indicating the board's displeasure or criticism of certain aspects of the doctor's practice.

QUESTIONS PRESENTED:

1. Do letters of concern or letters of reprimand constitute a decree of censure?

2. Is the board authorized to issue letters of reprimand or letters of concern as a result of an informal interview or a hearing?

3. If not, what are the ramifications to the board and the license holder if such letters have been issued?

ANSWERS:

1. No. Applicable provisions of the Arizona Revised Statutes authorize the board to issue a decree of censure, fix a term and conditions of probation, or both, or proceed pursuant to a specific hearing process toward license suspension or revocation in specific disciplinary situations involving the professional competence of a medical doctor. There is no authority for the board to issue a letter of concern or letter of reprimand in place of or in addition to any of the statutorily prescribed disciplinary alternatives.

2. Existing state statutes do not authorize the board to issue either a letter of concern or a letter of reprimand.

3. Without knowing the context in which the board issues a letter of concern or a letter of reprimand, it is impossible to project the ramifications for either the board or the license holder.

DISCUSSION:

1. A.R.S. section 32-1451, subsection C provides that if any evidence questioning the professional competence of a medical doctor is found, pursuant to an informal hearing by the board, to be true but not of sufficient seriousness to warrant license suspension or revocation, the board may take either or both of the following actions:

a. Issue a decree of censure.

b. Fix such term and conditions of probation as are best adopted to protect the public health and safety and rehabilitate or educate the doctor concerned. Probation may include temporary suspension or restriction of the doctor's license to practice medicine.

It is assumed for the purposes of this memo that the referenced alternative forms of disciplinary action are used or at least considered by the board as an alternative to the more formal procedure of issuing a decree of censure or fixing a term or conditions of probation, or both. A letter of concern would appear to be the first level of disciplinary action referencing a situation in which the board merely issues a letter expressing its official acknowledgement that questions have been raised regarding the professional competence of the medical doctor in question. A letter of reprimand implies a more serious action, one in which the board would, following Black's Law Dictionary (5th Edition 1979):

> /R/eprove severely; . . . especially with authority; Federal Labor Union 23393, American Federation of Labor v. American Can Company, 28 N.J. Super. 306, 100 A.2d 693, 695 (1953). A public . . . formal . . . severe reproof administered to a person in fault by his superior officer or by a body or organization in which he belongs.

Still, a letter of reprimand would appear to fall short of the type of disciplinary action implied in a decree of censure. "Censure", following Black's Law Dictionary (5th Edition 1979), references:

> /T/he formal resolution of a legislative, administrative or other body reprimanding a person, normally one of its own members, for specified conduct. An official . . . condemnation.

The use of the term "decree" in conjunction with "censure" further reinforces the more formal nature of this type of disciplinary action.

Administrative agencies are creatures of legislation without inherent or common law powers. The general rule applied to statutes granting powers to administrative agencies is that they have only those powers as are conferred either expressly or follow by necessary implication. Sutherland, Statutory Construction section 65.02 (4th ed., Sands, 1972); Corporation Commission v. Consolidated Stage Company, 63 Ariz. 257, 161 P.2d 110 (1945); Garvey v. Trew, 64 Ariz. 342, 170 P.2d 845 (1946). The board must follow the dictates of the Arizona Revised Statutes in exercising its administrative powers and duties relating to permitted forms of disciplinary actions as well as with respect to every other matter.

It is an elementary principle of statutory construction that each word in a statute be given effect. Sutherland, id., section 46.06; State v. Superior Court for Maricopa County, 113 Ariz. 248, 550 P.2d 626 (1976). The words of a statute are to be given their common meaning unless it appears from the context or otherwise that a different meaning is intended. Ross v. Industrial Commission, 112 Ariz. 253, 540 P.2d 1234 (1975).

There is no explicit or implicit statutory authority for the board to take any disciplinary action against a medical doctor other than that specifically permitted by statute. If the Arizona Legislature had intended for the board to have the authority to issue a letter of concern or a letter of reprimand to a medical doctor instead of issuing a decree of censure or fixing the term or conditions of probation, or both, it must be assumed that it would have so provided. The Legislature could have taken the requisite enabling statutory action either specifically or through a general grant of administrative authority to the board to take such actions in certain disciplinary situations as the board were to see fit.

