SPECIAL STUDY

THE HEALTH REGULATORY SYSTEM

Report to the Arizona Legislature
By the Auditor General
December 1995
Report #95-13

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December 1, 1995

Members of the Arizona Legislature

The Honorable Fife Symington, Governor

Board Chairpersons and Executive Directors
Arizona Health Regulatory Agencies

Transmitted herewith is a report of the Auditor General, A Special Study of The Health Regulatory System. This study was conducted pursuant to a May 17, 1995, resolution of the Joint Legislative Audit Committee. The primary charge of this study was to determine whether an alternative regulatory structure for Arizona's 23 regulated health professions could better protect the public while ensuring due process.

Arizona can take significant steps to better serve and protect the health care consumer while retaining the strengths of the present system. An extensive search for alternative regulatory structures revealed that peer review (boards comprised of members of a profession who license and discipline others in their profession) is used universally, despite ongoing problems. Yet Arizona can join other governments on the forefront of regulatory reform, such as Ontario, Canada, Queensland, Australia, and the States of Massachusetts and Rhode Island, both by increasing public involvement in complaint decisions and by clearly establishing the rights of consumers to broad and open access to information on health professionals and the right to be heard during the complaint process.

Specifically, our report recommends statutory changes to: 1) create an all-public complaints review board to hear citizen appeals of board decisions to dismiss complaints, 2) increase public membership to 50 percent on all licensing boards, 3) guarantee citizens the right to comprehensive information on the disciplinary history of health professionals and 4) formally establish the importance of the complainant in the regulatory system, giving the complainant the right to notification of how the complaint is being handled and the right to be heard before decisions are made.

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

This report will be released to the public on December 4, 1995.

Sincerely,

Douglas R. Norton
Auditor General

Enclosure

SUMMARY

Pursuant to a May 17, 1995, resolution of the Joint Legislative Audit Committee, the Office of the Auditor General has conducted a special study of the Arizona health regulatory system. The primary charge of the study was to determine whether an alternative regulatory structure would better protect the public while ensuring due process.

The State has an important role in the regulation of health professionals because it is the only entity that can grant and revoke a license to practice. Arizona currently regulates 23 health professions. Nineteen of these are governed by volunteer boards, while the other four are regulated by the Department of Health Services. Our study found that the public could be better protected by increasing public representation in board decisions. Additionally, citizens should have better access to information about regulated professionals, and should be more involved in the complaint process.

The Legislature Can Better Protect the Public by Increasing Public Representation in Board Decisions (See pages 5 through 13)

Despite the problems of peer review systems, peer review (boards comprised of members of a profession who license and discipline others in their profession) is universally used. Arizona uses a peer review system to regulate its health professions. However, researchers and citizen advocacy groups claim peer-dominated boards do a poor job of protecting the public and public confidence in the peer review system is undermined. In their efforts to improve their peer review systems, other states have made various changes, such as slightly increasing the proportion of public board members, consolidating board activities, or forming an oversight agency. However, these changes have not altered the fundamental process by which a board considers evidence and decides whether disciplinary action is warranted.

Increasing public membership on the health regulatory boards to 50 percent, along with improving board member selection and training, may improve public protection and will introduce public oversight at the fundamental point where board decisions are made. The State of Rhode Island's medical licensing board, recreated in 1987, has 50 percent public membership. In addition, Ontario, Canada's health reform efforts included increasing public representation on its health regulatory boards from about 25 percent to between 42 and 49 percent. However, to ensure effective public representation, the State needs public board members who represent a diversity of interests and are well-trained.

In addition, a public review board could further strengthen public oversight. Currently, Arizona's health care consumers have no ability to request a review when health regulatory boards dismiss their complaints. Only the licensee can request the health boards to review

their decision. However, Ontario, Canada, has an all-public appeals board that provides the public a check in the complaint process, allowing complainants to appeal complaints they believe were not adequately investigated. If the Legislature wanted to broaden the responsibilities of the public review board beyond complaint review, the board could improve the system in several additional ways. For example, a review board could recruit and train public members on the licensing boards, monitor licensing board performance, and foster better public protection and perception.

Arizona Citizens Should Have Broad and Open Access to Information on Regulated Professionals (See pages 15 through 22)

Many consumers are denied access to the information they need to make informed decisions about health care providers. Health regulatory boards maintain detailed information on health professionals' education, licensing, and disciplinary history; however, much of the information is kept confidential and never disclosed to the public. For example, many health boards do not release information regarding pending or dismissed complaints.

Even the limited information provided is not easy to obtain due to board-created administrative barriers. For example, few boards provide disciplinary information on licensees over the phone. We visited ten Arizona health regulatory boards to determine what disciplinary information is provided to the public and how easy the information is to obtain. These visits revealed board procedures impede the public's efforts to obtain requested information. For example, three boards required us to schedule an appointment and return at a later date. Four of the ten boards required us to complete information request forms. One board would not allow the public to view the licensee's disciplinary information without direct supervision by board staff. Arizona's health regulatory boards should eliminate these administrative barriers and make disciplinary information easily accessible to consumers.

To further improve public access and protection, boards should take steps to educate the public about their services. Many people do not know the function of a medical board, or that they can obtain information and file complaints with one. Other states and regulated industries have developed innovative ideas for educating the public such as 800 numbers, information plaques displayed in professionals' offices, and newspaper, library, and Internet listings of disciplinary actions.

Boards Need to Involve the Complainant in the Complaint Process (See pages 23 through 26)

Arizona's health regulatory boards too often show little regard for the complainant. A survey of nine health boards revealed complainants are provided little, if any, information on the status of their complaints. In fact, two boards do not even inform the complainant that the

complaint was received . In addition, complainants are often not provided the opportunity to provide testimony during investigations, open meetings, or settlement agreements. The board's ability to identify and take action against incompetent or unethical practitioners depends largely on consumer reports of substandard care. However, if the public becomes so alienated by the state regulatory system that citizens no longer file complaints, the entire system fails. Statutory changes are needed to ensure complainants are given adequate notification regarding complaints and have a voice in the complaint process.

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INTRODUCTION AND BACKGROUND

Pursuant to a May 17, 1995, resolution of the Joint Legislative Audit Committee, the Office of the Auditor General has conducted a special study of Arizona's health regulatory system. Specifically, we were asked whether there is a better system to protect the public from incompetent health practitioners. The purpose of this special study differs markedly from prior Auditor General sunset reviews of individual boards in that it questions the viability of the regulatory approach used across boards, rather than the operations of an individual board.

The State has an important role in the regulation of health professionals as it is the only entity that can grant and revoke a license to practice. Health care consumers who believe they have experienced substandard care can pursue a complaint with a hospital or health plan, or file a civil lawsuit. Yet neither of these remedies protect other members of the public who might use the professional's services in the future. Additionally, the State has an important role in providing citizens with open access to information on health professionals so that citizens can make informed choices.

Across the country, however, citizens and public officials are dissatisfied with the performance of state health regulatory structures. These systems rely on members of the profession to discipline their peers and have changed little since their inception in the early 1900s. The primary and ever-present criticism of the system is that peer boards are reluctant to take disciplinary action and tend to protect the practitioner rather than the consumer.

This report presents the results of our research to identify alternatives.

Arizona's Health Regulatory System

As of October 1995, Arizona regulated 23 health professions. Nineteen of these are governed by volunteer boards comprised primarily of members of the regulated profession. The other four professions are regulated by the Department of Health Services.[1] Both professional and public board members are appointed by the Governor according to statutorily defined composition requirements.

The boards' primary responsibility is to protect the public by licensing and disciplining professionals. Boards accomplish this through a state agency that reports to the board. Thus,

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(1) Midwives, hearing aid dispensers, speech-language pathologists, and audiologists are regulated by the Department of Health Services (DHS). While hearing aid dispensers, speech-language pathologists, and audiologists have a peer board that serves in an advisory capacity, the DHS Director has final authority for licensing and enforcement decisions.

board staff check credentials, receive and investigate complaints, maintain associated files and computerized data, and provide the public with information on health professionals. Table 1 (see page 3) provides an overview of Arizona's boards. The largest, the Board of Medical Examiners, has 43 staff, regulates over 12,000 physicians, and handles over 1,000 complaints annually. In contrast, some boards have only one staff member and handle fewer than five complaints annually.

Arizona's boards have significant power and autonomy. Boards have authority to deny licensure as well as to limit, suspend, or revoke a practitioner's license. Additionally, in Arizona, the Executive Director of the agency reports to the board rather than another government office. Consequently, the board is responsible for the effective operations of the agency in addition to its licensing and disciplinary decisions. Board operations are funded by licensing fees and at least 10 percent of all revenues revert back to the State's general fund.[1]

Study Scope and Methodology

The primary charge of this study was to determine whether an alternative regulatory structure would better protect the public while ensuring due process. Most of our work involved an extensive examination of regulatory structures in other states, countries, and industries. For a more detailed description of our methods, see pages 32 and 33. Our work in Arizona boards consisted primarily of reviewing prior audits and surveying and reviewing information from 21 boards.[2] When additional information was necessary, we gathered it from a sample of nine boards. These nine boards, listed in the footnote on page 23, included the major medical boards as well as several smaller boards.

To identify alternative regulatory structures, our research included the following:

- Review of books, journal articles, research studies, and reports from governments or other organizations;
- Interviews with national regulatory organizations, consumer advocacy groups, authors of journal articles, academic and policy experts, and health professionals from other states and countries;[3] and

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(1) For the four professions regulated by the Department of Health Services (midwives, hearing aid dispensers, audiologists, and speech-language pathologists), 100 percent of licensing fees revert to the State's general fund.

(2) Speech-language pathologists and audiologists became regulated in the 1995 legislative session and were not yet staffed at the time of our audit work. Thus, they were not included in our surveys.

(3) Our comparative research in health regulatory systems focused primarily on major medical boards such as medical examiners, nursing, pharmacy, and dental.

