PERFORMANCE AUDIT

BOARD OF OSTEOPATHIC EXAMINERS

IN MEDICINE AND SURGERY

Report to the Arizona Legislature
By the Auditor General
April 1991
91-1

DOUGLAS R. NORTON, CPA
AUDITOR GENERAL

STATE OF ARIZONA
OFFICE OF THE
AUDITOR GENERAL

April 11, 1991

Members of the Arizona Legislature

The Honorable Fife Symington, Governor

Dr. William Inboden, President
Board of Osteopathic Examiners

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Board of Osteopathic Examiners in Medicine and Surgery. This report is in response to a June 14, 1989, resolution of the Joint Legislative Oversight Committee.

The report identifies several areas in which the Board can improve its effectiveness and efficiency in protecting the public from incompetent osteopathic physicians. We found that complaints are not always resolved in a timely manner; in five serious cases, resolution was delayed for up to three years due to inaction by Board staff or while awaiting negotiated settlements by the Attorney General. In addition, the Board is often reluctant to use its statutory authority to enforce professional standards. We recommend that the Board establish an effective method for tracking cases so that it is aware of delays. The Board should also review its disciplinary procedures to ensure that it takes appropriate action against physicians who violate standards of professional practice.

A response from the Board is contained on the yellow pages following the body of this report. The Attorney General's Office was also provided an opportunity to respond to this report, but chose not to do so. My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on April 12, 1991.

Sincerely,

Douglas R. Norton
Auditor General

DRN:lmn

Enclosure

2700 NORTH CENTRAL AVENUE • SUITE 700 • PHOENIX, ARIZONA 85004 • (602) 255-4385 • FAX (602) 255-1251

SUMMARY

The Office of the Auditor General has conducted a performance audit and Sunset review of the Board of Osteopathic Examiners in Medicine and Surgery, pursuant to a June 14, 1989, resolution of the Joint Legislative Oversight Committee. This audit was conducted under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S.) §§41-2351 through 41-2379.

The Board consists of five members, and is responsible for licensing osteopathic physicians and surgeons, reviewing complaints, and enforcing the standards of practice of the osteopathic profession. For fiscal year 1990-91, the Board was authorized 4.5 Full-Time Equivalent (FTE) positions and expenditures of $257,800.

The Board Could Improve The Management Of Its Complaints Process **(see pages 5 through 14)**

The Board needs to ensure the timely resolution of serious complaint cases. We found five serious complaints before the Board at the time of our review have been delayed without final resolution for up to three years. Three of these cases have been delayed due to inaction by the Board's investigative staff. However, two others have been delayed while awaiting settlement negotiations by the Attorney General. The Board should establish a case status reporting system to ensure that it is aware of such delays.

We also found the Board can reduce the amount of time taken to resolve less serious complaints. Our analysis of 140 complaints received by the Board from January 1, 1988 to June 30, 1990, reveals an average resolution time of 184 days. However, better complaint tracking and changes in the review process could reduce the time needed to resolve many of these cases.

Finally, the Board needs to do more to ensure the consistent handling of all complaints. Presently, the Board lacks well-defined policies on how to handle third-party and anonymous complaints.

The Board Has Not Taken Adequate Disciplinary Actions Against Physicians Who Have Violated State Statutes (see pages 15 through 22)

Even when the Board investigates complaints, it is often reluctant to use its statutory authority to enforce professional standards. Letters of Concern are issued by the Board for cases in which violations occurred and stronger enforcement action could be taken. In addition, when the licensees refund patient fees, the Board often dismisses the cases without taking any action, even in cases involving questions about the competence of a physician to practice medicine. Finally, the Board has not made use of its statutory authority to impose fines.

In addition to the general problems with the Board's enforcement actions, we identified several instances in which the Board failed to take appropriate disciplinary action in cases involving serious violations. For example, in one case, a licensee admitted administering large dosages of drugs to a patient who developed an addiction as well as a life-threatening condition as a result of numerous injections. Although stronger disciplinary actions such as suspension, probation, and fines were available, the Board issued a Decree of Censure to the licensee, one of the most lenient enforcement actions it could take.

The Board has also been reluctant to enforce stiff penalties against licensees who have received numerous complaints and committed several violations over time. For example, we identified five physicians, each of whom had more than 20 complaints filed against them. Although the number of documented violations by these physicians would appear to justify progressively stronger enforcement actions, the Board took no action or dismissed 110 of the 122 complaints against these physicians and issued nine Letters of Concern. Only two of the five physicians were placed on probation, and only one of these two physicians also had his license suspended.

The Board Has Not Complied With Statutes Governing Its Operations (see pages 23 through 27)

The Board did not follow State procurement statutes when obtaining professional services for the monitoring of chemically dependent physicians, laboratory analyses, and private investigation services. In addition, the Board made inappropriate and possibly illegal use of State monies when it paid for the travel expenses of an out-of-state candidate for employment with appropriated funds. Finally, the Board has not recorded the proceedings of its executive sessions as required by law.

Other Issues

In compiling information to respond to the twelve Sunset Factors, we noted that the Board has restricted public access to Board information on licensees. The Board will not provide any information over the telephone regarding disciplinary actions, even such basic information as the number and type of any disciplinary actions. Further, the Board will not inform the public of any current complaints against a licensee, or of the number and type of any complaints that have been dismissed. This information is a matter of public record and may be obtained by reviewing minutes of Board meetings. However, such an approach is time-consuming, and the Board's unwillingness to provide such information in a summary form places an effective limit on access to public records.

TABLE OF CONTENTS

	Page
INTRODUCTION AND BACKGROUND	1
FINDING I: THE BOARD COULD IMPROVE THE MANAGEMENT OF ITS COMPLAINTS PROCESS	5
Board Needs To Ensure Consistent Handling Of All Complaints	5
Board Could Improve The Timeliness Of Complaint Resolution	7
Board Should Ensure Timely Resolution Of Serious Complaints	10
Recommendations	14
FINDING II: THE BOARD HAS NOT TAKEN ADEQUATE DISCIPLINARY ACTIONS AGAINST PHYSICIANS WHO HAVE VIOLATED STATE STATUTES	15
The Board Has A Broad Range Of Enforcement Options	15
General Lack Of Enforcement	16
Board Has Not Taken Sufficient Disciplinary Action In Serious Cases	18
Recommendations	22
FINDING III: THE BOARD HAS NOT COMPLIED WITH STATUTES GOVERNING ITS OPERATIONS	23
Board Did Not Follow State Procurement Statutes	23
Inappropriate Use Of State Monies	25
Board Has Not Recorded Executive Session Proceedings	26
Recommendations	27
SUNSET FACTORS	29
AGENCY RESPONSE	

LIST OF TABLES

		Page
TABLE 1	BOARD OF OSTEOPATHIC EXAMINERS IN MEDICINE AND SURGERY ACTIVITIES FISCAL YEARS 1987-88, 1988-89, AND 1989-90	2
TABLE 2	BOARD OF OSTEOPATHIC EXAMINERS IN MEDICINE AND SURGERY STATEMENT OF REVENUES, EXPENDITURES, AND CHANGES IN FUND BALANCE FISCAL YEARS 1988-89, 1989-90, AND 1990-91 BUDGETED (unaudited)	3
TABLE 3	RESOLUTION TIMELINESS OF A SAMPLE OF COMPLAINTS RECEIVED BY THE BOARD FROM JANUARY 1, 1988 TO JUNE 30, 1990. . . .	8
TABLE 4	OVERVIEW OF DISCIPLINARY ACTIONS TAKEN BY THE BOARD DURING CALENDAR YEARS 1988, 1989, AND 1990	16
TABLE 5	ACTION TAKEN AGAINST REPEAT OFFENDERS IDENTIFIED IN COMPLAINT FILE SAMPLE.	20

INTRODUCTION AND BACKGROUND

The Office of the Auditor General has conducted a performance audit and Sunset review of the Board of Osteopathic Examiners in Medicine and Surgery, pursuant to a June 14, 1989, resolution of the Joint Legislative Oversight Committee. The audit was conducted under the authority vested in the Auditor General by Arizona Revised Statutes (A.R.S.) §§41-2351 through 41-2379.

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

Duties

The Board is responsible for examining and licensing osteopathic physicians and surgeons, renewing licenses biennially, reviewing complaints, holding hearings, and enforcing the standards of practice of the osteopathic profession. The various service measurements of the Board's activities are presented in Table 1, page 2. The Board consists of five members: four licensed physicians and a representative of the public.

TABLE 1

BOARD OF OSTEOPATHIC EXAMINERS IN MEDICINE AND SURGERY ACTIVITIES FISCAL YEARS 1987-88, 1988-89, AND 1989-90

Activity	1987-88	1988-89	1989-90
License Renewals	1,262	1,263	86(a)
New Licenses	112	96	67
Complaints Investigated	166	133	139
Days Board Met	8	8	7

(a) In 1989 the Board instituted a biennial licensing cycle.

Source: Board of Osteopathic Examiners in Medicine and Surgery, Fiscal Year 1991-92 Budget Request.

Staffing

For fiscal year 1990-91, the Board was authorized 4.5 Full-Time Equivalent (FTE) positions. The staff includes an executive director, an investigator, an administrative assistant, a clerk-typist, and a part-time medical consultant.

Revenues And Expenditures

Ninety percent of the licensing fees received by the Board are deposited in a special Board fund to support its operations. As shown in Table 2, page 3, Board expenditures have increased from approximately $199,000 in fiscal year 1988-89, to an estimated $257,800 in fiscal year 1990-91. A large percentage of the expenditure increase for fiscal year 1990-91 includes funding for the implementation of a substance abuse monitoring and rehabilitative program for chemically dependent physicians.