There is, unquestionably, a conflict with respect to permitted disciplinary procedures under A.R.S. section 32-1451, subsections C and D. Subsection C provides that, if, in the opinion of the board, the information presented questioning the professional competence of a medical doctor is or may be true, the board may request an informal interview with the doctor concerned. If the doctor refuses the informal interview invitation or if the results of the interview indicate that a license suspension or revocation might be in order, the statutorily prescribed formal complaint and hearing process applies. On the other hand, if the informal interview, together with such professional competence examination reports as are deemed necessary by the board, indicate that the information relating to medical incompetency or guilt of unprofessional conduct or the physical or mental inability to safely engage in the practice of medicine is true but not of sufficient seriousness to merit license suspension or revocation, the board may issue a decree of censure or fix a term and conditions for probation, or both.

A.R.S. section 32-1451, subsection C does not prescribe any grounds for determining the seriousness of the information received concerning the competency of a licentiate. Application of a rule of reason suggests that seriousness should be determined by an assessment of potential harm to patients, not by a balancing of the M.D.'s societal value.

In contrast to A.R.S. section 32-1451, subsection C, subsection D provides that, if, in the opinion of the board, the charge is or may be true, the board is required to serve on the doctor a summons and complaint requiring a hearing before the board. Under subsection D, the only requirement for advancement of a charge to the complaint stage is that it is or may be true. Unlike the case under subsection C, there is no reference under subsection D to an informal hearing at which time the board may issue a decree of censure or fix a term of probation in response to a less serious charge. To clarify the inconsistency between A.R.S. section 32-1451, subsections C and D, your office may wish to recommend corrective legislation to the Legislature.

2. Existing state statutes do not, as noted above, authorize the board to issue either a letter of concern or a letter of reprimand. Consequently, it is unnecessary to further respond to the question of whether such disciplinary actions may be issued pursuant to either an informal interview or a hearing.

3. The precise ramifications to the board of issuing letters of concern or letters of reprimand without the statutory authority to do so would depend on the circumstances of each case. Sutherland, id., section 65.05, reports a general policy of judicial liberalness toward responsible agency interpretations of the scope of their own statutory powers being manifested in decisions giving broad legal authority to their actions. Thus, following Sutherland, id., where the proper exercise of the powers of an administrative agency is dependent upon a determination of the facts, the findings and conclusions of the agency are usually assumed to be correct on judicial review. Consequently, it must be assumed, using a hypothetical example drawn from the given fact situation, that, if the

board were to issue a letter of concern coupled with fixing a term of probation, the latter would stand and the former would merely be no longer an official finding of the board.

Without knowing the context in which the board issues a letter of concern or letter of reprimand and what effect, if any, such disciplinary actions have on the professional practice of a medical doctor, it is impossible to determine whether the board would be liable for taking either disciplinary action. Similarly, without knowing the context in which the board issues a letter of concern or letter of reprimand and whether the letters are ever made public, it is impossible to determine what, in general, are the ramifications for the license holder.

It may be that, in a majority of cases, a medical doctor would rather be the recipient of a letter of concern or letter of reprimand than the more formal - and perhaps more pejorative in the sense of damage to professional reputation - decree of censure.

Once an investigation into the professional competence of a licensed medical doctor is initiated pursuant to A.R.S. section 32-1451, subsection A, neither A.R.S. section 32-1451 or A.R.S. section 32-1451.01 require that the investigation be terminated. Thus, it is possible that, with a letter of concern or letter of reprimand no longer classed as a final order of the board, such documents might become a part of an ongoing investigative file.

RECOMMENDATIONS:

If the board of medical examiners would find it beneficial to have the administrative authority to issue a letter of concern or a letter of reprimand instead of any of the other statutorily prescribed disciplinary alternatives, appropriate corrective legislation should be recommended to the legislature.

