



**STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL**

**A PERFORMANCE AUDIT
OF THE**

**BOARD OF OSTEOPATHIC EXAMINERS
COMPLAINT REVIEW PROCESS**

DECEMBER 1983

**A REPORT TO THE
ARIZONA STATE LEGISLATURE**



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AUDITOR GENERAL

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

December 21, 1983

Members of the Arizona Legislature
The Honorable Bruce Babbitt, Governor
Dr. Dana S. Devine, President
Board of Osteopathic Examiners

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Board of Osteopathic Examiners' complaint review process. This report is in accordance with Senate Bill 1379 enacted in 1982.

The blue pages present a summary of the report; a response from the Board of Osteopathic Examiners is found on the yellow pages.

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

Respectfully submitted,

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Enclosure

OFFICE OF THE AUDITOR GENERAL

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REPORT 83-22

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SUMMARY

The Office of the Auditor General has conducted a follow-up review of the Board of Osteopathic Examiners in Medicine and Surgery's complaint review process as required by Senate Bill 1379 enacted by the Legislature in 1982.

The Board of Osteopathic Examiners in Medicine and Surgery is responsible for examining and licensing osteopathic physicians and surgeons, renewing licenses annually, reviewing complaints, holding hearings and enforcing the standards of practice of the osteopathic profession.

The Board of Osteopathic Examiners has made some improvements in its complaint handling procedures since the previous audit. The Executive Director no longer has excessive complaint review authority. The current Executive Director, hired in May 1983, implemented changes modeled after the Board of Medical Examiners' (BOMEX's) complaint handling procedures. All complaints are sent to an outside reviewer and ultimately to the full Board for review. The Board no longer requests physicians to refund money or adjust their fees. In addition, due to a statutory amendment, the Board is no longer in violation of A.R.S. §32-1855 regarding patient confidentiality. The Board has also employed a part-time investigator to assist in complaint processing.

Despite these improvements, the Board's complaint handling process continues to be deficient. Complaints are not being processed in a timely, thorough manner. Of the 122 complaints received by the Board from January 1982 through August 1983, 34 or 28 percent were not resolved at the time of our review. As of October 1983, 18 of the 34 pending complaints were over 6 months old. Further, the investigation of several complaints appeared incomplete. In some of these cases the doctors involved had multiple complaints filed with the Board. The complaint problems are partially attributable to (1) turnover of the Board's administrative director and (2) the lack of a full-time investigator and medical consultant for adequate investigation and review. The Board should either be provided with resources or combined with BOMEX. Combining

the Boards would provide the types of resources needed by the Board and eliminate possible duplication. The Boards have similar scopes of practice, and 30 states have combined Boards. (In at least eighteen of these states, osteopathic physicians are one of several health occupations regulated by a centralized "umbrella" agency.)

INTRODUCTION AND BACKGROUND

The Office of the Auditor General has conducted a follow-up review of the Board of Osteopathic Examiners in Medicine and Surgery's complaint review process as required by Senate Bill 1379 enacted by the Legislature in 1982. This review is based on findings contained in report number 81-16, A Performance Audit of The Board of Osteopathic Examiners in Medicine and Surgery, dated December 1981.

The Osteopathic Board of Registration and Examination was originally established by the Legislature in 1949. The Board later became the current Board of Osteopathic Examiners in Medicine and Surgery (Board). The Board is responsible for examining and licensing osteopathic physicians and surgeons, renewing licenses annually, reviewing complaints, holding hearings and enforcing the standards of practice of the osteopathic profession. The Board is comprised of five members of whom four are licensed, practicing osteopaths and one is a representative of the public.

Osteopathic medicine is a branch of medical science. Doctors of Osteopathy (DOs) like Doctors of Medicine (MDs), have premedical education, four years of training in a medical college, and a one-year hospital internship. However, DOs have additional training in recognizing and correcting musculoskeletal problems. The scopes of medical practice of DOs and MDs are essentially the same.

Audit Scope

The scope of this audit is limited to a review of the Board's complaint review process. Auditor General report number 81-16 stated that improvements were needed in the Board's complaint review process and that the Board lacked adequate resources to thoroughly investigate complaints.

