REPORT OF THE
JOINT LEGISLATIVE AUDIT
AND REVIEW COMMISSION

FINAL REPORT: REVIEW OF THE HEALTH REGULATORY BOARDS

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 5

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Preface

House Joint Resolution 139 and the Appropriation Act, approved by the 1998 General Assembly, directed the Joint Legislative Audit and Review Commission (JLARC) to study the effectiveness of Virginia's health regulatory boards and the Department of Health Professions (DHP). DHP, and the 12 health regulatory boards for which the department provides staff support, have the responsibility for ensuring the safe and competent delivery of health care services through the regulation of health professions.

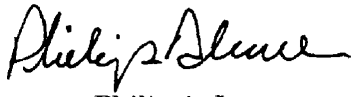
This review was conducted in two phases. The first phase included a review of licensing and rule-making functions of the boards, composition and structure of the boards, financial responsibilities of the boards and DHP, and the role of the Board of Health Professions. The second phase review focused on the disciplinary system used by the boards and the department. The findings from the first phase were presented previously in an interim report, and the findings from the second phase are presented in this final report.

The second phase of the study found that aspects of the disciplinary process work well. The quality of the work by DHP and board staff is generally good, and the system developed to process and adjudicate cases is effective. However, there are some areas in which policy and statutory changes are needed to improve the process. In addition, the inspection program does not meet stated goals and may not provide for adequate drug control. The report contains recommendations to address these concerns.

The report identifies several concerns regarding the time required to process disciplinary cases. Most boards take in excess of one year on average to resolve disciplinary cases, and the Boards of Medicine and Psychology take in excess of two years on average. The report also found that many of the cases that took too long to resolve involved serious misconduct by a practitioner, and the delay in resolving these cases created unreasonable and unacceptable risks to public protection and public safety. Recommendations to improve case processing time are provided.

The study also found that the Board of Medicine does not adequately protect the public from substandard care by physicians. With the current gross negligence standard for taking action, the Board of Medicine rarely sanctions physicians for standard of care violations. In addition, the Board of Medicine does not adequately handle medical malpractice payment reports. The report recommends that the General Assembly consider amending the *Code of Virginia* to define negligent practice (rather than the current standard of "gross negligence") as a violation of law. Recommendations are also provided to improve the process for handing medical malpractice complaints.

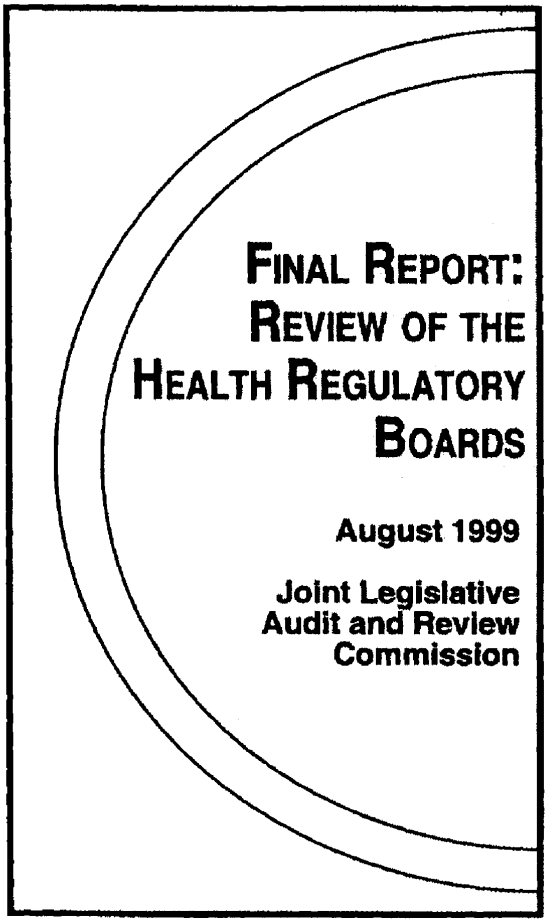
On behalf of the Commission staff, I would like to express our appreciation for the cooperation and assistance provided during the review by the health regulatory boards and the Department of Health Professions.



Philip A. Leone
Director

August 6, 1999

JLARC Report Summary



The Department of Health Professions (DHP) and Virginia's 12 health regulatory boards, along with the Board of Health Professions (BHP), have responsibility for ensuring the safe and competent delivery of health care services through the regulation of the health professions. DHP provides coordination and staff support for the health regulatory boards and BHP.

HJR 139 and the Appropriation Act, approved by the 1998 General Assembly, direct the Joint Legislative Audit and Review Commission to study the effectiveness of Virginia's health regulatory boards and DHP. This is the second of two reports that have been prepared to meet the study mandate. This report focuses on issues related to the boards' disciplinary function. An interim report primarily addressed issues related to the boards' composition, licensing, and rule-making functions, as well as budgeting and staffing issues and the role of the Board of Health Professions.

Significant findings of this report include:

- Aspects of the disciplinary process work well, but some statutory changes are necessary to improve the process, and the Board of Nursing may not be adequately addressing certified nurse aide cases involving serious misconduct.
- DHP should enforce laws against unlicensed practice of the health professions when Commonwealth's attorneys do not pursue these cases.
- The disciplinary process takes too long to resolve many cases, particularly some serious disciplinary cases, during which time the practitioners continue to practice and potentially threaten public safety.
- DHP's current inspection program is inadequate and needs to be reevaluated – about 25 percent of licensed pharmacy facilities had their last inspection eight or more years ago.
- The gross negligence standard that applies to Board of Medicine standard of care cases under current law does not appear to adequately protect the public from the substandard practice of medicine by physicians.
- The Board of Medicine does not adequately consider cases that derive from medical malpractice payment reports.

Recommendations to address problems cited in the review are included throughout the report.

The Disciplinary Process Generally Works Well, Although Some Changes Are Needed to Improve It

Aspects of the disciplinary process appear to work well. The quality of work by DHP and board staff is generally good, and the system developed to process and adjudicate cases is effective. Cases are screened effectively at the intake stage, and, for the most part, they receive adequate investigations. Finally, the process by which the board hears cases that present significant evidence of a violation appears to work relatively well and appears to be fair to respondents and keeps complainants well informed.

However, there are some areas in which improvements to the process of one or more boards are needed. For example, one area of concern is the current policy of the Board of Nursing to limit the number of certified nurse aide (CNA) cases referred to a formal hearing. This policy is a consequence of budget constraints resulting from federal funding cuts. While this policy does not violate federal or State law, a result of this policy is that many CNAs who have committed serious acts of misconduct are only reprimanded by the board and thus are allowed to retain their certificates even though they may not be fit to practice as CNAs. The Board of Nursing should continue working to resolve the certified nurse aide program's budget deficit in order for the Board of Nursing to have the funds necessary to base disciplinary decisions in CNA cases on the seriousness of the violation and the need to protect the public and not on financial constraints.

Several statutory changes are also recommended to improve the disciplinary process. The obligation to report misconduct and the associated immunity that currently extend only to licensees of the Board of Medicine need to be extended to the licensees of the other health regulatory boards. In addition, the use of license revocation as a sanction needs to be clarified. Moreover, eligibility to apply for reinstatement after license revocation needs to be made consistent across boards, and the reinstatement process needs to be made uniform. Finally, the *Code of Virginia's* prohibition against the use of trade names in the practice of dentistry does not appear necessary to protect the public and should be eliminated.

DHP Should Enforce Laws Against Unlicensed Practice

The Department of Health Professions needs to actively pursue some unlicensed practice cases that are currently closed without prosecution. Currently, DHP relies upon local Commonwealth's attorneys to prosecute these cases, and only those cases that a Commonwealth's attorney decides to prosecute are pursued. While Commonwealth's attorneys tend to prosecute the more egregious cases involving public harm, many cases that are not pursued involve individuals who are practicing without appropriate training and licensure and are putting patients at risk. DHP needs to pursue some unlicensed practice cases that are not prosecuted by Commonwealth's attorneys in general district court.

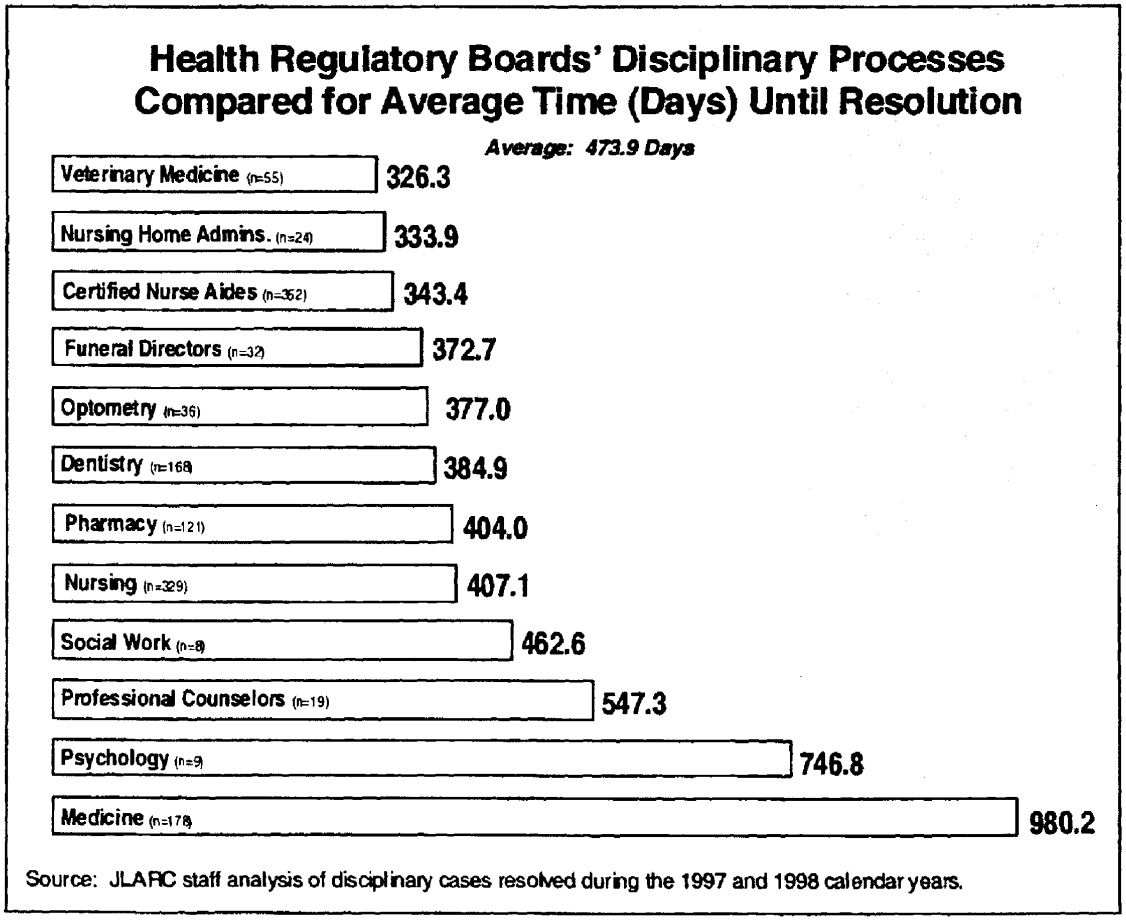
Disciplinary Process Takes Too Long To Resolve Cases and May Threaten Public Safety

While DHP staff and departmental management guidelines suggest that most disciplinary cases should be resolved in less than a year, most boards take in excess of a year, and two boards take in excess of two years (on average) to resolve disciplinary cases. Based on an analysis of cases resolved through a disciplinary hearing or consent order in 1997 and 1998, the Board of Medicine took more than 2.6 years on

average to resolve cases, and the Board of Psychology spent about two years on average. The figure below shows the average case resolution times for the various boards.

Analysis of disciplinary cases closed during the past several years raises the concern that delays in processing some serious cases for several boards may threaten public safety. Some complaints alleging serious wrongdoing by health professionals regulated by the Boards of Medicine, Psychology, Nursing, and Dentistry took between one and five years to process before the appropriate board suspended, revoked, or accepted the surrender of the practitioner's license. Long delays in processing these cases pose a significant threat to public safety because in many of these cases the practitioners were allowed to continue treating patients until the board rendered its decision.

The Department of Health Professions and the health regulatory boards need to take steps to reduce the time required to process and adjudicate disciplinary cases. DHP and the boards need to develop guidelines for the resolution of cases, regularly assess whether there are sufficient staff and board members to resolve cases in a timely manner, and establish procedures to ensure that serious cases are handled expeditiously.



Source: JLARC staff analysis of disciplinary cases resolved during the 1997 and 1998 calendar years.

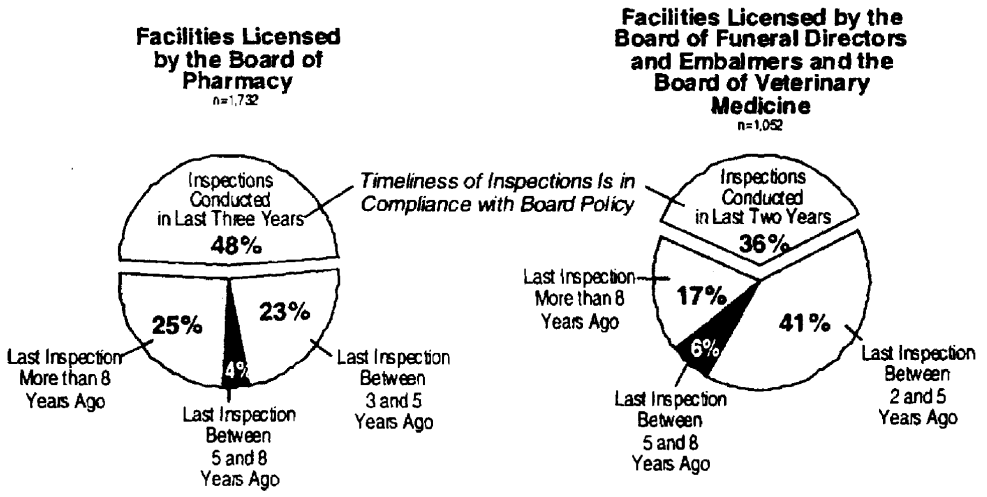
Inspection Program Does Not Appear to Meet Stated Goals and May Not Provide for Adequate Drug Control

DHP's facility inspection program, which was abandoned for several years, is currently failing to meet its goals for completing inspections of pharmacies, veterinary facilities, and funeral homes. The figure below shows that a majority of facilities are not being inspected within the time frames suggested in inspection plans. Many have not been inspected for over eight years. The current situation raises some drug law enforcement concerns, because a primary purpose of both pharmacy and veterinary inspections is to ensure that the distribution of drugs is properly controlled. The failure to meet these goals appears to be due in part to the assumption by inspectors of some investigative responsibilities and to a shortage of inspector positions. Given the existing problems with the inspection program, the Department of Health Professions, along with the relevant boards, need to fundamentally review the program and reevaluate the program's goals and the means necessary to achieve them.

Current Legal Standards for Board of Medicine Standard of Care Cases May Not Adequately Protect the Public

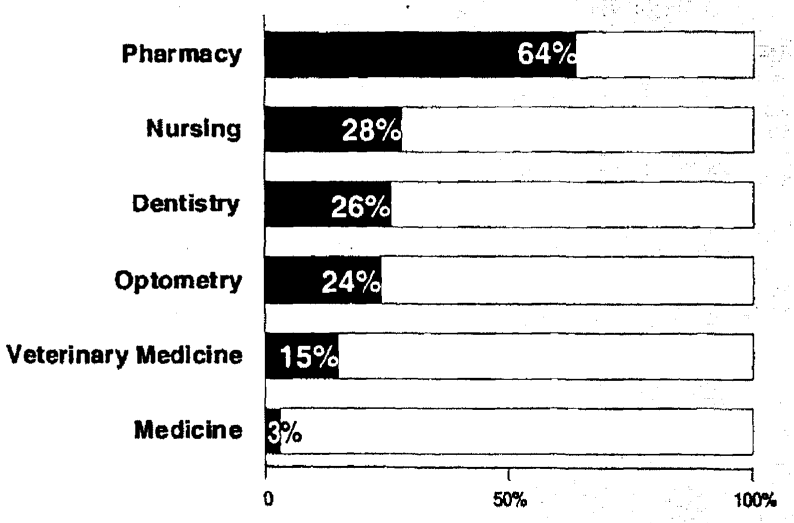
The Board of Medicine does not appear to adequately protect the public from substandard practice by physicians. Under Virginia law, a physician is not subject to discipline by the Board of Medicine for deviations from the accepted standard of care in the practice of medicine unless he or she is grossly negligent or is judged to be a public danger. With this high threshold for taking disciplinary action, the Board of Medicine rarely disciplines physicians for deviations from the accepted standard of care in the practice of medicine, even when such deviations result in serious injury or death. As the figure on page V demonstrates, only three percent of the Board of Medicine's orders over the last two fiscal years ad-

Frequency of Routine Inspections Conducted by DHP Inspectors at DHP-Licensed Health Care Facilities



Source: JLARC staff analysis of DHP inspection records.

Proportion of Violations During Fiscal Years 1997 and 1998 Which Exclusively Involved Standard of Care, by Board



Notes: Boards not shown had fewer than 30 orders over the two-year period. Orders related to reinstatement or probation are not included.

Source: JLARC staff analysis of orders issued by boards for FY 1997 and FY 1998.

dressed standard of care issues exclusively. The Board of Medicine closes almost all standard of care cases without a hearing even though some of these cases raise serious concerns about the standard of care provided by physicians and the potential threat to the public by the physicians' practices. The Board of Medicine is the only health regulatory board in Virginia with such a high threshold for deciding standard of care cases. The *Code of Virginia* or board regulations define negligent acts as standard of care violations for several boards and do not establish a gross negligence standard for any other board. In addition, the Federation of State Medical Boards, whose membership includes all of the state medical boards in the United States, recommends that medical boards take disciplinary action against physicians who are negligent in the practice of medicine. The General Assembly may wish to consider amending §54.1-2915(A)(4) of the *Code of Virginia* to define negligent practice as a violation of law.

Board of Medicine Does Not Handle Medical Malpractice Cases Adequately

As a result of the gross negligence standard and a general bias against medical malpractice cases, the Board of Medicine appears less likely to pursue cases based on medical malpractice payment reports (the reports that notify DHP of all malpractice judgements and settlements involving practitioners licensed in Virginia) than cases based on other complaints or required reports. More than one-third of these reports, which are a significant source of standard of care cases for the Board of Medicine, are closed at the intake stage without sufficient information on which to base a closure decision. In addition, medical malprac-

tice cases that proceed beyond the intake stage do not receive the same level of investigation as standard of care complaints received from the general public. The Department of Health Professions needs to modify its current policies for handling medical malpractice payment reports and adopt procedures that will ensure these reports are given adequate consideration at the intake and investigation stages.

Table of Contents

I. Introduction

The Department of Health Professions (DHP) and Virginia's 12 health regulatory boards, along with the Board of Health Professions (BHP), have the responsibility for ensuring the safe and competent delivery of health care services through the regulation of the health professions. DHP provides coordination and staff support for the health regulatory boards and BHP.

House Joint Resolution 139 and Item 16H of the Appropriation Act, approved by the 1998 General Assembly, direct the Joint Legislative Audit and Review Commission to study the effectiveness of Virginia's health regulatory boards and DHP. HJR 139 specifically directs staff to evaluate:

- the appropriateness of the composition of each board,
- the appropriateness of the boards' role in ensuring the qualifications of health care professionals in Virginia, and
- the boards' authority and involvement in establishing standards for high quality health care delivery by health care professionals.

In addition, the Appropriation Act directs that the JLARC review must include the following:

- a follow-up to JLARC's 1982 study recommendations related to the health regulatory boards;
- an assessment of the working and organizational relationships between the boards, the department staff, and the Board of Health Professions in the licensing and regulation of the health professions;
- an examination of the efficacy, fairness, and propriety with which the various statutes, duties, functions, and activities involved in the licensing and regulation of health professions are being performed and discharged; and
- an assessment of the adequacy of the department's staffing and automated systems to meet its current and future operations needs.

A copy of HJR 139 as well as the relevant Appropriation Act language are attached as Appendixes A and B.

This is the second of two reports that have been prepared to meet the study mandate. This report focuses on issues related to the boards' disciplinary function. The interim report primarily addressed issues related to the boards' composition, licensing, and rule-making functions, as well as budgeting and staffing issues and the role of the Board of Health Professions.

OVERVIEW OF THE REGULATORY BOARDS AND DHP

Virginia's 12 health regulatory boards are responsible for licensing and disciplining health practitioners and promulgating the regulations that govern regulated health professionals. Some boards also have additional responsibilities. For instance, the Board of Nursing approves nursing schools.

Currently, the 12 boards regulate nearly 240,000 health professionals, facilities, and other entities (Table 1). The number of professionals regulated by these boards has increased by about 62 percent in the last ten years. The boards also process thousands of disciplinary cases a year and promulgate dozens of regulations.

The Department of Health Professions is the State agency that supports the 12 individual regulatory boards and the Board of Health Professions. The department's staff support the boards through several means, but the members of the boards have the ultimate decision-making authority. Some of the agency staff serve as staff to the individual boards. In addition, the agency provides central staff to support the disciplinary function. The agency also provides the automated systems, budgetary and financial staff support, and human resource management support for the boards. Figure 1 provides an organizational chart of the agency.

HEALTH REGULATORY BOARDS' DISCIPLINARY SYSTEM

DHP staff and the health regulatory boards process thousands of complaints against health care practitioners each year (Table 2 on page five). DHP staff within the enforcement division receive and investigate complaints and prepare disciplinary cases against health care practitioners for hearings. Staff assigned to each board assist the boards in scheduling and conducting hearings. The primary roles of board members in the disciplinary process are to decide whether cases should be closed due to insufficient information, to dismiss cases which do not provide evidence of a violation, and to hear cases to determine whether a violation was committed and what type of sanction should be imposed.

Two additional components of the boards' disciplinary system are the facility inspection program and the Health Practitioners' Intervention Program (HPIP). DHP staff inspect certain types of facilities regulated by the boards. The outcomes of these inspections are reviewed by the appropriate board. When necessary, a board will take action against facility operators who do not abide by its regulations. HPIP is a program that allows health care practitioners with a physical or mental health disability or substance abuse problem to be treated for their condition in lieu of traditional disciplinary action by the board.

Table 1

Number of Licensees, Certified Professionals, and Registrants Regulated by Each Health Regulatory Board in 1988 and 1998

Board	Number Regulated in 1988	Number Regulated in 1998
Board of Audiology and Speech-Language Pathology	**	2,226
Board of Dentistry	6,815	8,297
Board of Funeral Directors and Embalmers	2,159	2,405
Board of Medicine	25,261	44,390
Board of Nursing	79,843	149,184
Board of Nursing Home Administrators	**	910
Board of Optometry	997	1,386
Board of Pharmacy	24,285	11,135*
Board of Licensed Professional Counselors, Marriage and Family Therapists, and Substance Abuse Professionals	1,768	6,304
Board of Psychology	476	1,914
Board of Social Work	1,722	3,915
Board of Veterinary Medicine	2,789	4,150
Total	**146,115**	**236,216**

*The number regulated by the Board of Pharmacy has decreased because the Board no longer registers approximately 21,000 health care practitioners who prescribe controlled substances. The federal government does register these individuals.

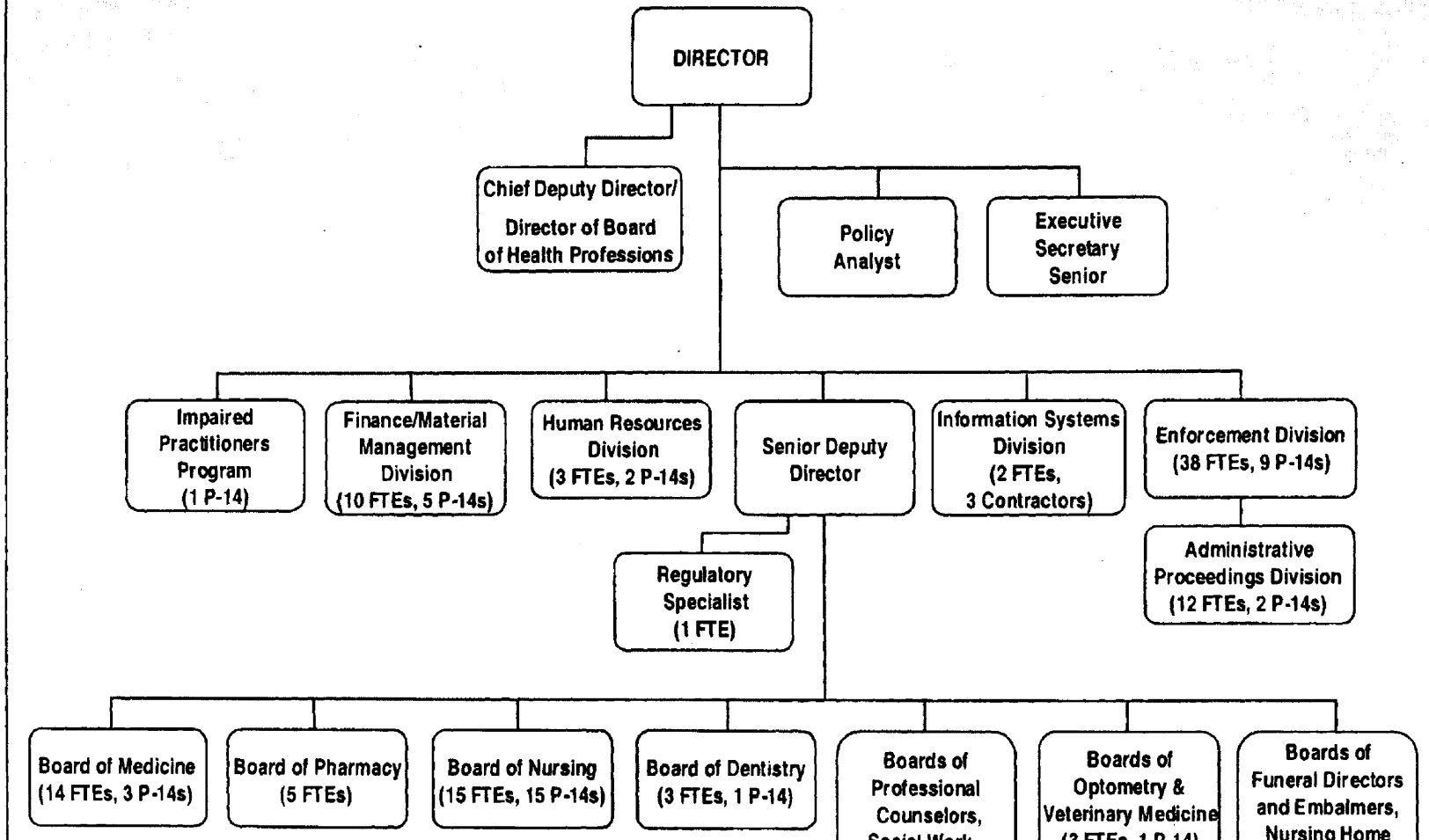
**These boards were not under the purview of DHP in 1988. Source: Department of Health Professions 1988 and 1998 Biennial Reports.

Statutes and Regulations Governing the Disciplinary Process

The disciplinary process is governed by the Administrative Process Act (APA), the statutory provisions applicable to all occupational regulatory boards, and the laws and regulations pertaining specifically to the health regulatory boards. The APA establishes the procedural framework for the disciplinary process and sets forth the funda-

Figure 1

Department of Health Professions 1999 Organizational Structure



Note: The Executive Director of the Boards of Optometry and Veterinary Medicine also serves as the Deputy Executive Director of the Board of Health Professions, and the staff to these boards also serve as staff to the Board of Health Professions.

Source: JLARC graphic based on staff analysis of DHP personnel data.

Table 2

Complaints Received by DHP for Fiscal Year 1998

Board	Number of Complaints Received	Number of Complaints Docketed	Number of Complaints per 1,000 Licensees
Audiology	8	2	3.59
Dentistry	343	172	41.34
Funeral Directors and Embalmers	63	30	26.20
Medicine	1,012	568	23.17
Nursing	1,047	527	7.02
Nursing Home Administrators	42	25	46.15
Optometry	50	33	36.08
Pharmacy	263	215	23.63
Professional Counselors	35	19	5.55
Psychology	36	12	18.81
Social Work	31	11	7.92
Veterinary Medicine	88	62	21.20
Total	**3,018**	**1,676**	**12.82**

Source: Department of Health Professions Biennial Report 1996-1998.

mental requirements that must be followed when conducting hearings. General provisions of the *Code of Virginia*, which are applicable to health regulatory boards, provide some additional requirements. The *Code of Virginia* also contains some provisions applicable to individual boards.

The laws and regulations specific to each health regulatory board establish the substantive basis for the disciplinary system. They define the types of actions that constitute grounds for disciplinary action against practitioners. Typical grounds for discipline include unprofessional conduct, negligent conduct in the practice of a profession, criminal conviction, and drug diversion. The Drug Control Act also serves as a basis for some disciplinary actions against pharmacists, physicians, dentists, veterinarians, licensed nurse practitioners, physicians' assistants, and certified optometrists.

Structure of the Disciplinary Process

Under the current disciplinary structure, DHP enforcement staff receive and review disciplinary complaints, and investigate complaints. Staff of the administrative proceedings division (APD) prepare and prosecute most cases. After an investigation is completed, staff for the relevant board assume responsibility for the hearing process and provide support to the boards during informal conferences and formal hearings. Board members, who are appointed by the governor to serve four-year terms, are responsible for hearing and adjudicating disciplinary cases. Attorneys from the Office of the Attorney General provide support to the process by serving as counsel to the various boards and by prosecuting most cases that proceed to a formal hearing.

Enforcement Division Staff. Staff in DHP's enforcement division provide the primary support for the disciplinary system. The division is composed of intake analysts, investigators, and inspectors, as well as other support staff. Three intake analysts screen all of the complaints received by the department. The intake analysts, who are all health care professionals, report to the deputy director of enforcement.

Fourteen full-time field investigators and four investigative supervisors investigate the majority of the cases that are not screened out at intake. The majority of these investigators are health care professionals. Each investigator is assigned to one of four regions in the State. One investigator in each region serves as an investigative supervisor. These supervisors, who report to the director of enforcement, are responsible for overseeing the assignment and completion of all investigations in the region.

These supervisors also oversee inspectors in each region. Each region has an inspector whose primary responsibility is to conduct pharmacy inspections. In addition, three of the four regions have a second inspector who is responsible for conducting veterinary medicine and funeral inspections. Five of these inspectors are health care professionals and the other two have law enforcement backgrounds. These inspectors also perform investigations for reinstatement and probation cases. Four part-time employees (P14s) also conduct investigations and inspections in three of the regions.

Two other types of positions that support the disciplinary process are located in the enforcement division's central office. Five administrative investigators handle the investigation of most lower priority disciplinary cases, primarily by telephone and written correspondence. The department also has one probation analyst who is responsible for tracking compliance with probation terms. All of these positions report to the deputy director of enforcement.

Administrative Proceedings Division Staff. The administrative proceedings division has ten senior legal assistants who have responsibility for preparing cases for hearing, drafting hearing notices and final orders, and presenting cases to the boards during hearings. The senior legal assistants report to the director of the administrative proceedings division who in turn reports to the director of enforcement.

Board Staff. Staff to the individual boards also play a role in the disciplinary process. The executive directors of the boards have responsibility for coordinating the review of cases that have been investigated, as well as for scheduling cases for hearings. They also provide staff support to the board members during informal conferences and formal hearings. The executive directors of the Boards of Medicine, Nursing, and Pharmacy delegate most of this responsibility for coordinating the disciplinary case proceedings to deputy executive directors. In addition, the executive directors of the boards of Medicine, Nursing, Pharmacy, Psychology, and Social Work have a role in reviewing complaints that may be closed at intake and in determining whether there is sufficient evidence after an investigation for cases to go forward to a hearing. Executive directors and deputy executive directors are assisted by other board staff who help with case scheduling and preparing case materials for board members.

Board Members. Board members have several responsibilities in the disciplinary process. Members of some boards review complaints received by the intake staff to determine if the complaints should be pursued further or closed without investigation. They also have responsibility for reviewing cases that have been investigated to assess whether they should be dismissed prior to an informal conference. Board members hear virtually all disciplinary cases that proceed to a hearing through informal conference committees comprised of two or three members. Finally, larger panels of board members are responsible for adjudicating cases that proceed to a formal hearing.