Table 1

Health Professions Regulatory Agencies
Year Ended June 30, 1995
(Unaudited)

Health Professions Regulatory Agencies	Full-time Equivalents	Expenditures	Licensed Practitioners	Complaints Received	Complaints Resolved[a]	Complaints Pending[b]	Average Months to Resolve a Complaint	Practitioner Board Members	Public Board Members	Profession-Related Board Members	Total Board Members
Behavioral Health Examiners	7.00	$ 356,281	5,004	42	61	22	8	8	4		12
Chiropractic Examiners	4.00	207,200	2,336	82	73	30	12	3	2		5
Dental Examiners	9.00	591,700	4,749	332	608	114	3	6	3	2	11
Dispensing Opticians	0.80	54,000	780	30	30	15	1	5	2		7
Hearing Aid Dispensers, Audiologists and Speech-Language Pathologists[c]	2.00	60,000	364	36	12	24	3				[d]
Homeopathic Medical Examiners	0.50	30,000	65	4	4	0	4	4	2		6
Medical Examiners	42.50	2,844,000	12,600	1,149	1,726	1,700	12	8	3	1	12
Medical Radiologic Technology Examiners	2.00	102,274	4,239	30	23	12	4	4	2	3	9
Midwifery[c]	1.00	41,456	46	4	2	2	3				[f]
Naturopathic Medical Examiners	1.00	57,200	180	4	0	4	3	3	2		5
Nursing	27.00	1,108,300	68,384	624	350	586	14	7	2		9
Occupational Therapy Examiners	2.00	88,600	1,221	6	6	4	2	3	2		5
Optometry	1.75	91,494	586	34	29	20	3	4	1	1	6
Osteopathic Examiners	5.50	290,910	1,508	143	139	135	4	5	2		7
Pharmacy	12.00	649,000	5,129	91	73	25	3	5	2		7
Physical Therapy Examiners	1.00	73,300	1,976	27	19	8	2	3	2		5
Physician Assistants	(e)	(e)	417	33	22	14	7	2	1	6	9
Podiatry Examiners	1.00	53,200	287	36	33	3	1	3	2		5
Psychologist Examiners	3.00	168,545	1,370	52	42	31	4	7	2		9
Respiratory Care Examiners	3.00	128,109	3,684	58	52	6	1	3	2	2	7
Veterinary Medical Examining	3.00	174,800	1,450	86	66	20	2	5	3		8
Total	129.05	$7,170,369	116,371	2,903	3,380	2,768	N/A	88	41	15	144

(a) Amounts listed may contain resolutions of complaints filed prior to fiscal year 1995.

(b) Pending complaints may have been filed prior to fiscal year 1995.

(c) Programs within the Arizona Department of Health Services rather than separate agencies.

(d) Hearing aid dispensers, audiologists, and speech-language pathologists have a committee that is "advisory" in nature. The committee is made up of eight profession-related members, two public members, and the Director of the Department of Health Services.

(e) The staffing and expenditures of the Board of Physician Assistants are included with the Board of Medical Examiners' budget.

(f) Profession has no board and is overseen by the Department of Health Services.

Source: Arizona Revised Statutes and Board responses to a survey conducted by the Auditor General's Office.

- Interviews with representatives of regulated industries that are not health-related.

Our research to examine the practices of Arizona health boards included:

- Mail and telephone surveys of board officials,
- Review of policies and other board materials,
- Attendance at board meetings,
- Review of disciplinary files available to the public, and
- Review of prior Auditor General reports.

This study presents findings and recommendations in the following three areas:

- Changing Arizona's regulatory structure to increase public involvement in board disciplinary decisions,
- Ensuring open public access to board information on licensed practitioners, and,
- Ensuring that citizens filing complaints are notified of complaint status and have the right to be heard.

Additionally, at the direction of the Joint Legislative Audit Committee, we also considered eight questions addressing the following four general topics:

- Should all boards operate under a single set of statutes?
- Are current statutes adequate to protect the public?
- Should the boards or certain board functions be consolidated? and
- Should complaint handling and investigation be standardized across the system?

Our response to these issues is presented in the final report section entitled "Answers to Legislators' Questions" (see pages 27 through 41).

The Auditor General and staff express appreciation to the various boards, executive directors, and staff for their cooperation and assistance throughout the study.

FINDING I

THE LEGISLATURE CAN BETTER PROTECT THE PUBLIC BY INCREASING PUBLIC REPRESENTATION IN BOARD DECISIONS

To improve Arizona's peer review system, more public perspective is needed when decisions are made. Despite years of criticism, peer review continues to be the system used to regulate health professions. Professional peers are considered to be best qualified to judge the appropriateness of another health professional's treatment decisions. However, peer boards continue to be criticized for their reluctance to take disciplinary action. Other states' efforts to change the peer structure have had little impact on protecting the public from incompetent health professionals. Still, Arizona can build on changes implemented in other states.

History of professional regulation and role of the State — Traditionally, government has played a major role in regulating professionals in order to protect the public from physical and financial harm at the hands of incompetent or unethical practitioners. For over 100 years, states have regulated health professions through peer boards. These peer review boards develop minimum qualifications for entry into a profession, establish standards to measure acceptable professional conduct, and take disciplinary action against violators of professional standards. Additionally, state boards provide the public with information on health professionals' credentials and disciplinary history.

While other systems help regulate health professionals, the State still plays a vital role in protecting the public. Recently, other entities have become more involved in regulating professions. For example, hospitals and health insurance companies now proactively review practitioners' records and procedures in an effort to improve the quality of their services. However, the results of these reviews are not generally available to the public.[1] In addition, consumers increasingly seek compensation from the courts but neither hospitals nor the courts can suspend or revoke a practitioner's license.

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[1] Although federal law requires hospitals to report any disciplinary sanctions taken against practitioners to the National Practitioners Data Bank, a 1995 U.S. Department of Health and Human Services' Inspector General report found that 75 percent of the nation's hospitals fail to report this information. However, even if it was reported, the public does not have access to this data bank.

Despite Problems, Peer Review Continues to Be Necessary for Health Regulation

Nationally, and internationally, peer boards have been criticized as tending to protect the professional rather than the public. However, our search for alternative health regulatory structures revealed that peer review is used universally. Due to their education and expertise, peer professionals need to be involved in evaluating treatment decisions.

Peer-dominated health boards harbor serious deficiencies — Although peer review is the most common health profession regulatory system, it has a myriad of problems that negatively impact its effectiveness. According to researchers and citizen advocacy groups, boards in general do a poor job of protecting the public. Peer board members are thought to be reluctant to discipline one of their own, either out of fear of ruining someone's livelihood, or out of a false sense of professional courtesy. For example, according to the Public Citizen Health Research Group, only about one-half of 1 percent of the nation's doctors ever face any disciplinary sanctions, although it has been estimated that from 1 to 6 percent of all practicing doctors provide substandard care.

In addition to the conflict-of-interest problem, consumer advocates as well as health policy experts note several other problems with peer review that are listed below. Further, our past performance audits have identified the same problems in Arizona.

- **Disregard for Consumers** — As discussed in more detail in Finding III (see pages 23 through 26), consumers often are provided no voice in the regulatory and disciplinary process of their health care provider. In many cases, boards do not adequately notify complainants regarding their complaint status, and do not allow complainants to speak on their own behalf at board meetings. Further, consumers have only limited access to information about their practitioners.

- **Insufficient Investigations** — Investigative efforts are often of poor quality, and many boards are reluctant or unable to devote adequate resources to this important function.

- **Complaint Backlogs** — Consumers may wait a year for a board to handle their complaints. Both Arizona's Board of Medical Examiners and Board of Chiropractic Examiners currently take approximately one year to resolve a complaint, and the Board of Behavioral Health Examiners takes eight months on average to resolve a complaint. Further, some Arizona boards have significant numbers of complaints pending resolution.

As a result of these problems, public confidence in the peer board is undermined. A 1991 study of 500 Utah residents by University of Utah professors Susan Chesteen and Joan Lally indicates that only 3 percent of the 105 respondents believed that licensing boards will protect them from incompetent doctors. The authors of this study described the public as "disenchanted, uninformed, distrustful, and in a sense defeated."

Peer review remains necessary — Despite the problems of peer review systems, our studies of health structures in other states and countries, as well as theoretical models yet untried, indicate that peer review is universally used to regulate health professionals. Due to their education and technical expertise, professional peers are considered the best qualified to judge another's decisions in the practice of health care.

Professional education and expertise are essential to evaluate many medical or other treatment decisions. For example, members of the general public are unlikely to have the knowledge needed to judge whether a medical procedure was handled improperly, or to know if a suicidal patient should have been prescribed a certain medication over another. Additionally, when we attended one board meeting, certain evidence that was brought to the meeting involved x-rays that only a member of that profession would be fully able to interpret. These brief illustrations demonstrate that the peers' technical expertise enables the board to understand the intricacies of often complex procedures and decisions.

Modifications to System Have Not Impacted Board Decision-Making

In their efforts to improve their peer review systems, other states have made various changes. States have modified their health regulatory systems by slightly increasing the proportion of public members, consolidating board activities, or forming oversight agencies. However, these changes do not alter the fundamental process by which a board considers evidence and decides whether disciplinary action is warranted.

The addition of public members to peer boards — States have tried to impact board decisions by slightly increasing the proportion of public members on boards. Although the evidence regarding its effectiveness is inconclusive, consumer advocates and experts continue to call for increased public membership, asserting that significant effects will not be realized until the proportion of public members is higher, and selection and training are improved.

Beginning in the 1960s and 1970s, advocates claimed that boards run exclusively by the professionals they regulate may place the professions' interest above the public's. Legislators responded by adding a small number of public members to boards. However, in the majority of medical boards, there are only one or two public members per board. In Arizona's medical boards, such as the Board of Medical Examiners, the Board of Nursing, and the Board of Osteopathic Examiners, public members are 3 of 12, 2 of 9, and 2 of 7 total members, respectively.

We evaluated five studies that attempted to determine public member effectiveness and the conclusions are mixed. While four of these studies conclude that public members make no significant differences in board performance, one study conducted in 1990 suggests that increased proportions of public members are associated with stronger board disciplinary

sanctions.[1] However, most studies are only preliminary. Public membership on boards is relatively new and researchers have typically only studied results of boards where, although increased, public members are still the minority. Nationally, percentages of public members on medical boards range from 0 to 46 percent, with a median of just under 22 percent. In Arizona, public members comprise from 11 percent to 40 percent of total board membership, with a median of 29 percent.