Your office may also wish to recommend corrective legislation to resolve the conflict in existing law with respect to the correct disciplinary procedures to be followed by the board following a determination that the evidence presented is insufficient to warrant license suspension or revocation. The operative statute (A.R.S. section 32-1451) provides at one point, subsection C, that, in such cases, the board is to proceed to issue a decree of censure, fix a term of probation, or both. At another point, the operative statute (A.R.S. section 32-1451, subsection D) provides that if the information presented relating to professional competence is or may be true, with no assessment as to relative seriousness, the board may move directly to the complaint and formal hearing stage.

cc: Gerald A. Silva
Performance Audit Manager

ARIZONA LEGISLATIVE COUNCIL

MEMO

May 22, 1981

TO: Douglas R. Norton
Auditor General

FROM: Arizona Legislative Council

RE: Request for Research and Statutory Interpretation (0-81-41)

This is in response to a request submitted on your behalf by Gerald A. Silva in a memo dated May 13, 1981. No input was received from the attorney general concerning this request.

FACT SITUATION:

Arizona Revised Statutes (A.R.S.) section 32-1451.02 requires medical liability insurers to report to the Board of Medical Examiners of the State of Arizona (BOMEX) any written or oral malpractice claims or actions against a doctor. Insurers are also required to report any malpractice judgments or settlements entered against a doctor:

> A. Any insurer providing professional liability insurance to a doctor of medicine licensed by the board of medical examiners pursuant to this chapter shall report to the board within thirty days of its receipt, any written or oral claim or action for damages for personal injuries claimed to have been caused by an error, omission or negligence in the performance of such insured's professional services....
>
> * * *
>
> C. Every insurer required to report to the board pursuant to this section shall also be required to advise the board of any settlements or judgments against a doctor of medicine within thirty days after such settlement or judgment of any trial court.

During the course of our review of court records, several malpractice suits filed or settlements entered against doctors were found which had not been reported to BOMEX or were reported late (more than 30 days after the claim was filed). A few of these suits were either filed or settled after the malpractice reporting law was passed in 1976. For example, a $1.75 million settlement entered in May, 1980 against one doctor has not been reported to BOMEX by the insurer, an out-of-state company.

QUESTIONS PRESENTED:

1. In the cases cited above, are the insurers in violation of A.R.S. section 32-1451.02?

2. Who is responsible for enforcing the malpractice reporting law and to whom should any violation be reported?

3. What are the ramifications to BOMEX and to the insurer if the insurer failed to report a suit filed or a settlement, or took longer than 30 days to report to BOMEX?

ANSWERS:

1. Yes. The duty imposed by A.R.S. section 32-2451.02, subsection A on any insurer providing professional liability insurance to report claims in a timely fashion is prescribed by use of the mandatory "shall" rather than the permissive "may". It is an elementary principle of statutory construction that each word in a statute will be given effect. Sutherland, Statutes and Statutory Construction section 46.06 (4th ed., Sands, 1972); State v. Superior Court for Maricopa County, 113 Ariz. 248, 550 P.2d 626 (1976). The words in a statute are to be given their common meaning unless it appears from the context or otherwise that a different meaning is intended. Ross v. Industrial Commission, 112 Ariz. 253, 540 P.2d 1234 (1975).

The duty imposed by A.R.S. section 32-1451.02, subsection A to report claims is clear and not subject to question. Subsection A provides, in pertinent part, that a professional liability insurance company providing malpractice coverage to medical doctors:

> /S/hall report to the board, within thirty days of its receipt, any written or oral claim or action for damages for personal injuries claimed to have been caused by.../a medical doctor under coverage/. (Emphasis added.)

The duty imposed by A.R.S. section 32-1451.02, subsection C to report any settlements and judgments is equally clear and unimpeachable. This subsection provides that every insurer required to report malpractice claims data pursuant to A.R.S. section 32-1451.02:

> /S/hall also be required to advise the board of any setlements or judgments against a doctor of medicine within thirty days after such settlement or judgment of any trial court. (Emphasis added.)

In both subsection A and subsection C of A.R.S. section 32-1451.02, use of the word "shall" imposes a mandatory duty to report on the part of the insurer within a limited 30 day period.

A.R.S. section 32-1451.02, which contains the reporting requirements at issue here, was passed as a part of omnibus medical malpractice legislation which became effective February 27, 1976. In the given fact situation, your office notes that "...several malpractice suits filed or settlements entered against doctors were found which had not been reported to BOMEX as were reported late...." Then it is reported that a "...few of these suits were either filed or settled after the malpractice reporting law was passed in 1976." In that A.R.S. section 32-1451.02 was not passed with a retroactive effective date, please note the reporting requirements would not apply to claims made or settlements or judgments entered prior to February 27, 1976.