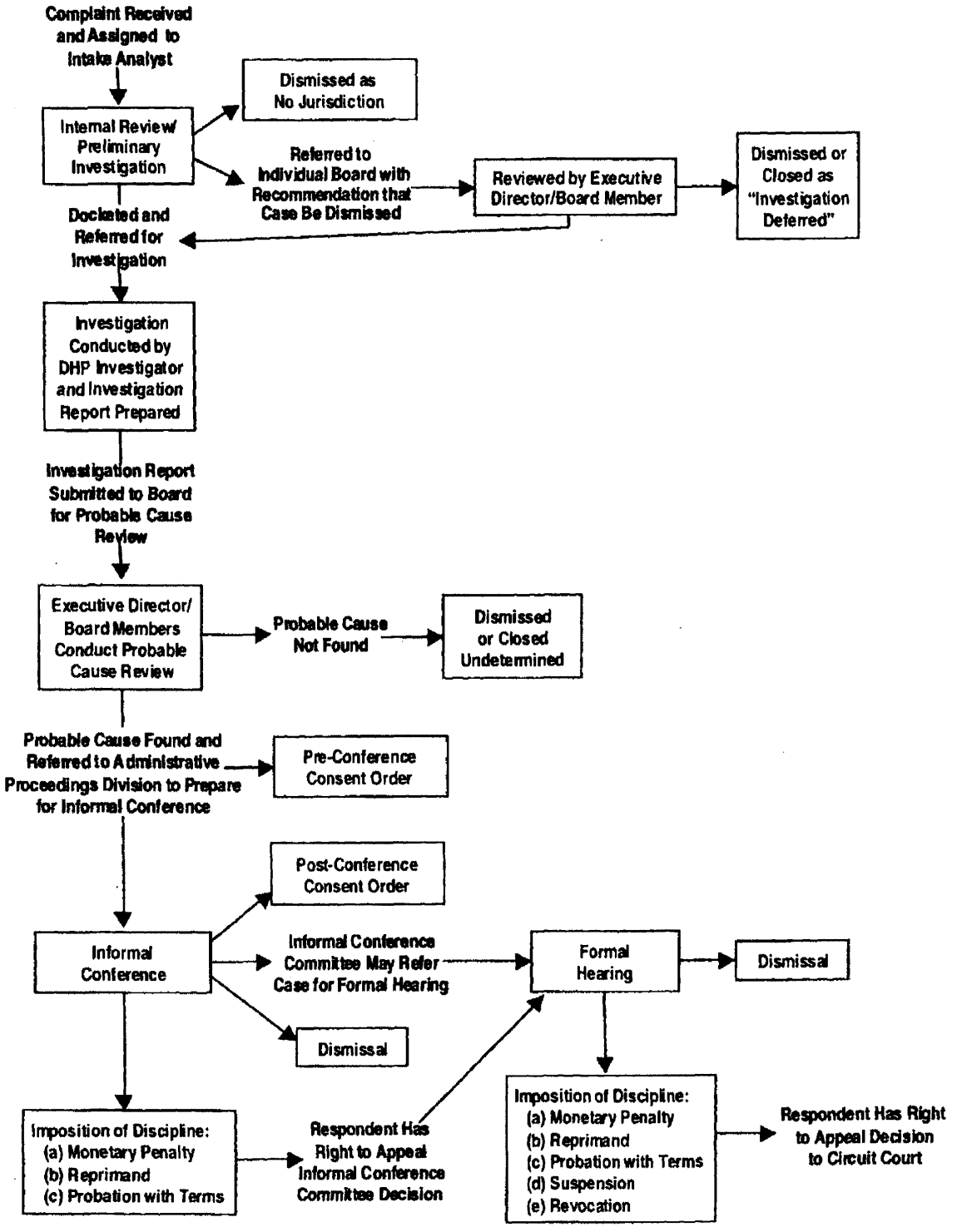
Office of the Attorney General Staff. Attorneys from the Office of the Attorney General serve two functions in the disciplinary system. Three assistant attorneys general serve as legal counsel to the 12 regulatory boards. They attend some of the informal conferences as well as all of the formal hearings to provide legal advice to the boards. Other assistant attorneys general prosecute some of the disciplinary cases on behalf of the State that proceed to a formal hearing and occasionally present evidence at informal conferences. Assistant attorneys general also handle court appeals of board case decisions.

Disciplinary Process

The disciplinary process is a multi-stage process that begins with the receipt of a complaint (see Figure 2). These complaints are reviewed at the intake stage and are either closed or docketed for investigation. Complaints that are docketed are investigated and then submitted to the appropriate board. The individual boards must then review the investigative reports and decide whether a case presents sufficient evidence of a violation to proceed to an informal conference or whether the case should be dismissed. Senior legal assistants are then responsible for preparing the cases that the boards schedule for an informal conference. Two to three board members hear these cases during informal conferences. Following the informal proceedings, cases involving possible suspension or revocation or cases in which a respondent wishes to appeal the decision of an informal conference are heard by a panel of board members at a formal hearing.

Figure 2

Health Regulatory Boards' Disciplinary Process



Source: Department of Health Professions *Adjudication Manual*, and *Code of Virginia*.

Intake Process. Most complaints are received either by telephone, in writing, or in person by the intake unit within the enforcement division. In addition, some complaints are generated through inspections or are initiated by the boards based on information they receive through newspaper articles or other means. Complaints are reviewed by an intake analyst to determine whether the allegations in the complaint, if true, would constitute a violation of statutes or board regulations governing the practice of the health professions. The intake analyst also determines if the information provided is sufficient to proceed with an investigation. If there is not sufficient information, the intake analyst generally conducts an informal, or preliminary, investigation to gather more information. This preliminary investigation usually consists of a letter to the practitioner or further contact with the source of the complaint.

If the intake analyst determines that the allegations are within a board's jurisdiction and there is sufficient information to proceed, the analyst dockets the complaint for investigation. The intake analyst also has responsibility for prioritizing each docketed case based on the risk to the public health, safety, or welfare. This prioritization of a case impacts the level of urgency with which a case will be investigated.

If an intake analyst believes that the complaint does not indicate a possible violation of board statutes or regulations, then the analyst recommends closing the complaint and forwards it to the appropriate executive director to consider the recommendation for closure. The process for review of complaints recommended for closure varies by board. With some boards, the executive director makes the final decision whether to close the complaint. With other boards, a board member must approve the closure of a complaint.

Investigative Process. The majority of cases that are docketed for investigation are forwarded to the investigative supervisor in the appropriate region. The investigative supervisor then assigns each case to a field investigator. Field investigators conduct investigations through interviews, reviews of patient records, and visits to facilities. Investigators then prepare written reports summarizing their findings. Most low priority cases are assigned to administrative investigators within the central office who conduct these investigations through phone interviews and correspondence. A small percentage of the investigations are conducted by inspectors and intake analysts.

Probable Cause Review. The next stage in the process is the probable cause review. After investigation reports are completed, the cases are sent to the appropriate board for review to determine whether the case should be forwarded for a hearing or closed administratively. According to DHP's *Adjudication Manual,* the standard for this review is whether there is probable cause, or more evidence for than against, of a violation of a statute or regulation.

Boards vary in the way that they conduct the probable cause review. In the past, some boards have sent the investigation report to two or three board members and requested that they independently determine whether the case should be sched-

uled for a hearing or closed. The Boards of Medicine and Nursing, however, have different processes. The executive director of the Board of Medicine reviews each case. Each case the executive director recommends for a hearing is reviewed by the board president. For each case recommended for closure by the executive director, one board member reviews the case and decides whether to close it. The deputy executive directors for the Board of Nursing have the authority to forward cases for hearing without input from board members. Along with this authority, they also have responsibility for recommending cases for closure. In contrast to the Board of Medicine, the deputy executive directors of the Board of Nursing present their recommendations for closure to a two-person informal conference committee which decides whether to accept the recommendation.

The Board of Pharmacy has recently authorized its executive director to refer cases for hearing without board approval and to develop closure recommendations to be presented to a two-member committee of the board for approval. Other boards have told JLARC staff that they plan to reduce to one the number of board members who review cases to determine whether there is probable cause to proceed to an informal conference.

Preparation of Cases for Hearing. After a board concludes that a case should proceed to an informal conference, the case is sent to the administrative proceedings division (APD). A senior legal assistant is assigned to the case and has responsibility for preparing the case for hearing. This includes developing a notice of hearing, which presents factual allegations that may constitute violations of statute or regulations by the health care practitioner. APD staff or assistant attorneys general are also responsible for preparing the evidence for a hearing and assessing which witnesses need to be subpoenaed to testify.

Prior to a hearing, a pre-hearing consent order can be proposed to resolve a case. Under such an order, the respondent must agree to accept the findings and sanctions in lieu of a hearing to decide the matter. The board must approve any proposed consent order.

Informal Conference. The next stage of the process is the informal conference stage. Approximately four-fifths of the cases for which probable cause is found proceed to an informal conference, and the remainder are resolved through a consent order. Respondents have a right to waive an informal conference and proceed directly to a formal hearing if the department consents to a waiver, but respondents appear to exercise this right rarely. Informal conference committees are comprised of two or three board members, depending on the board. There are some consistent general rules for how informal conferences are conducted, but each committee has discretion in the specifics of how the hearing proceeds. The committees usually allow the respondent to make any statement or present any facts that he or she wishes to present. In general, the board members question the respondent after his or her presentation. Witnesses may also testify at the informal conference as needed on behalf of the State or the respondent.

After hearing the information presented, the informal conference committee members may take one of several actions regarding the case. They may dismiss the case if they determine that there has not been a violation of any statute or regulation or if there is insufficient evidence of a violation. The informal conference committee also has the option of imposing one of three sanctions. It may impose a monetary fine, a reprimand, or probation with terms. In some cases, the informal committee may find that a violation occurred, but impose no sanction. The informal conference committee members may also conclude that the violations may warrant a suspension or revocation. If this is the case, they have two choices: they may propose a consent order for suspension or revocation and request the respondent's consent for such an action, or they may refer the case directly to the board for a formal hearing. A respondent has the right to appeal the decision of an informal conference committee. If the informal conference ruling is appealed, the board order is vacated, and a formal hearing is held.

Formal Hearing. The rules governing formal hearings are considerably different than those governing informal conferences. A quorum or a panel of at least five board members is required to adjudicate a formal hearing. Formal hearings are substantially more formal from a procedural standpoint. An assistant attorney general or a senior legal assistant acts in a prosecutorial role to present the case and question witnesses. Furthermore, in contrast to informal conferences, the witnesses are sworn under oath and provide testimony through direct questioning as well as cross-examination.

Like an informal conference committee, a formal hearing panel may dismiss a case, find a violation but impose no sanction, or find a violation and impose one of several sanctions. The panel may impose the same sanctions as an informal conference committee can impose. In addition, the panel may suspend or revoke the license of a practitioner. A respondent may appeal the decision of a formal hearing panel to the circuit court.

Summary and Mandatory Suspensions. The *Code of Virginia* also provides a mechanism to bypass the normal disciplinary process and take quick action in cases in which it is determined that a practitioner poses an imminent danger to the public. This process takes place after an investigation has been completed. If the board staff determines that a case may warrant consideration of a summary suspension, the case is sent to APD, which prepares the case and forwards the information to the Office of the Attorney General. If the Office of the Attorney General agrees that the case warrants a summary suspension, the information is then presented to the board. The statute provides that if a majority of a quorum of the board votes to approve the summary suspension of a practitioner's license, the board may suspend the license. The respondent has the right to a formal hearing on the suspension, which is scheduled at the time of the order summarily suspending his license.

The *Code of Virginia* also requires that the DHP director suspend the license of any practitioner who is known to have had his or her license suspended or revoked in another jurisdiction, has been convicted of a felony, has been adjudged legally incompe-

tent, or has paid for a license with a dishonored check. The DHP director is required to suspend licenses in such instances immediately without first conducting a hearing. However, a licensee who has had his or her license suspended pursuant to this provision is entitled to a hearing at the next regular board meeting that is at least 30 days after his or her application for reinstatement. A practitioner whose license has been suspended because of payment with a dishonored check may be reinstated immediately upon proper payment.

Inspection Program

The Department also has a regular inspection program for certain types of facilities. Pursuant to departmental inspection plans, inspectors conduct inspections of pharmacies and other types of facilities regulated by the Board of Pharmacy, veterinary medicine facilities, and funeral homes. The Board of Pharmacy inspection plan states that pharmacies should be randomly inspected at least once every three years. Inspection plans for veterinary facilities and funeral homes state that these facilities need to be randomly inspected once every two years. The inspectors also inspect all new facilities or facilities that change location before they can begin operation.

The purpose of these inspections is to ensure that facilities are in compliance with all applicable laws and regulations. Disciplinary cases before the Board of Pharmacy are often generated from inspections. In addition, pharmacy inspections may sometimes reveal physicians who are misprescribing or diverting drugs, resulting in disciplinary cases against these physicians. Inspectors also have the authority to conduct inspections of other medical facilities. However, they typically only conduct such inspections as part of an investigation of a practitioner.

Health Practitioners' Intervention Program

In 1997 the General Assembly enacted legislation establishing the Health Practitioners' Intervention Program (HPIP). The purpose of the program is to provide an alternative to the disciplinary system for the treatment of practitioners who are impaired. The program provides that disciplinary action may be stayed against a practitioner who enters the program if no other report of a violation of a law or regulation has been made against the practitioner, other than the impairment or the diversion of controlled substances for personal use. The statute also establishes an Intervention Program Committee that is responsible for establishing rules for practitioner eligibility and for determining who is eligible for stayed disciplinary action. This is a seven-member committee composed of licensed or certified health professionals.

Practitioners who enter the program are subject to fairly rigorous requirements. Typically, a practitioner will be required to undergo extensive treatment and regular monitoring, including regular random drug screens. A practitioner who enters the program usually is required to participate in the program for five years and is responsible for the costs of treatment and drug screens.

Description of Sanctions Imposed Through the Disciplinary Process

In part due to the diversity of the boards and the cases that come to the boards' attention, there are variations in the categories of violations that are most frequently addressed by the boards (see Figure 3). Despite the variations, certain categories of cases are similar across boards. Overall, the most frequent type of sanction used by the boards is a reprimand.

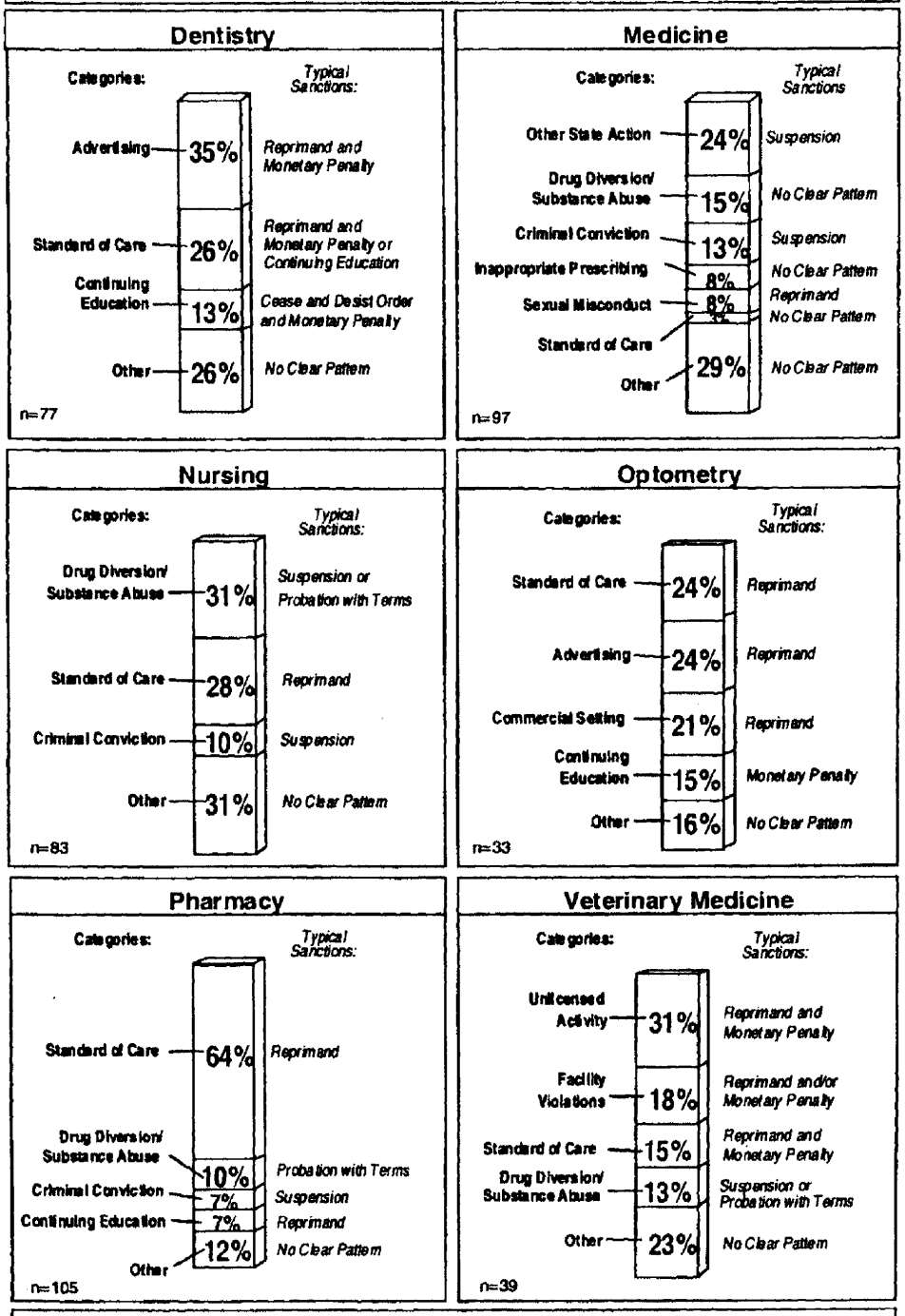
Typical Cases in which Sanctions Are Imposed Vary by Board. While most boards impose sanctions for the same broad categories of violations, the boards vary considerably in which categories of cases they most often impose sanctions. Of the six boards shown in Figure 3, all but two boards (Optometry and Pharmacy) vary in the type of case in which sanctions are most typically imposed. Some of the differences between boards are significant. For example, 64 percent of the Board of Pharmacy's disciplinary orders involved standard of care issues while only three percent of the Board of Medicine's orders were based on standard of care violations. (A standard of care violation is one in which a health care practitioner deviates from the accepted standard of practice in the direct care and treatment of a patient.) In addition, 31 percent of the Board of Nursing orders involved drug diversion and substance abuse while no other board had a similar percentage of such cases. Similarly, the Boards of Dentistry and Optometry had a large percentage of orders involving advertising violations. In contrast, none of the other boards had a significant number of advertising cases.

Despite the differences across boards, there are some similarities among them. For example, most of the boards issued some orders for substandard care cases. The Boards of Pharmacy (64 percent), Nursing (28 percent), Dentistry (26 percent), and Optometry (24 percent) all had a high percentage of standard of care cases. Orders involving drug diversion constituted another common category of violation across boards. The Boards of Nursing (31 percent), Medicine (15 percent), Veterinary Medicine (13 percent), and Pharmacy (10 percent) all had a significant number of drug diversion and substance abuse cases.

Sanctions Are Most Often Reprimands. Based on JLARC staff's review of final orders and observance of disciplinary proceedings, the sanction most frequently used by the boards is a reprimand that is often accompanied by a monetary penalty. However, the boards also impose probation, license suspension, and license revocation in more serious cases. It is difficult to assess whether the boards are consistent over time in the imposition of sanctions because most cases involve a unique set of factors which may impact the stringency of the sanction that is imposed.

Analysis of the consistency in the imposition of sanctions across boards was difficult, but some general observations can be made regarding some categories of cases. All of the boards with a significant number of standard of care cases appear to typically impose a reprimand as the sanction for a violation. The boards with a significant number of drug diversion and substance abuse cases usually impose suspension or probation with terms for this category of violation. There was also one notable differ-

Figure 3
Major Categories of Violations and Typical Sanctions Imposed by Professional Boards



Notes: The Board of Nursing percentages are based on approximately one-third of the nursing orders for the two fiscal years and do not include CNA cases. The Boards of Audiology and Speech-Language Pathology, Funeral Directors and Embalmers, Nursing Home Administrators, Psychology, Professional Counselors, and Social Work were not included in this analysis because each issued fewer than 30 orders during the two-year period.

Source: JLARC analysis of orders issued by the boards for FY 1997 and FY 1998. Orders related to reinstatement or probation are not included.

ence between boards in the imposition of sanctions. In drug diversion cases, the Boards of Nursing and Veterinary Medicine typically suspend the license of a practitioner for a period of time. In contrast, the Boards of Medicine and Pharmacy do not usually suspend the license of such a practitioner, but instead place the practitioner on probation with terms.

Civil Legal System Also Addresses Negligent Conduct by Health Care Professionals

It should be noted that in addition to the disciplinary system of the health regulatory boards, another process that addresses negligent conduct by health care professionals is the civil legal system. Any patient has the right to file a tort action against a health care provider whom he believes has delivered substandard care which has resulted in harm to him. However, the purpose of malpractice lawsuits is to provide a process for compensation of individuals who have been harmed as a result of substandard care. While the legal system may help to deter negligent acts by health professionals, it is not a system designed or intended to regulate health professionals or to ensure that the public is protected from substandard practice. There is no effort through the legal system to assess the professional competence of health care providers who have committed negligent acts or what remedial measures may be needed to correct or improve a health professional's practice. Instead, the focus of the malpractice system is to determine whether a patient who has filed a complaint has suffered damages from a negligent act for which he or she should be compensated.

The mandate for this study requires a review of the role of the disciplinary system of the health regulatory boards. However, given that there is some common area of interest between the two processes (negligent conduct by health professionals), it is inevitable that some of the same problem cases may come to the attention of both processes. Issues concerning this overlap are addressed in Chapter IV of this report.

JLARC REVIEW

JLARC has conducted two prior reviews of the health regulatory boards. In 1981-82, a performance review of Virginia's health regulatory boards was conducted and presented in two reports. Last year, JLARC staff completed the first phase of a two phase study of the health regulatory boards and the Department of Health Professions. The first phase of this study was an assessment of issues not directly related to the disciplinary system and included: an assessment of the composition and structure of the 12 health regulatory boards, an analysis of the boards' licensure and rule-making functions, an assessment of DHP's performance in managing the boards' financial and staffing responsibilities, and a review of the appropriate role of the Board of Health Professions.

This report provides a comprehensive review of the health regulatory boards' disciplinary function and the role of DHP staff in supporting this function. It includes an assessment of the following: the overall disciplinary process, board sanctions, disciplinary case processing time, the inspection program, and the Board of Medicine's treatment of standard of care cases. Some of the concerns noted in this review are similar to concerns raised in the prior 1982 JLARC reports (see Appendix C for an overview of DHP's implementation of the recommendations from the 1982 JLARC reports and their current relevancy). In addition, JLARC staff reviewed the status of DHP's automated systems, as required by the study mandate. The department appears to be making progress toward the implementation of a new computer system, but it is premature at this time to draw definitive conclusions about this system (see Appendix D for an overview of this aspect of the JLARC review).

A number of research activities were undertaken as part of this study in order to obtain a comprehensive understanding of the disciplinary system. These activities included: structured interviews, attendance of disciplinary hearings, analysis of board member surveys, extensive document and data reviews, and a review of other states' practices.

Structured Interviews

JLARC staff conducted a total of 39 interviews during the second phase of this study. These interviews included the following: board executive and deputy executive directors, investigators, inspectors, case intake staff, and other Department of Health Professions staff. JLARC staff also interviewed attorneys who represent health care practitioners before the health regulatory boards and staff from the Office of the Attorney General. In addition, JLARC staff interviewed 70 individuals during the first phase of the study. Among those interviewed during the first phase were selected board members from each of the health regulatory boards.

Attendance and Observation of Disciplinary Hearings

JLARC staff attended and observed over 130 disciplinary hearings of the health regulatory boards. The purpose of attending these hearings was to review the hearing process, observe the performance of staff, and assess the reasonableness of the hearing outcomes.

Survey of Board Members

As part of the review, JLARC staff conducted a mail survey of board members in August 1998. This survey was sent to 260 current and former board members. The survey asked for the board members' input on a wide range of issues related to the duties and responsibilities of DHP and the health regulatory boards. JLARC staff

reported on some of these responses in its November 1998 report. Some of the responses to questions regarding the disciplinary function of DHP and the boards are included in this report. Sixty-six percent of board members who were sent a survey submitted a response.

Document and Data Review

In addition to interviews, attending disciplinary hearings, and analyzing board surveys, JLARC staff reviewed various DHP documents and data as part of this study. The following information was included as part of this review: DHP case processing data, inspection and investigation data, complaint intake records, unlicensed practice cases, cases closed after investigation, and board disciplinary orders.

Case Processing Data. JLARC staff reviewed DHP's automated data that documents disciplinary cases closed between July 1992 and February 1999. This data was analyzed to compute the amount of time it takes for a case to advance through each stage of the disciplinary process and to determine the causes of delays in managing these cases. JLARC staff also reviewed selected disciplinary and probation case files to obtain a more complete understanding of what causes significant delays in processing some cases. (See Appendix E, which is a technical appendix that describes the process used to analyze case processing time.)

Inspection and Investigation Data. Information regarding the most recent inspection dates of all facilities licensed or certified by the health regulatory boards was analyzed to determine how frequently facilities are inspected by DHP staff. In addition, data regarding the number of inspections and investigations conducted by DHP investigators and inspectors were reviewed to assess workload and productivity.

Complaint Intake Records. JLARC staff conducted a random review of 20 percent of the complaints closed at the intake stage in Fiscal Year (FY) 1998 (July 1, 1997 to June 30, 1998). These 268 complaints were reviewed to determine whether there was adequate basis for the closure decisions made at this level by intake staff and the boards. Because of concerns raised as a result of the initial review about the basis of closure decisions for medical malpractice complaints, JLARC staff also reviewed all (20) of the medical malpractice cases involving Board of Medicine licensees that were closed at the intake stage between July 1, 1998 and January 31, 1999.

Unlicensed Practice Cases. JLARC staff reviewed all unlicensed practice cases resolved by DHP in 1997 and 1998. These cases were reviewed to determine whether unlicensed cases are being prosecuted adequately.

Other Cases Closed Prior to a Hearing. In order to determine whether the boards are reasonably closing cases without a hearing based on the information contained in the investigative reports, JLARC staff conducted a random review of at least ten percent of the cases closed by each board at the probable cause stage during FY

1998. For the boards with less than 100 cases, JLARC reviewed up to 10 randomly selected cases. Based on the findings from the initial review, JLARC staff randomly selected and reviewed an additional ten percent of cases closed after investigation by the Board of Medicine.

Board Disciplinary Orders. Disciplinary orders issued by the health regulatory boards typically outline the findings of fact against a practitioner who is found to have violated board statutes or regulations and stipulate the sanction imposed by the board for these offenses. JLARC staff reviewed all the disciplinary orders issued by each health regulatory board, with the exception of the Board of Nursing, during FY 1997 and FY 1998. Because of the large quantity of orders the Board of Nursing issues each year, JLARC staff reviewed a random sample of one-third of all the disciplinary orders issued by the Board of Nursing during this time frame. These orders were analyzed to determine the types of offenses practitioners licensed by each board committed and the corresponding sanctions issued against these practitioners by the boards.

Other States' Information

Finally, in order to obtain another perspective from which to evaluate the performance of Virginia's health regulatory boards, JLARC staff reviewed information regarding other states. This review included studies conducted by legislative agencies in other states. In addition, JLARC staff reviewed other state information available in national association publications and conducted a statutory review of medical practice statutes in the mid-Atlantic and southeast regions.

REPORT ORGANIZATION

This report is organized into four chapters. Chapter II discusses the disciplinary process, including some statutory modifications to improve the process. Chapter III addresses disciplinary case processing time. This chapter also includes an evaluation of DHP's inspection program. Finally, Chapter IV assesses why standard of care cases are rarely pursued by the Board of Medicine, by reviewing the current law regarding standard of care violations by physicians and how the Board of Medicine handles standard of care cases.

II. Disciplinary Process

While this review of the disciplinary process has raised several serious concerns, particularly with the Board of Medicine, some aspects of the disciplinary process work well. The quality of the work by intake staff, investigators, and senior legal assistants is generally good; and board members, staff, and counsel generally provide strong support to the adjudicatory process. Moreover, the system developed to process and adjudicate cases is effective.

Although some aspects of the process work well, concerns raised by the review need to be addressed. Due to budget constraints, the Board of Nursing does not appropriately sanction some certified nurse aides with serious violations. Statutory changes are needed to: expand the obligation of health professionals to report on fellow practitioners, restrict eligibility for reinstatement after revocation, make the reinstatement process uniform, and eliminate a Board of Dentistry advertising restriction that is unnecessary. In addition, the department needs to use its present statutory authority to pursue unlicensed practice cases. Finally, serious concerns raised about delays in case processing and the Board of Medicine's lack of involvement in regulating standard of care, which are issues discussed in the final two chapters of the report, need to be addressed.

SOME ASPECTS OF THE DISCIPLINARY PROCESS WORK WELL

Aspects of the disciplinary process work relatively well. The intake staff, investigators, and senior legal assistants all generally perform their responsibilities effectively and provide strong support to the disciplinary process. Additionally, board members as well as board staff and counsel provide effective support to the process.

With the exception of the slowness of the disciplinary process discussed in Chapter III, the system established for processing and adjudicating cases appears to work effectively for resolving cases and provides adequate protection to respondents. Complaints, other than medical malpractice reports, generally appear to be screened appropriately at intake. Also, with the exception of medical malpractice cases, cases that are docketed by the intake staff are usually investigated fully. In addition, the boards have established effective systems for evaluating whether there is probable cause to proceed to a hearing. The case preparation process also appears to work relatively well. Finally, the case hearing process, which begins with an informal conference, seems to work well and usually leads to the satisfactory resolution of cases.

Cases Are Effectively Screened at Intake

The process used to screen complaints at the intake stage appears to generally work well. The intake analysts who are responsible for screening complaints at

this point in the process generally appear to make reasonable decisions about whether to docket complaints for investigation or to recommend closure of complaints to the boards. With the exception of one category of Board of Medicine cases, JLARC staff's review of complaints that are closed, or "off-lined," at the intake stage indicated that the decisions to off-line complaints at this point in the process are typically supported by the facts presented. Many of the complaints are off-lined because DHP does not have jurisdiction, such as complaints against facilities. Many of the other complaints that are closed by intake staff involve patient concerns but not violations of law. These complaints involve such concerns as fee disputes and rude conduct by practitioners.

In interviews, board executive directors all stated their view that the intake analysts effectively screen complaints at the intake stage. They further indicated that the boards rarely disagree with intake recommendations regarding complaints to off-line. They also stated that over the last several years, the intake staff have become increasingly effective at screening out complaints that do not need to be investigated, but that in past years might have been unnecessarily docketed for investigation.

Investigative Process Is Effective Overall

The investigative process currently used by the Department of Health Professions appears to be effective overall. Based on a review of investigative reports, JLARC staff found that the investigators generally conduct thorough investigations and obtain the information necessary for the boards to decide the cases presented to them for adjudication. JLARC staff analyzed the investigative reports prepared for the disciplinary hearings observed during the review as well as the investigative reports prepared for those cases reviewed by JLARC staff that were closed after an investigation. These reports were reviewed to evaluate whether the investigators interviewed the necessary witnesses, collected the appropriate documents and other relevant information, and presented the information in an understandable written report. JLARC staff found that approximately 95 percent of the investigation reports reviewed appeared to be adequate.

Based on interviews with board staff and senior legal assistants, they are generally satisfied with the quality of the investigations. In addition, in a JLARC survey of board members, 88 percent of the board members who responded expressed general satisfaction with the investigative reports prepared for the disciplinary cases.

Hearing Process Usually Works Well

Another aspect of the disciplinary process that appears to work well is the hearing process for adjudicating cases. The administrative proceedings division effectively supports this process. Likewise, board staff provide effective support to the process, and most board members handle their role in the hearing process effectively.

Administrative Proceedings Division Provides Strong Support to the Hearing Process. The senior legal assistants generally perform their responsibilities effectively. As discussed in Chapter I, these staff are responsible for preparing cases for hearing, including the preparation of the hearing notice. In addition, they are present during each informal conference to ensure that the relevant information is before the committee in making its decision. Finally, they prosecute cases on behalf of the State in formal hearings or support assistant attorneys general who are prosecuting cases for the State.

Through observance of these staff both at informal conferences and formal hearings, as well as through a review of notices for hearings prepared by them, JLARC staff found that these staff appear to serve effectively in their role. The notices prepared by these staff generally appear to reflect the appropriate allegations based on the investigative reports prepared. In addition, these staff provide effective and appropriate support during the hearing process. Finally, it was apparent from observing these legal assistants during hearings that they are typically well-prepared and have a good understanding of the cases that they are assigned.

Board Staff and Counsel Effectively Support the Process. The board executive directors and their staff generally provide strong support to the disciplinary process. They usually serve in a consulting role and provide guidance to the board members during the hearing process.

Board counsel appear to effectively perform their role as well. Like the executive and deputy executive directors, they provide guidance to the boards during the hearing process. However, their guidance is generally limited to legal issues.

Board Members Are Effective Overall. The board members themselves also handle their role in the process relatively well. Based on a review of cases closed at intake or after a probable cause review, their decisions to close cases without a hearing are generally supported by the law and the facts presented.

Likewise, board members are fairly effective in their adjudicatory role. In most instances board members with responsibility for adjudicating cases acted reasonably and appropriately, and their decisions regarding whether a practitioner violated the *Code of Virginia* or regulations promulgated by the boards were typically supported by the facts. However, in approximately eight percent of the cases observed by JLARC staff, board members acted inappropriately or seemed to lack an understanding of the disciplinary process. For example, in three instances board members expressly stated that they had reached conclusions about cases prior to the completion of the presentation of evidence. In another instance, a board member noted after a hearing that he knew the respondent personally but had decided not to disclose his relationship prior to the hearing. Also, JLARC staff observed other instances in which board members were sidetracked by issues not directly relevant to the facts of the case.

Process Appears to Be Fair to Respondents and Keeps Complainants Informed

With the exception of the case processing delays discussed in the next chapter, the process appears to be generally fair to both respondents and complainants. DHP has an established protocol for providing information to respondents and appears to consistently follow its established procedures. Respondents are given the investigative report as well as other pertinent documents prior to a hearing. The boards appear to consistently communicate their decisions regarding cases in writing to respondents. Moreover, staff take the time to educate respondents about the process both prior to and on the day of their hearings.

In addition, at the over 130 hearings observed by JLARC staff, boards and staff generally appeared to be respectful and protective of the rights of respondents. In a JLARC survey of board members, 90 percent of respondents to the survey indicated that they believe the disciplinary process provides for the fair treatment of licensees accused of wrongdoing. Moreover, in interviews with attorneys who represent practitioners before the health regulatory boards, most of the attorneys stated that they believe that the process is usually a fair one.

The boards also keep complainants advised during the process. They advise them in writing regarding the closure of cases either at the intake stage or after a probable cause review and of their final decisions in cases that are adjudicated. In addition, they advise complainants of the scheduled conference and hearing dates and may provide them with the opportunity to make statements at the informal conferences and testify at formal hearings.

SOME SERIOUS CASES OF PATIENT ABUSE AGAINST CERTIFIED NURSE AIDES ARE NOT CONSIDERED FOR SUSPENSION OR REVOCATION DUE TO FUNDING CUTS

The Board of Nursing does not suspend or revoke the certification of some certified nurse aides (CNAs) whom the Board believes are unsafe to practice. As a result of federal funding cuts in the CNA program, the Board of Nursing decided to limit the number of cases that are referred to a formal hearing. This practice does not violate any State or federal laws or regulations, but it allows many CNAs who have committed serious acts of misconduct to retain their certificates even though they may not be fit to practice as CNAs.

As discussed in the November 1998 *JLARC Interim Report: Review of the Health Regulatory Boards*, the federal government, which created and was the primary funding source for the CNA program, reduced its funding of the CNA program in 1994. This reduction in federal funding occurred at a time when the number of CNAs and the expense of regulating the profession were increasing. Along with the delays involved in implementing a fee increase for CNAs, this reduction in federal funding created a

deficit for Virginia's CNA program. Therefore, the Board of Nursing approved a formal policy to cut the costs of hearing CNA cases by reducing the number of cases that proceed to a formal hearing. Prior to this change in policy, CNA cases that involved allegations of serious misconduct would have been referred for a formal hearing.