TABLE 2

BOARD OF OSTEOPATHIC EXAMINERS IN MEDICINE AND SURGERY
STATEMENT OF REVENUES, EXPENDITURES, AND CHANGES IN FUND BALANCE
FISCAL YEARS 1988-89, 1989-90, AND 1990-91 BUDGETED
(unaudited)

	1988-89 (Actual)	1989-90 (Actual)	1990-91 (Budgeted)
FTE Positions	4.5	4.5	4.5
Revenues(a)	$336,691	$ 28,694	$475,200
Expenditures			
Personal services	126,687	123,294	136,900
Employee-related	28,642	22,268	30,400
Prof. & outside services	1,067	11,886	43,700
Travel, in-state	3,848	4,307	6,100
out-of-state	3,891	2,703	4,800
Equipment	2,305	15,086	-0-
Other operating	32,727	30,631	35,900
Total Expenditures	199,167	210,175	257,800
Excess of revenues over (under) expenditures	137,524	(181,481)	217,400
Beginning fund balance	358,790	496,314	314,800(b)
Ending Fund Balance	$496,314	$314,833	$532,200

(a) The Board of Osteopathic Examiners in Medicine and Surgery has a biennial licensing cycle.

(b) The fiscal year 1990-91 beginning fund balance does not agree to the State of Arizona Appropriations Report because approximately $228,000 was inadvertently excluded from the appropriations report.

Sources: Arizona Financial Information System reports for fiscal years 1988-89 and 1989-90; State of Arizona, Appropriations Report for the Fiscal Year Ending June 30, 1991; State of Arizona, Executive Budget for Fiscal Year 1992.

Scope Of Audit

Our audit contains Findings in the following three areas:

- the Board's need to improve the management of its complaints process;
- the Board's reluctance to use its authority to enforce professional standards; and
- the Board's failure to comply with various statutory provisions governing its operations.

As part of our audit work we present examples of actual cases before the Board in order to demonstrate its effectiveness in regulating osteopathic physicians. However, specific information that would identify the individuals involved or investigative findings has been eliminated to ensure the confidentiality of the information.

Our audit was conducted in accordance with government auditing standards.

The Auditor General and staff express appreciation to the Board members, the executive director, and the staff of the Board for their cooperation and assistance during the audit.

FINDING I

THE BOARD COULD IMPROVE THE MANAGEMENT OF ITS COMPLAINTS PROCESS

The Board of Osteopathic Examiners in Medicine and Surgery could improve the management of its complaints process. The Board could improve the general consistency and timeliness of its complaint resolution. More importantly, the Board also needs to ensure the timely resolution of serious complaints, including those awaiting action by the Attorney General.

Board Needs To Ensure Consistent Handling Of All Complaints

Although the Board has made improvements in handling complaints, it needs to do more to ensure the consistent handling of all complaints. While the Board has clear statutory authority to investigate any information that suggests unprofessional conduct by a licensee, it has not consistently pursued third-party complaints. Additionally, anonymous complaints have not been adequately addressed. The Board's lack of well-defined policies for handling complaints may contribute to inconsistent enforcement.

Clear authority to investigate - The Board has clear statutory authority to investigate allegations of misconduct. Arizona Revised Statutes (A.R.S.) §32-1855.A states:

> "The board on its own motion may investigate any information which appears to show that an osteopathic physician and surgeon is or may be guilty of unprofessional conduct...and any other person may, report to the board any information such physician or surgeon, association, health care institution or other person may have which appears to show that an osteopathic physician and surgeon is or may be guilty of unprofessional conduct...."

Based on this statute and A.R.S. §32-1854 that defines unprofessional conduct, in early 1990 the Board's Attorney General representative advised the Board in writing:

"...(I)t is apparent that anyone may advise the Osteopathic Board of information concerning possible unprofessional conduct of its licensees...Once information is received by the Board, its agents may properly organize and present that information to the Board for its consideration and for such action as the Board may deem appropriate."

Third-party complaints - Despite authority to pursue all complaints regardless of the source, the Board has not consistently investigated complaints received from third parties (someone other than the patient). This includes complaints from other doctors. For example, we identified a letter to the Board from a medical doctor questioning an osteopathic physician's use of an "experimental therapy" for the treatment of a young girl with AIDS. The doctor who made this complaint felt the osteopath's actions substantially increased the patient's risk of infection -- something particularly dangerous to AIDS patients. In response to the complaint, the Board's executive director informed the MD that the Board was unable to investigate the matter without a written complaint from the patient or her guardian. The Board's executive director later told us such complaints from physicians may not be pursued as they may be made in an effort to discredit competing physicians.

Since the Board does not record all the complaints it receives but only those that are investigated, it is impossible to document the number of third-party complaints submitted to the Board.

Anonymous complaints - In addition to complaints initiated by third parties, the Board has also failed to consistently pursue the complaints it receives anonymously. We identified a serious case that was initially presented to the Board anonymously, but not acted upon until later when a signed complaint was submitted.

- In 1985, the Board received and later dismissed a complaint alleging the unprofessional conduct of a licensee as a result of his relationship with a patient. Later the Board received several anonymous calls that identified the doctor and the patient in the 1985 case. The caller(s) reported that the doctor was dispensing and administering large quantities of drugs to the patient who, in addition to being an addict, had developed large, open sores on her body from the injections. Because the caller refused to file a formal complaint, the Board did not initiate an investigation. It

was not until December 1988, when a relative and friends of the patient submitted a signed complaint to the Board, that an investigation was begun. The results of this investigation substantiated all of the allegations made by the anonymous caller.

Lack of clear policies may contribute to inconsistent handling - The Board's lack of clear policies regarding third-party and anonymous complaints may contribute to the inconsistent handling of these complaints. For example, while all of the Board members informed us that the Board should investigate third-party complaints, the executive director stated that only those complaints submitted by the patient or the patient's guardian are investigated. Furthermore, although three Board members stated that the Board should pursue all anonymous complaints, the remaining two members and Board staff stated that the Board does not investigate anonymous complaints. The Board needs to clarify its policies regarding complaint handling and inform staff of their position.

Board Could Improve The Timeliness Of Complaint Resolution

The Board could reduce the amount of time taken to resolve complaints. Better tracking of complaints as well as changes in the complaint review process could improve the timeliness of complaint resolution.

Time to resolve complaints - Of the 140 cases we sampled(1), on average it took the Board 184 days from the day they received a complaint until the physician against whom the complaint was filed was notified of the Board's decision (see Table 3, page 8). The amount of time varied widely with the fastest turnaround being 13 days and the slowest 617.

---

(1) We reviewed 140 of the 293 complaints received by the Board between January 1, 1988 and June 30, 1990. We used the same sample of 140 complaints for all major analyses in this report. However, because information was missing in the complaint files, the actual sample size for a particular analysis on a specific variable may be smaller.

TABLE 3

RESOLUTION TIMELINESS OF A SAMPLE OF COMPLAINTS RECEIVED BY THE BOARD FROM JANUARY 1, 1988 TO JUNE 30, 1990

Amount of Time To Resolve Complaint	Number of Complaints	Percentage of Complaints
3 months or less	4	3
3 to 4 months	13	10
4 to 5 months	35	28
5 to 6 months	32	25
6 to 9 months	26	21
9 months to 1 year	10	8
more than 1 year	6	5
TOTAL	126(a)	100

(a) Of the 140 cases we sampled, 13 cases were open and one was missing information on dates. Therefore, only 126 cases were considered resolved.

Source: Auditor General staff analysis of a sample of consumer complaints received by the Board from January 1, 1988 to June 30, 1990.

Better complaint tracking - The Board could improve the timeliness of its complaint resolutions by improving the tracking of complaints during the review process. In our analysis of Board complaints, we found two stages of the review process that slow the resolution of complaints -- delays in receiving responses to complaints from licensees and the amount of time to complete medical reviews of cases. Both areas could be improved by a better system of complaint tracking.

One factor that slows the complaint review process is the Board's failure to adequately follow up on its requests for doctors to respond to complaints. When the Board notifies a physician that a complaint has been filed against him or her, they ask the physician to respond in writing within 15 calendar days. However, in our review of complaint cases, we found 16 cases in which the licensee did not respond within 30 days, and 5 cases in which the licensee did not respond for more than 90 days. In one instance, the licensee did not respond until 260 days after the Board's initial request. Although Board staff sent follow-up letters in most of these cases, letters often were not sent for two to three months.

Although the Board maintains a filing system designed to track cases during this initial stage of the review process, this system appears to have had little effect on ensuring timely responses from licensees.

In addition to the untimely response from physicians, the medical review of complaints is also delaying the complaint resolution process. Our analysis indicates that the medical consultant is taking an average of 55 days to complete the reviews(1), or approximately one-third of the time taken by the Board to process a complaint. Although the medical consultant attributes these delays to several factors(2), we found more than one-half of these cases did not involve quality of care issues and, therefore, required minimal medical review. Perhaps of greater significance is the fact that once the cases are presented to the consultant for review, they are removed from the Board's case-tracking system, making any monitoring of their progress more difficult.