With respect to all claims made or settlements or judgments entered against a medical doctor from and after the effective date of A.R.S. section 32-1451.02, the burden on the professional liability insurer is clear. The insurer must report the statutorily

required information in a timely fashion to BOMEX. The example given in the stated fact situation of a $1.75 million settlement entered in May 1980 should certainly have been reported to BOMEX in a timely fashion as required by law.

2. While the statutes are by no means clear on this matter, one can reasonably presume that BOMEX should be the primary enforcement agency. Given the lack of any statutory guidance, violations should be reported to BOMEX and to the director of the Department of Insurance.

The basic problem in enforcing the reporting provisions of A.R.S. section 32-1451.02 is that the statutes do not prescribe any consequences for the failure to report. Failure to report in a timely fashion is not even declared to be unlawful and an offense. If such was the case, failure to report would be defined as a petty offense under A.R.S. section 13-602.

BOMEX was established to license and regulate medical doctors in this state. It has no statutory or regulatory authority, either express or implied, over insurance companies in this state. The primary avenue through which BOMEX might enforce the reporting requirement would be indirectly through the imposition of sanctions on the medical doctor who has secured coverage from the professional liability insurer. A medical doctor who assisted or abetted a failure to report could be viewed as providing evidence of unprofessional conduct under A.R.S. section 32-1401, paragraph 10, subdivision (u). Subdivision (u) provides that unprofessional conduct includes:

> Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any of the provisions of this chapter.

Unprofessional conduct can subject a medical doctor to various sanctions under A.R.S. section 32-1451, including license suspension or revocation.

While any violation of the reporting requirement in A.R.S. section 32-1451.02 might be reported to the director of the Department of Insurance, the director has no specific statutory authority to use a failure to report under Title 32 as grounds for disciplinary action under A.R.S. Title 20. The director of the Department of Insurance is authorized, pursuant to A.R.S. section 20-142, among other Title 20 sections, to enforce only the provisions of Title 20.

Reference should, however, be made to A.R.S. section 20-1741 as a possible lever through which to require professional liability insurer compliance with the reporting requirement under A.R.S. section 32-1451.02. Section 20-1741 provides that:

> Each licensed insurer authorized to transact casualty insurance in this state and which writes professional liability insurance shall, as part of the annual statement required by section 20-223, report such professional liability claims and premium data as shall be prescribed by the director of insurance.

Review of the Official Compilation of Arizona Administrative Rules and Regulations (A.C.R.R.) indicates that the insurance director requires the reporting of certain medical malpractice claims data as part of the annual statement. A.C.R.R. R4-14-214, a copy of

which is attached, prescribes the components of this reporting requirement. Failure to file the required information with the annual statement would place the insurer in violation of state insurance laws and subject it to assorted disciplinary sanctions, including refusal to issue or renew the insurer's certificate of authority under A.R.S. section 20-216. If A.C.R.R. R4-14-214 were to be amended to require the reporting of the claims, settlement and judgment data required by A.R.S. section 32-1451.02 to BOMEX within 30 days, enforcement of section 32-1451.02 would have disciplinary meaning.

While A.C.R.R. R4-14-214 requires much of the same claims information as is required under A.R.S. section 32-1451.02, it is important to emphasize that the former requires that the information be reported only once a year while the latter requires the reporting of claims or settlement or judgment information within 30 days. Additionally, the two reporting requirements follow from somewhat different purposes. A.C.R.R. R4-14-214 is designed to facilitate the regulation of insurers and the management of the Joint Underwriting Plan. A.R.S. section 32-1451.02 is designed to facilitate the regulation and discipline of medical doctors by BOMEX.

Given the uncertainties in the enforcement of the reporting requirement under A.R.S. section 32-1451.02, your office may wish to recommend corrective legislation to the Legislature.

Another insurance reporting requirement under existing law which can be enforced and is thus worthy of your scrutiny is contained in A.R.S. section 20-223.01. This section requires a report from product liability insurers concerning product liability claims made against its insureds located in this state which have been closed during the preceding calendar year. The insurance director is authorized pursuant to A.R.S. section 20-142, as noted above, to enforce the provisions of A.R.S. Title 20. Under A.R.S. section 20-152, subsection B:

> If the director has cause to believe that any person is violating or is about to violate any provision of this title or any lawful order of the director, he may certify the facts thereof to the attorney general, who shall bring and prosecute such action as may be required for the purpose of enjoining the violation.