Our follow-up complaint study consisted of reviewing all complaints received by the State Osteopathic Board for the period January 1982 through August 1983. Of the 122 cases reviewed, 88 or 72 percent had final action taken at the time of our review.

The Auditor General and staff express appreciation to the employees and members of the Board of Osteopathic Examiners in Medicine and Surgery for their cooperation and assistance during the course of this audit.

FINDING

DESPITE RECENT IMPROVEMENTS, THE BOARD OF OSTEOPATHIC EXAMINERS' COMPLAINT REVIEW PROCESS CONTINUES TO BE DEFICIENT.

Despite some improvements, the Board of Osteopathic Examiners' complaint handling process continues to be deficient. Complaints are not being processed in a timely, thorough manner. These problems are partially attributable to turnover in the Board's Executive Director position and a lack of resources for adequate investigation and review. The Board should either be provided with resources or combined with the Board of Medical Examiners (BOMEX).

Improvements Made Since Prior Audit

The Board of Osteopathic Examiners in Medicine and Surgery has made some improvements in its complaint review process since Auditor General report number 81-16 was completed:

- The Board previously had given the Secretary-Treasurer, now referred to as the Executive Director,* excessive complaint-handling responsibility. The Board delegated the authority to informally hear minor complaints, thus most complaints were resolved without Board involvement. The Board's current Executive Director, appointed in May 1983, has developed complaint review procedures modeled after BOMEX. Currently, the Executive Director sends complaints to an outside reviewer and ultimately to the full Board for review.

- The previous audit found that the Board, on occasion, requested doctors to adjust their fees or refund money. The Statutes did not provide the Board with such authority. The Board no longer requests physicians to refund money or adjust their fees.

* With the hiring of the Board's latest administrator, this position's title was changed from Secretary-Treasurer to Secretary-Treasurer/Executive Director and will hereafter be referred to as Executive Director.

- In our initial audit report, we recommended that the Board no longer send signed complaints to the physicians involved. This practice was not permitted by statute unless the person's testimony would be essential to disciplinary proceedings. Due to a statutory amendment, the Board is no longer in violation of the confidentiality provisions of A.R.S. §32-1855, subsection A. The statute was amended in July 1983 to allow the Board, unless specifically requested not to, to disclose the name of a complainant to a physician.

" . . . Any person who reports or provides information to the board in good faith shall not be subject to an action for civil damages and as a result thereof and, if requested, such person's name shall not be disclosed unless such person's testimony is essential to the disciplinary proceedings conducted pursuant to this section." (emphasis added)

Further Improvements Needed in Complaint Handling Process

In spite of improvements made since our initial report, the Board still does not adequately investigate and resolve complaints. Complaints are not being processed in a timely and thorough manner.

Complaints Are Backlogged - Complaints are backlogged* and the Board has been unable to resolve complaints in a timely manner. Of the 122 complaints received by the Board from January 1982 through August 1983, 34 or 28 percent were not resolved at the time of our review. As of October 1, 1983, approximately half of the 34 had been pending for six months or more, while five were over a year old. The breakdown of these pending complaints is presented in the following table.

* The backlog is partially attributable to the Board's ceasing to process complaints from February through June 1983 due to lack of funds (see page 12).

0 - 3 months*	8
3 - 6 months	8
6 - 9 months	5
9 - 12 months	8
Over one year	<u>5</u>
	<u>34</u>

As the Board meets quarterly and the last meeting was on October 1, 1983, complaints will not be brought before the Board until January 1984. Therefore, in January the Board will have 34 pending complaints plus those received between September 1983 and January 1984.

Lack of Thoroughness - In addition, all complaints are not thoroughly investigated. During our review of complaints, we noted several cases where investigation appeared incomplete. In some cases the doctors involved have had a history of violations and complaints. The following case examples illustrate lack of timely, thorough investigations:

Case 1**

The physician involved in this case has a long history of drug-related problems. In July 1972, he was arrested after attempting to sell almost 1,000 vials of amphetamines (at \$10 a vial) to a DPS officer. The doctor was found guilty of unlawful distribution of dangerous drugs, a felony, and placed on probation by a State Superior Court in February 1973. In addition, the doctor, who had been addicted to amphetamines, was convicted of related Federal drug violations in the U.S. District Court in Arizona.