Instead of forwarding serious CNA disciplinary cases to a formal hearing before the full board, informal conference committees of the Board of Nursing typically issue a reprimand with a "finding of abuse, neglect or misappropriation of patient property." This finding is submitted to the federally mandated nurse aide registry, and federal law prohibits nursing homes that accept Medicaid and Medicare funds from hiring CNAs with such a finding on the registry. This action has the same effect as suspending or revoking the certification of nurse aides who wish to work in federally funded nursing homes. However, a CNA who has been reprimanded would continue to have a valid certificate to practice and could still practice in home health care settings, hospitals, and private nursing homes as a certified nurse aide.

Some CNA cases are still referred to a formal hearing of the Board of Nursing, and as a result, some certificates are suspended or revoked. There are three different scenarios in which the board may hear a CNA case despite the board's general policy not to conduct such hearings. First, some respondents appeal an informal conference committee's decision and have a right to a formal hearing. Second, if a CNA is summarily suspended, the CNA has a right to a formal hearing to consider the case. Third, some informal conference committees will forward particularly egregious CNA cases to a formal hearing despite the board's general policy against such action. However, the executive director of the Board of Nursing stated that almost twice as many cases would be heard by a formal hearing if not for the budget constraints.

The following are examples of CNA disciplinary cases which the Board of Nursing did not forward to a formal hearing:

> *An informal conference committee made findings that one CNA struck a nursing home resident on multiple occasions, including hits to the resident's face and head. This CNA struck another resident on multiple occasions on the back, shoulders, face, and buttocks and spoke to this resident in an inappropriate way. In addition, the board found that this CNA failed to make appropriate notes regarding her patients on the nurse's notes. As a result of these findings, this CNA was reprimanded and a finding of abuse was entered against her in the nurse aide registry.*
>
> * * *
>
> *An informal conference committee entered an order against a CNA, which included findings of multiple instances of physical and verbal abuse. The committee found that the CNA pulled a nursing home resident from the bed by the collar and spoke to this resident harshly*

using profanity; twisted another resident's ears, pinched his toes and feet, and hit his buttocks; and hit another resident in the chest and squeezed his hand to keep him from making noise. In addition, the CNA was found to have pinched an additional nursing home resident and to have used profanities when speaking to multiple residents. The informal conference committee reprimanded this CNA and entered a finding of abuse in the nurse aide registry.

* * *

An informal conference committee made multiple findings against a CNA, which included the neglect of two patients resulting in significant injury including a broken arm. In addition the CNA used a patient's telephone without permission to make nearly $2,000 worth of long distance phone calls. The informal conference committee reprimanded the CNA and made a finding of neglect and misappropriation of patient property to be entered into the nurse aide registry.

As the case examples illustrate, some serious CNA cases are handled without the suspension or revocation of the CNA's certificate. While the current approach may ensure that these CNAs do not work in federally-funded nursing homes, these CNAs may still represent themselves as certified nurse aides with unrestricted certificates to gain employment in other health care settings. Therefore, this current policy of the Board of Nursing raises public safety concerns, and the financial limitations contributing to this policy need to be addressed.

Recommendation (1). **The Board of Nursing, with the assistance of the Secretary of Health and Human Resources, should work to resolve the Certified Nurse Aide program's budget deficit in order for the Board of Nursing to have the funds necessary to make disciplinary decisions in certified nurse aide cases based on the seriousness of the violation and the need to protect the public and not on financial constraints.**

STATUTORY CHANGES TO IMPROVE THE PROCESS

The review of the disciplinary process revealed four areas in which statutory changes would improve the disciplinary system. Reporting obligations and protections need to be extended to all practitioners. In addition, a more stringent restriction on eligibility for reinstatement after revocation should be applied to all health regulatory boards, and the reinstatement process needs to be made uniform. Finally, the statutory restriction that prohibits the use of trade names by dentists should be eliminated.

Reporting Obligation and Associated Immunity Should Be Extended to All Practitioners

Physicians and other practitioners licensed by the Board of Medicine are the only licensees obligated to report to DHP unprofessional conduct or incompetent practice by another practitioner licensed by the board. Along with this reporting obligation, licensees of the Board of Medicine are given immunity from any civil or criminal action that might arise out of making such a report. No other health care practitioners have a statutory obligation to make reports regarding other practitioners except when treating the practitioner for mental disorders, chemical dependency, or alcoholism. Likewise, licensees of boards other than the Board of Medicine do not have statutory immunity from civil or criminal liability from actions that might result from making a voluntary report.

The executive director of the Boards of Professional Counselors, Psychology, and Social Work has raised the concern that the current reporting obligations and lack of immunity for professionals desiring to make complaints is problematic. According to the executive director, she has received a number of calls from practitioners licensed by these boards who have serious concerns about fellow practitioners but are unwilling to make such reports under current law because they have no immunity.

The reporting requirements and immunity provisions that currently apply only to licensees of the Board of Medicine should be extended to the licensees of the other health regulatory boards. In the interest of public protection, licensees should be required at a minimum to report unprofessional conduct or possible professional incompetence by other licensees within their profession to the Department of Health Professions. Moreover, health practitioners should be given immunity from civil or criminal liability that might result from making such a report.

With professional counselors, psychologists, social workers, and psychiatrists, the reporting obligation and associated immunity should be extended across professions because of the vulnerability of many of the patients or clients of these professionals and the overlap in the treatment of these individuals. These practitioners often see the same patients for the same or related problems. Therefore, these practitioners inevitably become aware of professionalism or competency issues regarding health care professionals in these related fields. As a result, these practitioners should have an affirmative duty to report unprofessional conduct or competence concerns regarding other practitioners. In addition, they should be provided immunity from civil liability for such reporting.

The Board of Health Professions should study whether it would be beneficial to further extend reporting obligations to require all health care professionals to report misconduct by any other health professional. In addition to the behavioral science professions, there are many other situations in which health care professionals have the opportunity to observe directly the work of practitioners of other professions and to notice problems in their practice.

Recommendation (2). **The General Assembly may wish to consider amending the *Code of Virginia* to: (1) require that all licensees report unprofessional, incompetent, or substandard conduct or care by any other practitioner licensed by the same board; (2) require any licensed psychiatrist, psychologist, professional counselor, or social worker to report any unprofessional, incompetent, or substandard conduct or care by any other such licensee; and (3) provide immunity to any such person who makes a report from criminal or civil liability resulting from such report.**

Recommendation (3). **The Board of Health Professions should study whether the reporting requirements should be extended to require all health care professionals to report any unprofessional, incompetent, or substandard conduct or care by any other health professional to the Department of Health Professions.**

License Revocation Should Bar Reinstatement for an Established Period of Time

The amount of time for which the revocation of a practitioner's license bars his ability to apply for reinstatement varies significantly by board. As a result, boards are inconsistent in their use of suspensions and revocations as sanctions, and in some cases they are inappropriately using suspension as a sanction instead of revocation. The restriction on the ability to apply for reinstatement of practitioners whose licenses have been revoked needs to be made more uniform across boards as well as more stringent.

Eligibility to Apply for Reinstatement After Revocation Varies by Board. The 12 health regulatory boards vary in their restrictions on eligibility to apply for reinstatement after license revocation. Specifically, the time period which must pass before an individual can apply for reinstatement varies among boards. The *Code of Virginia* establishes reinstatement time periods for the Boards of Medicine and Optometry. Individuals who had been licensed by these boards must wait at least one year after revocation of their licenses before they may apply for reinstatement. The *Virginia Administrative Code* establishes regulations for time guidelines for the Boards of Professional Counselors, Psychology, and Veterinary Medicine. Individuals who had been licensed by the Boards of Professional Counselors and Psychology must wait at least two years before applying for reinstatement. The regulations for the Board of Veterinary Medicine allow practitioners to apply for reinstatement at any time following revocation of their licenses. It appears from the lack of statutory and regulatory guidelines for the other seven health regulatory boards that there is no restriction on when their licensees may apply for reinstatement after revocation.

Revocation Should Be Consistently Used As the Most Serious Form of Sanction. Revocation of a practitioner's license is a more serious sanction than sus-

pension in the hierarchy of sanctions. However, the statutory and regulatory guidelines for reinstatement of a revoked license are not consistent with this difference. Instead, as one executive director told JLARC staff, "I'm not sure there's a hill of beans difference between the two, other than perception."

While the perception may be that revocation is a more severe sanction, several executive directors told JLARC that their boards have used suspension in lieu of revocation in some cases because they can better prevent a practitioner from practicing for a longer period of time with a suspension sanction. Eight of the health regulatory boards appear to have no requirement for the amount of time that must lapse before a practitioner with a revoked license may apply for reinstatement. Therefore, individuals wanting to be reinstated by any of these boards can theoretically apply within days of an order revoking their licenses. With a suspension, however, boards may specify a particular period of time during which they can prevent a practitioner from practicing. One executive director told JLARC staff that she has observed cases in which the licenses of practitioners who have committed particularly egregious offenses have been suspended for a minimum of five years to avoid the possibility of a practitioner petitioning for reinstatement soon after revocation.

Individuals whose licenses have been revoked should not be permitted to return to practice soon after the revocation of their licenses. Any individual whose behavior and actions have been serious enough to warrant revocation of his license should not be eligible to apply for reinstatement for a substantial period of time. Moreover, the boards and DHP staff should not have to devote their time and resources to hearing requests for reinstatement until sufficient time has passed that reinstatement is a realistic possibility.

Code Needs to Be Amended to Clarify Use of Revocation. The *Code of Virginia* needs to be amended to clarify the use of revocation as a sanction. The *Code* needs to establish a set time period during which practitioners who have had their licenses revoked may not seek reinstatement. This time period should be consistent for all health regulatory boards. In addition, it should be a significant period of time. Most of the executive directors agreed that some minimum time period should be established, and several directors stated that five years might be the appropriate minimum time period to set.

Recommendation (4). **The General Assembly may wish to consider amending the *Code of Virginia* to prohibit any individual who has had his or her license revoked by any of the health regulatory boards from applying for reinstatement of his or her license for a substantial period of time. The General Assembly may wish to consider a minimum for all boards of between three and five years. The General Assembly may wish to allow the individual boards to have longer minimum revocation periods if they choose to do so by regulation.**

Statutory Differences Regarding Reinstatement Need to Be Addressed

Practitioners who have had their licenses revoked or suspended have the right to apply for reinstatement of their licenses. Under current law, there are differences in how reinstatement applications are handled by the health regulatory boards that are based on the means by which the suspension or revocation was originally imposed. In addition, the Board of Medicine handles reinstatement cases differently than the other boards.

Health Regulatory Boards Handle Reinstatements from Mandatory Suspensions Differently than Other Reinstatement Cases. Section 54.1-2409 of the *Code of Virginia* currently requires that health professionals who have had their licenses mandatorily suspended or revoked obtain approval of three-fourths of the members of the entire board at a formal hearing to gain reinstatement. In contrast, practitioners who have had their licenses suspended or revoked pursuant to a board hearing may seek reinstatement through an informal conference and are only required to obtain the approval of a majority of the informal conference committee members to obtain reinstatement.

There does not appear to be any policy justification for the difference in treatment of mandatory suspension cases and revocations or suspensions imposed by the boards through their hearing process. Moreover, the requirement that practitioners seeking reinstatement from mandatory suspensions obtain approval of three-fourths of the members of the board creates a potential inequity for practitioners in seeking reinstatement because there is no requirement that the full board participate in the reinstatement hearing. If one or more board members are not present for the reinstatement hearing, then the practitioner is required to obtain the approval of more than three-fourths of those board members present to gain reinstatement. JLARC staff observed one such reinstatement hearing in which two board members were absent. Two deputy executive directors told JLARC staff that every effort is made to have all board members present to avoid this potential inequity but that scheduling such a date can be extremely difficult.

Board of Medicine Handles Reinstatement Cases Differently. The Board of Medicine handles reinstatement cases differently than the other 11 health regulatory boards. Section 54.1-2917 of the *Code* states that any licensee who has had his or her license mandatorily suspended or revoked by the Board of Medicine may gain reinstatement of his or her license upon the approval of three-fourths of the members present at the hearing. The Board of Medicine follows this statutory requirement and therefore does not require that a practitioner seeking reinstatement from a mandatory suspension obtain the approval of three-fourths of the members of the entire board as the other health regulatory boards do.

Another difference between the Board of Medicine and the other health regulatory boards is that the Board of Medicine has interpreted the *Code of Virginia* as requiring the board to consider all applications for reinstatement through a formal hearing instead of an informal conference as the other boards do. While § 54.1-2400

states that informal conferences of the health regulatory boards have the authority to reinstate a practitioner's license, § 54.1-2919 of the *Code*, which describes the authority of informal conference committees of the Board of Medicine, makes no mention of authority to reinstate a practitioner's license. Given the absence of any language in this statutory provision giving the Board of Medicine the authority to reinstate licenses through informal conferences, the Board of Medicine requires that all applications for reinstatement be considered by a formal hearing panel.

These inconsistencies in handling reinstatement cases need to be addressed. There does not appear to be any policy rationale for the differences in how these applications are handled. Therefore, the *Code* should be amended to make the procedure for reinstatement consistent across boards and handle all reinstatement petitions in the same manner regardless of the means by which the suspension or revocation was originally imposed.

Recommendation (5). **The General Assembly may wish to consider amending the *Code of Virginia* to make the process for license or certificate reinstatement uniform across all health regulatory boards.**

Advertising Restriction Does Not Appear Necessary to Protect the Public

The *Code of Virginia* currently requires dentists to practice under their own names and prohibits them from practicing under a trade name. Dentistry is the only health care profession with such a prohibition, although the Board of Optometry requires through regulation that optometrists obtain approval for any trade name that they wish to use.

This restriction on the use of trade names does not appear to be related to protection of the public, but instead appears more directly related to the protection of the economic interests of dentists. The executive director of the Board of Dentistry stated that she is not aware of a member of the general public making a complaint regarding a trade name. Most such complaints are submitted by other dentists or by anonymous complainants.

The lack of a relationship between the restriction on the use of trade names and public protection is evident upon a review of some of the names for which dentists have been sanctioned. During the last two years, dentists have been reprimanded and fined for using names such as "Kempsville Comprehensive Dentistry," "Holland Road Dental Care," "Tysons Dental Associates," and "General Booth Family Dentistry." During the same time period, the Board has imposed comparable or less severe sanctions on dentists for much more serious standard of care violations like failing to diagnose and treat periodontal disease and failing to diagnose a tooth abscess.

These trade name cases unnecessarily add to the disciplinary caseload of the Board of Dentistry. During the last two fiscal years, 21 percent of the disciplinary orders issued by the Board of Dentistry were for trade name violations. These cases do

not protect the public, and they create additional work for the board members who have to hear the cases as well as the DHP staff who must investigate and prepare these cases for hearing.

Recommendation (6). **The General Assembly may wish to consider amending § 54.1-2718 of the *Code of Virginia* to remove the prohibition against the practice of dentistry under a firm name.**

DHP SHOULD ENFORCE LAWS AGAINST UNLICENSED PRACTICE

The Department of Health Professions needs to assume responsibility for bringing forward for prosecution some unlicensed practice cases that are not being prosecuted. Currently, only those cases that a Commonwealth's attorney decides to prosecute are pursued. As a result, some relatively serious cases are closed without prosecution. Even though the Commonwealth's attorney has decided not to prosecute them, some of these cases should be pursued by DHP in general district court, as is done by the other state entity with a major role in regulating professionals, the Department of Professional and Occupational Regulation.

DHP Processes and Investigates Complaints of Unlicensed Practice

Section 54.1-111 of the *Code of Virginia* makes unlawful the practice of any profession or occupation without holding a valid license. To practice without a license is a Class 1 misdemeanor, and the third conviction for unlicensed practice during a three-year period constitutes a Class 6 felony. The only exceptions to this involving the health professions are: performing an invasive procedure for which a license is required; prescribing, selling, distributing, or dispensing a controlled drug; and practicing a profession after the suspension or revocation of a license. Each of these acts constitutes a Class 6 felony on the first offense.

During the last two years, the Department of Health Professions received 93 complaints alleging unlicensed practice of the different health professions. Complaints alleging unlicensed practice are received by DHP's intake unit from the public in the same manner as complaints against licensees. An intake analyst reviews each complaint, and, for the most part, sends these complaints forward to be investigated. One intake analyst told JLARC staff that she dockets anything that "smells like unlicensed practice."

Once these complaints are docketed, they are investigated by the field investigators in a similar manner as investigations involving licensees. On occasions in which an undercover investigation is warranted, the State Police may also become involved in an investigation of unlicensed practice. In some of the most egregious situations, the local office of the Commonwealth's attorney may also be involved in an investigation.

Some Unlicensed Cases Are Prosecuted by Local Commonwealth's Attorneys

Once an investigation has been completed on a case alleging unlicensed practice, the director of enforcement reviews the case. Cases involving individuals whose licenses are expired or have been suspended or revoked by a board may result in disciplinary actions by that particular board. These cases generally are handled administratively and are rarely prosecuted within the criminal system. Approximately 70 percent of the cases of unlicensed activity received by DHP involve individuals who have never been licensed by a health regulatory board in Virginia. Of these, many egregious cases are prosecuted by local Commonwealth's attorneys, while the remaining cases are closed by DHP without any action against the unlicensed individual.

DHP Enforcement Division Sends Cases of Unlicensed Practice to Local Commonwealth's Attorneys for Review. Most cases of unlicensed practice are sent to the local Commonwealth's attorney's office for further action after DHP has completed the investigation. The Commonwealth's attorney then reviews the case and determines whether to prosecute the unlicensed individual. JLARC staff reviewed all cases involving unlicensed activity that were resolved in 1997 and 1998. In some of these cases reviewed by JLARC, it appeared that the decisions made by the Commonwealth's attorneys not to prosecute were based on a lack of evidence of patient harm. In many of the cases JLARC staff reviewed, the Commonwealth's attorneys' decisions appeared to be based on constraints posed by the limited resources available to the local Commonwealth's attorney. In some jurisdictions, for example, Commonwealth's attorneys do not prosecute misdemeanor cases. If a case is not prosecuted, the case is returned to DHP. In such instances, DHP closes the case, and no action is taken against the unlicensed individual. According to DHP staff, once an investigation is complete, DHP has no further jurisdiction over such a case.

Commonwealth's Attorneys Prosecute the Most Serious Cases Involving Unlicensed Practice. JLARC's review of cases involving unlicensed activity in 1997 and 1998 found that the most serious cases involving unlicensed activity were prosecuted by the Commonwealth's attorney having jurisdiction over the matter. Prosecuted cases included:

- an unlicensed dental hygienist who had practiced for a number of years under different dentists and who also had a history of problems with the law, including serving time in jail for forging checks;
- a doctor who continued to practice after the suspension of his license, and who prescribed significant amounts of medication, resulting in 40 warrants against him; and
- a veterinarian who used her prescriptive authority for animals ostensibly for her cat, but instead gave the medication to children.

In several instances, the local office of the Commonwealth's attorney worked alongside the DHP investigators to gather information on the unlicensed activity taking place in their jurisdiction.

Cases Involving Unlicensed Practice, But No Evidence of Public Harm, Generally Are Not Being Prosecuted by Commonwealth's Attorneys. While some of the more serious allegations of unlicensed activity in Virginia are prosecuted by local Commonwealth's attorneys, other allegations of unlicensed activity are not prosecuted. Although these allegations generally do not involve any clear evidence of patient harm, these unlicensed individuals are putting patients at risk by not having the appropriate training and licensure. The following are several examples of cases that were not prosecuted by a Commonwealth's attorney, and instead were closed by DHP with no disciplinary action:

An individual was practicing as a registered nurse (RN) while unlicensed in Virginia. This individual had previously been licensed as a licensed practical nurse (LPN) in Florida, but subsequently had her license as an LPN revoked there for practicing as an RN with a forged license. In Virginia, this individual had given her employer a forged license and a forged note from the executive director of the Board of Nursing. The Commonwealth's attorney declined to prosecute because there was no negative outcome to patients.

* * *

An unlicensed individual allegedly performed duties of a registered nurse (RN), represented herself to families as an RN, and billed patients for services at the rate used for RNs. She also allegedly presented herself as an RN to employees of the home health agency she owns, which provides health care services to patients in their homes.

* * *

An individual not trained or licensed as a veterinarian inappropriately provided health care to animals. This individual admitted giving vaccinations and neutering cats and dogs. The Commonwealth's attorney declined to prosecute because there was no evidence of harm.

* * *

Two complaints were filed against an individual whose funeral services license had been revoked by the Board of Funeral Directors and Embalmers. The complaint alleged that the individual was continuing to make funeral arrangements and sign contracts. In addition, the individual provided poor quality services and thereby caused many difficulties to the family of a deceased person. The problematic ser-

vices included a delay in transporting the body and putting incorrect information on the deceased's headstone. The individual was not prosecuted for practicing without a license, and the case was closed by DHP without disciplinary action.

In addition to these cases, DHP handled seven complaints in 1997 involving individuals who forged certified nurse aide (CNA) certificates, some of whom practiced as CNAs with these forged certificates. JLARC's review of unlicensed practice cases found that the Commonwealth's attorney only prosecuted one of these complaints, which involved an individual with a history of legal problems who was also being investigated for larceny.

DHP staff expressed frustration that some unlicensed practice cases are not prosecuted by the Commonwealth's attorneys, but they provided several possible explanations for the Commonwealth's attorneys' lack of attention to such cases. An investigator told JLARC staff that some Commonwealth's attorneys generally do not want to deal with the less serious cases because they are misdemeanors. Several investigator supervisors reported that, in some jurisdictions, Commonwealth's attorneys adequately pursue cases that involve a substantial public threat, but in cases that are less severe and more "administrative," they tend not to get involved. One assistant attorney general who prosecutes cases involving licensees before the boards told JLARC staff that some Commonwealth's attorneys have so many other cases that the unlicensed health practitioner cases usually "end up on the bottom of the pile."

DPOR Issues Warrants and Pursues Unlicensed Activity

The Department of Professional and Occupational Regulation (DPOR) regulates most regulated professions in Virginia other than the health professions. Section 54.1-306 of the *Code of Virginia* gives DPOR the authority to serve and execute warrants for unlicensed practice of the occupations it regulates. If an investigator has evidence of unlicensed activity, the investigator may request a warrant from a magistrate. If the magistrate finds probable cause of a criminal violation, the magistrate issues a criminal warrant or summons against the individual. The investigator can then serve and execute this warrant or summons on the unlicensed individual.

Cases involving unlicensed activity may be tried in general district court. Depending on the locality, a Commonwealth's attorney may determine that it has the resources to prosecute these misdemeanor cases. If not, the case proceeds before the general district court without the Commonwealth's attorney present, and the investigator from DPOR testifies as a witness for the Commonwealth.

In the last biennium, DPOR made 524 arrests, many of which were as a result of this warrant authority. Out of these arrests, there were 466 convictions. The majority of these cases were prosecuted in general district court without a Commonwealth's attorney present.

DHP Should Issue Warrants and Pursue Unlicensed Activity

DHP staff members have expressed concern about some of the unlicensed health practitioner cases that are not prosecuted by the Commonwealth's attorneys, and staff seem to believe that these cases are worthy of prosecution. Currently, these cases are closed by DHP with no further action. JLARC staff found, however, that DHP appears to have the authority to bring these cases forward for prosecution under Virginia law. Section 54.1-2506 of the *Code of Virginia* gives DHP the same authority as DPOR to serve and execute warrants. In addition, there do not appear to be any restrictions in the statutes governing the regulation of health professionals that would limit DHP's ability to pursue these cases in general district court as DPOR does.

With the authority to serve and execute general district court warrants, it appears that DHP should be able to pursue these cases of unlicensed practice. While many of the Commonwealth's attorneys prosecute cases that may present the most serious threats to public health and welfare, bringing these cases to general district court would enable DHP to ensure that less egregious cases and those cases that provide less evidence of patient harm are also adjudicated through the criminal system. Individuals who are practicing without appropriate training and licensure are putting patients at risk, even if patient harm has not been established. By pursuing cases of unlicensed practice, DHP would be able to underscore the boards' regulatory authority over the practice of health professions and help deter further unlicensed practice.

DHP's enforcement division should present all unlicensed cases which are supported by evidence to a magistrate for a criminal warrant or summons. Cases without evidence of unlicensed practice could be closed administratively by DHP. Simultaneous to presenting a case to a magistrate, the enforcement division should give the appropriate Commonwealth's attorney the opportunity to assume responsibility for the prosecution of the case. If the Commonwealth's attorney declines, and the magistrate determines that there is probable cause to issue a criminal warrant or summons, then the appropriate investigator should serve and execute the warrant and be available to testify as a witness in the court proceeding on behalf of the Commonwealth.

While the JLARC staff review found that DHP appears to have the authority to pursue unlicensed practice cases on its own, in the past, DHP has reportedly received informal advice from staff of the Office of the Attorney General that current law does not provide the department with such authority. To the extent that there remains uncertainty about DHP's authority to pursue these cases, the General Assembly may wish to amend the *Code of Virginia* to expressly give DHP the authority to pursue unlicensed practice cases in general district court.

Recommendation (7). **The Department of Health Professions should take a more active role in pursuing the unlicensed practice of the health professions through use of its warrant authority in § 54.1-2506 of the *Code of Virginia* to bring misdemeanor unlicensed activity cases to general district court. If there continues to remain uncertainty with regard to the Depart-**

ment of Health Professions' statutory authority to pursue cases of unlicensed practice, the General Assembly may wish to consider amending § 54.1-2506 of the *Code* to give the Department of Health Professions express authority to pursue unlicensed practice cases in general district court.

III. Case Processing Time and Inspections

Two areas in which the Department of Health Professions and some of the health regulatory boards have not performed satisfactorily are in processing disciplinary cases in a timely manner and in meeting the inspection goals for facilities licensed by the health regulatory boards. Most of the boards take in excess of one year on average to resolve their disciplinary cases that proceed to a hearing. This exceeds the six to twelve-month time frame within which executive directors of the boards have indicated cases could and should be processed. Many of the cases that have taken too long to resolve have involved serious misconduct by a practitioner, and the delay in resolving these cases has created unreasonable and unacceptable risks to public protection and public safety.

DHP's current inspection program also appears to be inadequate. Many facilities that are supposed to be routinely inspected under the program are not being inspected on a regular basis. JLARC's review of the program raises concerns about inspector output, the need for additional resources to meet program goals, and the need for a fundamental review of the program.

The problems with timely case processing and the inspection program suggest that the disciplinary system could benefit from increased oversight. The Board of Health Professions needs to play a more active role in overseeing the disciplinary system. In addition, the Department of Health Professions needs to provide information in its biennial report to the Governor and the General Assembly about the extent to which it is meeting goals for case processing times as well as on meeting the objectives of the inspection program.

THE DISCIPLINARY PROCESS TAKES TOO LONG TO RESOLVE CASES

As noted in Chapter I, the disciplinary process after intake includes five stages: the investigative process, a probable cause review, preparation of cases for hearing, informal conferences, and formal hearings. The time frame analysis in this chapter focuses on the cases that proceed through the typical stages in the process (see Appendix E for a technical appendix that describes the process used to analyze case processing time). The review of these cases indicates that several boards' disciplinary cases are not resolved within the six to twelve-month time frame in which executive directors of the boards and DHP management suggest cases should be processed. Many of these cases involved serious issues, and the lengthy time frames involved do not appear to protect the public from substandard practitioners.

It should also be noted that the boards have statutory authority to circumvent the normal process and summarily suspend the license of a practitioner. This can be done when it is determined that a practitioner poses an imminent and substantial danger to the public. Typically, this approach shortens the process. However, boards

other than the Board of Nursing rarely use this practice. JLARC staff found that summary suspensions are achieved more quickly than cases that went through the full board process. For example, the Board of Nursing and the four Board of Medicine summary suspension cases in the last two fiscal years took an average of seven months and six months to complete, respectively. This chapter focuses on cases that went through the full board process and not on the minority of cases that were resolved through a summary suspension.

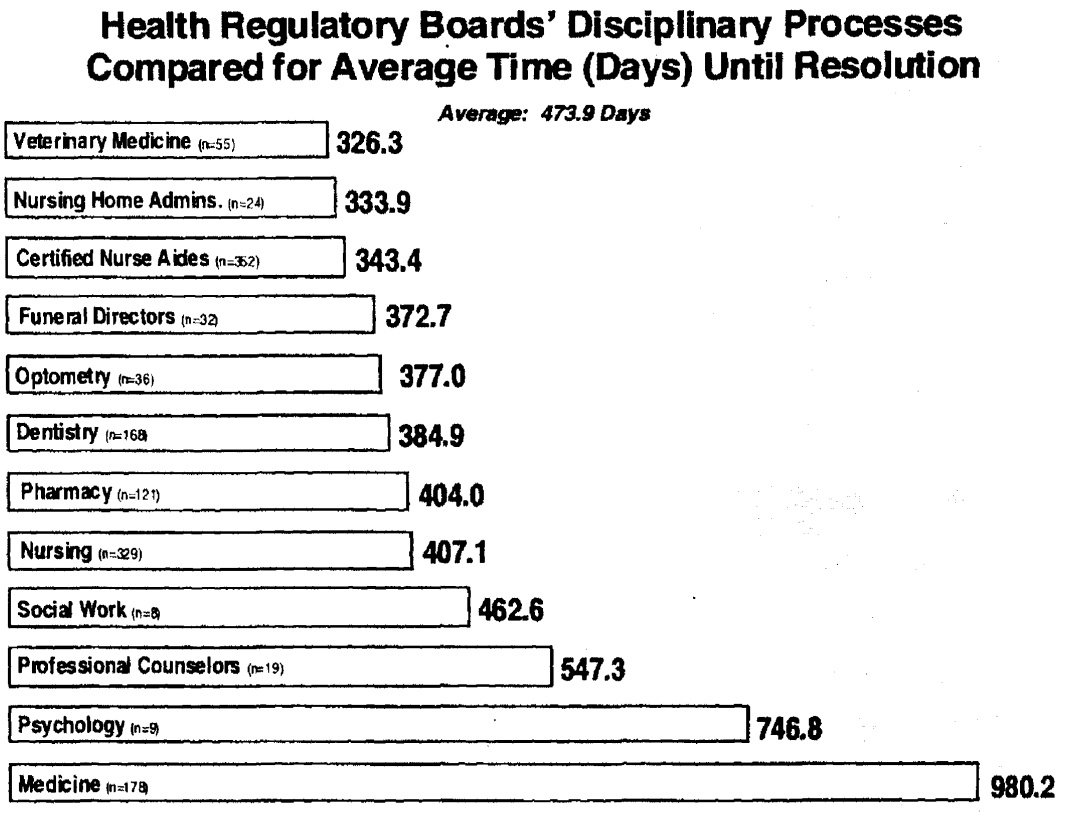
Most Health Regulatory Boards Require More Than One Year to Resolve Their Disciplinary Cases

The health regulatory boards' executive directors and DHP's deputy director of operations told JLARC staff that DHP and the boards should be able to resolve most disciplinary cases within one year. Several of the executive directors stated that cases should on average take no longer than six months. Current guidelines established for internal use by the department suggest that agency management believes that cases can be resolved within one year as well. The enforcement division's time guidelines state that all cases should be investigated within 130 days. In addition, performance expectations for the boards' executive directors state that cases which are ultimately resolved through an informal conference should be completed within 180 days of the receipt of a finished investigative report from the enforcement division. These guidelines provide for a total of less than 310 days to resolve most cases.

However, an analysis performed by JLARC staff indicates that several health regulatory boards are taking much longer than a year to resolve their disciplinary cases. JLARC staff examined 1,331 complaints that had been resolved either through a consent order or through a disciplinary hearing in calendar years 1997 and 1998. (As noted in Appendix E, this analysis excluded summary suspensions, which were rarely done by boards other than the Board of Nursing.) The analysis of these overall results, which are presented in Figure 4, indicates that the cases required an average of 474 days, or more than 15 months, to resolve.

As shown in Figure 4, there are substantial differences between the health regulatory boards' average case resolution times. The Boards of Veterinary Medicine and Nursing Home Administrators were able to resolve their cases in less than a year, on average. In addition, the Board of Nursing took less than a year on average to resolve certified nurse aide cases. The remaining boards took over a year on average to resolve their cases. The Boards of Social Work and Licensed Professional Counselors, Marriage, and Family Therapists and Substance Abuse Professionals (Professional Counselors) both took considerably longer than a year to resolve their cases. The Boards of Psychology and Medicine required the most time to resolve cases. The Board of Psychology spent about two years on average on its cases, and the Board of Medicine spent more than 2.6 years on average.

Figure 4



Notes: The Board of Audiology is not included in this graphic or in the series of graphics which follows because there was only one disciplinary case during the analysis period.

The average time shown for case resolution for each board does not include time taken to review cases at intake. Based on JLARC analysis, cases take 18 days on average to be processed by intake staff and docketed for investigation.

Source: JLARC staff analysis of disciplinary cases resolved during the 1997 and 1998 calendar years.