In order to significantly affect board decisions, it may be that public members on boards must feel equal to the professional members. Most often public members are greatly outnumbered and neither trained nor encouraged to act as advocates for the public. Additionally, consumer advocates from the Citizens Advocacy Center and experts from the Pew Health Professions Commission suggest that traditionally, public members selected to serve on peer review boards do not necessarily represent consumer advocates. Noted expert Benjamin Shimberg states that since public members are appointed out of political patronage, they are more apt to have little or no commitment to consumer advocacy. To ensure that public board members were selected from a diverse pool of applicants, Ontario, Canada, ran advertisements for public board positions in newspapers and other publications. According to the manager of the unit that handles public board member recruiting, this strategy has proven effective in establishing diversity among the public members.

Structural modifications leave decision-making unchanged — In addition to increasing the number of public members, states have attempted to improve health regulation by consolidating board functions or creating oversight agencies. While these changes may succeed in achieving increased accountability and control, such structural changes have left board decision-making processes essentially unchanged.

To describe the general organizational structure of health regulatory boards, it is helpful to understand the degree of autonomy with which they operate. When states consolidate board functions or create an oversight agency, they are removing certain powers and the autonomy of health regulatory boards. Boards with a consolidated investigation function, for example, no longer control this activity, but share the function with other boards. Boards reporting to an oversight agency must have their disciplinary sanctions reviewed by the agency, while an autonomous board would be able to issue its own disciplinary sanctions or conduct its own investigations. The costs and benefits of consolidating and creating oversight agencies are discussed further on pages 33 through 38.

Consolidation — Our research indicates that many states have board structures more consolidated than Arizona's. Some states consolidate minor administrative functions such as computer and personnel systems to take advantage of economies of scale and reduce duplication between boards. However, other states consolidate major functions like investigations to reduce board control and power. For example,

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(1) Grady, Elizabeth and Nichol, Michael. Structural Reforms and Licensing Board Performance. *American Politics Quarterly*. July 1990, 18(3), p. 376.

- Hawaii's complaint process is shared among 45 boards, commissions, and programs, and was implemented to diminish board control over investigations and to help reduce the boards' complaint backlog. Additionally, New York's and Virginia's investigation functions are also centralized between boards.

- Texas consolidated some board functions such as licensing and certifying professionals to lower the overhead expenses of many smaller boards. Officials recognized that many activities were being duplicated among these boards.

Although consolidating board functions is theoretically appealing, it has not proven to protect the public any better than completely autonomous boards. In fact, our analysis of three different disciplinary rankings showed that the most consolidated states are often associated with fewer disciplinary sanctions per thousand licensees than other, autonomous boards.[1] Additionally, in one of the most comprehensive studies on centralization, the authors concluded that increased consolidation was associated with fewer disciplinary actions.[2] Regardless of whether some board functions are consolidated, decisions to discipline are still made by the peer members in the same manner as autonomous boards.

Oversight agencies — Just as some states have consolidated health regulatory functions to improve health regulation, others have established an oversight agency with powers above those of the individual boards. As illustrated below, some states use an oversight agency as the final authority for reviewing all board disciplinary actions.

- In Utah, disciplinary authority is vested in the Division of Occupational and Professional Licensing, a state agency. Although the individual boards are consulted for technical assistance, the Division's director has final disciplinary decision-making authority.

- The director of the Illinois Department of Professional Regulation also has final disciplinary authority. While Illinois' boards issue recommendations of disciplinary sanctions to the director of the Department of Professional Regulation, the director makes the final disciplinary decisions.

Similar to consolidating board functions, establishing an oversight agency also has not been shown to increase public protection, possibly because the peers' influence over the process remains unchanged. Even when an oversight agency is established, peer members continue to influence disciplinary decisions in much the same way as they do on autonomous boards, so improved board performance may not result. According to recent Federation of State

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(1) Our analysis used three data sources: the 1985-87 and the 1995 Federation of State Medical Boards Annual Board Action Statistical Package, and a 1993 Public Citizen report entitled *"Comparing State Medical Boards."*

(2) Grady and Nichol, Structural Reforms and Licensing Board Performance, p. 389.

Medical Board disciplinary rankings, both Illinois' and Utah's boards take fewer disciplinary actions against physicians than many other states' boards. While these states may have achieved greater accountability and control, officials of both states expressed the opinion that the oversight agency tends to uphold the board's disciplinary decisions.

The Legislature Can Make Changes to Introduce More Public Representation into board Decision-Making

While retaining the strengths of peer review, the Legislature can improve public protection by introducing public oversight at the fundamental point where board decisions are made. Substantially increasing public membership on boards, along with creating an all-public complaints review board, will better balance professional and public interests.

Stronger public membership on boards will balance decisions — Arizona can take a dramatic step in the public interest by increasing public membership on all health boards to 50 percent. The State of Rhode Island's medical licensing board, recreated in 1987, has 50 percent public membership. According to the Chief Administrative Officer of Rhode Island's Board of Medical Licensure and Discipline, the physician community expressed reservations about the high percentage of public members; however, these feelings have changed as the professional board members have seen the public members making competent disciplinary decisions.

Ontario, Canada, has also greatly increased public representation on its health regulatory boards, increasing the percentage of public members on individual boards from about 25 percent to between 42 and 49 percent. In some cases, public members may be the majority on the pivotal committees that make disciplinary decisions. For example, the boards' disciplinary committees are comprised of between three and five members; at least two of whom must be public members.

To ensure effective public representation, Arizona needs public board members that represent a diversity of interests and are well-trained. Experts indicate that merely appointing public members to boards is not enough to assure that they will act in the public's interest. Health regulatory expert and consumer advocate Benjamin Shimberg states that recruitment is the key to success, and that public members should not be just anybody seeking a chance to participate. Potential applicants should have a strong interest in serving on the board, be willing to invest extensive time, and be able to work harmoniously with the professional members. In addition, experts suggest that public members be from diverse backgrounds and geographical locations, and be well-trained in their role to represent the public.

Increasing public membership on Arizona's health boards to 50 percent will require statutory changes and possible phased-in implementation.

A public review board could further strengthen public oversight — Our literature review and interviews with experts reveals that the public is often dissatisfied with board decision

processes, especially since most complaints are dismissed informally with no public input. As further discussed in Finding III (see pages 23 through 26), Arizona health care consumers often have no voice, and ultimately, no insight into the process by which boards decide whether a complaint will be dismissed or acted upon. An all-public complaints review board could provide recourse to the complainant and may increase public confidence in the overall system.

Board decision-making processes are generally closed to public oversight. Very few complaints result in a formal hearing before the board wherein testimony is taken and parties are legally represented. Typically, board staff investigate the case and prepare a case summary for the board to consider. The board may dismiss the case, or may decide to issue a letter of concern which is not a formal disciplinary action. The board may also take formal disciplinary action without a formal hearing. For example, in a settlement agreement with a doctor, the board may impose a formal disciplinary action to which the professional consents. While all of these cases appear on the board agenda for an open meeting where final action is taken, the decision- making processes, including information about the quality and extensiveness of the investigation, are open only to the board and its staff.

Unlike the rights afforded to the professional, the complainant has no ability to request a review of the case. In the regulatory statutes, because a case is an action by the State against the professional, the complainant is not a party to the case. While statutes currently give the professional 30 days in which to ask the board to review its decisions, the complainant has no right to request a review.

Unlike Arizona, citizens in Ontario, Canada, can appeal complaints that are dismissed or possibly handled inappropriately by a licensing board. Ontario's all-public Health Professions Board is comprised of 12 to 20 members and reviews dismissed complaints upon request of a complainant.[1] After reviewing a complaint, the Board may uphold a licensing board's decision on the complaint, direct the licensing board to further investigate, or require that the complaint proceed to a formal hearing. Additionally, if the licensing board has not resolved the complaint within the 120-day requirement, the Health Professions Board can conduct its own complaint investigation by contracting out for investigative assistance.

An all-public review board could benefit Arizona's health regulatory system in several ways:

- **Increased public confidence in the system** — By opening the currently closed investigation and decision-making processes to public oversight, there would be a check on peer boards' tendency to protect their professions. Increased public confidence may also benefit the boards. Currently, boards may be criticized even when their decisions are appropriate. Knowing that the system has a public review component, citizens in general may be less critical of board decisions not to pursue a complaint or take action.

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(1) After extensive research nationally, including contacting 21 states, (listed on page 33), we found Ontario, Canada's all-public review board unique in its ability to interject public oversight.

- **Improved quality of investigations** — The review board will examine complaint investigations from all 23 health boards. The thoroughness and quality of investigations may improve solely due to the existence of a public review process.

- **Improved public protection** — The public review board may result in discipline to professionals who otherwise may have avoided such action. While in many cases the public review board may uphold a licensing board's decision, in some cases professionals may now be identified for discipline who previously could have had their cases dismissed.

To implement a public review board in Arizona, the Legislature would need to define the complaints that could be reviewed by the public board. The Legislature should consider making complaints resulting in dismissal or a letter of concern subject to review *unless the decisions resulted from a formal disciplinary hearing.* New statutory language can be added in sections dealing with informal board processes that would make dismissals and letters of concern subject to review by the review board.

Statutes will also be needed to specify the duties and authority of the public complaint review board. The Legislature should consider giving the review board authority similar to that given Ontario's all-public review board including:

- Authority to review the adequacy of the complaint investigation brought for review

- Authority to direct the licensing board to reopen the investigation, conduct new interviews, consider portions of the case previously not considered, and reconsider its decision

- Authority to uphold the licensing board's decision

- Authority to interview parties or witnesses to the complaint

- Authority to contract to conduct its own investigation into cases, if necessary.

As defined, the public board's jurisdiction would apply to informal dismissals or letters of concern, but would not apply to licensing board decisions made after a formal hearing. The public board also could not direct that a complaint receive a formal hearing.

Whatever duties it is assigned, a review board would need funding for certain functions: a small staff to handle administration; a facility independent of the health boards; and funding to contract for investigative services, should it decide to conduct its own independent investigation of a complaint. Board-related expenditures could be funded through a small surcharge attached to all Arizona health professionals' licensing and renewal fees. According to our analysis based on fiscal year 1995 figures, an increase of only $3 to $5 per each licensee in the State annually would generate from about $350,000 to $580,000.

Finally, recruitment, selection, and training of the review board members will be of critical importance. As stated earlier, consumer advocacy groups and health regulatory experts stress that for public members to be effective, recruitment, selection, and training must be improved. The Legislature may want to consider specifying member selection and confirmation procedures.