Following his criminal convictions, the Board censured the doctor and placed him on probation for 10 years. Terms of his probation included reporting to the Board twice yearly and not engaging in activity which would constitute unprofessional conduct.

* These complaints had been recently received at the time of our audit. Although not part of the Board's backlog, they contribute to the Board's future work load.

** This case was also addressed in our previous audit.

In 1976, a Board of Pharmacy inspector discovered that the doctor, who still was on Board-ordered probation, had been prescribing and obtaining large amounts of Demerol (an addictive pain killer) for personal use. The doctor subsequently was admitted to the hospital for Demerol addiction, treated and discharged in 1977 with a "poor" prognosis for overcoming his chemical dependence.

In January 1978, the Board considered the doctor's request that his Federal permit to prescribe controlled drugs, which had expired, be reissued. The Board denied the request until the doctor's physical condition could be fully evaluated. In April 1978, following a personal interview with the doctor, the Board voted to recommend reissuance of his permit to prescribe drugs, but that the permit not include Schedule II* (narcotic) substances.

In 1979, a Board of Pharmacy inspector found that the doctor again was obtaining controlled drugs for his own use. The Board learned that the doctor had applied for and received a permit to prescribe Schedule II substances, contrary to the Board's directive of April 1978, and had written Demerol prescriptions for his wife.

Following a hearing in June 1980, the doctor surrendered his Schedule II permit to Federal authorities. During the hearing, the Board discussed a notarized statement from the doctor's wife indicating that she had used prescription blanks presigned by her husband to obtain Demerol supposedly for patients but in reality for her own personal

* The Drug Enforcement Administration classifies controlled substances into five categories based on addiction potential and other drug characteristics. Schedule I substances are illegal drugs for which no prescriptions can be written, e.g., marijuana and LSD. Schedule II and III drugs may be both physically and psychologically addicting, e.g., codeine and cocaine. Schedule IV drugs may lead to limited psychological or physical addiction. Schedule V drugs have a use potential and dependency less than a IV.

use. The doctor was subsequently sent a letter informing him that it is dangerous and unlawful for a physician to give presigned prescription blanks to anyone. He was also advised that no relative should be working in his office.

In September 1980, a Board of Medical Examiners investigator found that seven prescriptions for Talwin, an addictive Schedule IV substance, had been written by the doctor. Three of the prescriptions were for the doctor's office use, and three were made out to his wife. After an interview with the doctor, who indicated the prescriptions were written legitimately for patients and for his wife, the Board advised him that medication for his wife should be prescribed by a physician other than himself.

In May 1982, the Board terminated the doctor's probation, which was originally scheduled to end January 1984, and recommended reinstatement of the doctor's Schedule II DEA certificate. As of October 1983, the DEA had not reinstated the doctor's Schedule II permit, and DEA is requesting denial of the permit reinstatement.

In June 1983, a BOMEX investigator was informed by two pharmacists that the doctor was prescribing Talwin to two patients and it was being picked up by the doctor's wife. Although the doctor's office was located in Scottsdale, the patients lived on the west side of Phoenix. After an investigation, the police obtained a search warrant for the doctor's office. In the search, the police discovered two empty vials of Talwin and an empty bottle of Demerol in the doctor's desk. The doctor stated that he obtained Talwin by writing prescriptions "for office use only." The police also found a receipt in excess of \$500 for 10 cartons of Talwin allegedly shipped to the doctor's office. The doctor informed the police that he had no idea where the Talwin was, and that he kept no records of drugs brought into or leaving his office. The investigation also revealed that the

doctor's wife had been phoning in prescriptions for Talwin under patients' names. Office staff indicated that his wife was injecting patients with Talwin. She was subsequently arrested and booked on two counts of obtaining a narcotic drug by fraud.

In September 1983, the Board held an informal interview with the doctor. Although the Board expressed concern over the empty bottle of Demerol found in the doctor's desk, the Board dismissed the case. The doctor assured the Board he was not using Demerol personally, and his wife did not work in his office.