Changes in complaint review process could improve timeliness - Informal interviews and Board reviews could be conducted in a more expedient manner. Currently, even when both the medical consultant and the Board member assigned to review a case recommend an informal interview or a review by the entire Board, the Board waits until its next quarterly meeting to vote on these recommendations. This process inherently delays action by the Board for three months until the next quarterly meeting. However, according to the Board's executive director, it would be possible to hold a conference call prior to a Board meeting to vote on whether to conduct informal interviews at the next regular Board meeting. In addition, when reviewers recommend the review of a case by the entire Board, it would be possible to mail packets of information to all Board members so that the case could be addressed at the next meeting. These changes in the review process could improve the Board's timeliness by at least 90 days.

---

(1) This represents the average number of days from the date the Board receives the physician's response to the complaint until the date the medical consultant submits his recommendations.

(2) These factors include a) information being put into the case tracking system and not being passed on to the medical consultant for review; b) the complexity of some cases; c) the need for additional research, including contacting the physician for more documentation; and d) the use of outside consultants.

Board Should Ensure Timely Resolution Of Serious Complaints

The Board needs to ensure the prompt resolution of its serious complaint cases. In our sample of Board complaints, we found five serious complaints delayed without final resolution for up to three years. Three of these cases have been delayed due to inaction by Board investigative staff. However, the other two cases have been delayed while awaiting settlement negotiations by the Attorney General's Office. Providing periodic status reports to the Board would ensure that the Board is aware of major delays in resolving complaints.

Delays due to inaction by Board staff - We identified three serious complaints that have not been presented to the Board for its review because of delays by Board staff during the investigation of the case. As illustrated in the following case summaries, although coordination with a Federal law enforcement agency may have contributed to a portion of the delays in two cases, the delays are primarily attributable to incomplete and poorly administered investigations by Board staff.

- Case 1 - In January, September and October of 1988, the Board received three complaints, one from an osteopathic physician and the other two from former employees, respectively, regarding the activities of a licensee. These alleged activities included insurance fraud, the use of unlicensed and unqualified personnel to administer anesthesia, improper supervision of surgical residents, the adulteration of medications, and the alteration of medication expiration dates. In addition, the complainants reported extremely bizarre, unethical, and unprofessional conduct on the part of the licensee that involved perverse activities with anesthetized patients. These activities were often photographed by the licensee or his staff, and the photos were maintained in an album that the licensee used to "shock" his employees.

  In December 1988 the Board's investigator began an investigation of these allegations. However, in January 1989, the investigator was removed from the case due to complaints of unprofessional conduct made by the licensee and an associate. During most of 1989, aside from a few interviews conducted by the Attorney General's Office, little was done on the case. In November 1989, the Board's executive director, acting on advice of the Attorney General's Office, hired a private investigation firm to look into the case. In approximately June 1990, the private firm was released from the case after conducting several interviews with the doctor's former employees.

These interviews supported some of the allegations made by the complainants. However, little action has been taken in the investigation since June.

Comments - While Board staff have been aware of potentially serious wrongdoing by this licensee for almost three years, they have done little to resolve the current complaint in a timely manner. Consequently, other patients of this licensee have been potentially left at risk. To date, our analysis of the investigation indicates that, in addition to being untimely, this investigation was clearly not conducted in an aggressive manner nor well organized or administered. Specifically, depositions of other physicians associated with the licensee should have been conducted much earlier, and patients mentioned by the complainants should have been contacted and interviewed.

- Case 2 - Based on excessive purchases of controlled substances, the Federal Drug Enforcement Administration (DEA) and the Board began a joint investigation of a licensee. In September 1988 the DEA served a search warrant on a clinic operated by the licensee. The ensuing investigation identified fifteen separate Federal violations involving the licensee's failure to properly account for more than 200,000 dosage units of controlled substances and the failure to maintain complete and proper records of the receipt and distribution of controlled substances. In December 1989 the licensee admitted to ten of the violations and was assessed a civil penalty of $40,000 in March 1990. In addition, during the investigation, several other possible violations were identified, including using the DEA permit numbers of other physicians to order controlled substances and failing to properly secure controlled substances.

Comments - Although violation of Federal law is unprofessional conduct as defined by statute, more than two years have passed since the onset of the investigation and more than one year since the DEA civil action, this case has still not been presented to the Board for possible disciplinary action. In addition, the Board's investigative file contained little or no documentation of investigative work to either confirm or deny the additional alleged violations. When first asked about this case, the Board's investigator stated that since the DEA has already fined the licensee, he considered the case closed and had no plans to send it to the Board for their review and possible action.

Following our further inquiry into the case, the investigator changed his story and stated that although the violations committed by the licensee were minor and the case was weak, he now plans to send it to the Board for review and action.

- Case 3 - In June 1989, the DEA, in a joint investigation with the Board, served a search warrant on three weight loss clinics operated by a licensee. DEA investigators identified a substantial amount of evidence that the doctor was providing illegal prescriptions to the patients of his weight loss clinics. In January 1990, a DEA investigator compiled a computation chart showing that the licensee could not account for more than 1,100,000 dosage units of controlled substances, and in September 1990, the U. S. Attorney's office filed an action seeking a $200,000 judgment against the doctor for failure to maintain complete and accurate records of controlled substances.

  Comments - Although this case has been under investigation for over one and one-half years and contains ample evidence of inappropriate and potentially dangerous actions by the licensee, Board staff have not presented the case to the Board for possible disciplinary action against the licensee. According to the Board's executive director, they have been waiting to see how another weight loss clinic case develops before proceeding. However, that case remained unresolved for over one and one-half years after the Board voted to conduct a hearing on it. In the interim, the Board has received two additional complaints against the licensee concerning questionable prescription practices. According to a letter sent by the Board staff one of these complaints has been incorporated into the ongoing complaint investigation. We found no information about the manner in which the Board is addressing the second complaint.

Cases awaiting action by the Attorney General - In our sample, we also identified two serious cases that the Board had voted to send to a formal hearing and had referred to the Attorney General for prosecution. However, as illustrated in the following summaries of the cases, efforts to settle them without a formal hearing have resulted in delays of more than one year in each case.

- Case 1 - During the review of patient charts kept by a physician, the Board's medical consultant found instances of gross overprescription of controlled substances. For example, the licensee had been seeing one patient every eight to ten days (sometimes more frequently) for over six years. On each visit the patient was given narcotics, analgesics, or tranquilizers. Based on this evidence, the Board voted to send the case to a formal hearing. However, the licensee, through his attorney, offered to settle the case rather than go through a formal hearing.

  According to the Attorney General representative assigned to the case at the time, he had reached a verbal agreement with the licensee's attorney on settlement terms six months later. However, shortly thereafter he left the Attorney General's Office without finalizing the settlement. Although a new attorney was assigned to represent the Board in July 1990, he did not renew settlement negotiations with the licensee's attorney until November 1990. One year after the Board acted to send the case to a formal hearing, a settlement with the licensee was finalized by the Attorney General's Office.

Comments - Attorney General officials attribute the delay in this case to the turnover of the attorney assigned to the Board and the need for the new attorney to become familiar with the case. According to the new attorney, he received this case without an investigative report documenting the Board staff's investigation and he also had to review patient files. Although these activities had to be worked into the new attorney's ongoing caseload, the necessity of a four-month review appears questionable. We found that the physician admitted overprescribing controlled substances during a June 1990 deposition and had received a prior disciplinary action from the Board for prescribing controlled substances for his daughter.

- Case 2 - In March 1989, DEA seized the records of a weight loss clinic supervised by a licensee. The clinic had a history of illegal distribution of controlled substances. After reviewing 50 patient charts, the Board's medical consultant found the licensee's practice at the clinic constituted a danger to the public. Furthermore, evidence indicated that the licensee had continued to allow unlicensed personnel to authorize prescription refills despite a Decree of Censure issued to him by the Board in 1988 for the same offense. During its July 1989 meeting the Board voted to send the case to a formal hearing. However, the licensee, through his attorney, offered to settle the case rather than go through a formal hearing. The licensee was indicted in January 1990 on Federal drug charges and the ensuing settlement negotiation involved disciplinary action from the Board as well as Federal charges that included a large monetary forfeiture. As of January 1991, one and one-half years after the Board acted to formally hear the case, the Attorney General had not finalized a settlement with the licensee.

  Comments - The Attorney General attributes the delay in settling this case to the inaction of the U.S. Attorney in completing the Federal portion of the settlement. Attorney General officials told us that the licensee will not settle the administrative matter with the Board until the Federal criminal matter is settled. Internal memoranda obtained from the Attorney General indicate that the delay by the U.S. Attorney is a result of not completing the paperwork necessary to obtain a forfeiture, currently set at $75,000, from the physician. The Attorney General is to receive approximately $30,000 of this amount, and a portion of the monies is to be shared with the Board to pay future investigation expenses. Attorney General officials assert that although they are willing to proceed with the case to a hearing, upon instruction from Board staff, they have continued to pursue a settlement, despite the length of time that has passed.

Board not aware of some delays - The Board was unaware of the delays in several of the cases described in this report. The Board was also unaware of actions being taken on its behalf by the Board staff or the Attorney General's Office. The Board should become more informed about the status of ongoing cases by requiring its staff to periodically report the status of cases, including information such as the date a complaint was received, investigation efforts, prosecution or settlement negotiation activities, and the anticipated date of closure. Developing a reporting system would also help ensure that the Board is fully aware of the activities on all cases for which it is responsible.

RECOMMENDATIONS

1. The Board should establish and inform staff of well-defined policies to ensure that all third-party and anonymous complaints are appropriately addressed.

2. The Board should strive to resolve complaints in a more timely manner by

   - increasing the Board's complaint tracking efforts to ensure timely responses from physicians as well as timely medical reviews; and

   - arranging a conference call prior to each Board meeting to determine which cases can be resolved by an informal interview or a review by the entire Board.