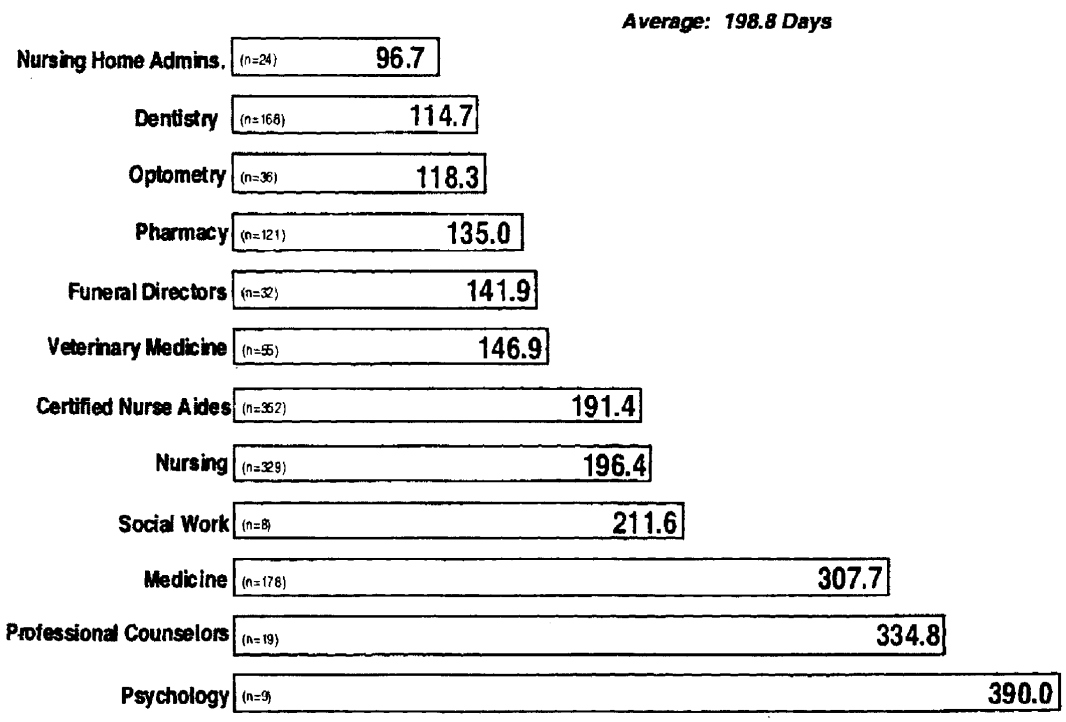
Delays in the Disciplinary Process Occur at Several Stages

Based on JLARC staff analysis of the time required to process and adjudicate disciplinary cases, delays appear to occur at several stages in the process. For purposes of time analysis, JLARC staff have divided the disciplinary process into five stages: (1) complaint investigation; (2) probable cause review; (3) case preparation; (4) scheduling for informal conferences; and (5) preparation for a formal hearing. The time required to complete each stage in the process varies by board, and several stages in the process appear to cause delays in total case processing times.

Investigation of Complaints Takes the Longest Time. The lengthiest stage in the process is the investigation of complaints received. As Figure 5 demonstrates, cases took an average of 199 days to investigate. This represents nearly 42 percent of

Figure 5

Boards' Disciplinary Processes Compared for Average Length (Days) of Complaint Investigations



Source: JLARC staff analysis of disciplinary cases resolved during the 1997 and 1998 calendar years.

the health regulatory boards' average case resolution time. Furthermore, the cases of the Board of Medicine and the three behavioral boards – the four boards with the longest overall case resolution times – took the longest amount of time to investigate. Board of Medicine cases took on average 308 days to investigate, and the Boards of Professional Counselors and Psychology cases took 335 and 390 days respectively.

According to the director of enforcement, the enforcement division has been working hard to reduce the investigation time for high priority cases. (Exhibit 1 lists the enforcement division's time goals by priority for the investigation of cases.) During the past two years, it appears that the enforcement division has been successful in reducing its case processing time for these cases. Currently, the division is typically meeting its goals that priority one cases should be investigated within 30 days and that priority five and six cases should be investigated within 128 and 90 days, respectively. Figure 6 shows the rate of compliance with goals for completion of investigation by priority for the last seven years.

Despite this improvement, the division is still not typically meeting its goals for investigating priority two, three, and four cases. During FY 1998 (the last full fiscal

Exhibit 1

Complaint Priority System with DHP Time Completion Goals

Priority Ranking	Potential Harm to Public	Investigation Completion Standard (in days)
1	Allegation represents an "imminent and substantial danger to the public"	30
2	Allegation represents a "substantial danger to the public, but not an imminent threat"	60
3	Allegation represents a "harmful act, but it is not an imminent or substantial danger to the public."	90
4	Allegation represents an act that "threatens harm without immediate risk to the public's health and safety."	130
5	Allegation represents an act that "will harm the public's welfare without obvious risk to its health and safety."	128
6	Allegation represents an act that "threatens harm to the public's welfare without obvious risk to its health and safety."	90

Source: Department of Health Professions.

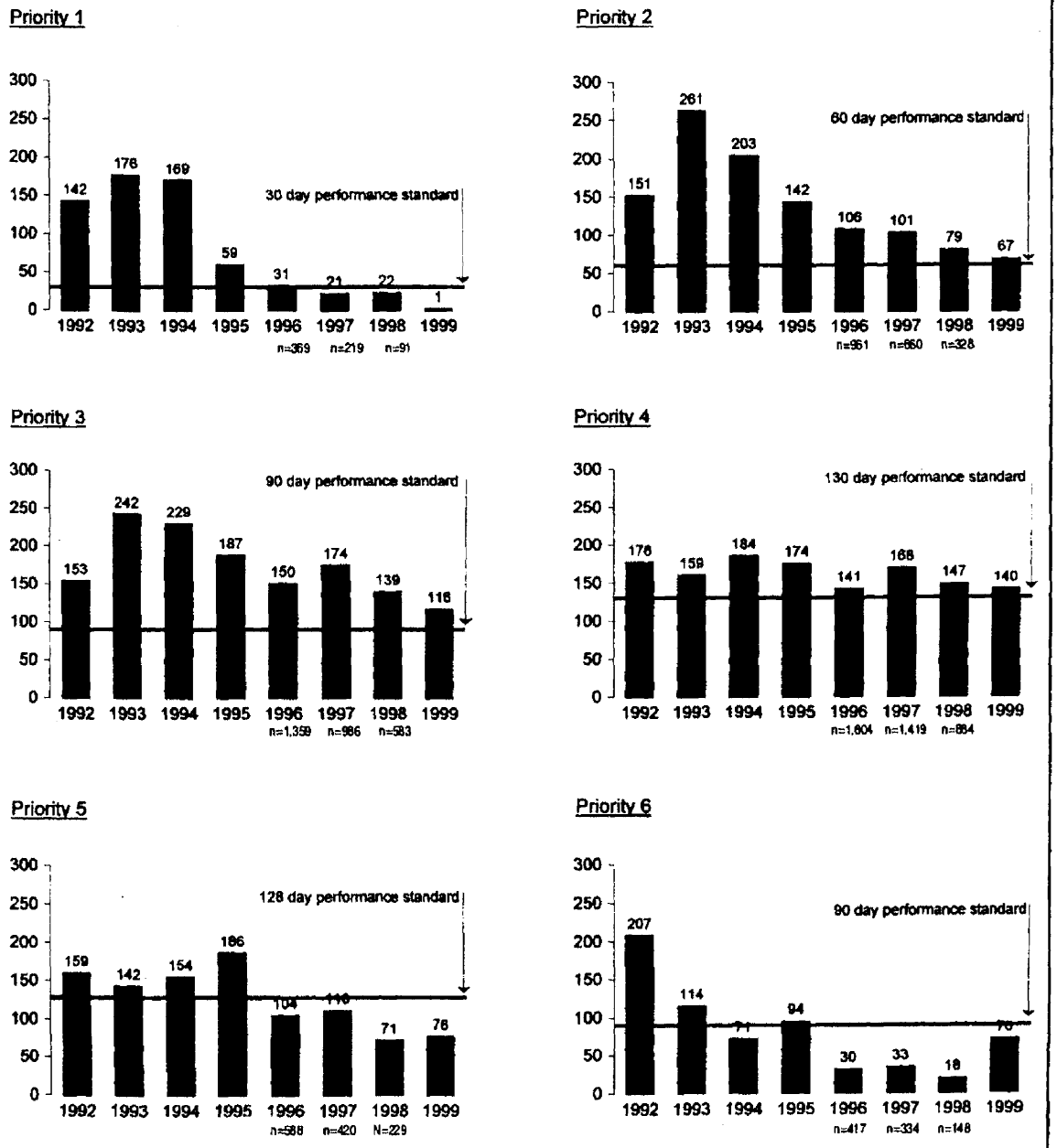
year for which there is data), the median time spent to complete priority two investigations was 79 days, which is 19 days longer than division's 60-day goal. In addition, the median time spent to complete priority three case investigations was 139 days, which is 49 days longer than the enforcement division's goal. Finally, the median time spent to complete priority four cases was 147 days, which is 17 days longer than the 130-day goal for the investigation of these cases.

Time Required to Complete Probable Cause Determinations Appears to be Excessive. After a complaint has been investigated, the next stage in the disciplinary process is to determine whether probable cause exists to proceed with a disciplinary hearing. The probable cause review consists of one to three board members reviewing the investigation report. As shown in Figure 7, the boards required an average of approximately 82 days to conduct this review. At this stage as well, the four boards with the longest overall case resolution times were among those boards requiring the most time to complete this process. The Board of Medicine took over six months to conduct this review, and the behavioral boards required nearly four months on average.

Case Preparation Stage of the Disciplinary Process Appears to Be Completed in a Timely Manner Among Most Boards. After completing the probable cause review, the next stage in the disciplinary process is to prepare the case for an

Figure 6

Median Days in the Investigative Stage, FY 1992-1999 Shown by Priority

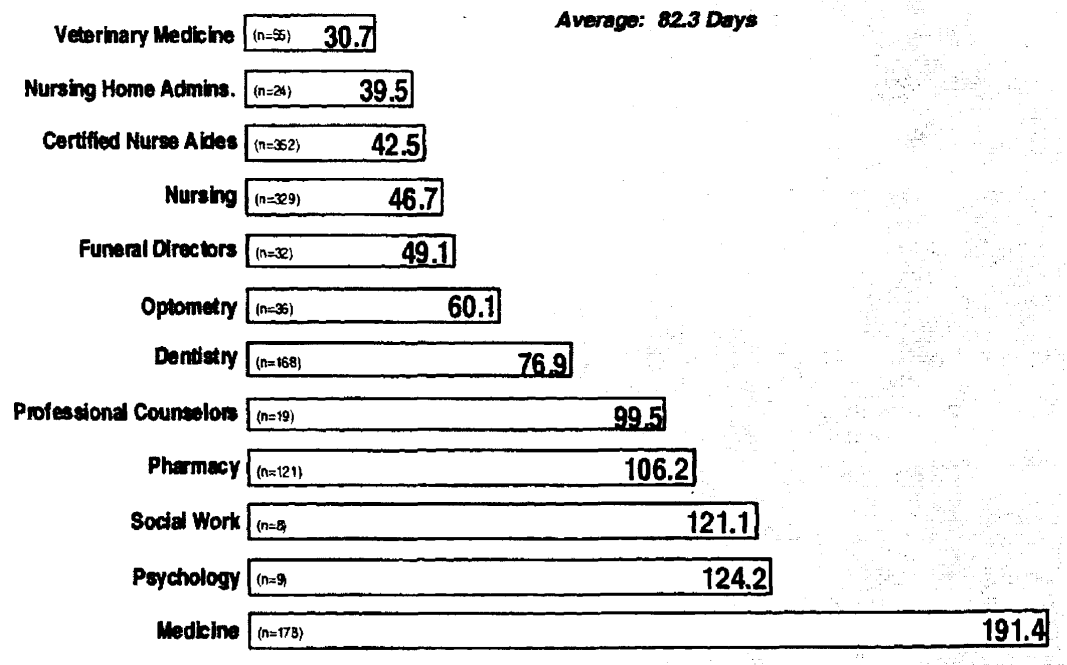


Notes: Number of cases (n) is provided where data was available. FY 1999 figures only include first quarter data.

Source: Virginia Department of Health Professions, as reported in their publication *Revisiting Investigative Time Performance Standards, FY 1999.*

Figure 7

Boards' Disciplinary Processes Compared for Average Length (Days) of Probable Cause Reviews



Source: JLARC staff analysis of disciplinary cases resolved during the 1997 and 1998 calendar years.

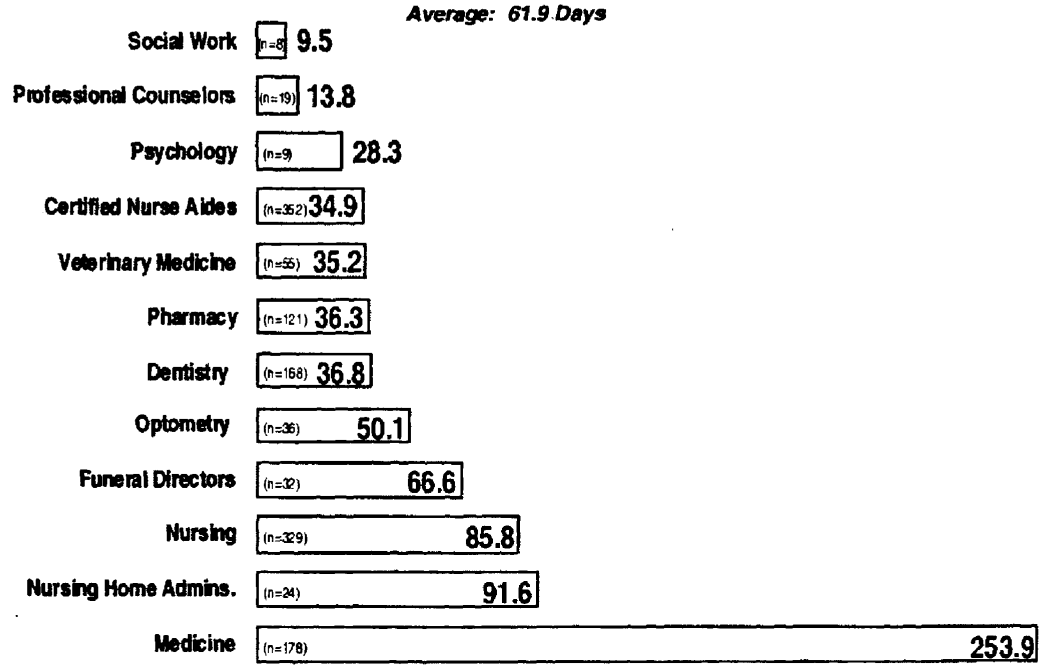
informal conference. Case preparation is conducted by the senior legal assistants in the administrative proceedings division (APD). Time analysis of this stage in the process indicates that most cases are prepared for hearing in a timely manner. At this point in the process, APD staff develop a notice of hearing and prepare the evidence for the case. As Figure 8 shows, across all boards the average time required to prepare cases resolved in 1997 and 1998 was 62 days. The board with the slowest case preparation time was the Board of Medicine. Medicine cases resolved in 1997 and 1998 took an average of 254 days to prepare for hearing. Clearly, this stage in the Board of Medicine cases was not completed in a timely manner.

According to the director of the administrative proceedings division, the time it takes his staff to prepare Board of Medicine cases for a hearing has decreased recently. However, JLARC staff could not verify this trend through systematic data analysis.

Time Required Between Case Preparation and Informal Conference or Pre-Hearing Consent Order Is Lengthy Among Some Boards. After a case has been prepared by APD staff, the next stage in the process is for board staff to schedule

Figure 8

Boards' Disciplinary Processes Compared for Average Length (Days) of Case Preparation



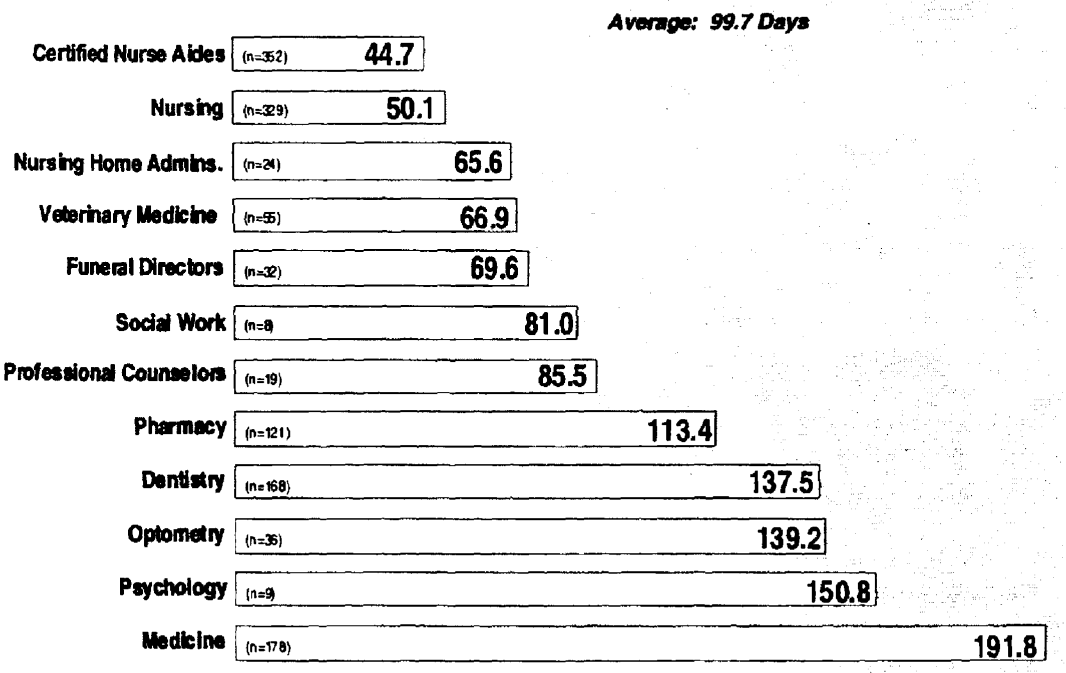
Source: JLARC staff analysis of disciplinary cases resolved during the 1997 and 1998 calendar years.

the case for an informal conference or to resolve the case through a pre-hearing consent order. Some of the boards appear to take longer than necessary to schedule and hear cases. As Figure 9 shows, the boards take on average more than three months to schedule and hear cases or to resolve them through consent orders, after they have been prepared by APD staff. However, the time taken at this stage varies widely by board. The Board of Nursing schedules and hears cases within two months of its cases being prepared by APD staff. In contrast, the Boards of Dentistry, Optometry, and Psychology take almost five months to schedule and hear cases. In addition, the Board of Medicine takes an average of more than six months to complete this stage in the process. Board of Medicine staff told JLARC staff that the amount of time required to schedule cases has recently been reduced; however, JLARC staff were not able to verify this through systematic analysis.

Time Lag Between Informal Conference and Formal Hearing or Consent Order Varies by Board. Only a small portion (about 10 percent) of cases that are investigated are resolved through a formal hearing. Approximately half that number of cases are resolved through consent orders agreed upon after an informal conference. A case may proceed to a formal hearing if an informal conference committee determines that the allegations against a practitioner may warrant the suspension or

Figure 9

Boards' Disciplinary Processes Compared for Average Length (Days) Between Case Preparation and Informal Conference or Pre-Hearing Consent Order



Source: JLARC staff analysis of disciplinary cases resolved during the 1997 and 1998 calendar years.

revocation of a practitioner's license. A case may also proceed to a formal hearing if the respondent appeals the decision of the informal conference committee or if a respondent waives the right to an informal conference. In other instances, cases are resolved at this point in the process through consent orders. On average, the boards require 197 days to schedule and hear cases that proceed to a formal hearing or to resolve the cases through a consent order. However, the individual boards vary significantly in how long it takes to resolve cases at this stage. Both the Boards of Dentistry and Funeral Directors and Embalmers take more than six months to close cases at this level. In contrast, both the Boards of Medicine and Pharmacy take less than four months to complete this stage in the process.

Four Boards in Particular Have Delays at Multiple Stages of Process. The four boards with the slowest case processing times appear to have delays at multiple points in the process. With the exception of the investigative stage, Board of Medicine cases take longer than any other boards' cases in each of the first four stages of the process. With regard to the Boards of Professional Counselors, Psychology, and Social Work, most of the delays in case processing appear to occur in the first two stages of the disciplinary process. Cases of these boards take longer to investigate than the cases of any of the other boards except Medicine. Likewise, the probable cause

review takes longer for the behavioral boards than all other boards except the Boards of Medicine and Pharmacy. Psychology cases also take a long time to schedule for an informal conference.

DELAYS IN PROCESSING SOME SERIOUS DISCIPLINARY CASES MAY THREATEN PUBLIC PROTECTION

JLARC staff's analysis of disciplinary cases closed during the past few years by the health regulatory boards found that delays in processing some serious cases for several boards may threaten public safety. Most complaints alleging serious wrongdoing by health professionals regulated by the Boards of Medicine, Psychology, Nursing, and Dentistry took between one and five years to process before the appropriate board suspended, revoked, or accepted the surrender of the practitioner's license. Boards typically only suspend, revoke, or accept the voluntary surrender of a license for cases in which they determine that the practitioners are unsafe to continue their practice. Long delays in processing these cases pose a significant threat to public safety because in many of these cases the practitioners were allowed to continue treating patients until the board rendered its decision.

In addition, it appears that the Board of Medicine sometimes delays its follow-up of serious probation violation cases, which could endanger public safety. The Board of Medicine sometimes places respondents who have committed acts that threaten public safety under probation with terms. These terms allow the board to closely monitor and sometimes restrict the practice of respondents to ensure that they do not harm their patients. However, in some instances, the Board of Medicine has taken years to follow-up on these terms and take action against those violating probation terms. Such delays pose a risk to public protection because they allow doctors who are known to have had problems with their practice and who do not meet probation conditions to continue to practice.

Board of Medicine Cases Resulting in Suspension or Revocation on Average Take More than Three Years to Resolve

JLARC staff analyzed the 12 instances in which a doctor surrendered his or her license or the Board voted to suspend or revoke a doctor's license in FY 1997 and FY 1998. This analysis revealed that it took on average more than three years to resolve each case. The most expeditiously processed case in this group took more than a year and a half to resolve, and the slowest case took close to five years to complete. This data did not include cases in which practitioners' licenses were mandatorily suspended pursuant to statutory requirements. These suspensions and revocations were not included in the analysis because they are imposed automatically by the DHP director.

The cases analyzed by JLARC staff which ended in the suspension or revocation of a doctor's license involved doctors the board ultimately determined were unsafe to practice. These doctors were not restricted from practicing medicine until years after a complaint was filed against them, due to delays involved in processing disciplinary cases by DHP and the Board of Medicine.

The following case examples were taken from JLARC's review of cases closed during the 1997 and 1998 fiscal years as well as the first six months of the 1999 fiscal year in which the suspension, revocation, or voluntary surrender of a doctor's license to practice medicine was involved. In addition, one example involves a practitioner whose license was placed on indefinite probation with very restrictive terms. Each of the following cases took an average of three years to process from the time the complaint was received by DHP until the doctor was sanctioned, and delays were encountered during each step of processing these cases.

In October 1994, DHP received a complaint against a doctor for whom the Board of Medicine found standard of care violations and sexual misconduct. Almost three and one-half years after this complaint was received, the Board of Medicine indefinitely suspended the doctor's license to practice medicine.

At a formal hearing in April 1998, the board found that this doctor had on multiple occasions provided substandard care. In addition, the board determined that the doctor made inappropriate sexual comments to multiple patients and inappropriately engaged in a sexual relationship with a patient whom he knew was being treated for psychological problems.

Evidence of the seriousness of the delay in sanctioning this doctor is indicated in a May 1994 psychiatric evaluation which found that the respondent was too "impaired to practice medicine with reasonable safety, and recommended that he withdraw from medical practice." However, the respondent continued his practice of medicine after this evaluation and retained his license until his suspension by the board, four years later.

* * *

Between April 1995 and September 1996, several complaints were filed against a doctor alleging that this practitioner was providing substandard care to seriously ill patients. The Board of Medicine did not hold a formal hearing to consider these allegations until October 1998, more than three and one-half years after the first complaint came to DHP, at which time the board voted to revoke this doctor's license to practice medicine.

At the formal hearing, the Board of Medicine found that the respondent provided ineffective and improper treatment to seven seriously ill patients. The board found that the respondent had failed to provide adequate care for illnesses associated with the HIV/AIDS diagnosis. The respondent failed to keep appropriate records justifying the questionable treatment or lack of treatment of these and other patients. The board also found that the respondent indiscriminately and excessively prescribed drugs with high abuse potential to known substance abusers.

* * *

In October 1994, DHP received a complaint against a doctor that included many allegations that the doctor had improperly prescribed drugs in a way that posed potential harm to patients. In September 1997, nearly three years after the complaint was filed, the doctor entered a consent order requiring that he voluntarily surrender his license.

The Board of Medicine found that this doctor indiscriminately and excessively prescribed drugs with high abuse potential in six documented cases. He failed to provide comprehensive physical exams for these patients despite the fact that they had been patients of his for between three and ten years. In addition, the doctor provided drugs to pregnant patients for whom the need was not documented nor substantiated by medical evidence. The medical community recommended against the use of such drugs during pregnancy.

* * *

Three complaints were received by DHP between February and May 1995 against a doctor for whom the Board of Medicine found multiple incidents of substandard care and sexual misconduct. The respondent surrendered his license in a consent order entered with the Board of Medicine in June 1997, more than two years after the original complaint was filed.

The board's findings included deficiencies from a March 1994 report conducted by a hospital with which the doctor had clinical privileges. These findings included a lack of daily visits to hospitalized patients, lack of progress notes and patient medical histories, and failure to respond to hospital staff's attempts to page and otherwise contact him to attend to emergency situations. The findings document instances of substandard care for five patients, which may have resulted in patient harm. The board found that on one occasion a patient died while waiting in the hospital for the doctor to respond to multiple emergency pages and telephone calls. The board also found that this doc-

tor had inappropriate sexual contact with two female patients while he was examining them.

* * *

Between October 1993 and August 1994, DHP received four complaints against a doctor who was later found by the board to have indiscriminately and excessively prescribed drugs "without accepted therapeutic purpose and contrary to sound medical judgement." In August 1997, nearly four years after the first complaint was filed, the Board of Medicine placed the respondent on indefinite probation with many restrictive conditions. Included among these conditions was a mandate forbidding the respondent from prescribing certain categories of drugs until he completed a "mini-residency" on proper prescribing.

The board's order documented the cases of 15 individuals in which the doctor indiscriminately and excessively prescribed controlled substances with high abuse potential on multiple occasions. In addition, some of these patients were known substance abusers. The doctor also failed to obtain an adequate medical history and conduct a physical exam for some of these patients. This respondent had been placed under a similar Board of Medicine order in May 1973 for inappropriately prescribing amphetamines and related drugs.

* * *

DHP received a complaint against a psychiatrist in July 1996 regarding sexual boundary issues. Twenty months after the complaint was filed, the Board of Medicine entered an order for a stayed suspension with conditions against the psychiatrist. The board order restricted the respondent from treating women, required him to receive formal supervision of his therapy sessions by a psychiatrist approved by the board, required continuing education regarding medical ethics and boundary violations, and instructed him to appear before the board again in one year for follow-up.

The board found that this psychiatrist had a sexual relationship with three patients. In at least one instance, this relationship caused "the patient to become severely depressed and angry toward [the psychiatrist]." The psychiatrist failed to terminate the therapist-patient relationship even after the sexual relationship began. The board had also disciplined this respondent in 1986 for a similar type of violation.

* * *

DHP received five complaints against a doctor between July 1992 and August 1994. The board found that the doctor had committed a wide

range of violations, including substandard care, indiscriminate prescribing, and fraudulent billing. This doctor signed a consent order that was entered in March 1997, nearly five years after the first complaint was filed, suspending the doctor's license. The suspension was stayed under the condition that numerous conditions be met.

The Board of Medicine found that this doctor indiscriminately prescribed controlled substances with high abuse potential to a known substance abuser in a way that was contrary to sound medical judgement. He was also found to have allowed members of his staff to forge his name on prescription blanks on numerous occasions.

In addition, this doctor misdiagnosed a patient in at least one documented instance and failed to provide another patient with lab results in a timely manner. He was also denied privileges at a hospital due to concerns about his quality of patient care and his failure to inform the hospital of disciplinary action taken against him at another hospital. The board also found that the doctor's record keeping was below the standard necessary for a licensed physician in Virginia.

The failure of the Board of Medicine to act more quickly in these instances is concerning because the board found that each of these doctors was unsafe to practice without restrictions. However, during the years between when DHP received complaints against these doctors and the board finally took action, they held valid unrestricted licenses which potentially endangered or threatened public safety.

One Serious Case Involving a Clinical Psychologist Took Five Years to Process Before the Respondent's License Was Revoked

It took more than five years for the Board of Medicine and the Board of Psychology to revoke the license of a psychologist for serious substandard care issues. It is rare that the Board of Psychology determines that a practitioner brought before it for a disciplinary case poses such a risk in his or her practice to justify suspension or revocation of his or her license. However, this case raises a concern about the slowness of both boards in handling serious cases and particular concern about the Board of Psychology's handling of cases involving psychologists who could jeopardize the safety of patients.

The following describes the case of a clinical psychologist whom the board ultimately determined to be a very serious threat to his patients' welfare. This case took five years to process. This clinical psychologist's license was finally revoked by the Board of Psychology this year.

A complaint was received by DHP against a licensed clinical psychologist in March 1994. This complaint included the following allegations: a sexual relationship with a patient, physical abuse of a patient,

malpractice, and unprofessional conduct. This case was originally forwarded to the Board of Medicine in October 1994. However, the board did not act on the case for nearly two years. In July 1996, when the regulation of clinical psychologists was transferred to the Board of Psychology from the Board of Medicine, the case was forwarded to the Board of Psychology.

On March 26, 1999, five years after the complaint was presented to DHP and more than two and one-half years after the case was received from the Board of Medicine with a completed investigation, the Board of Psychology voted unanimously to revoke the practitioner's license. The Board order revoking the license included the following findings of fact against the practitioner: unprofessional conduct; a long-term sexual relationship with a patient; physical abuse of a patient; failure to apply generally accepted diagnostic criteria; use of unorthodox, regressive, and dependency-fostering hypnotherapy; failure to adequately terminate or transfer treatment of the patient to another practitioner; and the improper diagnosis of a patient.

The board's findings were supported by taped therapy sessions, expert testimony, written and oral testimony from witnesses, and additional written evidence. As further testimony to the dangerousness of this practitioner, one board member told JLARC staff after the hearing that the psychologist had characteristics which suggested that he had probably harmed other patients.

It is unclear why a case with such serious allegations was allowed to move so slowly through the process. The source of this complaint provided considerable documentation of her allegations during the investigation of this case in the early part of 1994. Despite the seriousness of the allegations presented in 1994, this psychologist was allowed to practice without restriction for five years while this case advanced through the disciplinary process.

Many Serious Board of Nursing Cases Take More than One Year to Process

It took more than one year to process nearly 50 percent of the 16 disciplinary cases reviewed by JLARC staff in which the Board of Nursing suspended, revoked, or accepted the voluntary surrender of a nurse's license. Taking more than a year to resolve cases involving serious misconduct in which suspensions or revocations were ultimately imposed raises concerns that the public is not being adequately protected. This analysis was based on a random sample of one-third of the cases (not including CNA cases) in which a nurse was sanctioned in FY 1997 and FY 1998. The time frame calculation did not include cases in which a mandatory suspension or revocation was imposed by the DHP director or in which the license of a nurse was summarily suspended.

The following cases provide examples of the seriousness of some findings against nurses who were allowed to practice for well over one year after a complaint was filed against them:

> *A complaint was filed with DHP against a licensed practical nurse in August 1994. In October 1997, more than three years after this complaint was submitted, the Board of Nursing entered an order which revoked the license of this nurse. The findings against this nurse included many instances of substandard care, failure to assist with patients in need, and failure to report serious regressive changes in several patients' conditions to a physician. The board also found that this nurse failed to properly document her medical treatment of patients on an on-going basis.*
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> * * *
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> *In November 1995, a complaint was filed against a registered nurse, but the Board of Nursing did not act until sixteen months later. At that time, the Board of Nursing indefinitely suspended the nurse's license due to serious findings against her. The board found that on multiple occasions the nurse did not provide patients with the appropriate medications. This included giving patients drugs they were not supposed to have and failing to give other patients drugs that they needed. She also diverted drugs that were meant for patients for her own use. A drug test revealed that she had taken opiates and benzodiazepines for which she did not have a prescription. This drug test was taken immediately after she had completed working her shift at a nursing home.*

The failure of the Board of Nursing to more quickly revoke or suspend the licenses of nurses after serious complaints have been filed against them may have endangered the safety of patients placed in their care. As previously discussed, delays occur at multiple stages in processing these cases. However, the Board of Nursing and DHP need to ensure that cases in which the respondent may endanger the public are handled expeditiously.

Delays in Processing Two Board of Dentistry Cases Raise Concerns that Serious Cases Are Not Properly Expedited

JLARC staff's analysis of Board of Dentistry cases closed in the last two years found two serious substandard care cases which each took more than one and one-half years to resolve. One of these cases resulted in the revocation of the respondent's license, and the other case resulted in the indefinite suspension of the respondent's license. The Board had only two other cases during this time period that involved the suspension, revocation, or surrender of a dentist's license.

The following case examples describe in more detail the two serious Board of Dentistry cases which took an excessive amount of time to process. The first case took DHP and the Board of Dentistry 17 months to resolve, and the second case took more than two years to complete.

Between April 1996 and June 1997, three complaints, all alleging serious standard of care violations, were filed against a dentist. The June 1997 complaint alleged that the substandard care provided by this dentist contributed to and possibly caused the death of a patient. The Board of Dentistry considered these cases together in a formal hearing held in November 1998, seventeen months after the last complaint was filed. At this hearing, the board voted to revoke this dentist's license to practice dentistry.

The Board of Dentistry found that this dentist prescribed a large quantity of controlled substances to a patient who he should have known to be a substance abuser. He knew that the patient took an overdose of these drugs in his office just before a scheduled tooth extraction. However, the board found that this dentist, contrary to sound medical judgement, continued with the procedure using local anesthesia; and he then improperly discharged the patient even though she would not wake up and had to be taken out of the dentist's office in a wheel chair. Despite the fact that this dentist knew that the patient was over-medicated and reacting poorly, he did not secure appropriate emergency medical care for the patient. This patient was found later that day at home unconscious and not breathing, and two days later she was pronounced "brain dead" and allowed to expire.

The board also found that this dentist fractured the jaw of another patient while extracting a tooth. The dentist did not promptly inform the patient of this fracture or refer the patient to an oral surgeon for treatment. The board further noted in its findings that the jaw was broken due to the improper technique used by this dentist in extracting the tooth.

The board made a further finding that this dentist failed to perform a root canal properly for a third patient. The area where the root canal was performed became very infected and the tooth was fractured. The board also found that the dentist failed to provide the patient with adequate follow-up care.

* * *

In September 1995, DHP received a complaint against a dentist alleging multiple standard of care violations. However, it took more than two years to process this case before the Board of Dentistry indefinitely suspended the dentist's license in October 1997.