Comments

Although both the doctor and his wife had a history of drug-related problems, no follow-up was undertaken in this case. The Board did not request physical and psychological exams of the doctor to determine if he had resumed using drugs. This is particularly disturbing since (1) the doctor was previously addicted to Demerol, the empty drug container found in his desk drawer, and (2) Demerol is a Schedule II drug which he should not have had in his possession. The Board has the authority to request exams for doctors suspected of drug use, and could have exercised this authority.

The Board accepted the doctor's testimony without adequately pursuing questions raised in a police report obtained by the Board. In addition to not determining how the Demerol found in his desk had been used, the Board also did not determine (1) whether his wife was injecting patients with Talwin and (2) whether the Talwin purchased for office use had been used for accepted therapeutic purposes.

Case 2

In February 1982, the Board was notified by an insurance company of a malpractice claim indicating that a Summons and Complaint had been filed in the Superior Court against an osteopathic physician. The patient was suing the doctor for negligence.

The physician had treated the patient since August 1979 for a recurring muscle spasm in the upper right back region. In a January 1980 office visit, the doctor inserted approximately four needles into her upper back in the area in which the spasm was located. During the treatment the doctor allegedly perforated the patient's lung causing it to collapse.

Comment

In February 1982, a letter was sent to the doctor requesting all records on the case. The complaint came before the Board in an October 1982 meeting eight months later. The status of the case is listed in the Board minutes as "open - needs further review." As of October 1983, this case was over 19 months old and has not been reviewed by either a medical examiner or a Board member. If interviews are deemed necessary, a delay in action may hinder investigation of the complaint as the concerned parties may not be able to remember specific details concerning the case.

Case 3

In June 1982, the Board was notified by an insurance company of a claim alleging injury resulting in a patient's death. The patient allegedly received an injection from an osteopathic physician, and subsequently developed a toxic infection resulting in his death. An autopsy performed on the patient confirmed the cause of death was related to the injection. As the case involved a patient's death, a complaint file was established for the claim.

Comment

The Board obtained medical records on the patient. According to a Board member's review contained in the complaint file, the doctor may have used a contaminated vial or needle, or the contaminants may have already been on the patient's skin. In January 1983, six months after receipt, the Board heard the complaint and moved to have the complaint reviewed by a dermatologist to determine if the patient should have

been prescribed steroids. The file, as of November 1983, has not had the dermatologist review. The file is still pending and should be on the January 1984 agenda. As of September 1983, the Board had received 11 complaints and 4 malpractice claims against this doctor. At least one prior complaint also involved possible improper sterilization. In addition, in 1979 this doctor had his Illinois license suspended for four years for maintaining records of prescriptions for Schedule II Controlled Substances in an unprofessional manner.

Case 4

In March of 1982, the Board received a complaint from a doctor questioning the weight reduction program another doctor had prescribed for a patient. The patient allegedly told the doctor that she was on a weight loss program but that she could not lose weight beyond 20 pounds. The doctor felt the treatment had long since been discredited and that the Board should be aware of the treatment the doctor prescribed for the patient.

Comments

Although this complaint originated from another medical practitioner, little evidence can be found indicating that this case was investigated. The Board did not notify the complainant that the complaint was received, nor did they obtain the doctor's patient records. There is no evidence that the file had been reviewed or brought before the Board. The file has been closed, but there is no documentation of when it was closed.

Complaint Handling Problems Caused by Administrative Turnover and Lack of Resources

Administrative turnover and lack of resources have caused problems with complaint timeliness and investigation. The Board has experienced unusual turnover in the Executive Director position. In addition, the Board lacks resources for adequate investigation and medical review. Investigative resources are needed not only to aid complaint processing but also to improve the monitoring of probationers.

Administrative Turnover - Turnover of the Board's executive directors has contributed to the complaint backlog. The Secretary-Treasurer of the Board at the time of our last report retired in September 1982. The position was held by another osteopathic physician between October 1982 and April 1983. According to the Board's staff, this administrator worked on a part-time basis and did not devote adequate time to his administrative duties. From April 15, 1983, to May 15, 1983, the position was vacant. On May 15, 1983, the first lay administrator was appointed to serve as Executive Director. As each new administrator must learn the complaint process, complaints tended to backlog.