Other duties for the public review board — In addition to reviewing dismissed complaints and board investigations, the Legislature may want to give the public review board oversight responsibilities such as:

- **Selection and training of public board members** — The public oversight board could recruit, select, and train the public members on the health regulatory boards. As discussed earlier, selection may be critical to increasing public perspective on the peer boards. New York's public oversight board selects all licensing board members.

- **Monitoring how quickly boards handle complaints and establishing and monitoring other performance indicators** — A public review board can become a focal point for accountability by reviewing, evaluating, and reporting on measures of board performance.

- **Advising the Legislature and/or Governor on consumer concerns regarding health care regulation** — An all-public review board may be effective at identifying and advocating for consumer interests at the legislative and executive levels.

Although these additional responsibilities would increase oversight over the health boards and possibly strengthen their performance, they are more costly. However, experts warn that an oversight body's effectiveness is directly related to the extent of its responsibilities. Therefore, the Legislature should weigh the costs with the potential benefits to the system when determining the amount of authority delegated to a review board.

RECOMMENDATIONS

1. The Legislature should consider increasing public membership on all health regulatory boards to 50 percent.

2. The Legislature should consider implementing a public review board to give consumers an avenue for additional review of their complaints and to increase accountability and public confidence. To further increase oversight, the Legislature may want to give this board additional powers and duties such as selecting public members for licensing boards and monitoring licensing board performance.

FINDING II

ARIZONA CITIZENS SHOULD HAVE BROAD AND OPEN ACCESS TO INFORMATION ON REGULATED PROFESSIONALS

Recently, an Arizona newspaper published an article on an Arizona physician. If, after reading this article, a concerned consumer decided to visit the Board of Medical Examiners to find out more about this doctor, he or she would learn that this doctor received nine letters of concern from the Board between 1987 and 1992. Unfortunately, this consumer would leave the Board unaware that the physician also has 11 other complaints that were dismissed by the Board and 15 pending complaints. Several of the pending cases allege malpractice and unnecessary surgery.

Many consumers are denied access to the information they need to make informed decisions about health care providers. Health regulatory boards maintain detailed information on health professionals' education, licensing, and disciplinary history; however, much of the information is kept confidential and never disclosed to the public. A clear and comprehensive statute is needed to guarantee the public's right to obtain all pertinent information maintained by health regulatory boards. In addition, the boards should remove administrative barriers that impede consumer awareness. Finally, outreach programs are needed to increase public awareness of the health regulatory boards.

Public Has Limited Access to Board Information

Arizona's health regulatory boards currently release limited complaint information on licensees to health care consumers. Several other states have taken steps to provide increased information to the public. The Legislature should consider revising applicable health regulatory statutes to improve the information available to Arizona citizens.

Public receives limited and varying degrees of information — Despite the health boards' role to protect the public, consumers do not have access to information needed to make informed health care decisions. Health regulatory boards maintain a great deal of information about

licensees in their files;[1] however, much of it is not disclosed to the public. According to survey responses from 21 health regulatory boards,[2] some boards only release disciplinary information on final board actions, while others release the number and nature of both dismissed and pending complaints in addition to disciplinary actions.[3] For example, the Board of Nursing only discloses information on complaints that resulted in a disciplinary action or how many letters of concern a practitioner may have. However, the Naturopathic Medical Examiner's Board provides information on disciplinary actions, letters of concern, dismissed cases, and pending cases. Only one of the boards surveyed releases information on a licensee's medical malpractice experience or criminal charges and convictions. Figure 1 on page 17 illustrates the disparity of information provided by boards.

The disparity in information released results from various interpretations of confidentiality statutes. Statutory provisions common to most Arizona health boards prevent the release of patient information and investigation files to protect the patient's identity. However, boards have broadly interpreted this to include information on pending and dismissed cases. In fact, some boards believe statutes prevent them from informing the public of any current complaints against a practitioner. The vague statutory language permits boards to withhold this significant information without violating the law.

However, our analysis of statutes indicates that boards can release information about the number and nature of pending complaints, dismissed complaints, malpractice settlements, and actions taken against practitioners by other associations. In fact, legal counsel to one health regulatory board advised that it may release the number of pending complaints to the public, but board staff continue to keep the information confidential.

Other states provide increased information — In recent years, there has been a growing trend toward increased access to board information. In fact, a Massachusetts advisory committee recently proposed that their Board of Registration in Medicine share a greater portion of its information "with the public it is chartered to serve." Boards in several other states, including Massachusetts, have taken, or are considering taking, steps to provide increased information to the public. For example,

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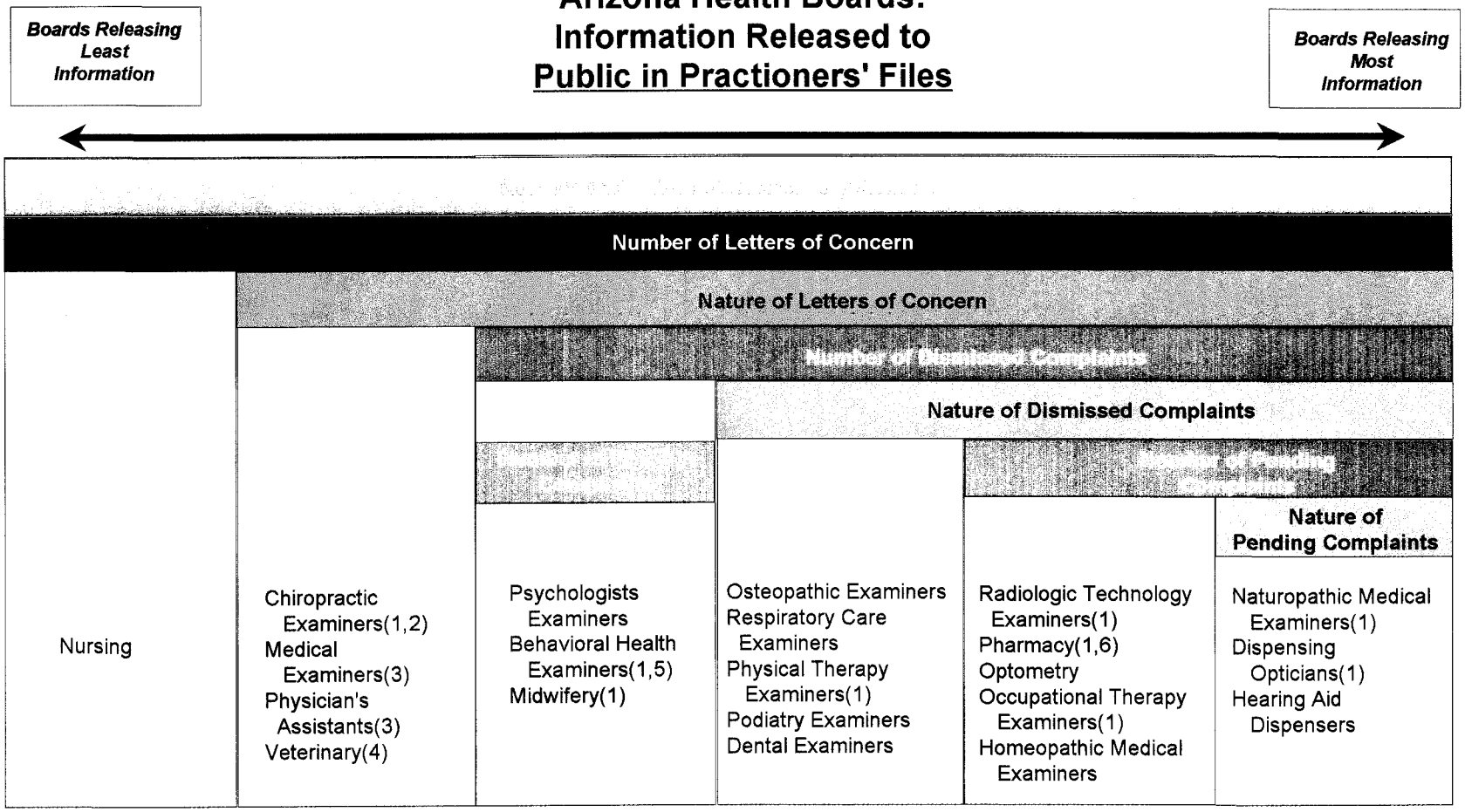
(1) Much of the information maintained is generated by the health regulatory board, such as licensing credentials, disciplinary actions, and general complaint information. Other information is generated elsewhere and reported to the board, usually because of a statutory or regulatory requirement. For example, malpractice information is reported by insurers, attorneys, and others. In addition, health care institutions are sometimes required to report disciplinary actions they take against health professionals.

(2) We developed a written survey to obtain budget, staffing, complaint/investigation, and disciplinary information from all 23 boards. However, speech-language pathologists and audiologists are not yet staffed.

(3) The following comprise disciplinary actions: revocation, suspension, probation, civil penalty, and censure.

Figure 1

Arizona Health Boards: Information Released to Public in Practioners' Files



1. Board does not have statutory authority to issue Letters of Concern.
2. The number of pending complaints, and the number and nature of dismissed complaints can be obtained through board minutes, complaint logs, board strategic plans, and performance measures on budgets.
3. The number of dismissed complaints is available through the minutes. The Joint Board of Physicians' Assistants reports it is revising its system to make information accessible to the public.
4. The number of dismissed and pending complaints are listed in the annual report. The board is revising its systems to make the information available to the public.
5. The board's administrative rules state that the nature of dismissed complaints is confidential.
6. Information on the nature of dismissed complaints is not in the disciplinary file provided to the public, but will be provided to the public if specifically requested.

Source: Board responses to survey conducted by Auditor General staff.

- According to a 1992 report by the Citizen Advocacy Center, nursing boards in seven states provide the number and nature of charges after an investigation has taken place, but before the board has taken final action. Only three of Arizona's health boards release information on the number and nature of pending complaints.

- The medical boards of Hawaii, Massachusetts, California, and Washington release the number and nature of dismissed cases. As illustrated in Figure 1 (see page 17) 13 of Arizona's health regulatory boards also provide this information; however, Arizona's largest health regulatory board, the Board of Medical Examiners, does not.

- A Massachusetts Advisory Committee formed to review citizens' access to health regulatory information recommended that their Board of Registration in Medicine release information about criminal convictions, disciplinary actions taken by other health organizations, and malpractice settlements.