The Board of Dentistry made findings against the dentist that included questionable and substandard care relating to the diagnosis and treatment of ten patients. The Board found that, among other items, the respondent improperly fixed and/or delivered bridges for several patients, failed to diagnose decay and other problems in several instances, and provided treatment which diagnostic tests did not demonstrate as necessary. Many of his actions resulted in the continuation or aggravation of existing dental problems, and in some instances his substandard care created additional dental problems for his patients.

Both of these cases raise serious public protection concerns because in both cases, dentists who were ultimately found to pose a serious risk to patients were allowed to continue to practice for an extended period of time. It is unclear why there were such long delays in resolving these cases despite the serious nature of the findings against the respondents.

The Board of Medicine Allowed Significant Lags in Probation Follow-Up for Several Cases in which the Respondent Appeared to Pose a Threat to Patients

The Board of Medicine places some respondents for whom it has serious concerns about their practice of medicine on probation with terms. This is an alternative to suspending or revoking the respondent's license which allows the board to exert more control over the respondent's practice. The board directly exerts control by requiring the submission of additional information and testing; establishing specific parameters, conditions, or supervision requirements which the respondent must follow; and more closely tracking the respondent's practice. The board believes that controlling and monitoring such respondents can protect the public without denying the respondent the ability to practice medicine.

However, JLARC staff's analysis of probation cases found several instances in which delays in following-up with probation cases may have resulted in patient harm. Some of these delays were due to the board's failure to promptly schedule hearings, either to consider problems which had been detected in the respondent's practice of medicine while tracking probation terms or to follow up with practitioners who failed to meet probation terms. In addition, there were substantial delays in the board's appointment of Medical Practice Audit Committees (MPAC) to review the medical practice of respondents as required by some board orders.

The following are case examples in which the board's delay in following up with probation terms allowed practitioners who posed a danger to the public to practice longer than they should have:

In November 1994, the Board of Medicine placed a physician on indefinite probation with terms due to evidence from multiple sources that he provided substandard care to patients. The probation terms included the passage of the Special Purpose Examination (SPEX), a

standardized exam that tests basic medical competency, and a review of his patient files by a MPAC within one year.

The physician did not take the SPEX, and the MPAC did not conduct its review until June 1996. The MPAC identified several serious deficiencies in the respondent's treatment of patients and in his medical record keeping. However, the respondent was not seen before the board again until May 1997. This was 18 months after the physician was supposed to have passed the SPEX and appear before the board, and it was almost a year after the board had received additional information suggesting the physician was not providing an acceptable standard of care to his patients.

The May 1997 board disciplinary order extended the respondent's probation and included requirements that the physician pass the SPEX by July 1, 1997, the board review a random sample of his patient records, the physician complete specified continuing medical education courses, and the physician submit to a facility inspection. The order further required that the physician appear before an informal conference committee in approximately six months.

Despite this physician's failure to meet most of these requirements, he was not seen before the board again until November 1998. The physician had not passed the SPEX despite numerous attempts, and a review of his patient records found these records to be seriously inadequate and suggestive that patients were not being properly treated for their ailments. At this time, the informal conference committee forwarded the case to a formal hearing so that suspension or revocation could be considered.

In April 1999, four and one-half years after the respondent was first placed on probation, a formal hearing was held by the Board of Medicine. At this time, the board suspended the physician's license based on concerns regarding the substandard level of care he was providing patients. The Board's findings included the following quote from the State's expert witness on this matter, "[The respondent] does not appear to possess even the most rudimentary assessment, diagnostic, and patient management skills" in the area in which the physician's practice focuses.

* * *

In September 1988, a physician was placed on indefinite probation with terms due to concerns regarding the standard of care she was providing to patients. This probation was continued by a May 1990 order which required, among other items, that the physician submit to a MPAC review of her practice. The board did not schedule this re-

view until January 1994, close to four years after the review was ordered. The MPAC review found multiple deficiencies with the physician's practice. These deficiencies included concerns that could negatively impact patient care.

Despite these concerns and the fact that this physician's clinical privileges had been discontinued from multiple hospitals due to concerns about her practice, the Board of Medicine did not schedule a hearing to consider these issues until May 1998. This was four years after the MPAC found problems and eight years after the board had ordered the MPAC.

In May 1998, the Board continued the matter for six months requiring that a number of conditions be met. The following were included among these conditions: a requirement that the physician pass the SPEX exam within 120 days and a requirement that a MPAC review of the physician's practice be conducted. All conditions were to be met, and the physician was to be noticed to appear before the board in six months.

An MPAC review of the physician's practice conducted in October 1998 found problems with her practice of medicine. Also, as of April 1999, the physician had failed to provide the Board with any documentation demonstrating that she had passed the SPEX. An informal conference committee hearing is scheduled for June 1999, eight months after the date required by the Board order.

* * *

The Board of Medicine issued an order against a physician which placed him on indefinite probation with conditions in September 1994. In this order the committee found that the physician had on multiple occasions made diagnoses and treatment decisions which were "without therapeutic purpose and contrary to sound medical judgment."

The conditions of the physician's probation included a requirement that within nine months the Board appoint an MPAC to review his practice and report to the board. This MPAC did not complete and submit its review to the Board until October 1997, more than three years after the Board order requiring the audit. The MPAC found that the physician, among other items, "fails to examine patients, adequately evaluate medical problems, do any appropriate diagnostic studies, document patient medications, or document history of medical problems."

The Board of Medicine did not schedule an informal conference to consider these issues until April 1998, six months after the MPAC made its findings. However, the physician's spouse requested a continuance

of this hearing and advised the board that the physician had recently become incapacitated due to physical illness.

As these cases demonstrate, the Board of Medicine sometimes uses probation with terms as a sanction for doctors who are found by the board to have committed serious violations which may endanger public safety. Such a sanction may be acceptable in these cases if the board is able to provide the appropriate tracking and follow-up of these cases. However, the cases described above suggest that some serious probation cases have lacked adequate follow-up by the board. It appears that DHP's probation division does an adequate job of tracking probation conditions and notifying the Board when probation requirements are not met. Instead, the delays in these cases appear to occur because of Board of Medicine difficulties in appointing MPACs and scheduling follow-up hearings for the respondents.

CASE PROCESSING DELAYS MAY ALSO BE UNFAIR TO SOME RESPONDENTS

Delays in case processing may also unfairly burden respondents who may have to wait extended periods of time to gain resolution of their cases. Several DHP staff, board members, respondents, and respondents' attorneys have expressed concern to JLARC staff that extensive delays in case resolution, particularly in Board of Medicine cases, have imposed unfair hardships on practitioners. At several Board of Medicine hearings attended by JLARC staff, respondents expressed frustration to the board with the amount of time required to resolve their cases.

Having an unresolved case before a health regulatory board can have direct adverse consequences for a licensee. Practitioners with pending cases may be required to report this information to current and prospective employers. In addition, a case pending before the Board of Medicine may adversely impact a physician's standing with health maintenance organizations or other insurers.

DHP staff and board members have also cited other problems with delays in hearing cases. Witnesses may be more difficult to locate and are less able to recall details of the cases. In addition, board members have stated that the age of a case can affect their assessment of the appropriate sanction to impose and that they are inclined to impose less stringent sanctions in older cases.

DHP AND THE BOARDS NEED TO DEVELOP A MORE TIMELY DISCIPLINARY PROCESS

The Department of Health Professions and the health regulatory boards need to take steps to reduce the time required to process and adjudicate disciplinary cases. While staff offer some reasons for the delays in the process, it appears that the process

can be significantly reduced for some boards and that most cases can be resolved in less than a year. DHP needs to work with the boards to develop formal guidelines for the resolution of cases. In addition, DHP management needs to regularly assess whether there are sufficient staff and board members to resolve cases in a timely manner. Finally, DHP and the boards need to make sure that procedures are in place to ensure that serious cases are handled expeditiously.

DHP Staff Offer Several Explanations for the Slowness of the Process

DHP staff state that a number of factors have contributed to slow case resolution. One factor they cite is a sudden rise in the number of complaints received by the department in the early 1990s. According to DHP staff, the department did not have enough staff to handle this large influx of cases as they worked their way through the system. This resulted in backlogs first at the investigative stage and then at subsequent stages in the process. The director of enforcement told JLARC staff that for several years the department did not have an adequate number of investigators. Similarly, the executive director of the Board of Medicine told JLARC staff that Board of Medicine cases were slowed down in the mid 1990s due to board staff shortages. Several staff have also stated that staff turnover contributed to the slowness of the process.

The director of enforcement told JLARC staff that the investigation process is often slowed by difficulties in obtaining needed medical records. She says that investigators often experience delays in obtaining medical records because some hospitals as well as other medical facilities are not cooperative and often resist providing records.

Board staff have also cited several other reasons for delays in the process. They note that requests for continuances by attorneys contribute to the slowness of the process. Some of the board staff who assist boards with high case volumes have also raised the concern that they are not able to schedule enough hearing dates to consider all of the cases that need to be scheduled due to limited board member availability. As a result, the boards are forced to delay scheduling of informal conferences for those cases. Board staff also note that board members sometimes do not review cases for probable cause within requested time frames when the cases are sent to them for review.

DHP and Boards Should Take Additional Measures to Ensure That Cases Are Resolved Within One Year

While the current Board of Medicine has expressed concern with the slowness of the disciplinary process and has taken action to reduce its case backlog, additional measures are needed to ensure that disciplinary cases are resolved in a timely manner. DHP and the boards should develop formal guidelines that set forth time frames within which cases are expected to be resolved. In addition to the time guidelines DHP has already developed for the investigative stage, the department and boards should de-

velop time frames for the other stages of the process that will require a case to be resolved within a year. The boards and DHP management need to closely track compliance with these guidelines.

DHP also needs to regularly analyze how long all of the stages in the disciplinary process are taking. While the department in the last two years has conducted detailed data analysis of case processing at the investigative stage, it has not conducted similar analyses of other stages of the process. Systematic data analysis of case processing should not be limited to the investigative stage, but should extend to all stages of the process.

The boards also need to develop special safeguards to ensure that cases in which there are allegations of serious misconduct and significant potential danger to the public are processed expeditiously. Although the priority system, which is the system used to rank cases based on the threat to public safety, appears to help expedite the investigation of some serious cases, it did not ensure that the cases discussed earlier in this chapter were adjudicated in a timely manner. DHP and the boards need to evaluate what additional measures should be taken to ensure that cases in which public protection is a significant concern are being resolved in less than a year and not taking three or four years to adjudicate.

DHP management also needs to regularly monitor staffing levels to assess whether various divisions and boards have sufficient staff to process disciplinary cases within the guidelines that have been developed. When staffing shortages arise, DHP management needs to act promptly to request additional staff as needed with detailed analysis and documentation to establish the need for the additional positions. The enforcement division is not currently meeting its own guidelines for processing cases, which suggests that more investigators may be needed. However, the director told JLARC staff that she does not need additional investigative staff at this time.

Likewise, the boards in conjunction with their staffs need to regularly assess whether the boards have a sufficient number of members to reasonably hear the cases that need to be scheduled for an informal conference. If the existing board members cannot handle the caseload, then the boards along with the staff should find alternative solutions to address the situation. One option would be to use hearing officers for some cases. Many of the cases heard by the boards do not involve standard of care issues and therefore do not necessarily require professional expertise. Board staff, in conjunction with board members, also need to consider whether the size of the boards needs to be increased so there will be enough members to handle the disciplinary caseload.

Board executive directors also need to take measures to shorten the time required for the probable cause review. This may require executive directors to exert more pressure on board members to conduct their reviews in a timely manner.

Finally, the Board of Medicine needs to examine its practice regarding continuances. Under the current practice, respondents can obtain at least one continu-

ance by providing any reasonable excuse, and often more than one continuance is granted. If unwisely exercised, this practice can contribute to delays in the disciplinary process and unnecessarily inconvenience board members. While it is important to meet due process concerns and allow respondents adequate time to prepare a defense, the board also needs to minimize the ability of respondents and their attorneys to delay conferences and hearings through excessive or unsubstantiated requests for continuances, particularly in cases in which the continued practice of a respondent poses a significant threat to the public.

In addition, the Board of Medicine needs to establish procedures to ensure that probation concerns are addressed expeditiously and that significant probation violations are addressed in a timely manner. In addressing this issue, the Board needs to examine how the current medical audit review process can be expedited or whether a more efficient process is needed to assess a physician's practice. One alternative means that appears to be currently available is to have an inspector randomly select medical records for review by the Board or physician experts retained by the Board.

Recommendation (8). **The Department of Health Professions, along with the health regulatory boards, should develop formal time guidelines for the resolution of disciplinary cases that establish time frames of less than one year for the resolution of most cases. At regular intervals, the Department should systematically analyze compliance with these guidelines in all stages of the process.**

Recommendation (9). **The Department of Health Professions should develop procedures and safeguards that ensure cases in which serious misconduct is alleged are handled expeditiously.**

Recommendation (10). **The Department of Health Professions, along with the health regulatory boards, should regularly assess case processing procedures and resources to determine whether modifications need to be made or additional resources are needed to process disciplinary cases in a timely manner.**

DHP'S INSPECTION PROGRAM DOES NOT MEET STATED GOALS AND MAY NOT PROVIDE ADEQUATE DRUG CONTROL

DHP's facility inspection program, which was severely reduced for several years, is currently failing to meet its goals for completing inspections. Time frames between pharmacy and veterinary facility inspections are long, which raises some drug law enforcement concerns, since one major purpose of these inspections is to ensure that the distribution of drugs is properly controlled. The failure of the program to meet its goals appears to be due in part to the assumption of investigative duties by inspectors and to a shortage of inspector positions. Given the existing problems with the inspection program, the Department of Health Professions, along with the relevant

boards, needs to fundamentally review the program and reevaluate its goals and the means necessary to achieve them.

An Overview of DHP's Inspection Program

According to Section 54.1-2506 of the *Code of Virginia*, DHP's investigative personnel have the authority to inspect "any office or facility operated by, owned by, or employing individuals regulated by any health regulatory board." Despite this broad authority, the inspection program is primarily focused on three types of facilities – funeral homes, pharmacies, and veterinary clinics. The program focuses on these types of facilities because they are the primary health care facilities licensed by Virginia's health regulatory boards. Other facilities, such as doctors' or dentists' offices, which are not actually licensed by the health regulatory boards, are typically inspected only after a licensee has become the subject of a disciplinary complaint. A full list of the facilities which DHP's personnel routinely inspect is provided in Exhibit 2.

The facility inspections have several purposes. The primary purpose of the pharmacy inspection program is to ensure that the distribution of drugs is properly controlled through compliance with statutory and regulatory provisions that include

Exhibit 2

Facilities Subject to Routine Inspections

Health Regulatory Board	Number of Licensed Facilities	Types of Licensed Facilities
Board of Funeral Directors and Embalmers	512	Funeral Service Establishments
Board of Veterinary Medicine	804	Veterinary Medicine Facilities
Board of Pharmacy	3,145	Pharmacies Special or Limited-use Pharmacies Physicians Licensed to Dispense Drugs Licensed Humane Societies Animal Shelters Wholesale Distributors Medical Equipment Suppliers Warehousers of Medical Equipment and Drugs Medical Equipment Manufacturers Practitioners licensed to sell controlled substances

Source: The Department of Health Professions' inspection plans.

detailed record keeping requirements. Another purpose of this program is to detect physicians who may be improperly diverting drugs through their prescription authority for their own or someone else's use. One of the primary purposes of the veterinary facility inspection program is to ensure that veterinarians are properly controlling the distribution of controlled substances because they have the authority to prescribe and dispense drugs in the treatment of animals. Another purpose of the veterinary facility inspections is to ensure that these facilities are kept sanitary. Funeral facilities are also inspected for cleanliness, but, according to DHP staff, the primary purpose of the funeral home inspections is to ensure that funeral directors are complying with the legal requirements applicable to the sale and use of pre-need funeral contracts.

Inspections have been a major source of disciplinary complaints. The enforcement division's deputy director told JLARC staff that prior to the interruption of the inspection program in 1991, approximately ten percent of the cases investigated by DHP were initiated based on inspection findings.

DHP's inspection program is organized into four regions. Each region is staffed by one pharmacy inspector and one senior inspector. Pharmacy inspectors, who must be licensed pharmacists, primarily inspect retail and hospital pharmacies. In contrast, the program's senior inspectors are responsible for inspecting funeral homes, veterinary clinics, and facilities other than pharmacies that are regulated by the Board of Pharmacy. In addition to their inspection responsibilities, pharmacy and senior inspectors also conduct background, probation, reinstatement, and disciplinary investigations.

Inspectors primarily perform two types of facility inspections. These inspections include new facility or facility change of location inspections and routine inspections. New and change of location inspections are conducted in response to applications for licensure submitted by facilities seeking either to begin operation or to move to a new location. The purpose of these inspections is to ensure that the facilities meet the State's initial requirements for operation.

In contrast, routine inspections are conducted to ensure that existing facilities continue to operate according to State requirements. Furthermore, routine inspections are conducted according to an inspection plan developed by the enforcement division's deputy director. An inspection plan has been established for each of the three health regulatory boards that regulate health care facilities. These plans describe how inspectors are to conduct routine inspections, the types of facilities that the inspectors are to inspect, and how frequently facilities are to be inspected. Inspectors may also perform complaint-based inspections of other types of facilities such as doctors' offices.

THE INSPECTION PROGRAM DOES NOT MEET ITS STATED GOALS FOR ROUTINE INSPECTIONS

DHP's inspectors do not meet the goals established by the department for its routine inspection program. Many facilities have not been inspected since 1991. The

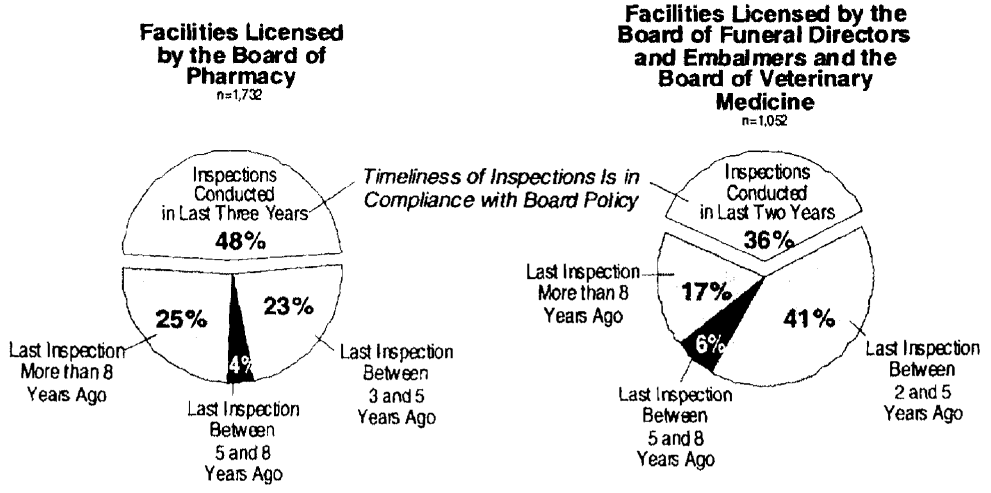
backlog in the inspection program results partly from the discontinuation of the program in 1991. However, even with the program's resumption in 1996, inspectors have been unable to meet the requirements outlined in the inspection plans.

A Majority of the Facilities Licensed by the Health Regulatory Boards Have Not Been Inspected in Accordance with Inspection Plan Goals. According to the three inspection plans, all pharmacies are to be inspected at least once every three years, and all funeral homes and veterinary clinics are to be inspected at least once every two years. However, the inspectors have been unable to meet these goals. A list of the licensed facilities provided by DHP indicates that only 48 percent of the facilities licensed by the Board of Pharmacy have been inspected during the past three years. This list also indicates that only 36 percent of the facilities licensed by the Boards of Veterinary Medicine and Funeral Directors and Embalmers have been inspected during the past two years. Furthermore, as shown in Figure 10, nearly 25 percent of the facilities licensed by the Board of Pharmacy and 17 percent of licensed veterinary clinics and funeral establishments have not been inspected in more than eight years.

The Routine Inspection Program Was Severely Reduced in 1991. The inspection program was originally established in 1986. However, the program was severely reduced in 1991 so that DHP's inspectors could assist with the investigative backlog that developed. Although this diversion of inspection resources was initially viewed to be a temporary solution to the investigation backlog, inspectors continue to have substantial investigative caseloads, and the routine inspection program was not

Figure 10

Frequency of Routine Inspections Conducted by DHP Inspectors at DHP-Licensed Health Care Facilities



Source: JLARC staff analysis of DHP inspection records.

reinstated until January 1996. During this five-year period, few routine inspections were conducted. Even with the resumption of the inspection program, a majority of the facilities have not been inspected within the two and three-year cycles prescribed in the inspection plans.

Investigative Responsibilities and Staff Shortages Appear to Be Limiting the Program's Effectiveness. Based on a review of inspections completed over the last two years, inspectors appear to complete a relatively low number of inspections. A review of inspections completed in 1997 and 1998 showed that inspectors are completing 11 inspections per month, which is substantially less than one inspection per day, despite the fact that inspections usually take no more than three hours to complete.

The director and deputy directors of enforcement state that the primary reason for the low number of inspections conducted is the other responsibilities that inspectors are required to assume. Inspectors are required to carry investigative caseloads and have responsibility for conducting probation, reinstatement, and background investigations. According to DHP records of inspector hours worked in FY 1998, inspectors spent only about one-third of their time conducting inspections and a majority of their time performing investigations. Responsibilities need to be reallocated to ensure that inspectors are at least meeting the current target of 15 inspections per month, which is still less than one inspection per day.

Even with increased productivity by the current inspection staff, some additional inspectors may be needed as long as inspectors are asked to maintain significant investigative responsibilities. If DHP had eight full-time inspectors, and they were able to meet the current target of 15 inspections per month, there would still remain approximately 270 facilities for which routine inspections would need to be conducted each year in order to meet current inspection plan goals. This does not include the new facility and change of location inspections that would need to be conducted. Moreover, increasing the frequency of pharmacy inspections, which is discussed in the next section and is being considered by DHP and the Board of Pharmacy, would add to the existing workload of pharmacy inspectors and further necessitate additional staff.

Inspection Program Has Other Deficiencies Including the Discontinuance of Drug Audits

The inspection program also appears to have other deficiencies that limit its effectiveness. These problems include an inadequate schedule for routine pharmacy inspections, the lack of use of drug audits as an oversight tool, and the use of announced inspections of veterinary facilities.

Current Three-Year Inspection Cycle for Pharmacies May Be Inadequate. Currently, the inspection plan for facilities licensed by the Board of Pharmacy states that all pharmacies will be inspected at least once every three years. However, board members and several DHP staff have told JLARC that inspections need to be

conducted more frequently. Seventy percent of current and former Board of Pharmacy members surveyed believed pharmacies should be inspected at least every two years. In addition, both the director and deputy director of the enforcement division, as well as the executive director of the Board of Pharmacy, have told JLARC staff that routine pharmacy inspections should be conducted at least every two years. One of the primary reasons they cite for requiring more frequent inspections is the laws governing record retention and required inventories.

According to the enforcement division's deputy director, federal law requires pharmacies to maintain the invoices and distribution logs for all Schedule II-V controlled substances for two years. Federal law also requires pharmacies to perform a biennial inventory of these substances. The biennial inventory is required by law to contain certain types of information, so it is often the starting point for a routine drug audit of a facility. However, the deputy director reports that after two years, pharmacies are allowed to dispose of this information. Therefore, he says that a three-year inspection cycle is inappropriate because an inspector may miss an entire inventory cycle.

Inspection Program No Longer Conducts Targeted Drug Audits. As a result of resource limitations, DHP no longer conducts targeted drug audits. A targeted drug audit is similar to an inspection but focuses exclusively on a facility's drug records and may even focus specifically on one type of drug. One source of information used previously by DHP for targeting drug audits was the information contained in the federal government's Automation of Reports and Consolidated Orders System (ARCOS) reports which record purchases of controlled substances. In the past, enforcement staff reviewed these reports to look for irregularities in the pattern of drugs purchased or significant changes in the quantity of drugs ordered. Drug audits were conducted based on irregularities discovered during these reviews. The enforcement division's deputy director told JLARC staff that these audits were the most effective tool for uncovering drug diversions by physicians. While the current inspection program uncovers the most flagrant drug diversion cases, the more focused drug audits can detect a much larger percentage of drug diversions. The Board of Pharmacy has stated that it would like to see drug audits re-instituted. However the deputy director of enforcement has told JLARC staff that the enforcement division does not presently have adequate staff to perform them.

Announcement of Veterinary Inspections Reduces Their Effectiveness. A third problem that limits the inspection program's effectiveness is the requirement that senior inspectors provide veterinarians with at least 72 hours notice prior to inspection of a veterinary facility. This requirement was apparently included in the veterinary inspection plan shortly after the inspection program was established.

According to the inspection staff, providing notice of an inspection significantly reduces the effectiveness of the inspection program. It appears that many veterinarians use the 72 hours advance notice they are given to conduct "house cleaning." The enforcement division's director told JLARC staff that "inspectors often find facilities have accounted for requirements on the day before the inspector arrived." Further-

more, one inspector told JLARC staff that inspectors have been told by former employees of veterinary clinics that licensees and their employees often spend the entire notification period cleaning their facility to avoid being found in violation of sanitary standards. Also, in one instance, an inspector reported having been told by a former employee of a veterinary clinic that a veterinarian had used the notification period to remove expired drugs from his office so that these drugs could be returned to the office after the inspection had been completed.

Recommendation (11). **The Department of Health Professions, along with the Board of Pharmacy, should modify the pharmacy inspection plan to require the routine inspection of pharmacies every two years.**

Recommendation (12). **The Department of Health Professions, along with the Board of Pharmacy, should re-establish the drug audit program.**

Recommendation (13). **The Board of Veterinary Medicine should modify its inspection plan to require that all routine inspections of veterinary facilities be unannounced.**

A Fundamental Review of the Inspection Program Should Be Undertaken

Based on the concerns raised in this report about the current inspection program, the boards and DHP need to conduct a fundamental review of the program. Recent history suggests that the inspection program has not been a high priority for DHP. However, the director of enforcement told JLARC staff that she has come to view the inspection program as equally important as the investigative process.

DHP, working in conjunction with the Boards of Pharmacy, Veterinary Medicine, and Funeral Directors and Embalmers, needs to establish clear goals for the program, determine the means necessary to achieve those goals, and identify the resources that will be needed to meet those goals. Some DHP staff that JLARC staff interviewed raised concerns about the approach used by the current program. Several staff have suggested that it may not be necessary to have as many routine inspections, but is more important to have truly random inspections.

In assessing staff needs, DHP needs to evaluate the role and responsibilities of the inspector positions. At present, inspectors spend a majority of their time conducting investigations instead of inspections. DHP should consider relieving inspectors of at least a portion of their investigative caseload so that they may give additional time to their inspection responsibilities. In addition, DHP management should evaluate the productivity of the current inspection staff to determine whether inspection output can be increased by increasing inspectors' productivity.

DHP should determine how the inspection program should be operated to cost-effectively protect the public and should make a commitment to consistently pro-

vide such a program. Further, it needs to make every effort to obtain the resources necessary for the program to function effectively.

Recommendation (14). **The Department of Health Professions and the Boards of Funeral Directors and Embalmers, Pharmacy, and Veterinary Medicine need to conduct a fundamental review of the inspection program. This review should include an examination of the goals of the program and of the means and resources necessary to achieve those goals.**

OVERSIGHT OF THE DISCIPLINARY PROCESS IS NEEDED

The seriousness of the case processing delays over the last several years and the current condition of the inspection program suggest that there should be some stronger oversight of the disciplinary process. While DHP appears to recognize that delays in case processing time are a problem and is taking measures to decrease the time involved at different stages of the disciplinary process, the seriousness of the problem over the last several years suggests that some outside oversight of the process would be useful to help ensure such delays do not occur again. The Board of Health Professions, which has statutory responsibility for overseeing the disciplinary process, needs to play a stronger role. In addition, DHP should be required to regularly report on case processing time in its biennial report so that the General Assembly, other policy makers, interested parties, and the general public will have information on which to assess the performance of Department of Health Professions and the health regulatory boards in processing cases.

Board of Health Professions Should Play a Stronger Oversight Role Over the Disciplinary Process

The *Code of Virginia* directs the Board of Health Professions to review the disciplinary process to ensure that the public is adequately protected and to ensure the fair and equitable treatment of health professionals. As discussed in the interim report, the Board of Health Professions has not completely fulfilled this statutory responsibility.

The problems with the current process that this review identifies demonstrate the importance of having effective oversight over the disciplinary process. The Board of Health Professions needs to periodically review the disciplinary process. This review should include an assessment of case processing times to ensure that cases are being processed within developed guidelines. In addition, the Board should analyze the staffing resources available to DHP and assess whether the Board has sufficient staff to fulfill all of its regulatory responsibilities. The Board of Health Professions should be required to report the results of its reviews, as well as recommendations for addressing any concerns the reviews raise, to the General Assembly and the Governor.

Recommendation (15). **The Board of Health Professions should take a more active role in oversight of the disciplinary process. The Board should periodically assess: (1) the efficiency of the Department and boards in processing disciplinary cases; (2) whether there are sufficient staff to provide for the timely resolution of cases; and (3) whether the inspection program is meeting its goals. These reviews should be conducted at least every four years and the results reported in the Department of Health Professions' biennial report.**

DHP Should Be Required to Report on Case Processing Time

Under current law, the Department of Health Professions is required to include in its biennial report the number of complaints of misconduct received and the number of investigations and disciplinary actions resulting from the reports. While this information is of some value, DHP does not provide any information regarding the efficiency of the disciplinary process. Based on the problems that some boards and the department have experienced with case processing times over the past several years, the department should be required to include in the report detailed information on case processing times by board and for each major stage in the process, as well as overall processing time. The biennial report should also include trend data for a six-year period that includes data on case processing time over the period, as well as detailed staffing data on the number of enforcement division and board staff positions that support the disciplinary system.

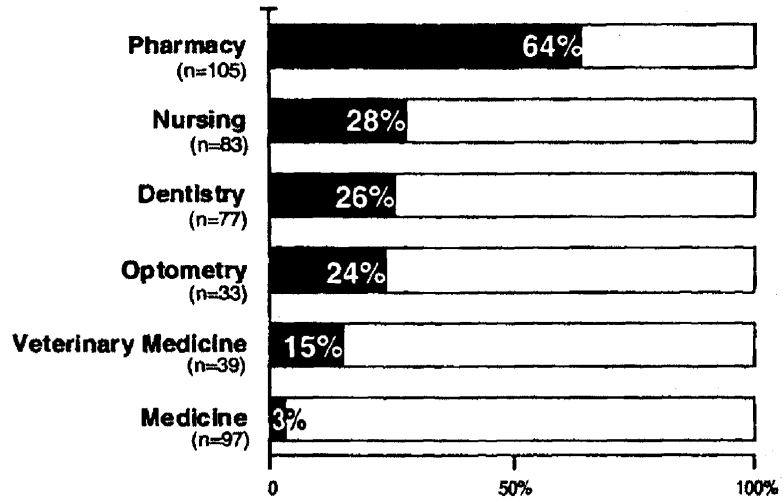
Recommendation (16). **The General Assembly may wish to consider amending § 54.1-2400.3 of the *Code of Virginia* to require the Director to include in the Department of Health Professions' biennial report the following information: (1) data on overall case processing time for all boards, as well as information on the time required to complete each major stage in the process by each board; (2) a six-year trend analysis of the time required to process and adjudicate cases; and (3) a detailed reporting of staffing levels for the six-year period for each job classification that supports the disciplinary process.**

IV. Board of Medicine Standard of Care Cases

JLARC staff's review of the disciplinary process found that while practitioners with standard of care violations were frequently sanctioned by many of the health regulatory boards, the Board of Medicine rarely sanctioned physicians for standard of care violations. As Figure 11 indicates, a substantial percentage of the orders imposed by five of the six boards with a large case load over the last two years involved standard of care issues exclusively, while only three percent of the Board of Medicine's disciplinary orders during the same time period solely involved standard of care issues. This chapter therefore focuses on the question of whether the Board of Medicine adequately protects the public from substandard practice by physicians.

Figure 11

Proportion of Violations During Fiscal Years 1997 and 1998 Which Exclusively Involved Standards of Care, by Board



Notes: The Boards of Audiology and Speech-Language Pathology, Funeral Directors and Embalmers, Nursing Home Administrators, Professional Counselors, Psychology, and Social Work issued fewer than 30 orders over the two-year period and thus were not considered in this violation category analysis. Orders related to reinstatement or probation are not included. Numbers in parentheses represent the total number of orders reviewed for each board.

Source: JLARC staff analysis of orders issued by boards for FY 1997 and FY 1998.

The mission statement of the Virginia Board of Medicine provides that the board's mission is to "foster the safe and competent delivery of health care services to the citizens of the Commonwealth." The board's vision statement indicates that the board expects itself to:

> Provide the optimal achievable regulatory system which promotes safe and effective delivery of services by practitioners of the healing arts.

> *The primary responsibility and obligation of the Virginia Board of Medicine is to protect consumers of health care services through proper licensing and regulation of doctors* [emphasis in the original].
>
> The practice of medicine is not an inherent right of an individual, but a privilege granted by the citizens of Virginia. To protect the public from the unprofessional, improper, and incompetent practice of medicine, the state must provide laws and regulations that outline the practice of medicine and the other healing arts. The responsibility of the medical board is to regulate that practice as outlined in state law.

JLARC staff found that the Board of Medicine rarely disciplines doctors for deviations from the accepted standard of care in the practice of medicine, even when such deviations result in serious injury or death. Under Virginia law, a physician is not subject to discipline by the Board of Medicine unless he is grossly negligent or is judged to be a public danger. Applying these statutory standards, the Board of Medicine closes most cases involving allegations of substandard practice without a hearing.

As a result of the gross negligence standard and a general bias against pursuing medical malpractice cases, the Board of Medicine does not appear to treat medical malpractice reports, which are a primary source of standard of care cases for the board, as seriously as other complaints or required reports. These reports are often closed without sufficient information at the intake stage. In addition, medical malpractice cases that proceed beyond the intake stage are not fully investigated.

GROSS NEGLIGENCE STANDARD USED BY BOARD OF MEDICINE MAY NOT ADEQUATELY PROTECT THE PUBLIC

The *Code of Virginia* stipulates that the Board of Medicine may take disciplinary action against a medical practitioner for his treatment of patients when his actions are grossly negligent or a danger to the health and welfare of his patients. With this high threshold for deciding standard of care cases, physicians are rarely held responsible by the board for care that deviates from the acceptable standard unless there is evidence of an egregious act or a pattern of acts of negligence.