3. The Board should establish procedures for obtaining periodic status reports for all complaints received against physicians licensed by the Board. The status reports should provide information such as the date on which the complaint was received, the current status of the investigation or prosecution, and the expected date for presentation to the Board or a formal hearing.

FINDING II

THE BOARD HAS NOT TAKEN ADEQUATE DISCIPLINARY ACTIONS AGAINST PHYSICIANS WHO HAVE VIOLATED STATE STATUTES

Even when the Board investigates complaints, the penalties imposed on physicians are often lenient. Although the Board has the authority to impose a wide range of penalties for violations, our review indicates that it usually chooses penalties that are relatively mild compared to the violations. We also found that the Board did not take appropriate action against physicians whose cases involved serious violations of osteopathic practice and physicians with long histories of complaints and violations.

The Board Has A Broad Range Of Enforcement Options

A.R.S. §§32-1803.A.2 and 32-1855 empower the Board with broad authority to investigate violations of the osteopathic statutes and take enforcement action against violators. The statutes specifically identify eight actions that the Board may take individually or in combination.

- **Dismiss the Complaint** if in the opinion of the Board it is without merit.
- **Issue a Letter of Concern** if there is insufficient evidence, or the information is not of sufficient seriousness to merit direct action against the physician's license. A Letter of Concern is an advisory letter to the physician and is a public document.
- **Enter into a Stipulated Order** if the information is true but not of sufficient seriousness to merit suspension or revocation. A Stipulated Order is a temporary restriction of a physician's license.
- **Issue a Decree of Censure** if the information is true but not of sufficient magnitude to merit suspension or revocation of license. A Decree of Censure is a formal written reprimand by the Board of a physician for violation of the statutes regulating the osteopathic profession. It constitutes an official action against a physician's license.
- **Fix a Period and Terms of Probation** if rehabilitation or education of the physician is warranted.
- **Impose a Civil Penalty** not to exceed $500 per violation.

- Suspend the License if the violation is not serious enough to revoke the license. Suspending a license, temporarily bars the physician from practicing medicine.

- Revoke the License if the Board feels that the physician should not be allowed to continue practicing medicine. Once a physician's license has been revoked, he must wait two years to reapply for licensure.

As shown below in Table 4, although the Board has broad powers to enforce the osteopathic statutes, it frequently takes no action or imposes the most lenient sanctions. During 1988, 1989, and 1990, the Board took disciplinary action against physicians' licenses in 11 percent of the complaints reviewed. Most complaints (75 percent) were dismissed.(1)

TABLE 4

OVERVIEW OF DISCIPLINARY ACTIONS TAKEN BY THE BOARD DURING CALENDAR YEARS 1988, 1989, AND 1990

Type of Action	1988	1989	1990
Dismissed Complaint	107	107	102
Issued Letter of Concern	21	15	19
Entered into Stipulated Order	7	8	10
Issued Decree of Censure	4	1	1
Placed Physician on Probation	5	3	1
Suspended Physician's License	2	2	1
Revoked Physician's License	1	1	2
Total	147	137	136

Source: Board of Osteopathic Examiners in Medicine and Surgery, Summary of Calendar Year Statistics.

General Lack Of Enforcement

Our review of complaint files suggests that the Board is generally unwilling to take strong action in complaint cases. We found the Board

(1) In addition to taking lenient enforcement actions, we found the Board restricts public access to information regarding complaints filed against licensees and disciplinary actions taken by the Board (see Sunset Factor 5, pages 30 and 31).

has issued Letters of Concern in several cases in which obvious violations have occurred. In addition, it has taken no action and dismissed cases in which, despite statutory violations or questionable professional practices, the licensee has in some way addressed the complaint to the satisfaction of the complainant. Finally, the Board has not made use of its statutory authority to impose fines.

Overuse of the Letter of Concern - The Board is not using Letters of Concern as intended by statute. Although Letters of Concern are intended for use in cases where there is insufficient evidence to support stronger action or in less serious cases, we found that the Board has issued Letters of Concern even when obvious violations of statute occurred. Of the 15 cases in our sample that resulted in Letters of Concern, we found that 12 were issued for cases in which violations occurred and stronger enforcement action could have been taken. For example:

- A physician falsely advertised himself as a certified laser surgeon although he was not certified in the use of lasers or in surgery. Despite three prior complaints for false advertising within a two-year period and clear evidence in this case that the licensee had violated A.R.S. §32-1854.16 that prohibits physicians from advertising in a false, deceptive, or misleading manner, rather than applying a stricter sanction such as a fine or a more serious action, the Board issued only a Letter of Concern.

Other cases in which the Board issued Letters of Concern included physicians who violated statutes by not exercising reasonable medical judgment, violating patient confidentiality, failing to provide medical records when requested, and overcharging patients.

Dismissing cases that should be pursued - In addition to inappropriate use of the Letter of Concern, the Board has completely dismissed at least 15 cases in which unprofessional practices occurred. According to the Board, disciplinary action was not warranted in several of these cases because the doctors were willing to negotiate a settlement with the complainant. However, dismissing these cases does not appear to be in the best interest of the public because it may not address the doctors' competence to practice or ensure that their conduct is appropriate. The following example illustrates this problem.

- A doctor performed surgery on a patient's nose and chin. After the surgery the patient stated that she was unable to breathe through the left side of her nose. She also began to experience pain related to her chin, which had received an implant. The patient was also dissatisfied with her appearance after the surgery, which resulted in a crooked nose and a lopsided chin. According to the patient, the doctor offered to correct these conditions through another surgery or refund the patient's $1,800. The patient took the money and had a second doctor correct the chin. According to the patient, the second doctor reported that the chin implant had been placed upside down. Despite 13 prior complaints against the first doctor regarding quality of care, the Board dismissed this case because the doctor settled with the patient.

  Comment: Although the Board had ample reason to question the physician's competence, it took no action to help ensure that such practices would not be repeated.

Reluctance to impose fines - The Board's general lack of enforcement is also evident by its reluctance to impose fines as sanctions for unprofessional conduct. In 1988, A.R.S. §32-1855.E.5 was added to authorize the Board to impose civil penalties of up to $500 per violation. Since that time the Board has assessed only two fines, despite numerous violations such as false advertising, excessive fees, substance abuse, immoral conduct, and endangering the health and safety of patients. We identified 27 additional formal actions taken by the Board during 1989 and 1990, all of which could have included a fine. The Board also issued 34 Letters of Concern, many of which could have included a fine.(1)

Board Has Not Taken Sufficient Disciplinary Action In Serious Cases

In addition to the general problems with the Board's enforcement actions, in several cases the Board has not taken appropriate action. We reviewed a number of cases in which the Board's action does not appear commensurate with the severity of the violation. We also identified cases in which the Board's actions do not seem strong enough given the physician's history of complaints and disciplinary actions.

---

(1) The Board may issue a Letter of Concern with or without an informal interview. If a Letter of Concern is issued after an informal interview, the Board may also impose a fine.

Action not commensurate with violation - We identified several cases in which the Board documented serious violations of professional practice but failed to take an action that reflected the severity of the violation. These cases included failure to perform routine procedures, unnecessary treatment, and improper prescriptions for addictive drugs. The following example illustrates the Board's reluctance to take strong action in a case where a physician clearly endangered a patient.

- After receiving a complaint from a female patient's family, the Board began investigating the patient's doctor. The family alleged that the doctor had been sexually involved with the patient and had administered large dosages of drugs to which she had become addicted. The Board had previously received anonymous complaints about this situation (see Finding I, page 6). When approached about the complaint, the doctor freely admitted the allegations, and the Board placed him under a stipulated order not to provide further treatment to the patient. The Board's investigation further revealed that the patient had a life-threatening condition as a result of abscesses that developed at the numerous injection sites. Eventually, the patient was involuntarily committed to the Arizona State Hospital and received a $950,000 settlement from the doctor's malpractice insurance carrier.

  The Board issued a Decree of Censure to the doctor for the following violations: 1) failing to keep records on the patient; 2) prescribing, dispensing, and administering prescription drugs for other than therapeutic purposes; and 3) endangering the health of the patient due to the licensee's inability to refuse the drugs the patient desired. The doctor's privileges to practice were in no way restricted beyond a continuation of the order not to treat the patient, and no monetary penalties were imposed.

  Comments: Although the doctor admitted to a serious breach of professional practice that resulted in severe consequences to a patient, the Board took one of the most lenient enforcement actions available. According to the minutes of the Board meeting, the Board did not feel that stronger action (such as additional restrictions on the doctor's practice, probation, or a fine) was justified because an investigation indicated that his treatment of his other patients was appropriate. However, we could find no evidence of this investigation in the Board's records (i.e., a review of patient files) that would usually be available to support this conclusion.

History of complaints - In addition to taking weak action when stronger action was warranted, the Board has not taken progressively stronger disciplinary actions against licensees who have received numerous

complaints and committed many violations over time. Despite repeated complaints being filed against some doctors, and the failure of lesser sanctions to modify their behavior, the Board has been reluctant to impose and enforce stiffer penalties.

We reviewed a sample of complaints filed between January 1, 1988 and June 30, 1990, and found that most of the physicians involved had some prior complaints; the average was four. To evaluate the Board's response to problem physicians, we identified five licensees with more than 20 complaints each. (Table 5).