The Board Lacks Investigative Resources - The Board lacks investigative resources to fulfill its statutory requirement to protect the public. The Board needs a full-time investigator and an adequate budget to support complaint processing.

The Board needs a full-time investigator. The Board currently has a part-time investigator supported by a total fund of \$4,000. This equates to about 500 hours of investigator time. According to the Executive Director in the 1984-1985 budget request, the Board is unable to meet its statutory requirements to protect the public health and welfare with only a part-time investigator.

"Of paramount concern is the ability to investigate complaints received from the public, pharmacy board, law enforcement agencies and related regulatory boards. In the past, we have been unable to follow through on many leads because we have lacked adequate investigatory personnel. . . .

"The lack of a full-time investigator is an unnecessary and possibly dangerous situation that should not be tolerated. Further, the Board is placed in a position of being unable to fulfill our statutory requirements. A full-time Investigator II is imperative if this Board is to adequately protect the public health and welfare as mandated by statute."

Budgetary restrictions have also hindered complaint processing. Complaints were not processed from February through June 1983 due to lack of funds. During this period, complainants were sent form letters indicating that complaints would not be processed until July. In addition, the Board's investigator indicated that, due to budgetary problems, she does not charge the Board for all her investigative and administrative time. She also stated that there is a vast amount of important investigative work which could be performed by an investigator.

The Executive Director has requested funding for a full-time investigator to be paid \$18,300 annually. Funds appear to be available to support a temporary budget increase. Renewal fees were increased this year from \$50 to \$100, and the Board had an estimated carry-forward fund balance of \$47,787 for 1983-84. However, to support a full-time investigator, the Board will need to use its carry-forward funds, and eventually the Board will need to further increase renewal fees. This does not take into account funds needed for a medical consultant, as discussed in the next section.

The Board Does Not Employ Medical Consultants - The Board also needs adequate medical review capability. Volunteers have been used recently by the Board in an attempt to meet this need, however, volunteer reviewers may not be effective.

The Board does not have funds appropriated for a part-time staff medical consultant. Instead, complaints are sent to osteopathic physicians who "volunteer"* to review complaint records and recommend a disposition of the complaint. The reviews are then sent to a Board member and ultimately to the entire Board.

* "Volunteer" reviewers are paid up to \$25 an hour for reviews. The total appropriation for outside reviews is \$2,700.

Reviews received from volunteer physicians appear insufficient. The reviews are not in a standard format and do not always contain sufficient detail. For example, one reviewer's report was only five sentences long. Reviewers rely on information and medical records contained in the file and do not contact the patient or doctor directly. In the October 1983 Board meeting, one reviewer commented that he was not aware he could request more information on a case.

Reviews from a part-time medical reviewer employed by the Board may be more consistent. In addition doctors could be interviewed by the reviewer for additional information. The reviewer could also be available for Board meetings and special projects.

BOMEX, by contrast, has two part-time medical consultants to review complaints and is seeking to fill two more part-time positions. These consultants not only review medical records, but they may also interview doctors or patients to obtain further information. The reports are prepared by the consultants and contain the facts of the case, a listing of the documents reviewed to generate the facts, an analysis of the facts and a recommendation for Board action. The consultants also present the cases to the Board at Board meetings and are available to answer questions.

Monitoring of Probationers - Investigative resources are also needed to improve the monitoring of probationers. Because it lacks investigative resources, the Board cannot adequately monitor doctors on probation.*

* The Board currently has five doctors on probation; four for overprescribing Scheduled drugs and one for mail fraud.

The Board does not routinely conduct pharmacy surveys* on its probationers for overprescribing drugs. Such surveys are necessary to ensure that the doctor is not prescribing drugs from which he has been restricted and to determine if the doctor may be overprescribing drugs from which he was not restricted. For instance, a doctor whose Schedule II DEA permit has been removed may begin to overprescribe Schedule III or IV drugs. BOMEX pharmacy surveys have identified doctors who had written prescriptions for Schedule drugs in which the doctors' DEA permits had been surrendered, as presented in the following example.