With the application of this standard to cases at the intake and probable cause stages, the Board of Medicine closes almost all standard of care cases without a hearing. Some of these cases involve allegations of seriously negligent acts that resulted in serious patient harm. No other health regulatory board in Virginia has such a high threshold for deciding standard of care cases, and a national association that provides guidance to state medical boards recommends that physicians be subject to discipline for negligent acts.

Standards Used By the Board of Medicine

Since 1932, the *Code of Virginia* has stipulated that the Board of Medicine may take disciplinary action against a practitioner for his treatment of patients when his actions represent gross ignorance or carelessness. In 1954, this standard was expanded to include gross malpractice. While a "negligence" standard, used by most of the other health regulatory boards in Virginia, refers to the failure to use such care as a reasonably prudent and careful person would under similar circumstances, the "gross negligence" standard, used by the Board of Medicine, is a rigorous standard. This standard refers to the intentional failure to perform a duty in reckless disregard of the consequences as would affect the life or property of another person. The Board of Medicine also interprets this standard to refer to a pattern of substandard care by a physician.

In addition to the gross negligence standard, the *Code of Virginia* allows for disciplinary action if a practitioner "conducts his practice in such a manner as to be a danger to the health and welfare of his patients or to the public." According to a senior Board of Medicine staff member, this standard may encompass more activity on the part of a practitioner than the gross negligence standard, including activity that does not meet the gross negligence standard, but threatens public safety. However, the Board of Medicine's executive director told JLARC staff that this standard is similar to the gross negligence standard. For a practitioner's actions to be considered a "danger to the health and welfare of his patients or to the public," the executive director told JLARC staff that he looks for a pattern of substandard care, although he is not sure how many incidents of substandard care are necessary to meet this standard.

In its *Consumer Guide to the Board of Medicine*, the Virginia Board of Medicine articulates how it construes these standards. While medical malpractice claims represent a significant number of standard of care complaints received by the board, few of these cases meet the high threshold for disciplinary action. In its explanation for why medical malpractice claims are regularly dismissed, the board states:

> Malpractice claims are based on the concept of an error in professional judgement. A single such error may not establish gross ignorance, carelessness, or gross malpractice or support a claim that the practitioner conducts his practice in a dangerous manner, both of which are legal bases for discipline by the Board.

Cases Involving Possible Deviations from the Standard of Care Are Being Closed at the Intake Level

With the rigorous statutory standards, the Board of Medicine closes many cases at the intake stage without full consideration. Standard of care cases are often dismissed without sufficient information on which to judge the seriousness of the physician's deviation from the standard of care. DHP and Board of Medicine staff have

justified these dismissals on the grounds that the physician's conduct would not likely be judged in violation of law under the gross negligence standard.

One category of cases often dismissed without sufficient information is medical malpractice cases. A primary source of the standard of care complaints involving physicians received by the Department of Health Professions is medical malpractice payment reports (MMPR). Sent by insurance companies representing medical practitioners after the completion of malpractice proceedings, MMPRs briefly outline a specific allegation of malpractice against a practitioner and list the amount of settlement or judgment reached in the malpractice suit. JLARC staff reviewed 41 closures of MMPR cases at the intake level, of which 17 raised concerns. Many of these reports describe allegations that represent potentially serious standard of care concerns about the practitioner involved in the malpractice claim and appear to warrant further investigation regarding the practitioner's conduct or competence. It appears, however, that many of these malpractice complaints were dismissed without collecting any further information about how serious the physician's conduct may have been.

The following four case examples of complaints closed at intake provide evidence of a deviation from the standard of care on the part of the physicians, as well as possible patient harm. However, these cases were dismissed at the intake level without an investigation. In two of these cases, the board president requested additional information, but the information was not obtained, and these cases were closed. Each of the following examples raises concerns about whether potentially troubling malpractice complaints are prematurely dismissed at the intake stage without adequate information:

> *A physician failed to diagnose nasopharyngeal carcinoma (a malignant tumor in the lining behind the nose) in an 18-year old male. The patient was in an advanced stage of tumor development when he first saw the patient. The patient was subsequently diagnosed and treated and was disease-free at the time of the legal settlement. The malpractice suit was settled for $150,000. The complaint to the disciplinary system was dismissed at intake without an investigation.*
>
> * * *
>
> *A doctor prescribed a sulfa-based drug for a patient. The malpractice report stated that the patient "alleged [the doctor] knew or should have known that [the] patient was allergic to sulfa." The patient had a severe allergic reaction. The malpractice suit was settled for $40,000. The complaint to the disciplinary system was dismissed at intake without an investigation.*
>
> * * *
>
> *In performing a cesarean section, a physician failed to remove a surgical sponge used for the procedure from the body of the patient. This*

omission resulted in the need for additional surgery to remove the sponge. The malpractice suit was settled for $6,750. The complaint to the disciplinary system was dismissed at intake without an investigation.

* * *

A mechanical device damaged the patient's left hand. The patient alleged that his injury was not treated aggressively enough, resulting in the amputation of his hand. The malpractice suit was settled for $75,000. The complaint to the disciplinary system was dismissed at intake without an investigation.

In each of these cases, the disciplinary case was closed at the intake stage without an investigation.

Cases Involving Negligent Activities Are Being Closed Administratively Without Disciplinary Action

Once a complaint involving a practitioner has been docketed and investigated, the respective licensing board reviews the case for probable cause of a violation of the board's statutory standards. If probable cause is found, the case proceeds to a hearing or a pre-hearing consent order. If probable cause is not found, the case is closed, either as "no violation," which is a permanent closure, or as "undetermined," which allows the board to re-open the case at a later date if the board receives further information about the practitioner. JLARC staff conducted a random review of cases closed at the probable cause stage in order to determine whether the information contained in the investigative reports provided reasonable basis for the boards to close these cases without a hearing. While JLARC staff found that all of the health regulatory boards, including the Board of Medicine, are generally making reasonable closure decisions given current statutory standards, the review raised concerns about the statutory standards applied by the Board of Medicine when reviewing cases.

The Board of Medicine's rigorous statutory standards result in the closure of cases that raise serious concerns about the standard of care of the physicians involved and the potential threat to the public by the physician's practices. The board reviews all investigated standard of care cases to determine whether there is probable cause that a practitioner's practice is grossly negligent or poses a danger to the public. Under these standards, cases in which there is substantial evidence of a negligent act resulting in patient harm, but that do not rise to the level of gross negligence, are closed by the board without an administrative hearing.

The following are five examples of cases JLARC reviewed that illustrate the severity of some cases closed by the Board of Medicine without a hearing:

A physician allegedly failed to follow through and act promptly on a hospital's request to test a newborn child for galactosemia, a genetic disorder requiring urgent diagnosis with symptoms including vomiting, jaundice, and malnutrition in infancy. Although the hospital where the baby had been born contacted the doctor and requested that the baby be tested for galactosemia, the test was not performed for over two weeks. The physician did state that he asked his lab technician to perform the test. The doctor allegedly did not discuss the hospital's request with the baby's parents. In addition, the baby was examined twice by the physician during the two week period without the detection of galactosemia. The parents claim the child had symptoms of galactosemia, while the physician stated that there were no conclusive clinical signs or symptoms. It was alleged that the delay in diagnosis led to the infant losing eyesight in one eye and to developmental problems. This complaint was received by DHP both as a medical malpractice payment report and through a complaint made by the baby's parents. The malpractice suit was settled for $200,000. The disciplinary case was closed by the Board of Medicine without a hearing.

* * *

A 13-year old female, who was admitted to a pediatric intensive care unit with upper gastro-intestinal bleeding and abnormally low blood pressure, died as a result of a perforation in an artery conveying blood toward her lungs during a line insertion under her left collar bone by a physician. Two chest films, one performed before death and one after, indicated that the central line was not in a vessel. The gross autopsy found that the tip of the catheter, inserted by the respondent, was in the pericardial sac. The pericardial sac, which surrounds the heart and great vessels, was filled with blood. A small puncture wound found at the base of the artery was believed to be the cause of the patient's death. This complaint was received by DHP as a medical malpractice payment report, and the malpractice suit was settled for $425,000. The disciplinary case was closed by the Board of Medicine without a hearing.

* * *

A physician allegedly failed to remove a surgical sponge during the insertion of a pacemaker. After the insertion of the pacemaker, the pacemaker pocket began to swell. The patient went to a second doctor who removed the pacemaker and found that a gauze sponge had been left in the pocket. This complaint was received by DHP as a medical malpractice payment report, and the malpractice suit was settled for $75,000. The disciplinary case was closed by the Board of Medicine without a hearing.

* * *

A physician allegedly provided substandard care in the performance of surgery for vertigo, an illusory sense that the environment or one's own body is revolving. The surgery resulted in partial facial paralysis of the patient. The paralysis allegedly resulted from damage to the patient's facial nerve by the physician. This complaint was received by DHP as a medical malpractice payment report. The report indicated that there was a court verdict in favor of the plaintiff. The malpractice suit was ultimately settled for $601,800. The disciplinary case was closed by the Board of Medicine without a hearing.

* * *

A radiologist incorrectly interpreted an ultrasound, resulting in an inaccurate diagnosis, which allegedly led to a patient's death. The patient presented at the hospital with complaints of lower abdominal pain and low back pain. During an ultrasound, the respondent observed abdominal films and diagnosed the patient with appendicitis, rather than an abdominal aortic aneurysm. In addition, the ultrasound was terminated prior to completion when it appeared that the doctors had the information they needed. A review of the hard copy films by the same radiologist again resulted in the same inaccurate diagnosis. The patient's appendix was removed, and the patient died two days later. This complaint was received by DHP as a medical malpractice payment report, and the malpractice suit was settled for $350,000. The disciplinary case was closed by the Board of Medicine without a hearing.

While each case involves clear evidence of patient harm on the part of the physician as well as substantial evidence of physician negligence, these cases were deemed by the board to not meet the gross negligence threshold. As a result, each case was dismissed upon the review of one board member without a hearing and without any disciplinary action against the practitioners.

Board of Medicine Standard Is Not Consistent with that of Other Health Regulatory Boards and Recommendations of the Federation of State Medical Boards

The Board of Medicine is the only health regulatory board in Virginia with such a high threshold for deciding standard of care cases. The *Code of Virginia* defines negligent acts as standard of care violations for several of the boards and does not establish a gross negligence standard for any other board. In addition, the Federation of State Medical Boards recommends a negligence standard, and neighboring states have a negligence standard for standard of care cases.

Several Boards Have a Negligence Standard. The *Code of Virginia* or board regulations expressly establish a "negligence" standard for disciplinary cases involving standard of care issues for six of the 12 health regulatory boards in Virginia. The Boards of Dentistry, Nursing, Pharmacy, Professional Counselors, Psychology, and Audiology and Speech-Language Pathology all review complaints, screen for probable cause, and sanction licensees based on a standard of negligence. In addition, the Boards of Optometry, Social Work, and Veterinary Medicine all apply a negligence standard in reviewing and adjudicating cases even though the *Code* and regulations do not expressly set forth a negligence standard. The remaining two boards, the Boards of Funeral Directors and Embalmers and Nursing Home Administrators, do not regulate licensees who provide direct care to patients or clients and thus do not have comparable standard of care cases.

The following are examples of cases in which other boards disciplined licensees for negligent acts. These examples demonstrate the difference between the treatment of standard of care cases by the Board of Medicine and the treatment of these cases by the other health regulatory boards.

A dentist prescribed a medication containing aspirin to a patient whom he knew, or should have known, to be allergic to aspirin. The patient had an allergic reaction requiring emergency treatment. The Board of Dentistry reprimanded and fined the dentist.

* * *

A patient presented to a dentist with complaints of pain and sensitivity around a tooth. The dentist failed to properly diagnose and treat this patient despite the patient's continued complaints. The patient was diagnosed by another dentist with an abscess around the tooth. The Board of Dentistry reprimanded the dentist and ordered the dentist to successfully complete a remedial continuing education course in oral diagnosis.

* * *

During an ear crop of a dog, a veterinarian cropped the ears much shorter than acceptable standards. The Board of Veterinary Medicine reprimanded and fined the veterinarian.

* * *

A pharmacist dispensed a Schedule VI medication and labeled the prescription with the incorrect patient name. The Board of Pharmacy reprimanded the pharmacist.

* * *

A pharmacist substituted a drug for the prescribed Schedule VI medication without verifying the substitution with the prescribing physician. The Board of Pharmacy reprimanded the pharmacist.

Each of these cases involved a one-time deviation from the standard of care on the part of a practitioner. While clearly negligent acts involving deviations from the standard of care by the practitioner, all of these cases would have been dismissed without a hearing under the Board of Medicine's threshold for standard of care cases. However, these boards clearly viewed negligent acts by their licensees to warrant disciplinary action.

The Federation of State Medical Boards Recommends a Negligence Standard. Like the other state medical boards across the United States, the Virginia Board of Medicine is a member of the Federation of State Medical Boards. The Federation provides policy guidance to the state medical boards, including recommendations for laws and regulations governing medical practice. Among its recommendations in *A Guide to the Essentials of a Modern Medical Practice Act*, the Federation recommends that medical boards take disciplinary action against licensees for "negligence in the practice of medicine as determined by the Board." There is no mention of the concept of gross negligence.

JLARC staff conducted a survey of the statutes of other southeastern and mid-Atlantic states to determine what standards other states have for disciplining physicians in standard of care cases. JLARC staff found that several states have a gross negligence standard, while a number of states, including Virginia's neighboring states of North Carolina and Maryland, have standards more resembling simple negligence. North Carolina's statute, for example, allows for disciplinary action against a practitioner who commits "unprofessional conduct, including, but not limited to, departure from or the failure to conform to the standards of acceptable and prevailing medical practice."

Negligence Standard Would Better Ensure Protection of the Public

With the current gross negligence standard, the Board of Medicine does not appear to adequately fulfill its role in the protection of the public from substandard practice by physicians. Under the current standard, physicians are rarely held accountable by the board for care that deviates from the acceptable standard unless they commit a single egregious act or a series of acts of negligence. The board's limited role in the regulation of the practice of medicine is evidenced by the fact that the board imposed disciplinary sanctions in only three cases exclusively involving standard of care issues during the last two fiscal years.

One of the primary problems with the current standard is that the threshold for disciplinary action is so rigorous that only the most egregious cases are heard by the board. Cases involving substantial deviations from the standard of care that result in serious patient harm do not necessarily proceed to a hearing unless there is evidence

of intentional misconduct by the physician or a pattern of substandard care. While many negligent acts by physicians do not necessarily warrant disciplinary action, some negligent acts do warrant such action. Yet serious negligence cases receive the same treatment as more minor negligent acts and are dismissed without a hearing or disciplinary action.

The problem with the current approach is demonstrated by the case example on page 73 of this report. In this case, a physician failed to promptly administer a diagnostic test for a disease that required urgent diagnosis, and the delayed diagnosis may have caused the patient's loss of sight in one eye. This is the kind of serious case that needs to be heard by the board in an open hearing, but instead was closed under the current standard by a single board member in closed session.

A further problem with the current standard and policies used by the board is that the process limits the ability of the board to even fully apply its current gross negligence standard. According to the board staff and board counsel, one of the means by which gross negligence can be established is if there is a pattern of negligent acts by a physician. However, a pattern is not likely to be established under the board's current policies and procedures. The board closes most of the standard of care cases after investigation as having "no violation." Cases closed with this designation cannot be used in the future to establish a pattern of negligent acts even if additional complaints are received against that respondent. The board closes some cases as "closed undetermined" to avoid this problem. A case closed with this designation can be re-opened to establish a pattern if additional complaints are received. However, the board appears to close most standard of care cases with the "no violation" designation. For example, four of the five cases discussed in the probable cause case examples were closed as "no violation." Therefore, those cases could not be used to establish a pattern if additional complaints were received against the practitioners.

Establishing a negligence standard would require the board to assume more responsibility for protection of the public from the negligent practice of medicine. Requiring the board to hear cases involving deviations from the standard of care would allow for an assessment of the seriousness of the negligent act in a public forum. The board's informal conference committee would have the discretion to decide what sanction is appropriate based on the seriousness of the negligent act. In cases in which the negligent act does not involve a substantial deviation from the standard of care, the informal conference committee could choose to impose no sanction.

However, in cases in which a physician substantially deviates from the standard of care, the board needs to be able to consider disciplinary action both to protect the public from such negligent acts in the future and to impose upon the practitioner any terms that may help to make him or her a better physician and avoid such occurrences in the future. In addition, hearing the negligence cases instead of dismissing them as "no violation" would further serve to protect the public by ensuring that a record of a practitioner's negligent acts is being established so that significant patterns which may require more serious disciplinary action can be identified and supported.

Recommendation (17). **The General Assembly may wish to consider amending § 54.1-2915(A)(4) of the *Code of Virginia* to change the gross negligence standard and define the negligent practice of medicine as a violation of law.**

BOARD OF MEDICINE DOES NOT HANDLE MEDICAL MALPRACTICE CASES APPROPRIATELY

The Board of Medicine does not appear to view medical malpractice cases as seriously as other cases it receives. Complaints stemming from medical malpractice payment reports (MMPR) represent a significant source of information for DHP and the Board of Medicine about practitioners in Virginia who may have deviated from the standard of care in the practice of medicine. Sent by insurance companies representing medical practitioners after the completion of malpractice proceedings, these MMPRs briefly outline a specific allegation of malpractice against a practitioner and list the amount of settlement or judgment reached in the malpractice suit. As a subset of the standard of care complaints the board reviews, however, these complaints are subject to even less scrutiny than other standard of care complaints. Once a MMPR is received from a practitioner's insurance company, the intake staff and the Board of Medicine review the report to determine if further investigation is warranted. Complaints that do not appear to warrant further investigation are closed. Many of the MMPR complaints are closed with minimal information and should receive further investigation. Even when malpractice complaints are docketed for investigation, these complaints receive a lesser level of investigation than standard of care complaints received directly from a patient. As a result, DHP and the Board of Medicine need to re-examine their approach to these cases to ensure that these reports are screened appropriately and receive a thorough investigation.

Intake Unit and Board of Medicine Review Medical Malpractice Reports to Determine If Further Investigation Is Warranted

Section 54.1-2909 of the *Code of Virginia* requires that malpractice insurers report to the Board of Medicine any malpractice judgment or any incident of two malpractice settlements within three years. In addition, federal law requires that all malpractice settlements and judgments be reported. Currently, DHP's intake unit actually receives notification of all malpractice judgments and settlements involving practitioners licensed in Virginia. Between July 1, 1997 and December 31, 1998, a total of 299 medical malpractice reports involving Board of Medicine licensees were resolved by DHP. When DHP receives a MMPR, an intake analyst (a health professional in the enforcement division) reviews the report to determine if the information provided indicates a possible violation of law or regulation and thus warrants an investigation. The decision whether to forward a complaint to the Board of Medicine with a recommendation that it be closed or to docket a complaint for further investigation is based solely on the minimal information provided in the report. The DHP *Adjudication Manual*,

which outlines the case adjudication processes to be used by DHP and the boards, states, "If the Intake Analyst requires additional information to make a determination, a preliminary investigation is instituted." Nevertheless, preliminary investigations are conducted only occasionally for medical malpractice cases. One intake analyst told JLARC staff that if more information is deemed necessary for an MMPR case, then it will be docketed without a preliminary investigation.

If the intake unit recommends that a complaint be dismissed, it is sent to the board's executive director and then the president of the board for review. If they both agree with the closure recommendation, then the case is closed. The board reviewers may also request that the intake unit obtain additional information, or they may request that the case be docketed.

There are several different categories of case closure at the intake level. Most complaints are closed either as "no violation," when a complaint does not warrant an investigation, or "no jurisdiction," when a complaint does not involve a board licensee. These complaints may not be re-opened for investigation. However, complaints involving malpractice reports are generally placed in a category entitled "investigation deferred." This category was designed to allow intake analysts to return to a case if more information indicating a violation surfaces. Despite this separate category, both intake analysts and several board executive directors told JLARC staff that with DHP's mainframe, the category is a "black hole," and few of these cases are ever reopened.

Many Closed Malpractice Complaints Do Not Provide Sufficient Information and Should Be Investigated

When first received by DHP, MMPRs provide minimal information about allegations of malpractice. Typically, these reports provide basic demographic information about the practitioner, a one or two-sentence description of the allegation, and the amount of the settlement or judgement. Occasionally, these reports, which are provided by the practitioner's insurance company, will include information beneficial to the practitioner's case, such as a sentence indicating that had the case gone to court, the insurance company had expert witnesses prepared to testify on the practitioner's behalf. No information is provided on the patient's behalf, nor is there any specific information about the behavior or practice of the practitioner.

In order to close a complaint at the intake stage, an intake analyst must recommend, and the board reviewers must agree, that the allegation and available evidence do not reflect possible violations of the statutes governing the board. Based on the minimal information they receive, however, the intake staff and the Board of Medicine close more than one-third of the MMPR complaints prior to an investigation. JLARC's review of MMPR complaints closed at intake found that a number of complaints dismissed at the intake level provided insufficient information about the alleged violations and did not receive a preliminary investigation.

Following are examples of three MMPR complaints that were closed by the Board of Medicine at the intake level, and the entirety of information that was provided in each of the complaints:

> *"2-year old female outpatient alleged medication error." This case was settled for $40,175.*
>
> * * *
>
> *"Doctor closed a wound that should have been left open to combat infection for an additional 48 hours." This case was settled for $25,000.*
>
> * * *
>
> *"Alleged negligent performance of circumcision retained foreskin." This case was settled for $9,234.*

These case examples reveal that complaints are being closed without sufficient information to determine if an investigation is warranted. It is problematic that DHP does not gather preliminary information about malpractice allegations that may indicate a deviation from the standard of care prior to concluding that a violation has not occurred. Without further information about these cases, such as a description of the events that took place or medical records, it does not appear possible that the intake staff or the Board of Medicine could conclusively assess the seriousness of these allegations against the practitioner.

DHP and Board of Medicine Staff Views on Treatment of Medical Malpractice Cases

Some staff within DHP expressed concern that the Board of Medicine does not view medical malpractice cases as seriously as other cases. In addressing a backlog of cases that collected at DHP several years ago, the enforcement division noted that the board rarely acted on medical malpractice cases. Consequently, the director of enforcement told JLARC staff that it was determined at that time that fewer medical malpractice cases should be docketed for investigation in order to increase agency productivity. Likewise, investigators have been hesitant to spend a great deal of time investigating malpractice cases, because they feel these cases rarely go forward to a hearing. Consistent with this sentiment, of the 195 investigated medical malpractice cases that were resolved by the Board of Medicine between July 1, 1997 and December 31, 1998, only 21 proceeded to a hearing. Of those cases, violations were found in just two cases. Although these concerns seem widespread in the agency, the director of enforcement told JLARC staff that the way medical malpractice cases are treated is "evolving," and that DHP staff are currently trying to handle malpractice cases in a similar manner as other standard of care cases.

The level of screening of malpractice complaints at intake and the lack of thoroughness of malpractice investigations seem to result from a view that malpractice settlements are a suspect basis for determining whether disciplinary action is appropriate. In a brochure entitled *Consumer Guide to The Virginia Board of Medicine*, the board makes it clear that it views medical malpractice cases as a suspect category of cases:

> Malpractice claims or settlements may not constitute statutory or regulatory violations. This apparent disparity exists because anyone can file a malpractice suit without showing evidence of damages and malpractice insurance carriers may settle claims rather than incur the expense of a court appearance. Such a settlement may be unrelated to the practitioner's wishes or to a reasonable assessment of his competence.

The Board of Medicine also seems to rely on the dollar amount of a settlement in determining whether a case warrants investigation. The Board of Medicine executive director told JLARC staff that the board rarely dockets cases with settlements less than $100,000. According to the board executive director, cases settled for less than $100,000 do not necessarily represent the physician's wishes or an admission of a mistake on the part of the doctor, and thus usually do not warrant an investigation. Just as the smaller settlements do not necessarily indicate a problem, they also do not necessarily indicate a lack of a problem, and the cases should be investigated or not investigated based on the evidence presented.

Malpractice Cases Should Be Treated With the Same Scrutiny as Other Standard of Care Cases at the Intake Level

Malpractice complaints should be treated with the same scrutiny as other standard of care cases at the intake level. While most standard of care allegations received from a patient involving Board of Medicine licensees proceed to an investigation, a significant number of malpractice claims do not. Of the 20 percent of cases closed at the intake stage in fiscal year 1998 that were reviewed by JLARC, only three standard of care complaints involving Board of Medicine licensees that were received from patients were closed, and none of those closures raised concerns for JLARC staff. Of the 299 MMPRs resolved by DHP between July 1, 1997 and December 31, 1998, however, 104 were closed at the intake stage, and over 40 percent of the MMPR complaints reviewed by JLARC staff that were closed at intake raised concerns.

Malpractice complaints should be evaluated based on the behavior and practice of the practitioner. Based on the lack of information the intake analysts and board reviewers have about these cases prior to closure, this does not seem to be taking place. The Board of Medicine appears to view malpractice cases differently "because anyone can file a malpractice suit." This rationale for dismissing malpractice cases seems questionable. Any individual may also file a complaint with DHP against a physician.

Unlike many malpractice cases, however, most standard of care complaints received by DHP from a patient appear to be docketed by the intake staff. Regardless of the source of a complaint alleging substandard care, the complaint should be taken seriously, and additional information about the alleged activity should be collected.

The Board of Medicine also relies heavily on the dollar amount of the malpractice settlement in determining whether a case warrants an investigation and tends to dismiss cases with a settlement below $100,000. This is an arbitrary measure that raises several concerns. First, closing cases based on the monetary amount of a malpractice settlement in conjunction with the minimal information provided in an MMPR report gives physicians the benefit of the doubt at the intake level. At this stage, if there is any question about the physician's care, more information should be collected before closing the case. In addition, settlement amounts vary depending on the type of medicine being practiced and the particular procedure involved. While a $100,000 settlement may be relatively low in the case of a patient death resulting from a surgeon's negligence, a $100,000 settlement may be extremely high for negligence by a doctor performing a more routine procedure. Regardless of the amount of the settlement, different types of doctors may be providing care that deviates from the standard of care. A further problem with relying upon the monetary amount is that the amount of the settlement may be less related to the seriousness of the physician's act than to the abilities of the attorneys negotiating the settlement or trying the case.

The director of enforcement told JLARC staff that she has recognized the need to treat malpractice cases like other standard of care cases and is working with the enforcement division to evaluate complaints based on the behavior and practice of the practitioner, rather than on the type of case and the dollar amount involved. In order to treat these cases with the same scrutiny as other standard of care cases, DHP should collect additional information upon receipt of a malpractice complaint, and complaints that reflect a possible deviation from the standard of care on the part of a practitioner should be investigated.

Recommendation (18). **The Department of Health Professions should handle medical malpractice payment reports like other standard of care complaints at the intake stage and only close such cases at this stage when there is adequate information on which to base the closure.**

Malpractice Investigations Are Not Always Adequate

Most medical standard of care cases received by DHP through a complaint from a member of the public are investigated by field investigators located in one of four regions across the state. The DHP *Adjudication Manual* states that field investigations may include face-to-face interviews with those involved in the case, as well as inspections of facilities, sites, and records. After the investigation is complete, the field investigator typically prepares an investigative report, which contains a summary of the investigation, documentation of the interviews the investigator conducted, and related evidence such as patient records, correspondence, and inspections.

Investigations resulting from medical malpractice payment reports are generally not as thorough as the investigations for other cases. For the most part, MMPR investigations are handled as document collections rather than as full-fledged investigations. Despite the potential standard of care concerns raised by some of the malpractice claims, investigative staff see these as "easy" cases because full investigations are not considered necessary. The majority of these cases are handled by administrative investigators, who conduct investigations primarily by telephone and correspondence from DHP's central office. Even when field investigators handle these investigations, investigators are directed to collect documents pertaining to the medical malpractice lawsuit and to conduct no further investigation, according to several investigator supervisors. Many of these documents do not contain any information on the practitioner's actual behaviors and practice. In addition, the documents are usually collected through the practitioner or his attorney and do not include information from the perspective of the patient. Unlike other standard of care cases, the investigator does not interview the respondent, patients, or witnesses.

Once the document collection is complete, the investigator attaches a brief cover sheet to the documents and forwards them to the Board of Medicine for review. The Board of Medicine executive director and a board member then review the information to determine whether there is enough evidence to indicate a possible violation. Without a full investigation of these MMPR cases, the board may lack sufficient documentation to determine whether a practitioner has been grossly negligent or is a danger to the public. Before making a final determination to close a case, the Board of Medicine executive director and the board member who reviews the case before closure need to have sufficient information about the circumstances surrounding the case and the actual behavior and practice of the practitioner.

DHP Could Create a Separate Process to Ensure Medical Malpractice Cases Are Appropriately Investigated

In order to provide greater protection to the public from substandard practitioners without unnecessarily increasing the workload of current investigators, DHP and the Board of Medicine need to fundamentally re-examine the way in which medical malpractice claims are handled. DHP and the Board of Medicine may want to consider creating a new process for screening and investigating medical malpractice cases.

An Intake Analyst or Administrative Investigator Could Conduct Initial Investigation. To ensure that there is adequate information to determine closure of a malpractice case at each step in the disciplinary process, DHP could create a separate procedure for handling these cases. An intake analyst or administrative investigator could have sole responsibility for reviewing all incoming MMPRs. This individual would look at all of the reports and dismiss, with the approval of the Board of Medicine, any extraneous malpractice claims that clearly provide sufficient information for closure. For the rest of the malpractice reports, this individual could be responsible for contacting the respondent or attorneys involved in the lawsuit to collect and

access the documents currently collected by a DHP investigator. This document collection could be done from the DHP central office without significant field work.

Board of Medicine Could Review Results of Document Collection. Once the basic document collection is complete on a malpractice case, the case could then be forwarded to the Board of Medicine executive director and president for an initial review. The board would have more information about each case than it currently does at the intake stage before making a decision as to whether the case warrants further investigation. The decision process at this point would focus on whether the evidence indicates a possible violation, and not whether there is probable cause that a violation took place. If the document collection does not provide evidence of a possible violation, then the case would be closed.

If the document collection indicates a possible violation of law, the board would determine if additional information was needed to conduct the probable cause review and to decide whether the case should proceed to a hearing. If the board concluded that additional information is needed, then the case could be assigned to a field investigator who could conduct a typical field investigation with interviews of the practitioner, patients, and witnesses. After completion of the investigation, the board could then review the case to determine whether there was probable cause that a violation had occurred.

New Screening Process Could Provide Several Advantages. This procedure could provide several advantages over the current malpractice screening and investigation process, and thus could serve to better protect the public against doctors who deviate from the accepted standard of care. First, no decisions to close a case would be made without sufficient information. Few, if any, MMPRs provide enough evidence about a case to determine whether the practitioner deviated from the standard of care. With this process, cases would not be closed without sufficient basis. Legal documents would be collected for all complaints prior to a decision to dismiss a complaint, unless there was clear evidence that no violation had taken place. Additionally, cases that provide evidence of a possible violation could be fully investigated if needed.

Recommendation (19). **The Department of Health Professions should re-evaluate its current policies for handling medical malpractice payment reports and develop a process that ensures sufficient evidence is gathered on which to assess these reports prior to closure.**

Appendixes

Appendix A

House Joint Resolution No. 51
1998 Session

Requesting the Joint Legislative Audit and Review Commission to study the effectiveness of Virginia's health regulatory boards.

WHEREAS, Virginia's health regulatory boards regulate a number of professions, including medicine, osteopathy, chiropractic, podiatry, physical therapy, occupational therapy, respiratory therapy, pharmacy, nursing, dentistry, the practice of physician assistants, and other health professions; and

WHEREAS, the activities of the health regulatory boards are intense, requiring significant disciplinary investigations and hearings, as well as the processing of applications for licensure; and

WHEREAS, the advent and growth of the managed care industry has resulted and will continue to result in significant changes in the paradigm of health care; and

WHEREAS, the health regulatory boards' authority to regulate remains more administrative and quasi-judicial than focused on quality assurance; and

WHEREAS, the time and resources of the health regulatory boards may be becoming stretched to meet their extensive disciplinary case load; and

WHEREAS, because of the limits on time and resources, the health regulatory boards' ability to provide careful and in-depth evaluation of their disciplinary cases, while providing a licensure program designed to ensure that Virginia has high quality practitioners, may be taxed; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Legislative Audit and Review Commission be requested to study the effectiveness of Virginia's health regulatory boards. In its study, the Commission shall include: (i) an evaluation of the composition of the respective boards to determine their appropriateness vis—vis the evolving duties and responsibilities for health profession regulation; (ii) an assessment of the respective boards' appropriate roles in ensuring the qualifications of physicians and other health care professionals in this Commonwealth; and (iii) an evaluation of the respective boards' authority and activities to establish standards for high quality health care delivery by physicians and other health professionals in Virginia.

All agencies of the Commonwealth shall provide assistance to the Commission, upon request.

The Joint Legislative Audit and Review Commission shall complete its work in time to submit an interim report of its findings and recommendations to the Governor and the General Assembly no later than January 1, 1999, and shall submit a final report to the Governor and General Assembly no later than January 1, 2000 as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Appendix B

Study Mandate

Item 16H - 1998 Appropriation Act

Health Regulatory Boards

The Joint Legislative Audit and Review Commission shall conduct an evaluation of the Department of Health Professions, the Board of Health Professions, and the health regulatory boards. The evaluation shall include, but not be limited to, (i) follow-up of the Commission's 1982 and 1983 study recommendations related to the health regulatory boards, (ii) an assessment of the working and organizational relationships between the boards, the department staff, and the Board of Health Professions in the licensing and regulation of health professions, (iii) an examination of the efficacy, fairness and propriety with which the various statutes, duties, functions, and activities involved in the licensing and regulation of health professions are being performed and discharged, and (iv) an assessment of the Department's staffing and automated systems needed for current and future operations. The Department of Health Professions and the health regulatory boards shall cooperate fully with the Commission and shall provide all information requested by the Commission and its staff. The boards shall also provide the Commissioner's staff with full access to all disciplinary or other proceedings of the boards, including executive sessions, and to all disciplinary files and records of the boards or the Department of Health Professions. The Commission shall make an interim report to the Governor and the General Assembly no later than January 1, 1999, and a final report no later than January 1, 2000.