TABLE 5

ACTION TAKEN AGAINST REPEAT OFFENDERS IDENTIFIED IN COMPLAINT FILE SAMPLE

Doctor	Total Complaints Closed	No Board Review(a)	Complaint Dismissed	Doctor Addressed; No Board Action(b)	Letter of Concern	Stip-ulated Order	Pro-bation
A	26	1	14	5	4	1	1
B	25	0	22	0	2	0	1
C	25	3	9	12	1	0	0
D	23	5	13	5	0	0	0
E	23	1	16	4	2	0	0
Total	122	10	74	26	9	1	2

(a) These complaints, which were older, were not reviewed by the Board. In some cases this was because the Board had no jurisdiction. Since then, the Board's jurisdiction has increased and they now hear all complaints.

(b) In these cases, after the complaint was brought to the attention of the Board, the physician corrected the problem either by refunding the patient's money, forwarding the records as requested, settling the case by paying damages, or another method of restitution. The Board then took no action against the doctor.

Source: Auditor General review of complaints received by the Board between January 1, 1988 and June 30, 1990, and a history of complaints obtained from Board's database. The complaint histories shown include complaints received by the Board from 1976 through June 30, 1990, and were obtained from the Board records for individual physicians.

While the number of documented violations accumulated by these physicians would appear to justify a pattern of progressively stronger actions against their privilege to practice medicine in Arizona, Board sanctions appear relatively limited. The Board's most common action in complaints against these doctors has been to dismiss the complaint. Of the 122 complaints filed against the five doctors listed in Table 5, 74 were dismissed with no action and another 26 were dismissed after the doctor settled with the patient. Although dismissal would normally suggest that the complaint was without merit, our review of the overall handling of complaints by the Board (see pages 16 through 18) does not support this assumption.

Even when the Board found that these physicians engaged in repeated acts of unprofessional conduct, Board sanctions were usually mild. For example, in 1987 the Board suspended Doctor A's license and placed him on probation for drug abuse. However, the Board's determination in other cases that Doctor A failed to inform a patient of abnormal thyroid test results, allowed staff to provide treatment in his absence, conducted unnecessary testing, overcharged for services, and advertised falsely, resulted only in Letters of Concern. Similarly, Doctor B was placed on probation for Medicare fraud in 1981, but subsequent findings that he failed to conduct appropriate tests on a patient, abandoned another patient, and engaged in false advertising were addressed with Letters of Concern. We conclude that the Board's reluctance to enforce professional standards is equally evident even when physicians have long histories of unprofessional conduct.

The Board is also unwilling to take meaningful action against a physician with a history of the <u>same</u> type of unprofessional conduct. We reviewed one case in which the Board, despite at least four prior complaints regarding fees, dismissed the case against a physician who asked a patient with insurance to sign a contract agreeing to a fee of $900, but promised that if the insurance company did not pay the $900, the fee would be only $190. This is clearly a violation of the statutes that prohibit physicians from obtaining a fee by fraud, deceit, or misrepresentation.

The Board, however, dismissed this case based on the doctor's promise to disclose his true, accurate, and complete charges without any material omission to insurance companies and patients.

RECOMMENDATIONS

1. The Board should review its disciplinary procedures and establish clear policies to guide it in determining the appropriate level of action against physicians who repeatedly violate the standards of professional practice. These policies should provide well-defined criteria to be used in determining disciplinary actions based on the severity of the violation, the physician's previous violations, and any additional factors the Board feels are relevant. The Board should provide written justification and documentation for actions that deviate from those criteria.

2. As part of this review, the Board should re-evaluate its policy of dismissing complaints when the licensee negotiates a settlement with the patient, and determine when official sanctions may still be appropriate.

FINDING III

THE BOARD HAS NOT COMPLIED WITH STATUTES GOVERNING ITS OPERATIONS

The Board has not complied with the various statutory provisions governing its operations. Specifically, the Board did not always comply with the State procurement statutes when obtaining professional services. In addition, the Board made inappropriate and possibly illegal use of State monies when conducting interviews for a new executive director. Finally, the Board has failed to record the proceedings of its executive sessions for at least six years.

Board Did Not Follow State Procurement Statutes

The Board failed to follow State procurement statutes when obtaining professional services. This includes services for the aftercare monitoring of chemically dependent physicians, laboratory analysis, and private investigation services.

Services for monitoring dependent physicians - The Board did not comply with State procurement statutes when obtaining more than $27,000 of professional services to monitor chemically dependent physicians. In July 1990, the Board entered into an agreement with the Arizona Medical Association (ArMA) to monitor and provide treatment to osteopathic physicians who are found to be impaired by alcohol and drug abuse. The agreement calls for the Board to compensate ArMA $20 annually for each physician licensed by the Board, or approximately $27,000 for the provision of these services for fiscal year 1990-91.

While the Board had obtained the necessary statutory authority and funding to enter into an agreement for these services, it did not comply with provisions of the State procurement code requiring the competitive bidding of contracts for professional services. According to an official with the State Procurement Office (SPO), the Board acted illegally when it failed to solicit bids through a Request for Proposal (RFP) for a aftercare monitoring contract. Additionally, if the Board felt that ArMA

was the only vendor available to provide the services, it should have sought a sole-source determination from the SPO director. Further, since the agreement with ArMA exceeded the amount that it is authorized to administer on its own, the Board should have administered the procurement through SPO.

The Board's failure to comply with the State procurement code appears to be due to the former executive director's lack of knowledge or disregard of the procurement code. According to the former executive director, she negotiated only with ArMA for aftercare services and did not solicit bids because the Board had obtained legislation to contract for the services. In addition, she stated that there were no other vendors that offered services similar to those offered by ArMA. However, the legislation authorizing the Board to obtain aftercare services did not authorize the Board to bypass the procurement statutes. Furthermore, while the former executive director felt that ArMA was the only suitable vendor, she failed to properly act upon this decision and request a sole-source determination from SPO.

Regardless of the cause, the Board has taken steps to resolve its inappropriate procurement of ArMA services. Based on our conversations with the Board's current executive director, he contacted SPO and requested a sole-source determination for aftercare monitoring services with ArMA. In early December 1990 SPO approved that request.

<u>Laboratory analysis and private investigation services</u> - The Board also failed to comply with State procurement statutes when obtaining professional services for laboratory analysis and private investigation services. Since approximately 1986, the Board has utilized only one private laboratory to analyze specimens obtained from chemically impaired physicians monitored by the Board. The cost of these services averages approximately $1,500 annually.(1) In the case of private investigation services, in 1989 the Board hired a private investigations firm to probe the activities of a licensee. This investigation by the private firm,

---

(1) Although the licensee pays the cost of the analysis, the Board specifies the laboratory that will conduct the analysis.

which extended over a period of approximately seven months, cost the Board more than $2,600. In both instances, the Board not only failed to comply with the requirements of the procurement code and obtain competitive bids for the provision of these services, but also failed to obtain a written contract for the services.

According to the former executive director, it never occurred to her that the Board needed to follow the procurement statutes when obtaining laboratory services. In the case of the private investigation firm, the former executive director contends that she followed the requirements of the procurement code by obtaining bids from four vendors. However, the documentation for this was placed on a piece of "scratch paper" that cannot be located now.

Inappropriate Use Of State Monies

In addition to noncompliance with State procurement statutes, the Board has made inappropriate and possibly illegal use of State monies. Specifically, the Board violated State statutes when it used appropriated monies to pay for the travel expenses of an out-of-state candidate for employment. However, inaccurate advice from a State personnel official may have contributed to the violation.

Travel expenses for out-of-state candidate - The Board's use of State monies to pay the travel expenses of an out-of-state candidate for employment, violated State statutes prohibiting such activities. In June 1990, the Board's executive director announced her resignation, effective the end of August 1990. On her recommendation, in late June the Board interviewed an out-of-state candidate for the executive director's position. The Board paid travel expenses of approximately $550 for this candidate. By doing so, the Board violated A.R.S. §35-196.01 that stipulates:

> "After July 1, 1978, no appropriated monies may be expended by any budget unit for transportation or other travel expenses necessary for bringing any person into this state who is not a resident of this state for an interview for prospective employment...unless such monies are appropriated for such specific purposes."

A review of the Joint Legislative Budget Committee appropriation reports indicates the Board had no specific appropriation for this purpose.

The statutes also prescribe specific penalties for violating the prohibition against the use of State monies for such travel expenses. Specifically, A.R.S. §35-197 stipulates: "Any officer, agent or employee of the state who knowingly fails or refuses to comply..." with the prohibition is guilty of a Class 1 misdemeanor. In addition, A.R.S. §35-196 indicates, "Any state officer or employee who illegally withholds, expends or otherwise converts any state money to an unauthorized purpose...," is liable for those monies, plus a 20 percent penalty.

Inaccurate advice may have contributed to the violation - While the Board violated the prohibition against the use of State monies for the travel expenses of an out-of-state candidate for employment, inaccurate advice provided by a Department of Administration (DOA), Personnel Division official may have contributed to the violation. According to the Board's former executive director, the Board paid the candidate's travel expenses based on the advice of a DOA personnel specialist assigned to assist the Board in its search for a new executive director. In fact, the Personnel Division official admits that although he was aware of the prohibition against the use of State monies for this purpose, he advised the former executive director that the Board could pay for the candidate's travel if they had available funds. However, the official added that he may not have made it clear that the statute requires these funds must be appropriated to the Board for that specific purpose.

Board Has Not Recorded Executive Session Proceedings

The Board has not recorded the proceedings of its executive sessions as required by statute. A.R.S. §38-431.01 requires all public bodies to take written minutes or recordings of all meetings, including executive sessions. According to the statute, minutes of executive sessions shall include the following information:

- the date, time, and place of the meeting;

- the members of the public body recorded as either present or absent;
- a general description of the matters considered; and
- such other matters as may be deemed appropriate by the public body.