- The California Medical Board releases information on malpractice settlements totaling more than $30,000.

Since Arizona boards interpret the statutes differently, the statutes should be clarified so all boards are required to provide the same information to the public. Although no one state provides complete information, Arizona could incorporate models used by several other states. Ideally, statutes would clearly state that all boards will provide the public with open access to disciplinary actions, the number and nature of letters of concern, and pending and dismissed complaints; as well as actions reported to the board by other entities encompassing the practitioner's history including malpractice settlements, criminal convictions, and disciplinary actions taken by hospitals or health plans.[1]

Administrative Barriers Impede the Public's Ability to Obtain Information

Even the limited information provided is not easy to obtain due to board-created administrative barriers. Few boards provide disciplinary information to the public over the telephone. In addition, we visited ten health regulatory boards to review disciplinary information on licensees and found that the public is not being well-served, and could be intimidated by board staff and policies. Boards should eliminate procedures that discourage public access to information.

Limited information available by telephone — Many health regulatory boards do not provide disciplinary information about a licensee over the phone. These boards require

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(1) Arizona statutes do not require courts or law enforcement agencies to report criminal conviction information to health regulatory boards, although at least one board indicated it does receive this information.

the public to either visit their offices or submit a written request for information. Since the phone is a quicker and more convenient method for the public to contact boards, access by telephone to a summary of a professional's history would better serve consumers. One board, the Board of Medical Examiners, states they will provide disciplinary information over the phone. However, their computerized telephone messaging system informs the public that disciplinary information is **not available** by phone and instructs the caller to either submit a written request or schedule an appointment to view a licensee's file.

Other barriers to obtaining information — Even if someone takes the time to visit the board office, board procedures impede efforts to obtain requested information. We visited ten Arizona health regulatory boards to determine what disciplinary information is provided to the public and how easy the information is to obtain. Although most boards allow the public to view disciplinary records, we encountered various unexpected and unusual situations when requesting information about specific health professionals with known disciplinary violations. For example,

- At one board, staff told us the board does not have licensing files for the public to view.
- Three boards required us to schedule an appointment and return to the board at a later date; one board requires a **written** request to schedule an appointment.
- Four of the ten boards requested us to complete information request forms. When questioned, board staff stated that the form is maintained in the licensee's file so that, if interested, the health professional would know who had reviewed the file. In fact, one board is **statutorily required** to annually notify its licensees of each request from the public to examine the licensee's file.
- One board would not allow the public to view the disciplinary information without direct supervision by board staff. This may have an intimidating effect on a consumer wishing to review a practitioner's file.
- In one situation, the board director discouraged us from viewing the disciplinary records. Instead, we were provided with a copy of board minutes that contained statutory references to disciplinary violations.
- Two boards remove older disciplinary information from the licensee's file. For example, one board maintains only disciplinary actions imposed in the last five years while another board maintains only disciplinary actions imposed in the last three years. As a result, an individual viewing these boards' disciplinary files could be led to believe that his or her health professional had not been subjected to disciplinary actions.
- Staff at several boards appeared surprised by public requests for disciplinary information and seemed unaware that the public had access to disciplinary records.

In contrast to most of the Arizona boards visited, the Board of Podiatry Examiners does not impede the public's ability to obtain information about health professionals. This board provided disciplinary information both over the phone and in person and no appointment was required to view disciplinary records.

Boards should eliminate barriers — Arizona's health regulatory boards should eliminate administrative barriers, such as the ones described above, and make disciplinary information easily accessible to consumers. Arizona's health regulatory boards need to recognize that, in addition to their regulatory functions, they have the important responsibility of serving and informing consumers. With this thought in mind, the boards should review their public access policies and evaluate current restrictions.

Boards Offer No Outreach Programs for the Public

To further improve public access and protection, boards should take steps to educate the public about their services. Currently, Arizona boards offer few outreach programs to inform the public of the board's role and how to file complaints. In contrast, boards in other states have developed innovative ideas for educating the public.

Need for education exists — Educational programs are a critical component to public access and public protection. A 1993 report by the Public Citizen Health Research Group, a consumer advocacy organization, claims that many people do not know what a medical board is, and do not know that they can obtain information or file complaints with such boards. For example, citizens often contact local medical associations or the Better Business Bureau to file complaints. In addition, a popular newspaper advice columnist advised readers to contact the American Medical Association if they have experienced problems with a physician, but did not mention the state medical board. However, if the majority of the general public is unaware that health regulatory boards exist, then only a small percentage of complaints will ever be filed with them. As a result, only a portion of problem practitioners will be reported to regulatory agencies.

Despite the importance and need for them, the majority of Arizona health boards have not developed outreach programs. We surveyed health regulatory boards to identify what types of outreach programs the boards had developed. Most indicated that they had no outreach program; however, several consider their listing in the phone book to be an outreach effort. In addition, a few boards publish and distribute newsletters to their licensees; although these newsletters are geared toward the practitioners and are not distributed to the public unless requested. In contrast, the Arizona Behavioral Health Board has developed public service announcements for television in both Spanish and English.

Educational efforts in other states and regulated industries — In contrast to Arizona, several other states and industries are taking steps to provide greater public access to

information. For instance, Texas has created an 800 number that will serve as a referral service for the health boards. Consumers can call the 800 number and be referred to the appropriate board to register a complaint. In addition, a Maine task force recommended that each health profession develop an informational brochure to distribute at health professionals' offices. As illustrated below, other states have also gone beyond the more traditional outreach efforts to further increase public awareness.

- Texas requires information plaques to be placed in all physician's offices, with information on the licensing board and the phone number. Additionally, the board publishes a listing of disciplinary actions taken against physicians, and distributes the information to local libraries.

- The Massachusetts Board of Registration in Medicine has developed an informational system that will provide disciplinary information on physicians through the Internet. Also, the Board plans to publish a physician profile directory, containing essential information about a physician's education, training, employment, board disciplinary actions, criminal convictions, and malpractice experience.

- In Utah, local newspapers publish information about disciplinary actions taken against various health practitioners.

More aggressive outreach programs could be adopted from regulated industries other than health licensing boards. For example, boards could compile and publish the number of complaints received by each licensee each year as compared to all other licensees in the licensee's specialization or field of practice. This would be similar to complaint ratio data compiled on insurance companies and published by various departments of insurance in the country. Or, boards could issue and require licensees to post in their offices a certificate stating whether the licensee has a higher than average, average, or lower than average number of complaints as compared to other practitioners in the same field or specialization. Such a posting would be the functional equivalent of the public posting of restaurant licenses indicating whether a restaurant is an "A" or "C" facility.

RECOMMENDATIONS

1. The Legislature should consider clarifying health board statutes so that all boards are required to provide the public the following information for the length of a health professional's career:

   - Number and nature of dismissed complaints
   - Number and nature of pending complaints
   - Disciplinary actions taken by the board
   - Actions reported to the board by other entities such as malpractice settlements, criminal convictions, and disciplinary actions taken by hospitals or health plans.

2. The boards should:

   - Provide, over the phone, summary information on disciplinary actions against health professionals.
   - Provide disciplinary records to the public without requiring identification or request forms.
   - Develop information plaques or certificates to be displayed in a prominent location at each licensee's office. The certificates should contain the name and number of the licensing board and information on where to file a complaint.
   - Develop information brochures describing the licensing board and the complaint process. These brochures should be available in every health professional's office.
   - Develop and implement other consumer education programs to inform the public of the board's existence.

3. If the boards do not implement the suggested recommendations within an acceptable time frame, the Legislature should consider mandating these procedures.

FINDING III

BOARDS NEED TO INVOLVE THE COMPLAINANT IN THE COMPLAINT PROCESS

If the public becomes so alienated by the state regulatory system that citizens no longer file complaints, the entire system fails. Yet, Arizona's health boards too often show little regard for the complainant. Statutory changes are needed to ensure complainants are given adequate notification of complaint status, and have a voice in the complaint process.

The board's ability to identify and take action against incompetent or unprofessional practitioners depends largely on consumer reports of substandard care. With the exception of fee disputes, the regulatory system is not designed to compensate the complainant, but rather protect future health care consumers. Thus, the complainant is performing a service to both the board and the public by filing a complaint. The board's treatment of citizens filing complaints should reflect the importance of the complainant's critical role in the success of the regulatory system.

Boards Should Notify Complainant of the Status of Their Complaint

A citizen who files a complaint with a regulatory board deserves to be notified of the complaint's status. The current notification policies of some boards are inadequate and do not convey that the filing of complaints is valued. All boards should notify complainants at specified times in the complaint process.

We surveyed a sample of nine health boards to obtain information on complaint procedures.[1] The survey revealed that many of these boards provide little information to a consumer who has filed a complaint. In fact, two of the nine boards surveyed do not notify the consumer that the complaint has been received, and three do not notify the complainant of the date of the public meeting involving the case. The following case example illustrates how little regard is given to the complainant.

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(1) We surveyed the following nine boards: Board of Nursing, Veterinary Medical Examining Board, Board of Dental Examiners, Board of Behavioral Health Examiners, Board of Medical Examiners, Pharmacy Board, Board of Chiropractic Examiners, Board of Osteopathic Examiners, and Midwifery. These boards were selected to include most of the large medical boards as well as a few other health professions.

- One consumer wrote to the Board of Medical Examiners (BOMEX) charging that a physician acted unprofessionally and unethically while caring for her dying aunt. Her charges included allowing unqualified office staff to provide medical advice, ignoring a pre-hospital directive, and not responding to requests for pain medication for the dying woman. According to information provided by the complainant, a nurse became so concerned that she convinced another doctor to prescribe the requested painkillers two days later. The board sent a letter to the consumer acknowledging the complaint in November 1994. She heard nothing from the board for the next 10 months. Then, in August 1995, the board notified her that the complaint had been dismissed 6 weeks earlier. No further information was provided. The complainant expressed her frustration in a letter to the Auditor General's office, an excerpt of which appears below:

  "You will note that they [the Board of Medical Examiners] did not find him 'in violation of the Medical Practice Act.' They do not say how they came to this conclusion, whom they consulted or whether the question of breach of medical ethics was discussed. They did not ask me for any additional information, nor was I notified of their 'Open Session,' so that I might have had the opportunity to attend."

While BOMEX may have made an appropriate disciplinary decision, its communication practices in this case show little regard for the complainant or the importance of the complaint.