3. Failure of professional liability insurers to report claims filed or settlements or judgments entered pursuant to A.R.S. section 32-1451.02 will hinder the ability of BOMEX to regulate the medical profession as intended by the Legislature. The clear purpose of the reporting requirement, as prescribed by A.R.S. section 32-1451.02, subsection E, is to:

> /D/etermine whether it is necessary to take rehabilitative or disciplinary measures prior to the renewal of a medical doctor's license to practice.

BOMEX would appear to be under an affirmative duty to inform the Legislature if its regulatory activities were being interfered with through noncompliance with state law on the part of professional liability insurers doing business in this state.

There is, as noted above in question 2, no specific penalty or disciplinary sanction which can be levied under existing law against an insurer for a failure to report as required by A.R.S. section 32-1451.02. The reticence on the part of an insurer to report

the required information is curious given the fact that, under A.R.S. section 32-1451.02, subsection D, BOMEX is required to maintain the information on a confidential basis. Subsection G of this section provides further protection to the insurer in the reporting of the required information through the following immunity clause:

> There shall be no liability on the part of and no cause of action of any nature shall arise against any insurer reporting hereunder or its agents or employees, or the board or its representatives, for any action taken by them in good faith pursuant to this section.

Encl.

cc: Gerald A. Silva
Performance Audit Manager

APPENDIX VII

LEGISLATIVE COUNCIL OPINION 0-81-30

May 21, 1981

ARIZONA LEGISLATIVE COUNCIL

MEMO

May 21, 1981

TO: Douglas R. Norton
Auditor General

FROM: Arizona Legislative Council

RE: Request for Informal Research and Statutory Interpretation (O-81-30)

This is in response to a formal request submitted on your behalf by Gerald A. Silva in a memo dated May 14, 1981. No input was received from the Attorney General concerning this request.

FACT SITUATION:

During the course of a follow-up investigation of a doctor on probation with the board of medical examiners (board), the board learned that the doctor had ordered and obtained a scheduled drug substance from a drug salesman. At the time the purchase was made, the doctor's Federal Drug Enforcement Administration (FDEA) certificate authorizing the purchase of such a substance had been surrendered and was void. The board took no action regarding this situation at the board meeting following its disclosure to them.

QUESTIONS PRESENTED:

1. Did the doctor violate any federal or state laws by purchasing a scheduled drug substance for which he did not possess a valid FDEA certificate?

2. If yes, should the board have reported this violation to a law enforcement agency?

3. If yes, what are the ramifications if the board failed to report such information?

4. Is the board obligated to take any additional disciplinary action if a doctor on probation violates the conditions of his probation which, in this particular case, included not prescribing scheduled substances?

DISCUSSION:

1. Title 21, United States Code section 801 et seq. relates to the prevention and control of drug abuse. 21 U.S.C. section 812 lists several drugs or other substances, listed under the heading of scheduled drugs, which are defined as controlled substances and subject to federal law.

Federal law provides that every person who manufactures, distributes or dispenses any controlled substance or who proposes to engage in the manufacture, distribution or dispensing of any controlled substance shall annually register with the United States attorney general according to rules and regulations promulgated by him. 21 U.S.C. section 822. Pursuant to 21 U.S.C. section 824, the United States attorney general may revoke or suspend the registration of a person upon certain findings. Federal law

prohibits a person from knowingly or intentionally acquiring or obtaining possession of a controlled substance by misrepresentation, fraud, forgery, deception or subterfuge. 21 U.S.C. section 843. In addition, it is a federal violation for any person to knowingly or intentionally possess a controlled substance except if obtained with a valid prescription or if the person possesses a valid registration statement. 21 U.S.C. section 844. Knowledge of the presence of a narcotic, control over it and power to produce or dispose of the narcotic constitutes elements of this offense. Amaya v. U.S., 373 F.2d 197 (1967).

Under Arizona law, a person who knowingly possesses a narcotic drug except upon a written prescription by an authorized person is guilty of a class 4 felony. To be found guilty of such a crime, a person must have physical or constructive possession of a narcotic with actual knowledge of the presence of the narcotic substance. State v. Donovan, 116 Ariz. 209, 568 P.2d 1107 (App. 1977).