Despite this requirement, the Board did not document its executive sessions during the last six years. Therefore, we were unable to review the minutes of the executive sessions of the Board for that period. According to the Board's former executive director, during the six-year period she served in that position, she simply failed to record the proceedings of the executive sessions, although she was aware of the need to do so. Beginning with the October 1990 Board meeting, the present executive director has begun to record and maintain the minutes of these meetings and has indicated he will continue to do so.

RECOMMENDATIONS

1. The Board should ensure that all contracts for goods and services are administered in compliance with requirements of the State procurement code.

2. The Board should ensure that it complies with appropriate statutes during any future recruiting efforts, particularly those prohibiting the use of State monies for out-of-state candidate travel expenses.

3. The Board should continue recent efforts to properly record the proceedings of its executive sessions.

SUNSET FACTORS

In accordance with Arizona Revised Statutes (A.R.S.) §41-2354, the Legislature should consider the following 12 factors in determining whether the Board of Osteopathic Examiners in Medicine and Surgery should be continued or terminated.

1. The objective and purpose in establishing the Board

Arizona Revised Statutes Chapter 17, Title 32, Sections 1800 through 1871 establish and empower the Board. Historical Note Laws 1982, Chapter 144, Section 1, states:

> "The goals and objectives of the state board of osteopathic examiners in medicine and surgery are to help assure competent osteopathic medical care and prevent conduct on the part of osteopathic physicians which would tend to do harm to the health, safety and welfare of the public."

In order to carry out this responsibility, A.R.S. §32-1803.A empowers the Board to examine candidates for licensure as osteopathic physicians and surgeons; enforce standards of practice; maintain a roster of all osteopathic physicians and surgeons licensed by the Board; and maintain records of all Board actions.

2. The effectiveness with which the Board has met its objective and purpose and the efficiency with which the Board has operated

The Board can improve its effectiveness and efficiency in fulfilling its statutory responsibility to protect the public from incompetent osteopathic physicians. Our review shows that the Board has not ensured the timely resolution of some serious complaints, has not taken adequate enforcement actions in many of the complaints it has addressed, and has not acted against licensees who have had numerous complaints and violations (see Finding I, page 5 and Finding II, page 15).

3. The extent to which the Board has operated within the public interest

The Board has generally operated in the public interest through its licensing and complaint resolution responsibilities. However, the Board's failure to take adequate and timely enforcement actions in some cases has limited its ability to properly protect the public from incompetent and potentially dangerous licensees. In addition, the Board's failure to comply with statutory requirements regarding procurement, its inappropriate use of State monies, and its failure to record the minutes of executive sessions has not been in the public interest (see Finding III, page 23).

4. The extent to which rules and regulations promulgated by the Board are consistent with the legislative mandate

Recent legislation has directed the Board to promulgate rules and regulations in order to enforce statutes addressing the dispensing of drugs by osteopathic physicians and the qualifications of medical assistants. Although this legislation became effective in September 1989, the Board has not yet promulgated the necessary rules. To date, the Board has drafted the rules and begun to advance them through the review and public hearing processes.

5. 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

The Board has not promulgated rules since 1987. However, recent efforts to draft rules and regulations addressing the qualifications of medical assistants and the dispensing of drugs have included a task force of members of the osteopathic community. Furthermore, the Board publishes minutes of its meetings as well as an annual newsletter, which are distributed to individuals and organizations within the osteopathic and medical communities.

The Board has restricted public access to Board information about licensees. Currently, if a member of the public wants to review whether the Board has taken any disciplinary actions against a licensee, he or she must either make an appointment for an in-person review of the physician's licensing file, or make a request in writing

that the Board provide a brief summary of any disciplinary actions. The Board will not provide any information regarding disciplinary actions over the telephone, including basic information such as the number and type of any disciplinary actions.

In addition, the Board recently acted to limit the information made available to the public by removing any dismissed complaints against a licensee from the summary record given to those making inquiries. The Board took this step although this information is public record contained in the minutes of the Board's meetings. Further, this incomplete disclosure of information could mislead the public about a licensee's competence to practice osteopathic medicine. For example, Doctor D in Table 5 (see Finding II, page 20) has had 23 complaints brought against him and is currently under investigation for unprofessional conduct (see Example 1, Finding I, page 10). However, because the Board has never taken a disciplinary action against him, members of the public reviewing his licensing file would be unaware of the 23 previous complaints.

6. <u>The extent to which the Board has been able to investigate and resolve complaints that are within its jurisdiction</u>

The Board needs to ensure the consistent handling of third-party and anonymous complaints, and strive to improve overall the timeliness of its complaint resolution process. In addition, the Board needs to resolve some of its most serious complaint cases -- cases that have been open for as long as three years, including those awaiting settlement negotiations by the Attorney General (see Finding I, page 5).

7. <u>The extent to which the Attorney General or any other applicable agency of State government has the authority to prosecute actions under the enabling legislation</u>

Unlike some other regulatory boards, the Board's enabling legislation does not specifically empower the Attorney General or any other agency of State government to prosecute actions. However, according to the Board's Assistant Attorney General representative, based on the provisions of A.R.S. §41-192, which delineate the powers and duties of that Office, the Attorney General is authorized to represent the Board.

8. <u>The extent to which the Board has addressed deficiencies in its enabling statutes which prevent it from fulfilling its statutory mandate</u>

In 1988 the Board supported legislation that resulted in significant changes in its authority to regulate the osteopathic profession. This legislation included provisions that allow the Board to enter into stipulated orders; impose civil penalties without conducting a formal hearing; appoint a hearing officer to conduct formal hearings; require licensees to report any unprofessional conduct of osteopathic physicians; and issue biennial licenses.

9. <u>The extent to which changes are necessary in the laws of the Board to adequately comply with the factors listed in the Sunset Law</u>

Based on our audit work, we do not recommend any changes to the Board's statutes.

10. <u>The extent to which the termination of the Board would significantly harm the public health, safety or welfare</u>

Termination of the Board would significantly endanger the public. The unregulated practice of osteopathic medicine could pose a threat to public health, safety, and economic well being. For example, several of the complaints we reviewed involved critical health and safety considerations, such as the overprescription of controlled substances, inadequate or inappropriate surgical procedures, and sexual abuse. Other complaints dealt with excessive fees and charges for services that were not provided.

11. <u>The extent to which the level of regulation exercised by the Board is appropriate and whether less or more stringent levels of regulation would be appropriate</u>

Based on our review, the current level of regulation exercised by the Board appears appropriate. By statute, only one category of licensure exists, Doctor of Osteopathy. Further, the Board is not authorized to issue temporary or limited licenses.

12. <u>The extent to which the Board has used private contractors in the performance of its duties and how effective use of private contractors could be accomplished</u>

The Board has made extensive use of private contractors for services it can not provide in-house. Specifically, the Board has contracted for the aftercare monitoring and treatment of chemically dependent physicians, laboratory analysis of bodily fluid samples, private investigation services, and hearing officers to conduct formal hearings. While the Board has contracted for these services, in most instances it has failed to comply with requirements of the State procurement statutes when obtaining professional services (see Finding III, page 23).

PRESIDENT

William C. Inboden, II, D.O.
3974 North Campbell Avenue
Tucson, Arizona 85719

VICE PRESIDENT

Paul M. Steingard, D.O.
4220 North 19th Avenue
Phoenix, Arizona 85015

ARIZONA BOARD OF OSTEOPATHIC EXAMINERS IN MEDICINE AND SURGERY

1830 WEST COLTER, SUITE 104
PHOENIX, ARIZONA 85015
(602) 255-1747
FAX (602) 255-1756

MEMBERS

Madelene Van Arsdell
1830 West Colter Street, #104
Phoenix, Arizona 85015

Richard Darby, D.O.
1830 West Colter Street, #104
Phoenix, Arizona 85015

Paul C. Geimer, D.O.
444 West Osborn Road, #207
Phoenix, Arizona 85013

EXECUTIVE DIRECTOR
Robert J. Miller, Ph.D.

ADMINISTRATIVE ASSISTANT
Phyllis Lundy

INVESTIGATOR
James L. Clubine

MEDICAL CONSULTANT
R. E. Dennis, D.O.

April 4, 1991

Douglas R. Norton
Auditor General
2700 North Central Avenue, Suite 700
Phoenix, AZ 85004

Dear Mr. Norton:

Enclosed please find the Board of Osteopathic Examiner's response to the draft preliminary report of your office's performance audit of the Board. It is our understanding that this response will be published, as submitted, in the final draft of the report.

At this time the Board wishes to thank you and your staff for providing us with the opportunity for input into the report. Should you have any questions regarding our response, please feel free to contact the Board office.

Sincerely,

William Inboden, II, D.O.
P.L.

William Inboden, II, D.O.
President

Robert J. Miller, Ph.D.
Executive Director

INTRODUCTION

The report of the performance audit of the Board of Osteopathic Examiners in Medicine and Surgery, submitted by the office of the Auditor General, has been reviewed by the Board, and our response is contained herein. The report has identified several areas of administrative procedure which can be improved upon and has made recommendations to that effect. In this regard, the Auditors have functioned effectively and within the scope of their knowledge and expertise.