Boards should improve complainant notification practices. In 1995, the Legislature statutorily directed BOMEX to establish notification policies. The new policies include complainant notification of informal interviews of the physician, formal hearings or rehearings, and appeals. Other organizations are required to notify citizens about the status of their complaint. For example, the New Hampshire Board of Registration in Medicine's statutes mandate that the board notify both the health professional and the complainant at least 15 days before the hearing. Providing such notice to complainants would be similar to notification requirements found in the criminal justice system. The Arizona Victims' Bill of Rights defines more than 8 points when victims of criminal offenses must be notified. For example, victims are notified of the defendant's initial appearance, of any additional proceedings, of the trial dates and results, and of any post-conviction review, modification, or appeal.

Complainants Have Little Input into the Complaint Process

Boards show further disregard for the complainant by not allowing the complainant the right to be heard. The complainant is often not provided the opportunity to provide testimony during investigations, open meetings, or settlement agreements.

Our survey of nine health boards revealed that four of the nine boards often do not interview the complainant during the investigation process. Additionally, attendance at the meetings of six health boards revealed that both complainants and the general public may be prohibited from testifying. For example, in one case complainants drove from Tucson to Prescott to attend the board meeting at which their complaint was discussed. Prior to the meeting, board staff informed the complainants that they would not be allowed to speak due to board policy. At the meeting of a second board, a complainant was refused the right to speak because her name was not on the agenda. This occurred because the board was advised that the open meeting law required the complainant to be on the agenda and prohibits agenda changes not posted 24 hours in advance. Boards, however, can allow public testimony by simply scheduling time for it on the agenda, or by stating on the agenda that public testimony may be taken at any time during the meeting.

Even when complainants are allowed to speak, they may not be treated appropriately. For example, after one complainant had given testimony and left the room, board members proceeded to make derogatory comments, and laugh at the complainant during the open meeting.

Some Arizona boards allow the public to comment during the open meetings. For example, the Dental Board allows any member of the public to speak during the meeting. Individuals who sign in prior to the meeting will be given time to present testimony. While health boards may be concerned that taking public testimony will lengthen the meetings, boards are free to limit the time each individual may testify.

In addition to the minimal participation allowed in public meetings, health boards do not allow the complainant a voice in settlement agreements. Many complaints are resolved through an informal process between the board and the health professional, without any involvement from the complainant. In contrast, the New Hampshire Medical Practice Act requires that before the Board of Registration in Medicine makes a settlement agreement, the complainant must be allowed to speak. Again, this is similar to rights afforded to crime victims by the Arizona Victims' Bill of Rights, which mandates that victims of a crime will be allowed to discuss their views on a case, before any plea or settlement agreements are made between the prosecutor and defendant.

Keeping complainants informed of their complaint status and offering complainants the opportunity to be involved in the process will increase the board's workload, and may impact resolution timeliness to some extent. The boards will need to determine who will be responsible for notifying the complainant, how the complainant will be notified, and the increased costs associated with notification efforts. In addition, all involved should recognize that increasing the complainant's role in the process may impact how quickly boards resolve complaints. For example, it may take additional time to obtain the complainant's input prior to a settlement agreement.

RECOMMENDATIONS

To formally establish the importance of the complainant in the health regulatory system, the Legislature should consider the following statutory requirements, or mandate that boards adopt rules that include these elements:

- Complainants should be notified: 1) upon board receipt of the complaint, 2) at regular intervals during the processing of their case, and, 3) at least 15 days in advance of the date, time, and place of every meeting that their case will be discussed by the board, including notice of a formal hearing before a hearing officer.

- Complainants should be notified of proposed settlement agreements and allowed to present their views prior to a final agreement.

- Complainants should be interviewed either at the time their complaint is delivered or during the course of the investigation.

- Boards should be required to take public testimony at every open meeting. Complainants should not be required to provide advance notice of their intent to speak.

ANSWERS TO LEGISLATORS' QUESTIONS

In addition to the three finding areas, our work addressed eight specific questions included in the JLAC resolution directing us to perform this study.

1. Examine previous performance audits of health profession regulatory boards and agencies to determine if there are any common findings and recommendations in these audits.

Poor complaint handling and inadequate disciplinary action are the most common problems associated with health regulatory boards and agencies. To reach this conclusion, we reviewed 27 Arizona Auditor General performance audits conducted on various Arizona health regulatory agencies over the past 16 years. In addition, we examined ten audits of health regulatory boards in other states and found that some of these entities experience similar problems handling complaints and disciplining licensees.

Following is a brief summary of the five most common findings and subsequent recommendations based on Auditor General performance audits of health regulatory boards in Arizona.

- Eleven of 27 reports (41 percent) identified various complaint investigation problems. Recommendations to address these problems varied, ranging from suggesting that investigators interview witnesses to developing policies for prioritizing complaints.

- Nine of 27 reports (33 percent) revealed that agency recordkeeping was inadequate and recommended better handling of complaint and investigation material.

- Nine of 27 audits (33 percent) reported complaints were backlogged. In some cases, complaints were taking a year to resolve. To address this problem we recommended, in most cases, that boards seek increased funding to hire additional investigators.

- Nine of 27 reports (33 percent) found that disciplinary actions against practitioners were inadequate. Developing guidelines for investigating and resolving complaints and increasing the proportion of public members on the boards were the two most common recommendations made to address this problem.

- Eight of 27 reports (30 percent) identified deficiencies in license examination procedures. In four of the eight reports we recommended that the boards allow scores from national examinations to fulfill licensing criteria.

2. Compare existing regulatory statutes to determine the similarities and differences in the complaint process, hearing process, sanctions, the powers and duties of the regulatory boards or agency, the investigation process, and the licensure or certification requirements.

For the most part, the existing regulatory statutes for Arizona's health professions are similar. An extensive analysis of the regulatory statutes is summarized below.[1]

- **Complaint/Investigation Process** — There is no specific complaint process prescribed by the statutes. Boards receive complaints regarding practitioners from various sources including patients, other health care practitioners, and health care organizations. Most boards will accept complaints by phone although they prefer to have complaints in writing. The Board of Dispensing Opticians is the only board whose statutes require that complaints be notarized.[2]

  Any source of information can trigger an investigation. Every board has a statute authorizing it to investigate any evidence that appears to show a practitioner may be incompetent or engaging in prohibited conduct except pharmacy, radiologic technologists, and hearing aid dispensers. However, investigative authority is probably implied for these three boards. While all 23 boards have subpoena power, 10 boards can review a licensee's records without a subpoena. As a result, these ten boards can obtain and review a licensee's patient records much quicker and easier than the other boards.

  One investigation avenue is the informal interview, a process available to 13 of the boards. The informal interview generally includes questioning the licensee, considering the seriousness of the conduct, and determining appropriate sanctions, to which the licensee apparently consents. If the licensee does not consent, or refuses to participate in the informal interview, a formal hearing may be scheduled.

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(1) According to A.R.S §32-3101, the "health professions" include but are not limited to the following 18 regulated professions and occupations: podiatry, chiropractic, dentistry, medicine, naturopathy, nursing, dispensing opticians, optometry, osteopathic medicine, pharmacy, physical therapy, veterinary medicine, psychologists, physician's assistants, radiologic technologists, homeopathic physicians, midwifery, and hearing aid dispensers. In addition, we included the boards of behavioral health, occupational therapy, respiratory care, and the professions of audiologists and speech-language pathologists.

(2) The dental board statute requiring complaints to be notarized was eliminated in the 1995 legislative session, as recommended in a previous Auditor General report.

- **Hearing Process** — The hearing process is defined by the adjudicative proceedings portion of the administrative procedures act, which applies to all agencies. In addition, 15 boards have similar, if not identical, statutes that identify when an investigation, including an informal interview, becomes a formal hearing.

  Formal hearings occur when the licensee rejects the informal interview or when the case is so serious that an appropriate sanction is to suspend or revoke the license. Any person who disagrees with a board order refusing, suspending, or revoking the license may request a rehearing. Each board has a statute allowing for an appeal to the superior court following a decision on the request for rehearing.

- **Sanctions** — The options available to discipline licensees vary somewhat among the boards. Possible sanctions for boards that conduct informal interviews include censure, probation (including limitation of practice), and civil penalties. All boards have the statutory authority to suspend or revoke licenses after a formal hearing. Once a formal hearing is held, most boards also have authority to censure, impose probation, and impose civil penalties (fines). The boards of naturopathic examiners and respiratory care therapists may censure after informal interviews but not after formal hearings. The Department of Health Services does not have censure authority in the regulation of midwives. Further, radiologic technologists and midwives' regulatory bodies cannot order probation and the respiratory care therapists board may order probation only pursuant to an informal interview. Dispensing opticians, respiratory care therapists, and physician's assistant boards cannot impose civil penalties.

  The definition of unprofessional conduct, which is the main basis for imposing sanctions for most boards, varies widely among them. All professions except chiropractors, dispensing opticians, and midwives specifically define unprofessional conduct in statute; some define it in great detail.[1] The number of categories constituting unprofessional conduct range from 5 for the Pharmacy Board to 46 for the Board of Osteopathic Examiners. Most of the boards that define unprofessional conduct also identify other types of conduct that may result in disciplinary action.

  An illustration of the diversity of unprofessional conduct standards among the boards relates to fees. Charging an unreasonable, inappropriate, or excessive fee is unprofessional conduct only for podiatrists, allopathic physicians, homeopathic physicians, physical therapists, and osteopathic physicians. In addition, only 13 of 23 boards may base disciplinary action on fraud or misrepresentation.

- **Powers and Duties** — Each board's primary duty is to safeguard the public's health, safety, and welfare from unqualified or unprofessional practitioners through licensure and regulation. If not explicitly stated, the statutes imply that each board is responsible for licensing, regulating, and disciplining the members of its profession. Additionally, all boards have the authority to promulgate rules and regulations and the implied authority to contract.

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(1) These boards have statutorily described conduct that is used as the basis for imposing sanctions.

- **Licensure/Certification** — Licensure and certification statutes are very different due to the wide range of professions involved. However, they are similar in that they all set forth specific education requirements, application and application fees, and entry standards unique to each profession.