Case Example

In September 1980, BOMEX placed a doctor on probation for overprescribing Schedule II and III drugs and other violations. The doctor was requested to surrender his Schedule II and III Controlled Substances Registration Certificate to DEA, which he did in October 1980. In June 1981, a BOMEX pharmacy survey identified three prescriptions for Preludin Endurets, a Schedule II drug, allegedly written by the doctor.

Combination of the Osteopathic Board with BOMEX

As an alternative to providing the Board with resources, the Board could be combined with BOMEX. Combination of the Boards would (1) provide the type of resources needed by the Board and (2) eliminate possible duplication in pharmacy surveys and data processing systems. The Boards have similar scopes of practice, and most states have combined Boards.

* Pharmacy surveys are audits of physician prescriptions on file in pharmacies.

In our initial audit, we recommended that the Board of Osteopathic Examiners be combined with BOMEX. BOMEX has the types of resources needed by the Osteopathic Board, including investigators, medical consultants and access to hearing officers. BOMEX has four full-time investigators and one investigation supervisor. These investigators perform pharmacy surveys, deliver subpoenas and conduct investigational interviews. The investigators are also used to monitor doctors on probation. In addition, BOMEX is authorized four part-time medical consultants. According to the Director of BOMEX, additional staff would be needed to process the osteopathic Board's work load. Staff of the Joint Legislative Budget Committee are currently reviewing the cost of combining the two boards.

Combining Boards would eliminate possible duplication in pharmacy surveys and computer systems. BOMEX investigators conducted 541 pharmacy surveys in 1982-1983 to guard against possible overprescribing or other prescription-related problems. These pharmacy surveys could be performed simultaneously for both osteopathic and allopathic doctors as prescription records for all types of medical practitioners are intermixed. BOMEX investigators are experienced in conducting surveys and, in fact, trained the Board's investigator. Combination could also avoid duplication of data processing systems. The Board requested, in its 1984-1985 Budget Request, a \$4,000 appropriation for a new information retrieval and text editing system. BOMEX currently has a computer system which could easily accommodate the Osteopathic Boards needs.

The Osteopathic Board and BOMEX have similar scopes of practice. As noted in our previous report the Osteopathic Board licenses physicians who earn a Doctor of Osteopathy (DO) degree. BOMEX licenses physicians who earn a Doctor of Medicine (MD) degree. The scopes of medical practice of DOs and MDs, however, are the same and include the uses of drugs, radiation and surgery in the treatment of disease.

Most states have combined Boards. At the time of our previous audit, 30 states and the District of Columbia licensed and regulated osteopathic physicians and medical doctors through a single composite board. Only 16 states, including Arizona, maintained separate osteopathic and medical boards. In four states osteopathic physicians were licensed by an osteopathic board and a medical board, but the scopes of practice differ within those states.

CONCLUSION

The Board of Osteopathic Examiners has improved its complaint handling procedures since our first audit, however, the complaint handling process continues to be inadequate. Complaints are backlogged and are not being resolved in a timely manner. In addition, complaints are not thoroughly investigated and reviewed. These deficiencies are partially attributable to administrative turnover and a lack of resources. As an alternative to providing the Board with resources, it could be combined with BOMEX.

RECOMMENDATION

The Board of Osteopathic Examiners should be provided with investigative resources through either a) combination of the Board with the Board of Medical Examiners or b) an appropriation for a full-time investigator and increased funds for medical reviews.

OTHER PERTINENT INFORMATION

During our audit, other pertinent information was reviewed regarding letters of concern.

Because the Board lacks specific authority to issue letters of concern, the Executive Director plans to request legislation this year to obtain such authority.

The Board issues a letter of concern if it lacks sufficient evidence to constitute unprofessional conduct but is concerned with the doctor's actions. These letters allow the Board to develop and document a "track record" on a doctor for possible future action. The Board began issuing letters of concern in July 1983. In the October 1983 Board meeting, the Board requested five such letters be issued.

The Board's current statutes do not provide specific authority for letters of concern. A.R.S. §32-1855 allows the Board to 1) issue a decree of censure, 2) place a doctor on probation, 3) suspend a license, or 4) revoke a license.