The report has also sought to evaluate the medical and medico-legal review and decision-making performance of the Board, especially in areas of complaint resolution and physician discipline. In these areas, the auditors have strayed far from their field of training and knowledge, and have sought to "second-guess" the medical judgements of licensed Arizona Physicians. While the Board does not deny the validity, indeed the desirability, of periodic performance review, it is our contention that such review should be carried out by individuals with training and experience in the field under review. Although the auditors have identified certain areas of concern which have merit, the overall impact of their conclusions must be questioned, due to the failure to include a genuine "peer review" in the audit process. While these concerns have been raised previously with the auditor general's staff, we note with regret that they have not been addressed in the performance audit report. We would, therefore, again urge the auditor general to incorporate a true "peer review" process, by individuals possessing the appropriate background and training, in all future performance audits of professional regulatory boards. Such a process can only serve to enhance the credibility of the audit process.

Our response to the audit report will address each of the three findings contained therein, the sunset factors which follow them. In general, our concerns with the report focus on Findings I and II. We feel that the results and recommendations of Finding III are, in the main, accurate. The recommendations made in Finding III are appropriate, and either have been, or will be, implemented.

FINDING I

THE BOARD COULD IMPROVE THE MANAGEMENT OF ITS COMPLAINT PROCESS

This finding has identified certain areas which can be refined, and improved upon. Specifically, complaints from third parties, and complaints received from anonymous sources should be accorded the same investigative effort as are complaints received from patients, the most common source of such information. It is also the case that the complaint tracking system which was in use during the period audited did not always lend itself to accuracy, and did not always ensure that the status of complaints was monitored to the degree necessary.

The latter finding, as identified, requires some elaboration, since a timely resolution of a complaint involves a number of interdependent steps. A timely response from the physician involved, prompt review by Board staff and Board members and action by the Board on said recommendations are all required, and all consume time. While the auditors have gone to great lengths to point out that the Board takes, on average, 184 days to resolve a complaint, they fail to note that fully 66%, of all complaints they reviewed were resolved in six months or less. In other words, two-thirds of the complaints reviewed were resolved in less that the average time for resolution of all complaints reviewed. When the time frame is extended to nine months or less, 87% of all reviewed complaints have been resolved. This clearly demonstrates that the auditors allowed a small proportion of complaints, which took inordinate time to resolve, to distort the average time figure for complaint resolution. Clearly this is a situation wherein presentation of a simple statistic can obscure reality, and create a false impression.

Although the Auditors do not summarize their statistics for the medical review process, as they did in Table 3 for the overall complaint process, we have similar concerns as regards the use of the finding that "... the medical consultant is taking an average of 55 days to complete the review..." While we recognize, and accept, that this process can be completed in a more expeditious manner, we feel that the methodology used in deriving the "average" figure serves to grossly overstate the actual time involved in the medical review process.

In general, while we take issue with the specifics cited regarding the length of time required to resolve complaints during the audit period, we are in agreement that certain processual charges could be made to enhance the timely completion of the process. The Board has already implemented a procedure for holding conference calls on concurring recommendations for Informal Interview, and will review a similar method for dealing with Full Board Review recommendations. Steps are also being taken to refine the complaint tracking procedure, which will monitor the status of complaints from receipt through Board resolution. By instituting a better tracking system, it is anticipated that the "average" length of time to resolution, skewed as it may be, will be substantially reduced. The Board is also in the process of obtaining a new computer system for the office, which will include a system for tracking complaints. This will serve to augment, but not replace, the procedures currently being implemented. Problems with funding, and delays in acquiring the necessary programming support from the DOA Data Center have slowed this project, and it will now not be completed until sometime in FY 1992.

Board Should Ensure Timely Resolution of Serious Complaints

Under this sub-heading the auditors have identified five "serious" complaints which have not been resolved. Three of the cases are cited as instances of inaction by the Board staff while the delay in resolution of the remaining cases is attributed to problems in the Attorney General's office. We will address specific remarks to each of these examples.

In example 1, the auditors alledge that the investigation was not conducted in an aggressive manner, and that physician associates of the doctor against whom the complaint was made, as well as patients, ostensibly identified in the complaint, should have been contacted and either deposed or interviewed.

In fact, while coordination of the investigation, including retaining a private investigation service for the case, left something to be desired, at no time, save perhaps for the period June-October 1990, the period between termination of the private firm's service and re-assignment of the Board's investigator to the case by the new Executive Director, was the investigation allowed to lainguish unattended. Despite reviewing a number of lengthy interviews with former employees and others associated with the physician in question, and evaluation of patient records obtained from the physician's office, little of material substance has been obtained to date. Although the allegations made against the physician are of a profoundly serious nature, the Board has, as yet, despite its efforts, been unable to develop a solid case for disciplinary action to present to the Board.

Despite that noted above, it is important to point out that this investigation is on-going, and continues to be a priority for the staff. Nonetheless, it is our belief that, far from serving to exemplify staff inaction, this example serves to demonstrate the fact that not all complaint cases are either straight forward, or lead themselves to neat and ready solution.

In example 2, the auditors address a case in which the Board cooperated with the Drug Enforcement Administration to investigate and prosecute a physician for violation of federal statutes pertaining to record keeping for controlled substances. The auditors present this example as though the Board's staff failed to acknowledge a serious problem with a physician's practice. In fact, the auditors were briefed on this case several times during the course of their fact finding, and were informed that the Assistant Attorney General assigned to the Board during the period in question had agreed with the Board's investigator that the allegations cited were record keeping violations, and would not constitute a strong actionable case if presented to the Board in current form. However, as was also pointed out to the investigators, the Board was investigating other practice related issues with the physician, and these, if combined with the federal charges, would constitute a far more actionable case.

Again in example 2, a longer than expected period of investigation cannot be directly inferred to represent staff inaction, or failure to properly recognize and act upon a serious situation. As to the auditors' inference that the Board's investigator "....changed his story...", we find the wording, and implications thereof, to be offensive and not in keeping with accepted standards of professionalism. The language used would be more appropriate in a work of fiction than in a state agency document.

Example 3, summarizes another case involving a cooperative investigation of a weight control clinic between the Board and the Drug Enforcement Administration. The auditors comment that although this case is one and one-half years old and ample evidence exists of the physician's misconduct, the case has not been presented to the Board for disciplinary action. The report accurately states that the delay in presenting this case to the Board was predictated on the outcome of a similar case pending with the U.S. Attorney's Office.

However, as a matter of record, it should be noted that the decision to delay presentation of this case to the Board was made by the Board's legal counsel from the Attorney General's office--not the Board staff. The fact that a previous case, as well as this one, were stalled by legal posturing by government and defense attorneys has been inaccurately reported by the auditors as examples of incomplete or untimely investigation by this agency. Both DEA investigators and Board staff agree that the investigation of this case has been completed pending appropriate legal action. Moreover, when it became apparent that this case had the potential for the same delays as experienced in the prior matter, the Board staff contacted the Attorney General's Office and initiated the commencement of appropriate Board legal action independent of DEA and the U.S. Attorney's Office. This action by the Board staff preceded the sunset review by the Auditor General, and was the result of a conscious effort by this agency to prevent a repeat of the delays experienced in the previous case. It is also important to note that the physician's actions, which may have constituted an imminent threat to the public, ceased upon service of the search warrants on the clinic in question. Currently, there is no evidence to suggest that immediate action by the Board against this physician is required to protect the public. Again, this information was available to the auditors, but was not included in their report.

In addition, a thorough and exhaustive review of the Board's file of complaints, as well as all files on the physician in question, failed to turn up the two additional complaints which the auditors alledge have been filed against this physician since the original case in question was opened. It would appear that the auditors have confused this case with another, a matter of confusion which is unfortunate as it erroneously suggests that the Board has not acted with due diligence to protect the public health and safety.

While it is true that these three cases cited by the Auditor General's Office have been delayed in presentation to the Board for their review and action, it is important to note that two of the three cases involve joint federal/state drug investigations. The complexity of these investigations, and potential consequences to both the public, and the physicians involved, demanded that this Board's representatives conduct themselves with the utmost professionalism in collecting relevant evidence, while exercising diligence in ensuring due process rights for those accused. Not only have these requirements been satisfied during the pendency of these, admittedly, lengthy cases, but more importantly, at no time has the safety of the citizens of the state of Arizona been compromised by any investigator's actions.

We will not comment on the audit reports finding, regarding the Attorney General's office and their handling of areas cited as examples 1 and 2 under the heading "Cases awaiting action by the Auditor General."

RECOMMENDATIONS

The Board is in agreement with the auditors' recommendations 1 and 2, although it should be noted that, due to resource availability, it will always be necessary to prioritize complaints to some degree. With respect to third-party and anonymous complaints, the Board's current position, that these are not to be accorded complaint status, should be reviewed. It is also clear that this policy is not always followed, as the Board has responded quickly and decisively to two recent instances of physicians diverting controlled substances and/or self-medicating, which were initiated by third-party informants. A general review of the policy will be undertaken, with the intent of establishing clear guidelines for evaluation of all such information received.

With respect to recommendation 3, we have some genuine concerns, both operationally and philosophically. Currently the staff serves in investigative and recommendation-making capacities, with the Board sitting as arbiter and decision-maker. To involve the Board in the investigative process would, we feel, compromise the evaluation process, and move Board members into a management role, one not envisioned for them to statute. Once a decision has been made, the Board should be kept informed as to the status of its implementation, and a procedure for this will be developed. It would also be useful to provide quarterly summaries on complaints received and resolved, and actions taken, so that Board members, and staff, will be better acquainted with, and attuned to, the work flow of the agency.