3. Evaluate the feasibility of conforming the various regulatory statutes.

The Legislature could conform the various health regulatory statutes if desired. As previously discussed, the existing regulatory statutes for the 23 professions included in this study are already quite similar, with the exception of licensing requirements. While conforming statutes has a variety of benefits and appears to be the logical avenue to pursue, the Arizona Legislature may have legitimate reasons for maintaining independent statutes for each profession.

Conforming the regulatory statutes makes sense for various reasons. First, conformance would streamline the statutes, making them more user friendly for consumers. In addition, statutes would be easier to maintain if all 23 health professions operated under one statute. For example, if statutory revisions were needed to address an area that affected all boards, only one statute would need to be revised. Finally, conforming or revising the statutes would provide each of the regulatory agencies with similar regulatory authority, flexibility, and oversight.[1]

Other states such as New York, Utah, and Michigan have consolidated regulatory functions for various occupations and professions and consequently conformed some of their statutes. For instance, New York has a singular statute that governs the complaint and investigation process for more than 30 professions. Michigan conformed its statutes in 1977 to simplify and standardize board operations. In addition, Montana, which has numerous autonomous regulatory boards, recently conformed their professional and occupational licensing board statutes. Conforming the statutes eliminated redundancy, streamlined procedures across occupations and professions, and provided all boards equal authority while maintaining board autonomy.

Although conforming the various health regulatory statutes is feasible, there may be legitimate reasons for maintaining a distinct and separate set of statutes for each profession. For example, the Legislature may not want all health regulatory boards to have equal power and authority. As illustrated below, there are some distinct differences among the various regulatory agencies' statutes.

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(1) The 23 professions already have similar regulatory authority; however, the Board of Medical Examiner's statutes generally provide the greatest flexibility and oversight compared to the others. BOMEX's statutes clearly and comprehensively define unprofessional or prohibited conduct and provide a wide range of disciplinary sanctions. The midwife and hearing aid dispenser statutes provide the least regulatory authority, probably because they are regulated by DHS, whose primary duties involve providing health services.

- Although each of the 23 regulatory boards have subpoena power, only 10 can review a licensee's records without a subpoena.[1]

- Only the Board of Dental Examiners has a statutory time requirement for investigating complaints.

- Only the Boards of Medical Examiners, Podiatry Examiners, Homeopathic Medical Examiners, Physical Therapy Examiners, and Osteopathic Examiners can take disciplinary action for charging excessive, inappropriate, or unreasonable fees.

We did not research the original intent of each board's statutes, or the reasons for differences among the statutes.

4. Examine how effective existing regulatory statutes that provide for regulation of a profession by a body of the profession's peers are in protecting the public's health and safety.

Current regulatory statutes are adequate to support routine board operations. However, statutes could be strengthened to ensure the public's health and safety is further protected by 1) allowing complainants a voice in the investigation and disciplinary process, 2) providing the public with accurate and complete information about licensees in the least restrictive manner, 3) creating a public review board, and 4) increasing public membership on boards to 50 percent.

Complainants should be afforded more opportunities to participate in the board's investigation and disciplinary process. As discussed in Finding III (see pages 23 through 26), most boards rarely interview the complainant, fail to notify the complainant of the status of their complaint, and do not inform the complainant when their complaint will go before the board. Although the boards are not statutorily required to keep complainants informed, it seems logical that a board whose main purpose is to protect the public's health, safety, and welfare would make an effort to involve the complainant in the process.

In addition, all relevant information regarding a licensee's background should be easily accessible to the public. As discussed in Finding II (see pages 15 through 22), consumers need complete, accurate, and timely information regarding complaints and disciplinary actions taken against licensees, regardless of how minor or how long ago the incident occurred. Furthermore, regulatory boards should make it easier for the public to obtain information on licensees. Currently, 11 boards release disciplinary information over the

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(1) The Board of Medical Examiners, the Board of Chiropractic Examiners, the Board of Respiratory Care Examiners, the Board of Osteopathic Examiners, the Board of Homeopathic Medical Examiners, the Board of Behavioral Health Examiners, the Board of Physician Assistants, the Board of Dental Examiners, the hearing aid dispensers, and midwives.

telephone, while others require the consumer to make an appointment to view the licensee's file. If consumers are to make an informed decision when choosing a health care provider, they need to have relevant information that can be obtained easily and quickly.

Further, statutory changes will also be needed to implement the creation of a public review board and increase public membership on individual boards as recommended in Finding I (see pages 5 through 13).

5. Review other health profession regulatory systems to determine if another system is more effective in ensuring due process and the public's health and safety.

We conducted an extensive search to determine if a health profession regulatory system *other than peer review* is more effective in ensuring public health and safety and due process. We contacted numerous states, spoke to many experts in the health field and even looked outside the country in our attempt to find an innovative and more effective model. However, our search revealed that peer review, or a modification of peer review, is consistently used throughout. Thus, while some regulatory models have been modified by adding more internal controls or by increasing public oversight, they still rely heavily on peer review. A description of our research efforts is presented below.

- **Literature search** — Numerous periodical databases and online library catalogs were searched as part of our literature review. We reviewed approximately 50 relevant documents including journal articles, studies, and books. In addition, we reviewed more than 30 reports from the federal government and nongovernmental organizations.

- **Contacts with national organizations** — We interviewed the executive directors and/or staff at 13 national organizations, including: the Council of State Governments; the National Conference of State Legislatures; the Federation of State Medical Boards; the Federation of Associations of Regulatory Boards; the Public Policy Institute; the World Health Organization; the Pew Health Professions Commission;[1] the National Health Lawyers Association; the National Clearinghouse on Licensure, Enforcement and Regulation; the Center for Public Policy and Contemporary Issues; the American Medical Peer Review Association; the American Enterprise Institute for Public Policy Research; and the National Organization for Competency Assurance.

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(1) The Pew Health Professions Commission was established in the spring of 1989 and is administered by the University of California at San Francisco, Center for the Health Professions. The Commission is charged with assisting health professionals, workforce policy makers, and educational institutions in responding to the challenges of the changing health care system.

- **Consumer advocacy groups** — We identified and interviewed key personnel at eight consumer advocacy organizations including the Citizen Advocacy Center, the Consumer Federation of America, the Public Citizen, the People's Medical Society, the National Consumer's League, the Common Cause, the American Association of Retired Persons, and the Arizona Center for Law in the Public Interest.

- **Interviews with experts in the health field** — We conducted over 50 interviews with professors, experts, and authors in the fields of health economics and public policy. For example, we spoke with 2 professors from Arizona universities and contacted the authors of 11 relevant research articles.

- **Information from other states** — Ten states with regulatory systems substantially different from Arizona were surveyed. We also contacted 11 states noted for their innovative approaches to regulation such as using mediated dispute resolution or having 50 percent public membership on a peer review board. [1] Additionally, we reviewed over 20 reports and audits from other states.

- **Information from outside the country** — In our attempt to look outside the United States for alternatives, we contacted six foreign embassies, the Department of State, and the World Health Organization. We interviewed personnel from two Canadian provinces and reviewed a book detailing the Ontario model of health regulation entitled *The Regulated Health Professions Act: A Practical Guide*. In addition, we contacted personnel in Queensland, Australia, to obtain information on their consumer-oriented health regulation system.

- **Electronic mail** — We requested information on health regulatory systems via Internet electronic mail on two separate "listservs" (computerized discussion groups).

The most promising ideas identified through our research are presented in Finding I. In summary, Finding I concludes that in order to improve the peer boards' willingness to take disciplinary action, public oversight is needed when decisions are made.

6. Evaluate the feasibility of consolidating health professions regulatory boards and agencies or components of these boards and agencies.

While consolidation may be beneficial in reducing professional influence and standardizing processes, there is no evidence to conclude that consolidating regulatory functions increases public protection or reduces costs. In fact, our research indicates that the opposite sometimes occurs.

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[1] We contacted the following 21 states: Alaska, Colorado, Connecticut, Florida, Hawaii, Illinois, Massachusetts, Michigan, Minnesota, Montana, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Rhode Island, Tennessee, Texas, Utah, Washington, and Virginia.

Effects of Consolidation on Disciplinary Actions and Costs

Consolidation does not appear to have a positive effect on disciplinary actions. In fact, one study on consolidation concluded that increased consolidation was associated with fewer disciplinary actions. The authors of the study explain that when boards are consolidated, expected savings result in budgets being cut. As a result, the investigative function may be affected, resulting in fewer disciplinary actions. Our own research did not uncover any evidence that consolidated boards take more disciplinary actions against practitioners. We compared national data that ranked states according to the number of disciplinary actions taken against practitioners and found that none of the 3 most consolidated states fell within the top 25 percent of the state rankings.

Little information is available on the costs and benefits of consolidation. In discussion with Michael Nichol, a respected author on regulatory boards' performance, Mr. Nichol commented that cost/benefit information on consolidation is very difficult to obtain. He explained that centralized states usually do not have the detailed financial information needed for comparative purposes. However, as the following examples illustrate, consolidating regulatory functions does not always result in reduced costs.

- Iowa's dental board was assessed 20 percent of their budget for indirect costs when they were consolidated under the Department of Health. Since becoming an independent board, the dental board reduced its indirect costs to 8 percent.

- In 1994, Arizona's Office for Excellence in Government initiated a study to determine the benefits of consolidating many of Arizona's regulatory boards, including 19 health boards and 1 program. The study was later dropped, concluding no large dollar savings would be realized by combining the boards.

Models of Consolidation

To speak of consolidation in general terms may be misleading since the degree of consolidation varies from state to state. Our review of regulatory structures identified the following models that illustrate various forms of consolidation.

- **Consolidated Oversight** – In this model, an oversight entity is granted the power and authority to take actions. Autonomous boards exist for each of the professions; however, they only advise the oversight group regarding policy and disciplinary matters. Examples of this model include New York and Utah. In Utah, all of the boards are subordinate to the Division of Occupational and Professional Licensing, a state entity; whereas in New York, the boards are subordinate to a citizen body.

- **Regulation Without a Board** — In this model, the profession is regulated without the assistance of a board. A program manager typically handles licensing, examination, complaint investigation, and other regulatory activities. The program manager is usually given assistance from a governing department, and legal support from the Attorney General's Office. The program manager might receive assistance from an advisory committee, where volunteers from the profession give advice on regulation procedures.