Appendix C

Follow-Up to JLARC's December 1982 Report: *The Occupational and Professional Regulatory System in Virginia*

Recommendation (1). In order to provide a consistent legislative base for all regulatory boards, the General Assembly may wish to clarify the applicability of the general provisions of Title 54 to all boards. The legislature may also wish to consider recodifying the statutes for the health boards to provide a general legislative framework within which regulations would be promulgated.

This recommendation has been implemented.

Recommendation (2). DOC and CHRB should take steps to ensure that accurate and sufficient copies of proposed regulations are available for public inspection prior to and at each public hearing. The agencies should also improve their public information efforts to secure increased public involvement in hearings.

This recommendation has been implemented as it applies to the health regulatory boards.

Recommendation (3). The Board of Commerce and the Commission of Health Regulatory Boards should develop guidelines to be followed by all boards in preparing economic impact statements. The statements should specify, at a minimum, additional restrictions on entry into the occupation, limitations on competition, and potential effects on cost.

The *Code of Virginia* has been amended to require a detailed economic analysis of any proposed regulation by the Department of Planning and Budget in coordination with the agency proposing the regulation.

Recommendation (4). The General Assembly may wish to require each board to promulgate regulations in a consistent format that: (a) organizes rules by major categories; (b) uses simpler language; (c) limits numbered regulations to related criteria; and (d) distinguishes between statutory and administrative requirements. Guidelines for this format should be prepared by DOC and DHRB. Boards should also identify the authorizing section of the Code for each regulation they promulgate. Board staff should work with the assistant attorneys general assigned to DOC and DHRB to develop a format and procedure for determining the proper reference and authority of the board.

In addition, the General Assembly may wish to study the feasibility and cost of adopting an administrative code for the Commonwealth which would standardize the style and

format and provide a single source of regulations and a system of referencing and indexing regulatory requirements.

This recommendation has been addressed with the publication of the *Virginia Administrative Code.*

Recommendation (5). DOC and DHRB should develop procedures for comprehensive support of board activities during the consideration of new regulations. Moreover, the General Assembly may wish to amend Sections 54-1.25 and 54-955.1 to explicitly give BOC and CHRB the power to review board regulations.

The Department of Health Professions has established procedures to support the health regulatory boards in the development of new regulations. In addition, the Board of Health Professions has been granted express statutory responsibility for reviewing and commenting on proposed regulations.

Recommendation (6). The General Assembly may wish to direct the regulatory boards by resolution or by statute to conduct general reviews of existing regulations and report to the General Assembly on the results. Reviews should be conducted by each board according to a schedule, standard criteria, and format to be developed by DOC and DHRB. Regulations should be reviewed to determine whether they are authorized by statute, clearly defined, and relevant to practitioner competence or protection of the public.

As part of regulatory review actions, boards should address problems with regulation that include but are not limited to areas identified in the JLARC review.

Where statutory authority for a regulation is lacking, boards should repeal the regulation or request necessary authority from the General Assembly. Each request should include documented reasons for the change and continued need for regulatory authority by the board in that area.

DOC and DHRB should prepare reports which specify actions taken by the boards to repeal, modify, or retain regulations. Where applicable, recommendations should be made to the General Assembly for needed changes in existing statutes or enactment of new statutes.

This recommendation has been implemented.

Recommendation (7). The General Assembly may wish to consider further or request an opinion of the Attorney General regarding the constitutionality of legislative review and approval of the rules of regulatory boards as provided by Sections 54-1.25, 54-1.28, and 54-955.1. The General Assembly may also wish to review the statute concerning the legislative review function and assign responsibility for review to a new or existing joint committee.

The General Assembly has amended the Administrative Process Act to address constitutional concerns.

Recommendation (8). *BOC, CHRB , and the regulatory boards should improve their efforts to make the public aware of avenues for handling complaints against regulated practitioners. Options include using more public service announcements, publishing agency telephone numbers under "Community Service Numbers" in local telephone directories, installing toll-free telephones to receive complaints, and requiring licensees to display information about the boards with their posted licenses or to include such information on contracts with clients.*

DOC, DHRB, and the boards should also identify all organizations which may receive complaints about practitioners and encourage their cooperation in referring the complaints to the boards.

This recommendation has been implemented.

Recommendation (9). DOC, DHRB, and the boards could improve receiving and evaluating complaints by:

(a) developing guidelines for evaluating the seriousness of complaints received by telephone, appropriately recording the information, and referring complaints for investigation,

(b) eliminating requirements that letters of complaint be notarized as a routine condition for investigation,

(c) establishing guidelines for handling complaints administratively and developing standard record keeping systems to retain information on the complaint and the action taken;

(d) establishing a central index of all complaints received by boards.

This recommendation has been implemented.

Recommendation (10). DOC, DHRB, and the board should implement procedures to ensure that board members do not review complaints prior to adjudication. Alternatively, the General Assembly may wish to consider amending Title 54 of the Code of Virginia to shift the responsibility for receiving complaints from the regulatory boards to DOC and DHRB. The agencies, in cooperation with the boards, could establish central units for receiving, evaluating, and determining the need for investigation for all complaints filed against practitioners.

This recommendation has been implemented.

Recommendation (11). DOC and DHRB should consider developing written procedures for classifying complaints based upon the potential physical or financial harm to consumers and on the number of other complaints against the practitioner. Time guidelines for each classification could specify reasonable parameters for investigations and be used as part of a tracking system to monitor the timely completion of cases.

This recommendation has been implemented.

Recommendation (12). DHRB needs to take steps to ensure that investigations are thorough and that all necessary evidence is collected and clearly reported. Improvements that could be made include:

(a) establishing a standard format for presenting case findings and carefully reviewing reports;

(b) training enforcement personnel in investigative techniques, report writing, and laws and regulations;

(c) providing full-time clerical support to the enforcement unit;

(d) establishing periodic group meetings to better coordinate and improve communications among investigators;

(e) establishing at least one additional supervisory position from within existing staffing levels.

This recommendation has been implemented.

Recommendation (13). DOC, DHRB, and the boards should develop a tracking system to alert boards to cases delayed during adjudication and take steps to close cases in a more timely manner. Special attention should be given to expediting cases that do not require a hearing.

The Department of Health Professions and the health regulatory boards have instituted a tracking system. However, as discussed in detail in Chapter III of this report, many cases are still not resolved in a timely manner.

Recommendation (14). Each board should review its regulations and statutes to ensure that it has sufficient authority to discipline in the area of professional competence. Where statutory authority is lacking, the boards should request appropriate powers from the General Assembly. Moreover, boards should make greater use of the consent order to resolve specific consumer problems. Repairs, refunds, or corrective action may be directed through consent orders.

With the exception of the Board of Medicine, the health regulatory boards appear to have sufficient authority to discipline in the area of professional competence. However, as discussed in Chapter IV of this report, the existing statutory provisions applicable to the Board of Medicine do not appear to give the board sufficient authority to discipline its licensees in the area of professional competence. The second half of the recommendation regarding the use of consent orders for consumer problems does not apply to DHP and the health regulatory boards.

Recommendation (15). Boards should establish procedures to review and approve all decisions that are made on behalf of the full board by subcommittees or agency personnel, particularly with regard to cases that are determined to be unfounded.

This recommendation has been implemented.

Recommendation (16). DHRB and the health regulatory boards should refer all potential violations of criminal law to local Commonwealth's attorneys for disposition. For drug cases, DHRB and the State Police should consider greater cooperation in investigating potential criminal and regulatory violation involving licensed practitioners.

Cases involving potential criminal violations are referred to Commonwealth's attorneys. This report recommends that DHP refer misdemeanor unlicensed practice cases to the appropriate magistrate and simultaneously advise the local Commonwealth's attorney of the referral. DHP and the State Police appear to cooperate adequately in the investigation of licensed practitioners.

Recommendation (17).

Not applicable to the health regulatory boards.

Recommendation (18). DOC and DHRB should take steps to ensure that qualitative inspections are kept up-to-date. The agencies should consult with the boards about the appropriateness of some inspection activities to establish frequency of inspection of this type. In addition, the agencies need to improve their records and information on inspections by establishing central records of facilities that require inspections and suspense files to identify which facilities are due for inspections.

DHP has consulted the regulatory boards about the appropriateness and frequency of inspections. However, as discussed in Chapter III of this report, DHP has not effectively implemented the other aspects of this recommendation.

Recommendation (19). Administrative activities at DHRB could be improved by:

(a) separating support and operating functions which are combined in single positions;

(b) assessing workload and adjusting the allocation of staff resources;

(c) improving staff communication and input in policy making and budget development;

(d) ensuring that accounting systems accurately allocate direct and indirect costs to the boards, strengthening fiscal controls over board expenditures, and improving financial reporting to the boards;

(e) decentralizing data processing operations and expanding data processing capabilities to include enforcement activities.

Most of these recommendations have been implemented. However, the interim report noted that additional steps need to be taken to ensure compliance with the statutory limitation on budget surpluses.

Recommendation (20). The General Assembly may wish to consider reconstituting CHRB to provide for a broader public perspective than is now represented. If technical expertise is required, it could be provided on an ad hoc basis by the regulatory board members.

This recommendation has not been implemented. In 1982, seven of the 11 members of the Commission of Health Regulatory Boards were appointed from the health regulatory boards, and four of the 11 members were appointed from the public at-large. Currently, 12 of the 17 members of the Board of Health Professions are appointed from the 12 health regulatory boards and five members are appointed from the public at-large.

Recommendation (21). The Commission of Health Regulatory Boards should more actively carry out its responsibility for monitoring DHRB. The Commission should require DHRB to develop plans for resolving management problems and monitor the agency's performance through periodic status reports.

As discussed in the interim report, the Board of Health Professions does not adequately fulfill its oversight role, though some of the monitoring activities discussed in the 1982 report may no longer be necessary.

Recommendation (22).

Not applicable to the health regulatory boards.

Recommendation (23).

Not applicable to the health regulatory boards.

Recommendation (24). The General Assembly may wish to consider options for improving the administrative efficiency and regulatory cohesion of the system for occupational and professional regulation. Options include:

(a) requiring DHRB and DOC to explore opportunities for increased efficiency and cost savings through sharing of common services and functions;

(b) realigning the regulatory boards to more clearly establish the "business—regulation" orientation of DOC and the "health-regulation" orientation of DHRB;

(c) merging DOC and DHRB into a single support agency in which the health and commercial boards constitute distinct divisions;

(d) reconstituting BOC and CHRB as a single advisory board to review the activities and regulation of existing boards and review the need for additional regulation of professions and occupations.

No legislative action has been taken to merge or share the services or functions of the Departments of Health Professions and Professional and Occupational Regulation or the Boards of Health Professions and Professional and Occupational Regulation. However, three boards aligned with the Department of Professional and Occupational Regulation at the time of the 1982 report (Audiologists and Speech Pathologists, Behavioral Science, and Nursing Home Administrators), have been realigned with the Department of Health Professions as five separate boards.

Appendix D

Status of Automated Systems

The study mandate for JLARC's evaluation of the Department of Health Professions requires an assessment of the department's automated systems. The Department of Health Professions (DHP) is in the process of developing and implementing a new automated system. DHP senior staff expect the All Health Licensing and Disciplinary Information Network (AHLADIN) to be fully operational by the middle of June.

AHLADIN will facilitate the entry, management, maintenance, and support of DHP's licensing processes, including processing fees and applications. The system is also expected to enable DHP to track and maintain complaints and violations against health care practitioners.

DHP has already begun using the AHLADIN system to renew the licenses of current licensees. The licensing portion of the system will maintain licensing data for both individuals and business entities, including demographic, licensure, education, employment, and supplemental information. AHLADIN will facilitate: license denials, generating and printing licenses, registrations, certifications, permits, and other correspondence pertaining to the licensure process.

The disciplinary and compliance modules of AHLADIN will track complaints and violations against health care practitioners in Virginia. The AHLADIN system will replace the current disciplinary tracking systems used by DHP, including the Complaint Tracking and Reporting System (CTARS) database. The AHLADIN system is specifically expected to maintain complaint, violation, restitution, and compliance information, including the following: case number, stage of the disciplinary process, status of the case, priority, region, complainant information, type of complaint, persons involved, case findings, actions taken by the boards and DHP, sanctions, and monitoring information.

AHLADIN will also facilitate financial and accounting transactions for the department. The system will provide detailed audit trails and transaction histories, including amounts posted, changes to a licensee's record, renewals generated, out-going license verifications, and other licensee transaction correspondence.

DHP also expects AHLADIN to be able to facilitate reporting activities. Specifically, the system will be able to produce statistical information so that staff can evaluate growth and activity within the various boards under the department's purview.

The department's progress to date and plans for the future generally appear appropriate. It is premature, however, to reach definitive conclusions about the department's implementation of the automation initiatives, because substantial work remains to be accomplished.

Appendix E

Technical Appendix

The purpose of this technical appendix is to describe the methodology employed by JLARC staff to analyze the timeliness of the disciplinary process after cases have been docketed. Specifically, the technical appendix describes the source of the data used by JLARC staff, the specific steps that JLARC staff employed to analyze that data, and the basic methodological framework for this analysis.

Description of the Data Source. The source of the information used to conduct the case processing analysis was the Complaint Tracking and Reporting System (CTARS) database. This mainframe database contains disciplinary case records. Specifically, JLARC staff used the CTARS status files, or screens, to conduct the analysis. These status files contain a record of key dates for each case, as recorded by DHP staff, so that staff can track the status of cases as they proceed through the disciplinary process.

Data Analysis Procedure. To conduct its case processing analysis, JLARC staff selected all cases that were resolved during the 1997 and 1998 calendar years through a consent order, informal conference, or formal hearing. JLARC staff reviewed each recorded entry for these cases to identify the relevant dates. For each case, the following dates were identified: (1) the date the case was docketed; (2) the date the case was forwarded to an investigative supervisor to be assigned to an investigator; (3) the date the investigative report was submitted to the board for a probable cause review; (4) the date the case was submitted to the administrative proceedings division to prepare the case for adjudication; (5) the date the case was returned to the board from the administrative proceedings division to schedule for an informal conference or to send a consent order; (6) the date the case was resolved through a pre-hearing consent order or informal conference; and (7) the date the case was resolved through a post-hearing consent order or formal hearing, if applicable. The status files often did not provide entries indicating the exact date of informal conferences and formal hearings. Therefore, JLARC staff used the first date entered in the status files following the hearing date to calculate the time between case preparation and hearings.

Certain cases were excluded from this analysis because of incomplete data in CTARS or because the process used was very unrepresentative of typical cases processed through the disciplinary system. Cases were excluded from the analysis if any of the key dates in the process could not be determined from the status files. JLARC staff also excluded cases that circumvented particular stages of the process, such as those involving summary or mandatory suspensions (73 cases were summary suspensions, most of which – 62 cases – were cases of the Board of Nursing) or cases stayed prior to resolution pursuant to the Health Practitioners' Intervention Program. In addition, cases in which follow-up information was requested of the enforcement division after the investigative report was submitted to the board were excluded. Because of the dual investigation, these cases tended to require more time than a typical case; and further, the classification of these cases into distinct time frames is problematic, due to the repetition of certain stages.

Methodological Framework. JLARC staff assessed the timeliness of the disciplinary process by determining the total number of days that DHP and the health regulatory boards required to resolve their disciplinary cases after the cases were docketed. This measure was calculated by examining the number of days that passed between when a disciplinary case was entered on CTARS and its final resolution. A case was determined to have been finally resolved when one of the following occurred: a pre-hearing consent order was agreed to by a licensee and a board; an informal hearing was convened and an order made; a post-hearing consent order was agreed to by a licensee and a board; or a formal hearing was convened and the case decided by a panel of a board.

In addition to examining the total time required by DHP and the health regulatory boards to resolve disciplinary cases, JLARC staff also examined how much time cases spent in each individual stage of the disciplinary process. This analysis was performed by determining when disciplinary cases entered and completed the various stages in the process. Through Statistical Analysis Software (SAS) analysis, JLARC staff subtracted the date of entry from the date of completion to determine how long each case spent in each particular stage of the process.

Once JLARC staff determined how much time was required for each case to complete the entire disciplinary process as well as the individual stages, SAS analysis was used to calculate an average overall resolution time and an average resolution time for each major stage in the process for each regulatory board. JLARC staff then calculated an average of the individual board averages for overall case resolution time as well as for each major stage in the process.

Appendix F

Standard Deviations for the Averages Shown in Figures 4 – 9

Figure 4: Average Time Until Resolution (in days)

Health Regulatory Board	Average Case Resolution Time	Total Cases Examined	Standard Deviation
Nursing	407.1	329	237.0889
Medicine	980.2	178	437.9532
Pharmacy	404.0	121	267.8221
Veterinary Medicine	326.3	55	164.0447
Dentistry	384.9	168	216.8578
Funeral Directors and Embalmers	372.7	32	229.4707
Optometry	377.0	36	244.7255
Professional Counselors	547.3	19	325.5504
Psychology	746.8	9	356.4529
Social Work	462.6	8	137.1578
Certified Nurse Aides	343.4	352	206.3551
Nursing Home Administrators	333.9	24	174.7028

Source: JLARC staff analysis of disciplinary cases resolved during the 1997 and 1998 calendar years.

Figure 5: Average Length of Complaint Investigations (in days)

Health Regulatory Board	Average Length of Investigation	Total Cases Examined	Standard Deviation
Nursing	196.4	329	207.6930
Medicine	307.7	178	250.0320
Pharmacy	135.0	121	152.3309
Veterinary Medicine	146.9	55	134.2672
Dentistry	114.7	168	153.2370
Funeral Directors and Embalmers	141.9	32	193.5393
Optometry	118.3	36	182.4005
Professional Counselors	334.8	19	286.8657
Psychology	390.0	9	323.2917
Social Work	211.6	8	72.2158
Certified Nurse Aides	191.4	352	191.0969
Nursing Home Administrators	96.7	24	138.3875

Source: JLARC staff analysis of disciplinary cases resolved during the 1997 and 1998 calendar years.

Figure 7: Average Length of Probable Cause Reviews (in days)

Health Regulatory Board	Average Length of Review	Total Cases Examined	Standard Deviation
Nursing	46.7	329	37.0001
Medicine	191.4	178	233.0795
Pharmacy	106.2	121	117.4304
Veterinary Medicine	30.7	55	48.3976
Dentistry	76.9	168	44.2333
Funeral Directors and Embalmers	49.1	32	49.0104
Optometry	60.1	36	63.4535
Professional Counselors	99.5	19	86.6663
Psychology	124.2	9	92.2968
Social Work	121.1	8	74.1262
Certified Nurse Aides	42.5	352	40.5105
Nursing Home Administrators	39.5	24	32.4064

Source: JLARC staff analysis of disciplinary cases resolved during the 1997 and 1998 calendar years.

Figure 8: Average Length of Case Preparation (in days)

Health Regulatory Board	Average Length of Case Preparation	Total Cases Examined	Standard Deviation
Nursing	85.8	329	44.1112
Medicine	253.9	178	203.9852
Pharmacy	36.3	121	40.4292
Veterinary Medicine	35.2	55	29.7332
Dentistry	36.8	168	56.6121
Funeral Directors and Embalmers	66.6	32	50.8298
Optometry	50.1	36	34.0510
Professional Counselors	13.8	19	10.3311
Psychology	28.3	9	34.1833
Social Work	9.5	8	10.0143
Certified Nurse Aides	34.9	352	21.5793
Nursing Home Administrators	91.6	24	65.9485

Source: JLARC staff analysis of disciplinary cases resolved during the 1997 and 1998 calendar years.

Figure 9: Average Length Between Case Preparation and Informal Hearing or Consent Order

Health Regulatory Board	Average Time Between Events	Total Cases Examined	Standard Deviation
Nursing	50.1	329	33.7058
Medicine	191.8	178	116.4801
Pharmacy	113.4	121	111.8849
Veterinary Medicine	66.9	55	36.9432
Dentistry	137.5	168	86.0194
Funeral Directors and Embalmers	69.6	32	50.2862
Optometry	139.2	36	141.2409
Professional Counselors	85.5	19	108.6577
Psychology	150.8	9	112.9765
Social Work	81	8	55.5595
Certified Nurse Aides	44.7	352	24.0775
Nursing Home Administrators	65.6	24	32.3095

Source: JLARC staff analysis of disciplinary cases resolved during the 1997 and 1998 calendar years.

Appendix G

Agency Responses

As part of an extensive data validation process, State agencies involved in a JLARC assessment effort are given the opportunity to comment on an exposure draft of the report. Appropriate technical corrections resulting from written comments have been made in this version of the report. Page references in the agency responses relate to an earlier exposure draft and may not correspond to page numbers in this version.

This appendix contains the responses from the Department of Health Professions and the Board of Medicine.

JUN 10 1999

COMMONWEALTH of VIRGINIA

Department of Health Professions

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June 10, 1999

Philip A. Leone, Director
Joint Legislative Audit and Review Commission
Suite 110
General Assembly Building
Capitol Square
Richmond, VA 23219

Dear Mr. Leone: Phil

Attached is the response of the Department of Health Professions to the just completed JLARC review of our agency and its operations. I plan to attend the meeting of the Commission on Monday, June 14, 1999 at 10 a.m. I will have with me Ms. Faye Lemon, Director of our Enforcement Division and Dr. Warren Koontz, Executive Director of our Board of Medicine. All three of us will respond to your staff report, using the enclosed responses.

I want to congratulate you and your staff on their professionalism and attention to detail. We have all enjoyed working with them.

We all know this is not a perfect world. If it were, you and your staff would be out of work. We accept that there are areas for improvement in our operations and have already begun to take action. In some areas, there must be legislative changes, and we will certainly respond quickly as those occur.

I look forward to seeing you and your staff on Monday.

With kind regards,

John W. Hasty,
Director

Department of Health Professions (DHP) Response to the Joint Legislative Audit and Review Commission (JLARC) Final Report: Review of the Health Regulatory Boards

This report is the second half of the study on the functions of DHP and its regulatory boards which began in the spring of 1998. The first report which was completed in October 1998 covered the licensure and rulemaking functions of the boards, a review of board composition, financial responsibilities of the boards and the department, and an overview of the role of the Board of Health Professions.

The Board of Health Professions has accepted the recommendations of the first report that the Board should be more pro-active in their role of reviewing various agency processes and reporting to the General Assembly on issues and concerns. At the back of this report is an attachment on a recent "Study of the Department of Health Professions' Disciplinary Processes." This study by the Board of Health Professions will be used to facilitate several recommendations made in today's report.

As has been stated previously, this second phase of the study is focused on issues related to the boards' disciplinary function. There is considerable emphasis on the case processing time and efficiency of the inspection procedures of the department. The final chapter of the study report is devoted to the Standard of Care cases handled by the Board of Medicine.

I am very pleased at the many instances throughout this report and the first report in which the performance of DHP staff and board members was complimented. The staff of JLARC was always easy to work with, attentive to our response to questions and went to any length to ensure their facts were correct. I felt that everyone worked well together in an effort to produce an accurate report.

Although the time required to produce the two reports spanned better than 15 months, there was a positive result. The boards and staff began immediately to address concerns as they were identified. I would like to highlight the efforts already underway to implement some of the recommendations made in this report.

There are a few general observations that should be noted to keep the dialogue of the report and the ensuing recommendations in focus.

- The report reflects (but does not discuss) that decisions on disciplinary cases are, by statute, in the hands of health regulatory boards. The decisions of the Boards, after the complaint has moved through their informal conference and formal hearing process, can only be appealed to the courts. The only party that has the right of appeal

- to the Board's decision is the licensee (respondent) named in the case; the person filing the complaint is not a party to the case.

- The agency strategic plan which is being developed has as one of its three major issues, a systematic review of our "disciplinary processes as they relate to timeliness, appropriateness and efficient use of resources". This has already begun and should address many concerns identified in the investigation and inspection processes of the agency.

- It has been recommended in numerous places in the first report and again in the final report that we need additional resources to carry out agency functions. This will result in higher licensing fees.

- There are timeliness issues which have covered the past two years that have been and are continuing to be addressed. The report did not reflect some of the recent improvements in reduction of time at the Administrative Proceedings Division (APD) and at the Board of Medicine. There are also some findings about case completion time at the Board of Medicine which call for further analysis.

- The only way to address the concerns cited in the final chapter related to the Board of Medicine is for the General Assembly to change the statutory standard relating to medical care.

- It is suggested that the Board of Health Professions (BHP) perform oversight of disciplinary activities. If it is contemplated that the role of BHP would include a review of individual cases, the law must be amended to permit access to confidential disciplinary information. Since BHP is comprised of members from the various regulatory boards, BHP members could be asked to evaluate their own work.

- To clarify some of the concerns raised about the disciplinary process of Certified Nurse Aids (CNA) it should be noted that when the Board revokes a CNA's certification, it can NEVER be considered for reinstatement. It should also be noted that a CNA certificate is stamped with any adverse findings, which would be obvious to any employer in the settings where a certificate is required for employment. There are many work sites that do not require a person to be certified as a CNA, but rather utilize "nursing assistants" or "unlicensed assistive personnel" (UAP's).

- The suggestion to allow boards, on a case by case basis, to proceed to a formal hearing (and dispense with the informal hearing) will address the nurse aide concerns and avoid some additional expense.

I have asked Ms. Faye Lemon, our Director of Enforcement, to respond to Chapter III which addresses Case Processing Time and Inspections. Dr. Warren Koontz, Executive

Director of the Board of Medicine will follow her with responses to Chapter IV that discusses Board of Medicine Standard of Care cases.

Enforcement
Response to Recommendations of the Report

I. OVERVIEW OF ENFORCEMENT

The responsibilities of Enforcement can best be described broadly by the following activities:

- The receipt and review of all complaints received by the DHP.
- The investigation of appropriate complaints.
- The review of activities of all licensees and certificate holders that require a background check or reinstatement after a lapse, suspension or revocation.
- The inspection of facilities that fall within the jurisdiction of the Department.
- The monitoring of individuals under the terms of an order from a Board.
- The monitoring of resources in Enforcement to assure productivity.

II. OVERVIEW OF ADMINSTRATIVE PROCEEDING DIVISION (APD)

III. ENFORCEMENT RESPONSES TO THE JLARC RECOMMENDATIONS

The Enforcement Division would like to express their appreciation to JLARC for their assistance in the review and identification of issues and concerns in the Division. The JLARC report highlights some of the major issues that should be resolved as soon as possible to assure the safety and welfare of the citizens of the Commonwealth.

RECOMMENDATION (7)
The Department of Health Professions should take a more active role in pursuing the unlicensed practice of the health professions through use of its warrant authority in § 54.1-2506 of the Code of Virginia to bring misdemeanor unlicensed activity cases to general district court. If there continues to remain uncertainty with regard to the Department of Health Professions' statutory authority to pursue cases of unlicensed practice, the General Assembly may wish to consider amending § 54.12506 of the Code to give the Department express authority to pursue unlicensed practice cases in general district courts.

Unlicensed activity (UL) cases encompass approximately 2% of cases investigated by Enforcement. These cases are investigated under §54.1-111 and are usually non-life threatening to the public. All UL cases are sent to the Commonwealth's Attorney (CA) for possible prosecution, although the majority of cases sent are not prosecuted. However, the more egregious cases, especially those that may end in a felony conviction, are prosecuted. The Enforcement Division has obtained warrants on behalf of the Commonwealth's Attorney on several occasions. The Department also has the authority to enjoin any person, partnership, corporation, or entity from engaging in UL activity (see §54.1-111).

- Enforcement will review the use of its warrant authority and its authority to enjoin with the Office of Attorney General (OAG). DHP's authorization under §54.1-2506 is not as expansive as DPOR's under §54.1-306. The Department of Professional and Occupational Regulation (DPOR) has the authority to issue an administrative summons and to seek a criminal warrant from a magistrate. The DHP Investigators have no such authority according to advice from our Assistant Attorney General. This may raise questions with local CAs. After further research and discussion with the OAG, Enforcement will review its role and function in cases involving unlicensed activity and the Department may seek necessary legislation to expand Enforcement's authority.

RECOMMENDATIONS (8), (9), (10)

Recommendation (8) The Department of Health Professions, along with the health regulatory boards, should develop formal time guidelines for the resolution of disciplinary cases that establish time frames of less than one year for the resolution of most cases. At regular intervals, the Department should systematically analyze compliance with these guidelines in all stages of the process.

Recommendation (9) The Department of Health Professions should develop procedures and safeguards that ensure cases in which serious misconduct is alleged are handled expeditiously

Recommendation (10) The Department of Health Professions, along with the health regulatory boards, should regularly assess case processing procedures and resources to determine whether modifications need to be made or additional resources are needed to process disciplinary cases in a timely manner.

Although Enforcement has greatly improved its investigational time, we continue to be concerned with the timeliness of investigations. A statistical review was conducted in 1996 by an outside entity to review the timeliness issue. Based on this review and continuing concerns, the Department instituted in September 1996 as part of their Agency performance measures, time standards to complete high priority investigations. High priority investigation were ranked as priority 1,2, 3. Other case priority standards, for priorities 4, 5, 6, were implemented by Enforcement in October 1996.

Priority (level of patient harm)=standard (days to complete)

1=	29
2=	60
3=	90
4=	130
5=	128
6=	90

Enforcement has met standards for the completion of investigation on priorities 1, 5, and 6.

- Enforcement will continue to vigorously monitor its compliance to case completion standards especially in cases with serious misconduct allegations.
- Enforcement will also seek additional assistance from an outside statistical analyst to determine if current standards are realistic.
- Enforcement will review with the Board of Health Professions' Enforcement Committee, issues related to case completion compliance and other Enforcement issues including staffing needs.
- Enforcement management will continue to monitor, on a monthly basis, compliance to case completion standards. Deviations from these standards must be maintained by the Regional Supervisor for review and discussion by Enforcement Director/Deputy Director. Regional managers will assure the priority of cases are appropriately adjusted on a timely basis.
- Enforcement will review its present staffing patterns to assure productivity

RECOMMENDATION (11)

Recommendation (11) The Department of Health Professions, along with the Board of Pharmacy, should modify the pharmacy inspection plan to require the routine inspection of pharmacies every two years.

- The pharmacy inspection plan is currently being modified to include changes in the routine inspection process (from every 3 years to every two years). It is expected to be completed by August 1, 1999.

RECOMMENDATION (12)

Recommendation (12) The Department of Health Professions, along with the Board of Pharmacy, should re-establish the drug audit program.

Enforcement discontinued formal drug audits and routine inspections in 1991 when Inspectors were utilized to complete the serious backlog of investigations. Drug audits are done only as a part of a complaint involving major drug discrepancies in pharmacies.

- Enforcement will begin to review the drug audit program with the Board of Pharmacy in June 1999. Additional staffing needed to conduct drug audits must be addressed.

RECOMMENDATION (13)

Recommendation (13) The Board of Veterinary Medicine should modify its inspection plan to require that all routine inspections of veterinary facilities be unannounced.

- Completed. To be implemented July 1, 1999.

RECOMMENDATION (14)

Recommendation (14) The Department of Health Professions and the Board of Funeral Directors and Embalmers, Pharmacy, and Veterinary Medicine need to conduct a fundamental review of the inspection program. This review should include an examination of the goals of the program and of the means and resources necessary to achieve those goals

- Enforcement and the Boards of Pharmacy, Veterinary Medicine, & Funeral Directors & Embalmers, will thoroughly review the inspection program and its present utilization of resources.
- Goals and objectives will be re-examined and re-established by August 1, 1999.
- Resources required will be presented to the Department in September 1999.
- New inspection plans (and required resources) will be implemented after approval by the Agency Director and the Boards to prevent another inspection backlog.
- Activities of Inspectors will be reviewed to assure productivity.
- The present backlog of inspections must be corrected and it is suggested that temporary inspectors be utilized for this purpose.

RECOMMENDATION (15)

Recommendation (15) The Board of Health Professions should take a more active role in oversight of the disciplinary process. The Board should periodically assess: (1) the efficiency of the Department and boards in processing disciplinary cases; (2) whether there are sufficient staff to provide for the timely resolution of cases; and (3) whether the inspection program is meeting its goals. These reviews should be conducted at least every four years and the results reported in the Department of Health Professions' biennial report.

- Enforcement and APD will review their processes with the Enforcement Committee of the Board of Health Professions at each of their meetings (also see the Strategic Plan).
- Staffing resources to effectively support these processes will also be reviewed.

RECOMMENDATIONS (18 & 19)

Recommendation (18) The Department of Health Professions should handle medical malpractice reports like other standard of care complaints at the intake stage and only close such cases at this stage when there is adequate information on which to base the closure.

Recommendation (19) The Department of Health Professions should re-evaluate its current policies for handling medical malpractice reports and develop a process that ensures sufficient evidence is gathered on which to assess these reports prior to closure.

Enforcement did not treat all medical-malpractice complaints as routine standard of care cases. In previous years many medical-malpractice complaints were being screened at the case intake level without obtaining any additional documents for the Board's review. Complaints that did require record retrieval and review were sent to investigative staff for

investigation. However, all investigators were not obtaining and reviewing all necessary documents before cases were sent to the Boards.

- Enforcement will assess and investigate all appropriate medical-malpractice reports as standard of care complaints.
- Systems will be put into place by September 1999 to assure that all appropriate documents and information are obtained for review and analysis by the case intake unit, investigators and the Boards.
- Additional case intake staff may be required to assure compliance.

Faye T. Lemon
Deputy Director for Enforcement

Response to Chapter IV of the June 1999 JLARC Report on the Board of Medicine

Mr. Chairman, I want to thank you for the opportunity to speak to the Joint Legislative Audit and Review Commission. No member of the Board of Medicine has seen this draft as yet, so I am speaking as the Executive Director of the Virginia Board of Medicine and this should not be construed as being the opinion of the Board. The Board of Medicine will convene shortly to formulate a response, which will be forwarded for inclusion in the report.

I would like to give you some statistics on what the Board of Medicine has been doing. In the early 1990s there was an influx of cases and complaints coming to the Board of Medicine. The board received in the early 90s up to 800 cases per year that were docketed for an investigation. This was partly due to reports mandated by federal law to be sent to boards of medicine. In 1993, the Board of Medicine had 1,408 open cases. In March of 1994, the number had been reduced to 1,167. There was a slow decline in 1995 to 952, 1996 to 897, 1997 to 715, 1998 to 705, and through March of 1999 the number of open cases was down to 590. During that same time period ending in March of 1999 for one year there had been 597 new cases docketed. From April of 1998 through March 31, 1999, 1,756 cases were closed with no violations, 120 informal conferences were conducted, 22 formal hearings were conducted and 12 consent orders were agreed upon.