Assuming that the doctor in your fact situation had the required mental state, it appears that the doctor may have violated federal and state laws relating to unlawfully obtaining and processing a prohibited substance. However, applying legal standards to a hypothetical fact situation is beyond the scope of this memorandum. Therefore it would be inappropriate to categorically state that a violation occurred without an examination into all the facts and circumstances of the incident.

2. There is implied in every public office an authority to exercise some portion of the sovereign power of the state in making, executing or administering the law. 63 Am. Jur. 2d Public Officers and Employees section 3 (1972). As a general statement, one who accepts public office assumes the responsibility of performing duties given and imposed with complete fidelity and must act only in the best interest of the state. Williams v. State ex rel. Morrison, 83 Ariz. 34, 315 P.2d 981 (1957).

One purpose of establishing a board of medical examiners is to protect the public against those doctors who are medically incompetent, guilty of unprofessional conduct or mentally or physically unable to safely engage in the practice of medicine. Arizona Revised Statutes (A.R.S.) section 32-1451. Thus, there is a duty upon members of the board to inform law enforcement agencies if they have a good faith belief that a medical doctor may have violated federal or state law relating to illegally obtaining a narcotic. This view is further reinforced since the action in question has a direct bearing upon the qualifications of a person to practice medicine in this state.

3. A.R.S. section 32-1402, subsection C, paragraph 1 states:

> A member of the board, after notice and a hearing before the governor, may be removed upon a finding by the governor of continued neglect of duty, incompetence, or unprofessional or dishonorable conduct, in which event such member's term shall end upon such finding.

This section prescribes statutory authority for removal of a member of the board for continued neglect of duty, incompetence or unprofessional or dishonorable conduct. Arguably a failure by the members of the board from informing law enforcement officials about a possible violation of state or federal law is grounds for removal from office. However, this determination could only occur upon a finding, after notice and a hearing, by the governor.

In addition, it is a class 2 misdemeanor for a public officer to knowingly fail to perform a duty to the public. A.R.S. section 38-443.

4. Under A.R.S. section 32-1451, subsection C, paragraph 2, the board may place a doctor on probation and:

> Failure /of a doctor/ to comply with any such probation shall be cause for filing a summons, complaint and notice of hearing pursuant to subsection D of this section based upon the information considered by the board at the informal interview and any other acts or conduct alleged to be in violation of this chapter or rules and regulations adopted by the board pursuant to this chapter.

A.R.S. section 32-1451, subsection D requires the board to conduct a complete hearing if the board believes that a charge of medical incompetence, inability to perform or unprofessional conduct by a doctor is or may be true. Therefore, according to the provisions of A.R.S. section 32-1451, subsection C, paragraph 2, failure to comply with probation requirements imposed by the board is grounds for triggering the hearing procedure mandated by A.R.S. section 32-1451, subsection D.

CONCLUSIONS:

1. Applying legal standards to the facts of an individual case is beyond the scope of this memorandum. It appears the doctor under your fact situation could be charged with a violation of several state or federal laws. However, it would be inappropriate to state that a violation occurred without examining all the facts and circumstances of the incident.

2. The members of the medical board have a general duty to the public to notify a law enforcement agency if they have a good faith belief that a medical doctor who is subject to regulation by the board has committed a violation of law.

3. Failure to report such a violation could be grounds for removal from the board. In addition, nonfeasance on the part of a public officer is a class 2 misdemeanor.

4. The board is required to hold a hearing and take appropriate disciplinary action if a doctor on probation violates the conditions of his probation.

cc: Gerald A. Silva
Performance Audit Manager

ARIZONA LEGISLATIVE COUNCIL

MEMO

June 2, 1981

TO: Douglas R. Norton
Auditor General

FROM: Arizona Legislative Council

RE: Request for Research and Statutory Interpretation (O-81-47)

This is in response to a formal request submitted on your behalf by Gerald A. Silva in a memo received May 26, 1981. No input was received from the attorney general concerning this request.

FACT SITUATION:

Arizona Revised Statutes (A.R.S.) section 32-1425.02, subsection D states:

> D. A limited license shall be issued for a period of not less than three years or more than five years during which period the licentiate shall obtain United States citizenship or complete the written examinations of the board with a grade average of seventy-five per cent or more.