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December 20, 1983

The Board of Osteopathic Examiners (OBEX) appreciates the recognition by the Auditor General of the many improvements made by the Board since their 1981 audit and also the recommendation to provide us with the needed resources to make further improvements. The Board is unanimously opposed, however, to the recommendation to merge with BOMEX having discussed this option with that agency following the recommendation in the 1981 audit to merge. It would appear the Auditor General has skewed the report to make a merger with BOMEX appear to be cost effective without having made a comprehensive study to determine if that is true. Mention of the additional resources needed by BOMEX to accommodate OBEX is glossed over with the slightest of comment. In fact, BOMEX would have to hire an additional full time investigator and additional other staff as well as seek larger office space not to mention the increased number of formal hearings and days of Board meetings would run 5 or 6 days long making them extremely unwieldy and difficult to administer.

Trying to compare the situation in Arizona with other states by the Auditor General's comment that "most states have combined boards" is misleading. The ratio of Osteopaths to Allopaths in

PLEASE DIRECT ALL COMMUNICATIONS TO THE EXECUTIVE DIRECTOR

Arizona is 10 to 1 which is considerably lower than 43 of the states that range from 13 to 1 all the way up to 528 to 1. In addition, over 70% of those states have boards that license and regulate 4 or more professions and cannot be compared to the recommendation being made by the Auditor in this report. The fact is, there is little available to look to in a comparison of the recommendation being promoted by the Auditor General. The Auditor also failed to conduct a survey of disciplinary actions to compare our Board against. Our findings indicate we compare most favorably with other state regulatory boards.

As a final comment in regard to the recommendation to merge with BOMEX, we would point out that no one has stepped forward to encourage the recommendation to merge since the 1981 audit -- not BOMEX, not the public, not the legislature and, most emphatically, not the Osteopathic profession.

One of the major complaints of the auditor's report deals with the backlog of complaints. It is unfortunate the Auditor's report came at a time when we were in the middle of a major overhaul in our complaint review process rather than in six months when the process would have been completed. It takes time to make changes and the Board has had the additional burdens of a turnover in administrators and refusal by the state to appropriate additional funds for investigation purposes leaving us in the precarious position of being unable to investigate complaints or process them for a period of several months. A backlog was inevitable. The Board is confident the backlog will be eliminated in the next 6 months now that circumstances beyond our control no longer exist. While frustrating to the Board, complainants and the physicians complained against, little

harm is done by delays in decisions. Those few complaints which were pressing have received priority and handled with speed and not put at the end of the line.

In the four cases selected for review in the report, the Board believes they are not representative of the total. The Board would point out some glaring problems with lay persons who were absent during the hearings and interviews and without the Board's background that is best illustrated by quoting a recent court of appeals opinion upholding the Board's decision to place a physician on probation paraphrased as follows:

Decisions based on the accumulated experience and expertise, technical knowledge and competence of Board members should not readily be interfered with.

Being absent when witnesses testify, not receiving legal counsel, not hearing the objections raised by the physician's attorney in protecting the physician's rights, makes it impossible for the Auditor General to fairly sit in judgment of the Board's decisions. The Auditor General also fails to understand the compassion of the Board in working with impaired physicians to rehabilitate themselves while at the same time protecting the public health, welfare and safety. Case #1 is a prime example of a happy outcome in which the Board followed the rehabilitation of an impaired physician very closely over a period of many years. During that time, no major complaints emerged against this doctor regarding his medical competency and, therefore, it is safe to say the public health, welfare and safety has not been endangered by the Board's actions in this case. If the Auditor General were to review similar cases under the auspices of other Boards, we

believe he would find a slip or two over a 7 to 10 year period being treated in the same manner as OBEX.

It is the conclusion of this Board that the Auditor General made a case for BOMEX and OBEX to merge based on little substance and much conjecture. It appears to us to be a case of fitting the facts to a preconceived conclusion and leaving out anything that didn't fit.

It is this Board's contention that the public health, welfare and safety is better served by an autonomous Osteopathic Board of Examiners.

Sincerely,



Dana S. Devine, D.O.
President



Mary L. Tucker
Executive Director