In the last biennium ending on June 30, 1998, the Board received 2,070 complaints, of which 998 were investigated. During that biennium, 169 violations of law were found and 196 sanctions imposed.

In 1998, the backlog of cases consisted of fully investigated cases, where probable cause had been found. Legal services had worked up the cases and presented them to the board saying the cases were ready for scheduling, and the statement of charges, or notice was ready. The number of this backlog swelled to between 30 and 40 cases. At that time the Board of Medicine went on an accelerated docket. From December 1, 1998 through June 1, 1999, 82 notices went out. The Board held 57 informal conferences and entered six consent orders. Of those 82 cases, where notices were sent, 39 had at least one continuance of 30 to 60 days, others have had longer periods. Almost 50% of the cases that were noticed for an informal conference had a continuance, all at the request of the respondent or his attorney. As of June 3, 1999, the number of cases at this status was down to 12. Again this means 12 have been presented to the board as investigated, probable cause found, legal services have worked them up and presented to the board for scheduling between April of this year and the present time. Notices have gone out and the docket is filled through June and July. These 12 cases will be presented and docketed for August and September.

Malpractice claims or settlements may or may not constitute statutory or regulatory violations. Such a settlement may be unrelated to the practitioner's wishes or to a reasonable assessment of his competence. The staff report raises the concern about the high bar for

finding a standard of deviation in standard of care cases. JLARC staff feels that the law should be changed to drop the word "gross" from gross negligence and gross malpractice. It may be that by dropping the word gross that more physicians would be charged with misconduct.

Under Senator John Watkins' bill for physician profiling, the Board of Medicine is now promulgating regulations that will make available to the public the malpractice history over the past ten years for all medical doctors, osteopaths, and podiatrists within the Commonwealth. If one looks at the evidence in Massachusetts, I think that this will give good statistics as to which specialties are sued the most and which specialties have the highest settlements and judgments. In Massachusetts 50% of the obstetricians and gynecologists have had a settlement or judgment within the past ten years. Twenty percent of the urologists, my specialty, have had a malpractice settlement or judgment in the past 20 years. In these profiles, the Massachusetts Board publishes information about both the malpractice history of the physician's specialty and the physician's history of payments. The Board places payment amounts into three statistical categories: below average, average, and above average. Putting information about the malpractice history of licensees in the hands of patients should also address the concerns raised in this report.

Another concern from JLARC staff is that the Board of Medicine is not consistent in the penalties imposed for an infraction. The board has struggled with this, but they have elected to take case by case the complaint, infraction, and, therefore, penalties imposed. The board has an opportunity in statute to exonerate a physician, to place the license on probation with or without terms and conditions, to issue a reprimand, to suspend the license, or revoke the license. Any sanction of the license has a number of repercussions. In my five years with the board, I have never seen the board issue a decision or decide not to impose a sanction because of collateral damage. Any time the board sanctions a physician from a revocation to the mildest sanction, a reprimand, a number of things occur. This is reported to the National Practitioner Data Bank, the Federation of State Medical Boards, American Medical Association, Department of Health and Human Services, and in the future will be reported to the Healthcare Integrity and Protection Data Bank (HIPDB). If a physician has been issued a reprimand, his license put on probation, or his license suspended and then stayed the physician usually loses all contracts with any managed care organization. It is reported to the healthcare community, in the *Board Briefs* which is published twice a year by the Board of Medicine, and the public has free access to the notice of hearing and the order.

The Board of Medicine does not use the Medical Practice Audit Committees and Medical Practice Investigative Committees effectively. Because of this there is a delay in having had these committees assist in the adjudication process. This is true. It has been difficult to have physicians volunteer for the Medical Practice Audit Committees and the Medical Practice Investigative Committees. A number of physicians have turned down this service because they miss one or two days of office practice and receive only a stipend and a small reimbursement for expenses per day. Because of this, the board has been using an

increasing number of experts who can be paid per hour for the time they spend in this important function.

JLARC feels that a revocation of a practitioner's license should be for longer than one year. They suggest three to five years. I would point out that in South Carolina revocation is permanent and one can never come back and be reinstated after revocation. Consequently, South Carolina rarely revokes a license. The longer one makes the revocation, the more likely a revocation may not be used as a penalty. It is interesting that in Mississippi they suspend a number of licensees, but then most of the time they stay the suspension and place the respondent on probation. The Virginia Board, except in unusual circumstances, must conduct an informal conference before a formal hearing. Because the informal conference only has the ability to reprimand or put the license on probation, we have an increased number of people who go on probation. The informal conference can recommend to the full Board that a formal hearing be held for suspension or revocation, but this requires a trial de novo before the Board. The board members and the board need flexibility in their decisions. A person whose license has been revoked or suspended must now prove to the board during a reinstatement process that they are safe and competent to resume practice. For revocation the practitioner must appear before a formal hearing of the Board of Medicine in order to have the license reinstated. The way the law is now written gives the practitioner and the public good protection.

JLARC staff criticizes the Board of Medicine because summary suspensions have taken an average of six months for the suspension to occur. They do not take into account that one has to build a case to show there is substantial danger to the public. Is the bar too high? Possibly. However, the board has been criticized because summary suspensions have occurred and the public felt that the board acted too quickly. These are complicated matters. The evidence has to be gathered, sometimes up to 34 to 50 pounds. Before a hearing the respondent receives all information that the board will use in the adjudication process. This would include the following:

1. Medical records, both hospital and office of the respondent regarding the patients involved.

2. Any consultant records of other practitioners who have seen the patient or patients.

3. Depositions.

4. Court testimony.

5. Interviews with respondent, with complainants, and with all witnesses.

6. In a number of cases there are interviews with attorneys associated with both the complainants and with the respondents.

7. Experts review a number of cases and these must be sent off after all the information has been gathered to get expert opinion as to whether or not a deviation in the standard of care has occurred.

8. The hospital that has taken action against a physician is usually reluctant to release peer-review records. Having been on the opposite side as chief of staff at a large university hospital, I feel that peer-review records should be protected otherwise peer review will be colored by the fact that this information may become public.

A summary suspension occurs two to five times per year by the Board of Medicine. This is done without a hearing and, therefore, without due process when there has been proof of substantial danger to the public health and safety. The Board may receive one or more complaints that do not rise to substantial danger. However, further complaints may cause the Board to be concerned that the substantial danger has been reached. By statute at the time of a summary suspension a formal hearing is scheduled 30-90 days later to complete due process.

Continuances have been a problem. The board has moved to send notices out not just 30 days in advance but up to 60 and even 90 days to reduce the likelihood of a scheduling conflict, as most respondents obtain an attorney. Respondents may change attorneys and then a continuance must be considered. Again the right to proper representation is everyone's right.

I would like to thank the JLARC staff headed by Mr. Harold Greer. He and his staff have conducted this yearlong research into the actions of the Department of Health Professions and the Board of Medicine and have always acted professionally with the mandate that they had been given. When I joined the Board of Medicine as its Executive Director in July 1994, the Department of Health Professions had 132 people assigned to our agency. The Board of Medicine had ten people in discipline with three senior legal assistants and three legal secretaries. At that time I asked for a fourth senior legal assistant and a fourth legal secretary. Because of a hiring freeze, a state workforce reduction policy, and early retirement that was offered to a number of personnel, by mid 1995 the discipline section of the Board of Medicine was down to one person, our deputy director who is an attorney, and one part-time employee. We were down to two legal assistants and the agency very correctly put all the legal assistants and the legal secretaries in the agency and combined them into one group where they remain today. This has made a much more efficient operation. The Department of Health Professions at that time dropped to a total of 98 personnel. I would say that no agency is able to function efficiently and effectively with a loss of that number of people. In 1999 we have climbed back to 120 people in the

Department of Health Professions. I would suggest that we still do not have enough people. It is important that the Department of Health Professions have more flexibility in adjusting staff and to set fees to cover expenses. It is important to point out that our agency gets no money from the General Fund. Our revenue is generated 100% from our licensees. Our new data management system will improve the efficiency of our operations and provide increased management tools for tracking disciplinary cases. However, discipline cases take people and cannot be totally automated.

I appreciate the opportunity to respond to the report.

Warren W. Koontz, MD
Executive Director of the Board of Medicine

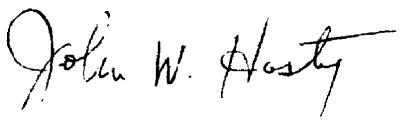
Closing Remarks

These reports have covered the 19 recommendations of the staff of JLARC. Most of those recommendations are fully accepted and already being addressed, or there are plans by the boards and staff of the Department of Health Professions to initiate studies on ways to accomplish the recommendations in a timely fashion.

A number of recommendations are directed to other entities of state government. Many of the key recommendations require action by the General Assembly in order that we may improve the regulation of health care providers for the benefit of citizens. We look forward to working with members as legislative proposals are developed.

In closing, I must emphasize that as this report has said in numerous places, without additional resources, and especially in the form of additional people, we will continue to struggle to meet the demands and our own goals. Our work and the findings within this report are all about the health and public safety of the citizens of the Commonwealth.

Respectfully submitted,



John W. Hasty
Director

Attachment

VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS
VIRGINIA BOARD OF HEALTH PROFESSIONS

STUDY ON THE DEPARTMENT'S DISCIPLINARY PROCESSES
POLICY OPTIONS
JUNE 8, 1999

1. **Report Board Decisions.** On a regular basis, publish and place on the Internet abstracts or briefs of case decisions. This effort would not include all case decisions but approximately 50 or so of the most instructive case decisions issued by health regulatory boards each year. This would not preclude individual boards from publishing their own discipline as they normally do in board briefs or newsletters, but would allow for a coherent view of disciplinary actions across boards.

   The anticipated benefit is to licensees as a guide for the conduct of their practice, to the public as information which will help them set their expectations regarding the extent of our impact on quality of care, and to attorneys who represent clients before our boards.

   The first edition should canvass the past two to three years. All future editions would remain contemporary.

   A contract could be established with a law publisher or law school to write the briefs/abstracts from the original orders and transcripts. Jim Banning may wish to staff the contracting and oversight of the effort.

   The cost is estimated to be less than $30,000 the first year.

2. **Review and make recommendations regarding informal conferences.**

   Amendments to the Administrative Process Act (originally based on JLARC recommendations) mandated the use of a prerequisite informal conference even for many of the most serious forms of misconduct. Unless a respondent ***agrees*** to a sanction, no action may be taken against the licensee without conducting a formal hearing. This new requirement has added to delays in taking definitive action against those providers who may represent the greatest threat to patients.

   The Board may wish to consider proposing amendments to the law that will allow health regulatory boards to dispense with informal conferences in cases where they believe there is probable cause that a danger exists to the patient.

3. **Improve training for those who make case decisions.**

Expand and possibly require training for members who make decisions of probable cause and conduct proceedings leading to case decisions. This should include, among other things:

- Presiding at an informal and formal proceedings
- The Administrative Process Act
- Basic statutes
- Rules of evidence
- Standards of proof

Such training could be conducted in conjunction with the Attorney General's Office and should expand the basic of Board member orientation. It should involve some of the more experienced appointees.

The costs could be absorbed within the existing agency budget.

4. **Assure criminal history checks are available.**

Beginning July 11, an improved identification system will be in place between state police and the FBI which allows for direct fingerprint checks. The costs should be nominal to the applicant (currently estimated between $25 to $40 to be paid to local sheriff or police department).

In addition, the agency should be in a position to inquire, either routinely or on an as needed basis, into the criminal history of current applicants, licensees and certificate holders.

This may require a change in law and agreement with the state police.

The Department of Health Professions should be empowered to access criminal history checks should it be determined to be needed. The board does not recognize the need to obtain criminal history checks on a routine basis for initial applicants and licensees.

5. **Assure better reporting systems on cases.**

We should utilize, to the extent possible, the data that are being collected and processed by the new AHLADIN System to assure the best management of cases for improved outcomes, to provide for more prompt resolution and more appropriate use of resources. Such systems should incorporate reasonable and appropriate performance standards.

Costs for AHLADIN should be budgeted.

6. **Review the legal standard of proof.**

An opinion of the Attorney General in the 1970's established meeting the standard of "clear and convincing evidence" as a requirement for taking action against a licensee for misconduct. Many other states use the more attainable standard of "preponderance of the evidence" as a criteria necessary for an adverse finding. It may be appropriate to determine if a change in Virginia law is warranted.

Costs should be minimal.

7. **Review grounds for disciplinary action.**

Patient abuse is, by law, grounds for disciplinary action against a nurse aide. However, no such standard exists for other practitioners licensed or certified within the Department. It may be appropriate to examine the current definitions and standards of misconduct embodied in law or regulation that apply to health care providers to determine if any changes are necessary to assure the safety and quality of health care delivery.

Costs should be minimal.

8. **Maximize the use of resources in the conduct of inspections.**

In conjunction with the Board of Pharmacy, Board of Funeral Directors and Embalmers, and the Board of Veterinary Medicine, the Department should evaluate its current inspection practices. This should include a review of systems employed by other states and regulatory agencies and should take advantage of "best practices."

9. **The Department should collect sufficient facts.**

The Department should obtain sufficient information to make a decision on reports of patient harm associated with practitioner conduct regardless of the source of such reports. The information should be sufficient to allow all boards to make informed decisions on probable cause or case closure.

JUL 14 1999

COMMONWEALTH of VIRGINIA

Department of Health Professions

John W. Hasty
Director

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July 12, 1999

Philip A. Leone, Director
Joint Legislative Audit and Review Commission
Suite 110
General Assembly Building
Capitol Square
Richmond, Virginia 23219

Phil

Dear ~~Mr. Leone:~~

Attached is the final response from the Board of Medicine regarding the recent review of our agency by your staff. Please note that the first six pages are the actual minutes of the meeting of the committee that reviewed the report and made recommendations to the full Board.

The last pages are the minutes from the full Board meeting on June 23, 1999, when the report of the special committee was received. You will note that the full Board did not rubber stamp all of the committee suggestions, but I feel the Board is very positive in their desire to make meaningful change in their operations. Using a quality assurance (Q.A.) approach by the agency will help all the Boards to continually review their procedures and their effectiveness.

Again, my appreciation for the very professional staff of people from your office who worked with us.

Best wishes and I look forward to seeing you soon.

Sincerely,

John W. Hasty
Director

Enclosure

AD HOC COMMITTEE FOR REPONSE TO THE JLARC REPORT
MINUTES
JUNE 18, 1999

The Ad Hoc Committee for Response to the JLARC Report met on June 18, 1999, at 2:00 p.m., at the Department of Health Professions, 6606 West Broad Street, Richmond, Virginia. The meeting was called to order by Joseph A. Leming, MD, Chairman.

MEMBERS PRESENT:	Joseph A. Leming, MD, Chair J. Kirkwood Allen, Public Member Harry C. Beaver, MD Cheryl Jordan, MD
MEMBERS ABSENT:	Brian R. Wright, DPM
STAFF PRESENT:	Warren W. Koontz, MD, Executive Director John Hasty, Director, DHP Robert Nebiker, Deputy Director, DHP Karen Perrine, Deputy Executive Director of Discipline Deborah A. Ordiway, Recording Secretary
GUESTS PRESENT:	Leslie Herdegen, Lobbyist for the Virginia Nursing Association Mike Jurgensen, Medical Society of Virginia Rebecca Snead, Virginia Pharmacists Association Beth Hudson, Virginia Pharmacists Association Lynn Warren, Virginia Association of Health Plans Mark Pratt, Virginia Association of Health Plans

ADOPTION OF AGENDA

Dr. Leming moved to adopt the agenda. The motion was seconded and carried unanimously.

PUBLIC COMMENT ON AGENDA ITEMS

There was no public comment.

Preliminary Draft response to the JLARC report

Mr. Hasty stated that some of the suggestions in the report can be done and some cannot. At the current time the department is working on a six to eight week timeframe to work on those items that need legislative attention and conducting a manpower survey.

Mr. Nebiker stated that the section dealing with revenues and expenditures was not quite right, as the report tends to look backwards instead of looking to the future. The department does want to act quickly to ask for additional resources.

Dr. Jordan and Dr. Beaver stated the report has a more historical aspect to it and the board needs to look toward the present and future. Dr. Jordan stated that the board is comparing different specialties and that some of the malpractice cases need to be reviewed. Mr. Hasty stated that JLARC feels the board does not investigate any malpractice claims whatsoever. A method is being developed to screen the malpractice cases.

Mr. Allen stated his overall impression from the report was that JLARC was trying to put everything into cubicles and compare professions against each other.

Dr. Leming stated that anecdotal solutions rarely cause the effect that one wants. He complemented Mr. Hasty for the manpower study. This documents calls for a quality assurance (QA) process. This report contains historical data and much of the data is already outdated. Dr. Leming would like to see the creation of an ongoing QA process, which would identify a problem, conduct a study, make a recommendation, and implement the recommendation. This would provide an ongoing QA process.

There are four types of malpractice review: (1) Pre-court settlements. (2) Cases that have gone to court and have been adjudicated. (3) Plaintiff's attorney reporting the physician to the board. (4) Insurance company settlement with no professional review. These may need to be reviewed and investigated differently.

Mr. Nebiker stated that the fee issue is on the way to resolution.

JLARC Recommendation 4

> ***"The General Assembly may wish to consider amending the Code of Virginia to prohibit any individual who has had his or her license revoked by any of the health regulatory boards from applying for reinstatement of his or her license for a substantial period of time. The General Assembly may wish to consider a minimum for all boards of between three and five years. The General Assembly may wish to allow the individual boards to have longer minimum revocation periods if they choose to do so by regulation"***

Mr. Hasty stated there has to be different categories. What needs to be done for the Board of Medicine may not be applicable to a nursing home administrator. Dr. Leming stated that currently if a license is revoked the practitioner is allowed to reapply within one year. The Board of Medicine does not have a tool through regulations for permanent revocation. Ms. Perrine stated permanent revocation may be done through a consent order. The board can deny the reinstatement but cannot prohibit them from seeking reinstatement after one year. Dr. Leming stated that if the license is revoked and the petition for reinstatement is denied then a longer period of time could be imposed before the person can petition for reinstatement a second time.

Ms. Perrine stated that in order to do this a statutory change would be needed for § 54.1-2921. Mr. Nebiker stated the length of time should be specified in the code. The proposal reached by the committee was if the license was revoked, one year later the practitioner can apply for reinstatement, and if this petition was denied then the applicant would have to wait three years before applying again for reinstatement.

JLARC Recommendation 5

> ***"The General Assembly may wish to consider amending the Code of Virginia to make the process for license or certificate reinstatement uniform across all health regulatory boards."***

Ms. Perrine stated this is a statutory problem. Mr. Nebiker stated that all the other boards, except the Board of Medicine, could reinstate a license through the issuance of an order by an informal conference committee. The informal conference committee is allowed to reinstate a license, but it takes the full Board to revoke a license. The committee elected to continue the current structure of handling this situation and not seek proactive legislation to change this procedure.

JLARC Recommendation 7

> ***"The Department of Health Professions should take a more active role in pursuing the unlicensed practice of the health professions through use of its warrant authority in § 54.1-2506 of the Code of Virginia to bring misdemeanor unlicensed activity cases to general district court. If there continues to remain uncertainty with regard to the Department of Health Professions' statutory authority to pursue cases of unlicensed practice, the General Assembly may wish to consider amending § 54.1-2506 of the Code to give the Department of Health Professions express authority to pursue unlicensed practice cases in general district court."***

The committee decided that Department of Health Professions will handle this issue.

JLARC Recommendation 8

> ***"The Department of Health Professions, along with the health regulatory boards, should develop formal time guidelines for the resolution of disciplinary cases that establish timeframes of less than one year for the resolution of most cases. At regular intervals, the Department should systematically analyze compliance with these guidelines in all stages of the process."***

Dr. Leming stated this is a vertically integrated QA process. Mr. Hasty stated that some of this is currently under review. The Virginia Board of Medicine will develop through a vertically integrated quality assurance process utilizing its recently developed Case Manager staff position to identify either external and internal benchmarks for case resolution, and at regular

intervals the quality assurance committee shall analyze compliance with these guidelines and report to the full Board.

A vertically integrated committee could consist of members from the Board of Medicine and staff, a fiscal representative, a member from Administrative Proceedings Division, a member from Enforcement, and a member from data.

JLARC Recommendation 9

> ***"The Department of Health Professions should develop procedures and safeguards that ensures cases in which serious misconduct is alleged are handled expeditiously."***

The Virginia Board of Medicine will develop within its QA vertically integrated process procedures and safeguards to (a) prioritize investigative cases and (b) insure that cases within levels of prioritization are handled consistent with internal and external benchmarks.

Mr. Hasty stated that the Board of Medicine does not need to act on this as the agency has already addressed this issue.

Dr. Leming stated that the agency would address this issue.

JLARC Recommendation 10

> ***"The Department of Health Professions, along with the health regulatory boards, should regularly assess case processing procedures and resources to determine whether modifications need to be made or additional resources are needed to process disciplinary cases in a timely manner."***

Quality assurance process by Department of Health Professions.

JLARC Recommendation 15

> ***"The Board of Health Professions should take a more active role in oversight of the disciplinary process. The Board should periodically assess (1) the efficiency of the Department and boards in processing disciplinary cases; (2) whether there are sufficient staff to provide for the timely resolution of cases; and (3) whether the inspection program is meeting its goals. These reviews should be conducted at least every four years and the results reported in the Department of Health Professions' biennial report.***

Vertically integrated quality assurance process should report periodically to the Board of Health Professions.

JLARC Recommendation 16

> ***"The General Assembly may wish to consider amending § 54.1-2400.3 of the Code of Virginia to require the Director to include in the Department of Health Professions' biennial report the following information: (1) data on overall case processing time for all boards, as well as information on the time required to complete each major stage in the process by each board; (2) a six-year trend analysis of the time required to process and adjudicate cases; and (3) a detailed reporting of staffing levels for the six-year period for each job classification that supports the disciplinary process."***

The development of a vertically integrated quality assurance process will allow the director to report out intelligent data.

JLARC Recommendation 17

> ***"The General Assembly may wish to consider amending § 54.1-2915(A)(4) of the Code of Virginia to change the gross negligence standard and define the negligent practice of medicine as a violation of law."***

Ms. Perrine stated that the current statutory standard is (1) gross ignorance, gross carelessness and gross malpractice or (2) conducting your practice in a manner to be a danger to patients.

The Virginia Board of Medicine in the interest of protecting the public's health and to determine if further modification of the code is necessary needs more time to study this important issue.

JLARC Recommendation 18

> ***"The Department of Health Professions should handle medical malpractice payment reports like other standard of care complaints at the intake stage and only close such cases at this stage when there is adequate information on which to base the closure."***

Department of Health Professions is already working on this issue. The Board of Medicine will work with the Department of Health Professions and vigorously pursue this recommendation by adequately developing reports through the vertically integrated quality assurance process.

JLARC Recommendation 19

> ***"The Department of Health Professions should re-evaluate its current policies for handling medical malpractice payment reports and develop a process that ensures sufficient evidence is gathered on which to assess these reports prior to closure."***

Dr. Leming suggested developing independent consultants who would look at all medical malpractice cases and make a recommendation to the Board of Medicine. This is a retained

group of experts that would review the malpractice cases. The board can either accept or reject the expert's opinion.

The Virginia Board of Medicine with the Department of Health Professions will study this issue.

Adjournment

With no further business to discuss, the meeting of the Ad Hoc Committee for Response to the JLARC Report was adjourned.

Joseph A. Leming, MD
Chair

Warren W. Koontz, M.D.
Executive Director

Deborah A. Ordiway
Recording Secretary

THE VIRGINIA BOARD OF MEDICINE
CALLED MEETING MINUTES
JUNE 23, 1999

The Virginia Board of Medicine met on June 23, 1999, at 2:00 p.m., at the Department of Health Professions ("DHP"), 6606 West Broad Street, Richmond, Virginia. The meeting was called to order by Harry C. Beaver, MD, Vice President. Dr. Beaver declared a quorum.

MEMBERS PRESENT:
Harry C. Beaver, MD, Vice President
Brian R. Wright, DPM, Secretary/Treasurer
James F. Allen, MD
J. Kirkwood Allen, Public Member
Robert J. Bettini, MD
Cheryl Jordan, MD
Richard M. Newton, MD
Paul M. Spector, DO
Michael L. Stutts, Ph.D.
Connell J. Trimber, MD
Jerry R. Willis, DC

MEMBERS ABSENT:
Karen E. Knapp, MD
Joseph A. Leming, MD, President
Gary P. Miller, MD
Cedric B. Rucker, Public Member
Clarke Russ, MD
Jeffrey R. Vaughn, MD

STAFF PRESENT:
Warren W. Koontz, MD, Executive Director
Karen Perrine, Deputy Executive Director of Discipline
John Hasty, Director, DHP
Deborah A. Ordiway, Recording Secretary

OTHERS PRESENT: Lynne R. Fleming, Assistant Attorney General; Elaine Yeatts, DHP Senior Regulatory Analyst

GUESTS PRESENT: Richardson Grinnan, MD, Medical Society of Virginia and Trigon; Marni Eisner, Medical Society of Virginia; James L. Ghaphery, MD, Virginia Academy of Family Physicians

ADOPTION OF AGENDA

Dr. Wright moved to adopt the agenda. The motion was seconded and carried unanimously.

PUBLIC COMMENT ON AGENDA ITEMS

There was no public comment.

RESPONSE OF THE BOARD OF MEDICINE TO THE JLARC REPORT

Dr. Beaver reviewed the minutes of the Ad Hoc Committee for Response to the JLARC Report.

JLARC Recommendation 4

> ***"The General Assembly may wish to consider amending the Code of Virginia to prohibit any individual who has had his or her license revoked by any of the health regulatory boards from applying for reinstatement of his or her license for a substantial period of time. The General Assembly may wish to consider a minimum for all boards of between three and five years. The General Assembly may wish to allow the individual boards to have longer minimum revocation periods if they choose to do so by regulation***

The ad hoc committee recommended the following language for § 54.1-2921: "When the certificate or license of any person has been revoked, the Board may, after the expiration of twelve months and upon the payment of a fee prescribed by the Board, consider an application for and grant a new certificate or license in the same manner as original certificates or licenses are granted. When a petition to reinstate has been denied, the Board may, after the expiration of three years and upon the payment of a fee prescribed by the Board, consider an application for and grant a new certificate or license in the same manner as original certificates or licenses are granted. In either case, the granting of a new certificate or license shall require the affirmative vote of three-fourths of the members at a meeting. In the discretion of the Board, such certificate or license may be granted without further examination."

Dr. Willis recommended changing the above to a minimum of one year and a maximum of five years, in the discretion of the Board. Dr. Newton concurred with Dr. Willis in that the Board should have flexibility of imposing from a one to five-year time period.

Dr. Spector moved Dr. Willis' suggestion that for both the initial period of revocation and the period prior to subsequent petitions for reinstatement, the Board would have the discretion of imposing a minimum of one year up to a maximum of five years. The motion was seconded and carried, with Mr. Allen abstaining.

JLARC Recommendation 5

> ***"The General Assembly may wish to consider amending the Code of Virginia to make the process for license or certificate reinstatement uniform across all health regulatory boards."***

Dr. Spector moved to accept the ad hoc committee's recommendation that the Board continue the current structure of handling this situation and not seek proactive legislation to change this procedure. The motion was seconded and carried unanimously.

JLARC Recommendation 7

> ***"The Department of Health Professions should take a more active role in pursuing the unlicensed practice of the health professions through use of its warrant authority in § 54.1-2506 of the Code of Virginia to bring misdemeanor unlicensed activity cases to general district court. If there continues to remain uncertainty with regard to the Department of Health Professions' statutory authority to pursue cases of unlicensed practice, the General Assembly may wish to consider amending § 54.1-2506 of the Code to give the Department of Health Professions express authority to pursue unlicensed practice cases in general district court."***

Dr. Spector moved to endorse the ad hoc committee's recommendation that the Department of Health Professions will handle this issue. The motion was seconded and carried unanimously.

JLARC Recommendation 8

> ***"The Department of Health Professions, along with the health regulatory boards, should develop formal time guidelines for the resolution of disciplinary cases that establish timeframes of less than one year for the resolution of most cases. At regular intervals, the Department should systematically analyze compliance with these guidelines in all stages of the process."***

Dr. Spector moved to endorse the ad hoc committee's recommendation that the Virginia Board of Medicine will develop a vertically integrated quality assurance process utilizing its recent developed Case Manager staff position to identify either external and internal benchmarks for case resolution, and at regular intervals the quality assurance committee shall analyze compliance with these guidelines and report to the full Board. The motion was seconded and carried unanimously.

A vertically integrated committee could consist of members from the Board of Medicine and staff, a fiscal representative, a member from Administrative Proceedings Division, a member from Enforcement, and a member from data.

JLARC Recommendation 9

> ***"The Department of Health Professions should develop procedures and safeguards that ensures cases in which serious misconduct is alleged are handled expeditiously."***

Dr. Spector moved to endorse the ad hoc committee's recommendation that the agency would address this issue. The motion was seconded and carried unanimously.

JLARC Recommendation 10

> ***"The Department of Health Professions, along with the health regulatory boards, should regularly assess case processing procedures and resources to determine whether modifications need to be made or additional resources are needed to process disciplinary cases in a timely manner."***

Dr. Trimber moved to endorse the ad hoc committee's recommendation that the quality assurance process by Department of Health Professions would handle this issue. The motion was seconded and carried unanimously.

JLARC Recommendation 15

> ***"The Board of Health Professions should take a more active role in oversight of the disciplinary process. The Board should periodically assess (1) the efficiency of the Department and boards in processing disciplinary cases; (2) whether there are sufficient staff to provide for the timely resolution of cases; and (3) whether the inspection program is meeting its goals. These reviews should be conducted at least every four years and the results reported in the Department of Health Professions' biennial report.***

Dr. Trimber moved to endorse the ad hoc committee's recommendation that the vertically integrated quality assurance process should report periodically to the Board of Health Professions.

JLARC Recommendation 16

> ***"The General Assembly may wish to consider amending § 54.1-2400.3 of the Code of Virginia to require the Director to include in the Department of Health Professions' biennial report the following information: (1) data on overall case processing time for all boards, as well as information on the time required to complete each major stage in the process by each board; (2) a six-year trend analysis of the time required to process and adjudicate cases; and (3) a detailed reporting of staffing levels for the six-year period for each job classification that supports the disciplinary process."***

Dr. Spector moved to endorse the ad hoc committee's recommendation for the development of a vertically integrated quality assurance process that will allow the director to report out intelligent data. The motion was seconded and carried unanimously.

JLARC Recommendation 17

> ***"The General Assembly may wish to consider amending § 54.1-2915(A)(4) of the Code of Virginia to change the gross negligence standard and define the negligent practice of medicine as a violation of law."***

Dr. Spector moved to endorse the ad hoc committee's recommendation that the Board of Medicine needs more time to study this important issue and that legal counsel from the Attorney General's office and staff figure how to study this issue. The motion was seconded. It was suggested that approximately 12 states nationwide be studied to see how they handle this issue and have a committee appointed to study this issue. The motion carried unanimously.

JLARC Recommendation 18

> ***"The Department of Health Professions should handle medical malpractice payment reports like other standard of care complaints at the intake stage and only close such cases at this stage when there is adequate information on which to base the closure."***

Dr. Spector moved to endorse the ad hoc committee's recommendation that the Board of Medicine will work with the Department of Health Professions and vigorously pursue this recommendation by adequately developing reports through the vertically integrated quality assurance process. The motion was seconded. Dr. Trimber stated that the amount of payment made is not a valid evaluation of the malpractice involved. The motion carried unanimously.

JLARC Recommendation 19

> ***"The Department of Health Professions should re-evaluate its current policies for handling medical malpractice payment reports and develop a process that ensures sufficient evidence is gathered on which to assess these reports prior to closure."***

Dr. Willis moved to endorse the ad hoc committee's recommendation of developing independent consultants who would look at all medical malpractice cases and make a recommendation to the Board of Medicine. This is a retained group of experts that would review the malpractice cases and the board can either accept or reject this expert's opinion. The motion was seconded.

Dr. Willis concurred with Dr. Spector's substitute motion that Recommendation 19 be integrated into Recommendation 18. That the Board of Medicine will work with the Department of Health Professions and vigorously pursue this recommendation by adequately developing reports through the vertically integrated quality assurance process. The motion was seconded and carried, with Dr. Wright opposed.

Proposed Legislation

§ 54.1-2919. Procedure upon information that practitioner may be subject to disciplinary action; special conference committee; further proceedings.

The ad hoc committee recommended an amendment to § 54.1-2919 be included in the legislative package. The amended language would read as follows: "After the conference at which the practitioner may appear, if a majority of the committee agrees that a suspension or revocation of the practitioner's license or certificate may be justified, or in the event of a violation of the authorized terms of the probation that the committee determines should be considered by the Board, the Board shall proceed with a hearing in like manner and with the same effect as provided for a hearing on charges made directly to the Board."

Dr. Spector moved that the amended change to § 54.1-2919 be included in the legislative package. The motion was seconded and carried unanimously.

Continuation of Cases

Ms. Perrine stated that that Dr. Leming wanted the Board to adopt a policy that all requests for a continuance would be heard by and determined by the chair of the informal conference committee. Dr. Spector asked what is wrong with the way continuances are currently being handled. Ms. Perrine stated that Dr. Leming felt that committee chairs should be involved in every aspect of the process, board members would be more stringent and less willing to continue a case than staff had been, and that the board is held accountable for the length of

time any case took and therefore a board member should be involved in each step of the process.

Dr. Willis moved not to change the current way the Board is handling requests to continue a case. The motion was seconded and carried, with Mr. Allen opposed.

Other

Lastly, Dr. Newton gave an oral presentation of his personal opinion.

OTHER BUSINESS

Next Regularly Scheduled Board Meeting: October 14-16, 1999, 6606 West Broad Street, Richmond, Virginia.

ADJOURNMENT

With no further business to discuss, the meeting of the Board of Medicine was adjourned.

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Vice President

Warren W. Koontz, MD
Executive Director

Deborah A. Ordiway
Recording Secretary

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Kimberly A. Maluski

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Kelly J. Gobble
Joan M. Irby
Betsy M. Jackson
Becky C. Torrence

● *Indicates staff with primary assignment to this project*

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