The board of medical examiners (board) permits persons to practice medicine who have obtained a score on the written examination of greater than or equal to 70 percent but less than 75 percent if they practice in specified areas needing health practitioners (A.R.S. section 32-1425.02, subsection C). However, the board also allows some limited license holders to take a pass-fail oral examination and thus supplement their scores on the written examination. If the holder of a limited license successfully completes the oral examination, the grade on the written examination is raised to 75 percent and the individual is issued a regular license to practice medicine.

QUESTIONS PRESENTED:

1. Is the board's practice of supplementing the written examination with the oral examination for those whose scores are between 70 and 75 percent in compliance with the provisions of A.R.S. section 32-1425, subsection D?

2. If it is not, what are the ramifications to the license holder and to the board?

ANSWER:

1. No. If statutory language is plain and unambiguous, it must be given effect. Dearing v. Arizona Department of Economic Security, 121 Ariz. 203, 589 P.2d 446 (Ariz. App. 1978); Arizona State Board of Accountancy v. Keebler, 115 Ariz. 239, 564 P.2d 928 (Ariz. App. 1977). Applying this rule of statutory construction to A.R.S. section

32-1425.02, subsection D, it is clear that the method for a limited licensee to obtain a regular license to practice medicine in this state is to take a written examination from the board and receive a score of 75 percent or more. No provision is made in this subsection for the board to give a limited licensee an oral examination. If the legislature intended to give the board this option, they would have specifically stated so in the statutes. See A.R.S. section 32-1428, subsection B.

2. There is no general penalty statute in Title 32, chapter 13 for persons who violate the statutes relating to physicians and surgeons. In addition, board members would not be personally liable for any injury caused by wrongfully licensing a person after administering an oral examination rather than the required written examination. See A.R.S. section 41-621, subsection G. However, if the board continues to license limited licensees in this manner, in wanton disregard of their statutory duties, a court may attach liability to the board members. See State v. Superior Court of Maricopa County, 123 Ariz. 324, 599 P.2d 777 (1977); Industrial Commission v. Superior Court, 5 Ariz. App. 100, 423 P.2d 375 (1967).

Some courts hold that vested rights may preclude revocation of a license in this situation. If a valid license is issued and a person makes expenditures upon such license, some courts hold that the licensee has a vested right in such license and the state cannot revoke it unless the licensee commits an act which subjects him to revocation pursuant to statute.

However, other courts hold that a permit issued under a mistake of fact or in violation of law confers no vested right or privilege on the person to whom the license has been issued even if the person acts upon it and makes expenditures in reliance on the license. B & H Investments Inc. v. City of Coralville, 209 N.W. 2d 115 (Iowa 1973).

We cannot predict how a court would act if the license of a person issued under the facts as presented to us was subject to question because of the improper manner in which it was issued. Certainly, the acts of the board in violation of the statute raise grave questions about the validity of such licenses.

CONCLUSION:

1. The board is not in compliance with A.R.S. section 32-1425.02, subsection D when it supplements the written examination with an oral examination.

2. The board members would not be personally liable for this violation unless it was done in wanton disregard of the statutes. The board's action raises questions about the validity of licenses issued pursuant to such acts.

cc: Gerald A. Silva
Performance Audit Manager

ARIZONA LEGISLATIVE COUNCIL

MEMO

May 21, 1981

TO: Douglas R. Norton
Auditor General

FROM: Arizona Legislative Council

RE: Request for Research and Statutory Interpretation (0-81-11)

This is in response to a formal request submitted on your behalf by Gerald A. Silva in a memo dated May 14, 1981. No input was received from the Attorney General concerning this request.

FACT SITUTATION:

Arizona Revised Statutes (A.R.S.) section 32-1425.02 authorizes the board of medical examiners (board) to issue limited licenses to practice medicine in specified areas of the state determined to be in need of health practitioners. A.R.S. section 32-1425.02, subsection D states that:

> A limited license shall be issued for a period of not less than three years nor more than five years during which period the licentiate shall obtain United States citizenship or complete the written examinations of the board with a grade average of seventy-five per cent or more.