  Arizona's hearing aid dispensers, speech-language pathologists, audiologists, and midwives are regulated in this manner under the Department of Health Services (DHS). An advisory committee helps the program manager for hearing aid dispensers, speech-language pathologists, and audiologists establish licensing and examination criteria, and gives advice on professional conduct. In contrast, Arizona's midwives operate without the assistance of a peer advisory committee; however, the program manager can contract for technical assistance to review complaints and clinical records, and prepare and issue examinations.

- **Interdisciplinary Consolidation** — In this model, one board performs the regulatory functions for a variety of interrelated professions. This board is composed of members from multiple disciplines and might be organized similar to the following:

  - Medical interdisciplinary might combine physicians, podiatrists, osteopaths, nurses, and physician assistants

  - Mental health interdisciplinary might combine psychologists, psychiatrists, counselors, and social workers.

  We are not aware of any state that has a comprehensive system of interdisciplinary consolidation. However, according to the Federation of State Medical Boards, 36 states have one interdisciplinary board regulating both osteopathic and allopathic physicians. Arizona currently has an interdisciplinary board regulating dentists, dental hygienists, and denturists.

- **Consolidation of "Major Functions"** — With this type of consolidation, major regulatory components are consolidated to serve a variety of boards. This may include activities such as licensing, investigation of complaints, screening and prioritizing of complaints, complaint appeals, and handling of non-practice-related complaints. For example, Hawaii established the Regulated Industries Complaints Office in 1982 to receive and investigate complaints and pursue disciplinary action for 45 vocational and professional boards, commissions, and programs. Queensland, Australia, has established a State Commission that screens complaints for 12 boards, resolves non-practice-related complaints, and forwards profession-related complaints to the appropriate boards.

- **Administrative Consolidation** — Through this type of consolidation, regulatory agencies can share a variety of administrative resources. Resources may be in the form of managerial and administrative personnel, computer systems, or buildings. For example, 11 of Texas's larger health regulatory agencies are located in 1 building. According to the Administrative Officer of the Texas Health Professions Council, the agencies are establishing a networked computer system and developing a shared copy center/mailroom facility to reduce the need for each agency to maintain its own associated equipment and employees. In addition, they have established a toll-free complaint referral system to provide the public standardized assistance in the initiation of a complaint against a licensed health professional.

Advantages and Disadvantages of Three Consolidation Models

If the Legislature wants to implement some form of consolidation, it will need to weigh the advantages and disadvantages of a move to a new structure. As stated earlier, no model is yet proven to better protect the public or to decrease costs. Each model has both costs and benefits. In this section we will discuss the advantages and disadvantages of three consolidation options.

- **Interdisciplinary Model** — As was mentioned in the previous section, in this form of consolidation, one board manages and performs the regulatory functions for a variety of interrelated professions. Some of the **positive** aspects of interdisciplinary consolidation include:

  - **Reduced professional influence** — Because there is more than one profession serving on a board, the power and influence of any one profession is deemphasized. This reduces the chances of professions "protecting their own."

  - **Fewer board members to appoint** — When many boards are consolidated into one interdisciplinary body, the total number of board members needed may be reduced.

  - **Aiding in the resolution of cross - disciplined complaints** — Complaints that involve multiple professionals (i.e. physicians, nurses, physician assistants) can be resolved by one board, rather than a variety of boards.

  Some of the **negative** aspects of interdisciplinary consolidation include:

  - **Heightened conflict between the professions** — For example, a physician may resent being evaluated by a nurse or physician assistant.

- **Reduction in technical expertise** — When reviewing complaints outside their own discipline, board members may not be familiar with the technical procedures and vocabulary of another profession.

- **Increased volume of complaints** — Since one board will be responsible for complaints from multiple professions, the amount of incoming complaints will increase. This may result in an increased backlog.

- **Lack of supportive evidence** — Even though interdisciplinary consolidation is recommended by experts, this form of consolidation is rare in practice and lacks evidence of success.

- **Consolidated Investigations** — Consolidating the investigative function has been found to increase the number of disciplinary actions; however, so does increasing the number of board-controlled investigators. There are, however, some **benefits** to consolidating the investigative function. These benefits include:

  - **Efficiencies in data management** — Consolidating the complaint information for various boards may augment proficient tracking and monitoring of cases.

  - **Consistency in handling complaints** — Investigation for all complaints would be conducted through standard procedures.

  - **Prioritization of complaints** — The consolidated entity can direct resources toward the most serious cases, based on the severity of the complaint.

  - **Increased investigatory support for smaller boards** — Because of limited resources, smaller boards are often unable to employ full-time investigators.

  - **Increased validity of professional investigators** — One expert suggested that the professionals may be less likely to ignore the recommendations of professional investigative organizations.

  Some of the **disadvantages** of consolidating the investigative function include:

  - **Lack of technical expertise** — The pool of investigators may not be specialized in profession-specific procedures and vocabulary.

  - **Lower priority given to smaller boards' complaints** — Smaller boards may be considered "less important;" thus, the complaints of these boards may receive less attention.

  - **Costs unknown** — Cost studies specifically evaluating consolidation of the investigatory function are unavailable. Also, the cost of consolidating the investigatory function in Arizona may differ from that in another state.

- **Administrative Consolidation** — Through administrative consolidation, all health regulatory agencies share administrative support. This might include buildings, managerial and administrative staff, and other support components. Some of the **positive** aspects of administrative consolidation include:

  - **Greater convenience for the public** — By locating all of the agencies in one building, the public can contact one site for a variety of professions.

  - **Consistent treatment of the public** — Because a single department is responsible for handling the complaints for a variety of professions, the treatment to the public is more consistent across professions.

  Some of the **negative** aspects include:

  - **Start-up costs** — Start-up costs may result from modifying or replacing existing facilities, computer systems, or phone systems. Increased costs also could result from raising the administrative capabilities of some boards to the level of better funded boards. For example, some boards currently do not have computer systems to track complaints, while others do.

7. Evaluate the feasibility of standardizing the complaint and investigation process among the regulatory boards and agencies.

The health regulatory boards' complaint and investigation procedures are already very similar and could be standardized to a large extent. The major differences are who conducts the investigation and at what stages in the process parties involved are notified.

We compared the complaint and investigation process of each board as well as their related statutes and found variations in the way each board handles the investigation aspect. For instance, due to staffing and resource differences among the boards, some boards contract with investigators, others have full-time investigators on staff, and, in some cases, board members themselves conduct the investigations.

Another aspect of the complaint and investigation process that differs greatly from board to board is the extent to which the complainant is kept informed of their complaint's status. Some boards involve the complainant throughout the process while others send only an acknowledgement letter at the beginning of the process and a resolution letter at the end. Finding III (see pages 23 through 26), presents recommendations for standardizing the complaint notification process and suggestions for involving the complainant.

While there are some deviations to the process, for the most part the complaint and investigation process is quite similar among the boards. Our review of board survey responses and board complaint and investigation policies identified six steps common

to the complaint and investigation process. Additional information on boards' complaint and investigation processes is discussed in Question #2 on page 28.

Step 1 **Complaint received** — All boards and agencies currently manage their own complaint intake and most will allow the public to initiate a complaint over the phone. However, submitting the complaint in writing seems to be the preferred method among the boards and agencies.

Step 2 **Jurisdiction determined** — Upon receipt of the complaint, a staff member at the board or agency will decide if the complaint falls within its statutory jurisdiction.

Step 3 **Investigation** — As mentioned earlier, the investigation component varies from board to board. Thirteen boards have some form of informal procedure typically designed to clarify the facts of a case. Each board has the power to subpoena records; however, several boards have additional authority to review a licensee's records without a subpoena. Also, the Arizona State Board of Nursing is unique in that it has implemented an investigative case priority assignment system.

Step 4 **Findings and recommendations presented to the board** — After investigating the complaint, board staff typically submit a written report to the board that includes the facts of the case, an analysis of the facts, evidence reviewed to determine the facts, and a recommendation for board action.

Step 5 **Complaint deliberated and resolved** — The complaint is placed on an upcoming meeting agenda for board discussion and deliberation. The complaint may be resolved at a board meeting, with or without an informal interview of the licensee. The board may decide to refer a complaint on their agenda to a formal hearing prior to rendering a decision.

Step 6 **Parties notified of final board action** — Most of the boards notify both the complainant and the licensee in writing of what action the Board took on the complaint, regardless of the outcome.

8. Recommend alternatives to the existing regulatory system that will ensure due process and the public's health and safety.

In addition to studying health regulatory systems as described in Question #5 (page 32) we examined regulatory systems of industries outside the health domain. While some of these alternatives have unique regulatory components, they do not as a whole provide viable alternatives to peer review. Following is a brief summary of some of the regulatory components and alternative systems we evaluated.

- **The Federal Aviation Administration (FAA)** — The FAA uses attorneys to hear and settle complaints against pilots. While the use of attorneys may diminish the influence of the profession, the professional influence is not always eliminated. For example, complaints must be investigated by a licensed pilot before being heard by an attorney. An additional problem is that the use of attorneys can be costly.

- **The National Association of Securities Dealers (NASD)** — NASD uses binding arbitration to settle complaints against practitioners. Through binding arbitration, both parties agree beforehand that a panel's decision is final. While binding arbitration may diminish the influence of the profession (depending on the makeup of the hearing panel), it may also lengthen time of the hearing process.

- **The Arizona State Bar Association** — Attorneys are also regulated by peers. Ethical misconduct cases are resolved through a "peer review committee." More serious cases are resolved through a hearing officer. If additional action needs to be taken, the case is reviewed by the Disciplinary Commission of the Supreme Court.

- **The Maricopa County Public Health Department (MCPHD)** — MCPHD randomly inspects restaurants, public swimming pools, motels, grocery stores, and bakeries. While this type of regulation is effective at keeping facilities in compliance, it is time-consuming, requires a large staff, and can be costly. In addition, the data gathered from these facility inspections is easily measurable, whereas data measuring health care practice (such as competency or ethical conduct) may be difficult to quantify.

- **The Arizona State Insurance & Banking Departments** — These state agencies investigate and resolve complaints without the use of a board. Under this system of regulation, complaints are reviewed and investigated by department staff. The complaints are then resolved by either a department administrator or an administrative judge. This form of regulation limits peer influence. However, the types of disciplinary action taken by these agencies typically involve unauthorized business practices, which require less, if any, technical expertise to determine than the health professions.

As previously indicated, our recommendations to improve the existing regulatory system are outlined in Findings I, II, and III.