FINDING II

THE BOARD HAS NOT TAKEN ADEQUATE DISCIPLINARY ACTIONS AGAINST PHYSICIANS WHO HAVE VIOLATED STATE STATUTES

In their introductory statement to this finding, the auditors alledge that the Board "... usually chooses penalties that are relatively mild compared to the violations." It is our contention that this statement is unfounded, and reflects a general lack of knowledge of the Board's role as a professional regulatory body, and the processes by which it carries out its various functions. The auditors routinely have judged violations to be of a serious nature, even when the Board has found otherwise. As noted earlier, it is our belief that the auditors did not possess the knowledge and training in medicine, and the law, to appropriately make the judgements that they have made throughout the finding.

On page 16, the statement is made that: "During 1988, 1989, and 1990 the Board took disciplinary action against physicians licenses in 11 percent of the complaints reviewed. This is, purportedly, documented in Table 4, same page. However, the auditors fail to include Letters of Concern in their calculations. If, as is appropriate, these were included, the percentage of disciplinary actions taken, to complaints received, would be 25%.

Although the auditors do not document their methodology, we assume that the omission of Letters of Concern was a result of their belief that these do not constitute disciplinary actions. This is clearly not the case, as the following will attest:

A. Letters of Concern are perceived by physicians as disciplinary actions, since they are routinely appealed.
B. Letters of Concern must be reported as Board actions to the Federation of State Medical Boards (FSMB) and the National Practitioner Data Bank (NPDB).
C. The Board may impose fines along with Letters of Concern if the latter are issued following an Informal Interview.

Given these factors, especially the federal requirement to report all disciplinary actions, including Letters of Concern, to the National Practitioner Data Bank (N.P.D.B.) we believe that the auditors did not fully understand the Board's disciplinary process. Had they done so, we feel that they would have, more accurately, reflected the statistical picture of the Board's activities during the audit periods.

To further support our contention that the Board's actions have been misrepresented in the audit report, we would point out that, in June 1990, the national advocacy organization Public Citizen released a report on its study of medical boards across the country. Published under the title 6,892 Questionable Doctors, the report found wide disparities in the actions and effectiveness of medical boards nationwide. In its review of Arizona data, the report concluded that "Arizona has a separate Board of Osteopathic Examiners, which may be the most active board in the country." This finding, which derives from an organization which is not, in its focus, supportive of medical boards as they are currently constituted and administered, would appear to run counter to the position taken by the Auditor in their report. This information was provided to the auditors during the course of their fact finding, but was not included, or referenced in, their report.

General Lack of Enforcement

Under this sub-heading, the auditors addressed three purported areas of deficieny, with a general comment that the Board has routinely failed to take strong action in complaint cases. While this opinion is interesting, we feel that a more beneficial approach would have been to address the appropriateness of the Board's actions, rather than to simply review the harshness of sanctions imposed. While the latter course is, undoubtedly, a simpler task, it may often overlook the fact that the Board is mandated by statute to both determine when unprofessional conduct has been committed, and if such has occurred, what type and degree of sanction is required to protect the public, deter future events of said conduct, and where appropriate, serve to educate the physician in appropriate behavior and practices. The effective discharge of this multifacetted mandate cannot be adequately judged by simply assessing one component of the process.

While we are, somewhat, in agreement with the finding that Letters of Concern have been overutilized, we have concern with the Auditor's statement that said letters have been utilized "...even when clear violations of statute occured." In addition, the auditors suggestion that "...12 were issued for cases in which violations occured and stronger enforcement action could have been taken."(paragraph 1, page 17), demonstrates the auditors' failure to recognize that Letters of Concern may be issued in the case of statutory violations. It should be noted that these statements reflect the opinion of the auditors with respect to the cases they reviewed. To state categorically that statutes were violated, or that enforcement actions were inappropriate, without benefit of medical or legal background or training is not appropriate. As noted above, we would suggest that, if an accurate review of the appropriateness of Board actions on specific cases was desired, said cases should have been reviewed by physicians and attorneys conversant with both the practice of medicine and the statutes which govern same in Arizona. The examples cited in paragraph 2 of page 17 as meritting more stringent disciplinary action further illustrate this lack of basic understanding of process and particulars. Only in the instance of failure to exercise reasonable medical judgement would an action more stringent that a Letter of Concern, such as a Decree of Censure, be warranted. In the specific case cited to illustrate this point, the Letter of Concern was the most appropriate action which could be taken by the Board, in light of the physician's documentation of certification for having attended a training seminar in laser surgery. Given the fact that the auditors were present during the entire Informal Interview for this case, and that they were aware of all the facts in this matter, we find their citing this as an inappropriate use of the Letter of Concern to be suprising to say the least.

In respect to the sub-finding of dismissing cases that should be pursued by the Board, we can concur with the auditors' position. Clearly, once a complaint has been filed, it should be pursued on its merits, or lack thereof, and any settlement which may occur between physician and complainant should not bear on the Board's findings or actions. Adopting such a policy would serve to clarify the Board's position in this regard.

Under the heading "Reluctance to Impose Fines" the auditors clearly intimate that the Board has failed to exercise due diligence in its sentencing process. The imposition of a fine is clearly within the Board's discretionary authority, but is not mandated in any instance. If in the opinion of the Board, a fine is necessary, it should be imposed, but should not be considered as standard practice, to be utilized in all instances. To do so would transform the Board from a regulatory body to a police force and judicial system in one, a situation which, we feel, would not be in the long term interests of the people of Arizona.

The Board Has Not Taken Sufficient Disciplinary Action in Serious Cases

Finally, the auditors address, at length, the issue of the Board's failing to act against physicians with extensive complaint histories. While it would appear to be a simple matter of arithmetic progression, it has, in fact, been the Board's position that each complaint must be reviewed on its own merits. This policy has, recently, undergone some revision with a case being brought againt a physician for apparent recurrence of problems associated with particular surgical procedures. This precedent will be reviewed, and can be applied in the future if similar situations are seen to be developing.

At the same time, rather than incorporating past performance into the complaint evaluation process, it would more reasonably fit at the point of disciplinary action selection. A progressive imposition of disciplinary measures would seem to be appropriate, and such a policy will be addressed by the Board in the near future. It should be pointed out, however, that sheer numbers of complaints against a physician, even a number of complaints of the same type, do not equate with guilt, a fact which the auditors seem to overlook. Clearly, repeated instances of the same type of unprofessional conduct should not be condoned, and a policy of progressively stronger actions would be appropriate. To reiterate, despite a tendency to premature judgement in such instances, the Board does have the responsibility to protect the physicians' rights of due process in all cases. To overlook this fact, and assess guilt or innocence merely on volume would be both unfortunate and inappropriate.

While the above addresses itself to recommendation #1, page 22, we find no fault with recommendation #2. In general, it should be noted that the Board is a dynamic body, and has undergone significant turn-over during the period under evaluation. As such, there is clearly a need for better understanding of the nature and types of actions which can be taken with respect to complaints. It is the staff's responsibility to provide direction in this area, and the Assistant Attorney General assigned to the Board should provide greater input into the process of determining appropriate disciplinary actions.

FINDING III

THE BOARD HAS NOT COMPLIED WITH STATUTES GOVERNING ITS OPERATIONS

We do not choose to take issue with this finding. Steps have been taken by the staff to insure that all statutes governing agency operations are understood, and are complied with.

SUNSET FACTORS

The auditors' response to the Sunset Factors set forth in statute are generally appropriate, and, for the most part are concurred with by the Board. While we might wish to take issue with certain conclusions arrived at, we will limit our comments to the following:

A. in factor #2, a number of conclusions derived from the auditors Finding #1 are made, conclusions which we feel have been shown to be unfounded and erroneous in our discussion of the same finding.
B. in factor #5, reference is made to the Board's policies on disclosure of information, which, the auditors suggest, may mislead the public, or, in our opinion, serve to accurately portray a physician's capabilities while protecting his rights when complaints have been found to be groundless. Nonetheless, the Board is reviewing its policies and procedures in this area, with the intent to ensure adequate public disclosure of all relevant physician information.

With the exception of the matters cited above, we do not choose to address specific components of the auditors' elaboration on the sunset factors pertaining to the agency. Needless to say, we do concur with their finding that "Termination of the Board would significantly endanger the public."

CONCLUSION

In reviewing the report of the Auditor General's Performance Audit of the Board of Osteopathic Examiners in Medicine and Surgery, we have identified a number of areas of specific concern. While we believe that certain findings and recommendations are accurate, it is our opinion that the auditors did not adequately or appropriately educate themselves on the role and processes of the Board, especially with respect to the investigation and resolution of complaints and the specifics of the statutes which empower the Board to regulate the practice of osteopathic medicine in Arizona. Had they done so, we feel that the manner as well as specifics, of finding I would have changed materially.

The same could be said with regard to Finding II, especially as it is our belief that the audit should have addressed on the appropriateness of the Board's actions vis-a-vis the complaints received, rather than simply focussing on the perceived need for severity in meting out disciplinary actions. Furthermore, a major methodological short-coming, namely the failure to include a true "peer review" of Board actions would appear to undermine many of the conclusions reached in Finding II.

We also note, with interest, that the auditors did not address the Board's statutory function of licensing physicians. We can only assume that this is due to their finding that the Board and its staff are performing adequately and appropriately in this function.

At the same time, there is useful information contained in the report, and certain recommendations dealing with areas of administration and operations will be reviewed and incorporated into the agency's operational policies and procedures. A number of these, as noted in the report, have already been initiated, and additional changes will, undoubtedly, be forth coming. For these contributions to more effective agency operations, we wish to express our appreciation to the Auditor General and his staff. While there are obvious disagreements on specifics, it is clear that there is unanimity in the desire to make the Board's operations as effective, and as efficient, as possible.