On two recent occasions, the board has issued a new limited license to doctors whose original limited license had expired. In both cases, the doctors had failed to pass the board's written examination.

QUESTIONS PRESENTED:

1. Does the board have the authority to issue a new limited license to doctors whose original limited license has expired?

2. Can the board issue such a new limited license to a doctor if the board has received complaints against the doctor which were substantiated?

ANSWERS:

1. In interpreting the statute authorizing the board to issue a limited license to practice medicine to certain individuals, one must construe the statute with reference to the main purpose for which the legislature enacted the statute. Sutherland, Statutes and Statutory Construction section 46.05 (4th ed., Sands, 1972). As stated by the courts, the words of a statute must be construed in conjunction with the full text of the statute. Golder v. Department of Revenue, State Bd. of Tax Appeals, 123 Ariz. 260, 599 P.2d 216 (1979).

There is no authority in the statutes for the board to issue a new limited license to a medical doctor whose original limited license has expired.

Clearly the intent of the legislature in enacting A.R.S. section 32-1425.02 was to allow the board to temporarily authorize certain persons who show a minimal level of medical competence but lack certain other requirements to practice medicine in this state and thereby relieve the shortage of doctors in medically underserved areas. Under the legislative scheme, the person is allowed to practice medicine under close observation and evaluation while he attempts to fulfill those requirements which he lacks in order to achieve full status as a medical doctor. Furthermore, the legislature has afforded the person an adequate period of time, from three to five years, in which to attain these requirements.[1] A.R.S. section 32-1425.02, subsections D and F.

Therefore, based upon this legislative plan, the legislature did not intend that the board issue a new limited license to those individuals who could not meet the statutory requirements to be licensed as a medical doctor during the period of time in which they had a limited license. However, you may wish to recommend that the legislature clarify this area to specifically state whether or not they intend that the board issue a renewable limited license.

2. Even assuming that the board could issue a new limited license to a medical doctor, the applicant is still required to meet statutory requirements for the issuance of the limited license. A.R.S. section 32-1425.02, subsection B states:

> A limited license may be granted by the board to an applicant otherwise qualified for regular licensure except for one or more of the following:
>
> 1. If he is a foreign graduate and does not hold the standard permanent certificate of the educational council for foreign medical graduates or its equivalent.
>
> 2. If he has not completed the required approved internship or post graduate training.
>
> 3. If he has not obtained citizenship in the United States but is taking every action provided by law to become a citizen. The board immediately shall revoke his license to practice medicine in the event the physician's final petition for naturalization is denied, and, after hearing, shall revoke such license if it appears after a reasonable time that such physician has not secured or is not diligently attempting to secure his certificate of citizenship.
>
> 4. If he has failed the written examination of the board with a weighted grade average of not less than seventy per cent.

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[1] Nevertheless, the failing applicant may not retake the examination until the time prescribed by statute. See A.R.S. section 32-1428, subsections G and H.

Therefore, in order to receive a limited license, an applicant must still be otherwise qualified for regular licensure. A.R.S. section 32-1423 lists some of the qualifications required of an applicant in order to obtain a regular license to practice medicine in this state. Among these requirements are:

* * *

> 4. That he possesses a good moral and professional reputation.
>
> 5. That he is physically and mentally able safely to engage in the practice of medicine and submits to such physical examination, mental evaluation and interview, or any combination thereof, as the board may deem proper to determine the same.
>
> 6. That he has not been guilty of any act of unprofessional conduct or any other conduct which would constitute grounds for refusal, suspension or revocation of license under this chapter.

* * *

Thus, the board could not issue a limited license to a person if the substantiated complaints against the person would bring into question the person's good moral and professional reputation, show that he is not physically and mentally able to safely engage in the practice of medicine or that he is guilty of an act of unprofessional conduct or is guilty of an act which would constitute grounds for refusal, suspension or revocation of a license.

CONCLUSIONS:

1. There is no statutory authority for the board of medical examiners to issue a new limited license to a medical doctor whose original limited license has expired. You may wish to recommend that the legislature specifically state whether or not they intend that the board issue a renewable limited license.

2. The board should not issue a new limited license to a person if the substantiated complaints against the person indicate that the person is not qualified to receive a regular license using the criteria under A.R.S. section 32-1423.

cc: Gerald A. Silva
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