REPORT BY THE AUDITOR GENERAL OF CALIFORNIA

A REVIEW OF THE PROCESSING OF COMPLAINTS MADE TO THE MEDICAL BOARD OF CALIFORNIA

P-049 **APRIL 1991**

A Review of the Processing of Complaints Made to the Medical Board of California

P-049, April 1991

Office of the Auditor General
California

Kurt R. Sjoberg, Auditor General (acting)

State of California
Office of the Auditor General
660 J Street, Suite 300, Sacramento, CA 95814
Telephone : (916) 445-0255

April 18, 1991 P-049

Honorable Robert J. Campbell, Chairman
Members, Joint Legislative Audit Committee
State Capitol, Room 2163
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Office of the Auditor General presents its report concerning the processing of complaints against physicians and other health practitioners by the Medical Board of California and the Office of the Attorney General.

Respectfully submitted,

KURT R. SJOBERG
Auditor General (acting)

Table of Contents

Summary		**S-1**
Introduction		**1**
Audit Results		
Chapter 1	**Investigating and Disciplining Physicians and Health Care Workers Is a Lengthy Process**	**9**
	Recommendations	24
Chapter 2	**The Medical Board of California Could Improve Its Handling and Processing of Complaints**	**25**
	Recommendations	35
Appendices		
A	**Sources of Complaints**	**39**
B	**Calls Received, Complaints Logged, and Investigations Opened by All Board Offices Fiscal Years 1988-89 and 1989-90**	**41**

Responses to the Audit	**State and Consumer Services Agency**	**43**
	Medical Board of California	45
	Office of the Auditor General's Comments on the Response From the Medical Board of California	**55**
	Office of the Attorney General	**57**

Summary

Results in Brief

The Medical Board of California (board) is responsible for protecting consumers from incompetent, grossly negligent, unlicensed, or unethical medical practitioners. The board's investigation and discipline of health professionals is a lengthy process involving the board, the Attorney General's Office, and the Office of Administrative Hearings. During our review, we noted the following conditions:

- Effective January 1, 1991, the board was required to set a goal that by January 1, 1992, it would complete investigations within an average of six months. Based on the current time taken to process a case, this goal would be exceeded by eight months.

- Even if the board, the Attorney General's Office, and the Office of Administrative Hearings were able to meet each of the existing deadlines, the process of disciplining physicians and other health care practitioners would take approximately 1.7 years on the average.

- For the complaint cases the board identified as needing investigation, an average of 201 days elapsed between the receipt of complaints and the assignment to field investigators.

- In 13 percent of the cases we reviewed that had been assigned, investigators had not started working on their cases, even though they had been assigned for 30 days or longer. The investigators for another 21 percent of these cases had not worked on the cases for at least 30 days before November 30, 1990.

- From a sample of cases that the board referred to the Attorney General's Office to pursue discipline, the Attorney General's Office took 200 days to provide formal accusations to the board, exceeding its goal of 60 days by more than 233 percent.

- Of 180 cases we reviewed that the board closed without merit, 31 (17.2 percent) were closed for reasons that were not sufficient for concluding that the cases lacked merit.

- We found no evidence of supervisory approval for 23 (15.3 percent) of the 150 cases closed without merit that we reviewed involving allegations of physician negligence or incompetence or drugs.

- The board is required to maintain a central file of all licensee names, including all complaints of merit that have been filed within the preceding five years. However, the board is not always able to obtain complete case-file documentation from its central file.

- The board's toll-free complaint telephone number is not easily available to the public in some areas of the State.

Background

The board licenses physicians, and the committees and boards within the Division of Allied Health Professions licenses practitioners of other health care professions and occupations. The board investigates complaints against its licensees, and those of the committees and boards of the Division of Allied Health Professions. In addition, the board pursues discipline against those found guilty of violating laws and regulations. According to the board, as of June 30, 1990, 155,734 licenses were in effect. The board's responsibilities include, through its enforcement program, promptly responding to complaints against board licensees and investigating complaints within its jurisdiction. The board received 6,658 complaints, opened 2,689 investigations, and referred 378 cases to the Attorney General's Office for discipline during fiscal year 1989-90.

Lengthy Complaint Processing

The process of investigating and disciplining health care professionals is lengthy, predominantly involving the board and the Attorney General's Office. The board, the Attorney General's Office, and the Office of Administrative Hearings took an average of 2.8 years from the board's receipt of the complaint until discipline was administered. By January 1, 1992, a processing goal will be established for the time the board takes to investigate complaint cases. With the current case-processing times, the deadlines and goals would be exceeded by approximately one year. However, even if the new time frames were met, it would still take the board, the Attorney General's Office, and the Office of Administrative Hearings an average of approximately 1.7 years to process each case.

The Attorney General's Office, which prepares a formal accusation when the board pursues discipline in the case, set a deadline of 60 days for preparing the accusation. However, in a sample of 324 cases, the Attorney General's Office exceeded its time frame of 60 days to prepare the accusations by 233 percent.

Complaint Handling Could Be Improved

As part of processing complaints against health care practitioners, the board decides whether a case has merit or does not have merit and closes it accordingly. Although the board may or may not be appropriately closing cases as having no merit, the reasons provided for closing some of these cases is not consistent with the determination that the case has no merit. We also found that the board's policies regarding supervisory approval to close cases without merit as well as its guidelines for referring nonjurisdictional complaints to other agencies are not well-defined and could be improved. Finally, the board does not maintain its central file on its licensees in accordance with law, and its toll-free complaint telephone number is not easily available to the public in some areas of the State.

Recommendations

To ensure that, by January 1, 1992, the board can complete investigations within an average of six months, the board should evaluate the caseloads assigned to investigators to determine the optimal caseload that allows investigators to complete investigations more promptly. It should then seek staffing levels that would allow the optimal level of caseload. Furthermore, the board should seek legislation authorizing it to take disciplinary action against a physician who fails to provide medical records within a reasonable period determined by the board.

To decrease the time the Attorney General's Office takes to prepare accusations for the board, the Attorney General's Office should continue its efforts to establish and adequately staff the Health Quality Enforcement Section.

To ensure that the board closes each complaint appropriately, it should require that supervisors approve decisions to close cases without merit if the cases involve negligence or incompetence.

To ensure that the board's central file is in accordance with the law, the board needs to maintain case files, for cases closed with merit, in its central file at its headquarters.

To make the board's toll-free telephone number easily accessible to all consumers, the board should ensure that all telephone companies in all cities and counties in the State have a listing for the number.

Agency Comments

We received written responses from the State and Consumer Services Agency, the Medical Board of California (board), and the Office of the Attorney General (AGO). The State and Consumer Services Agency agreed with the findings in our report and indicated that it will work with the Director of the Department of Consumer Affairs and the board to implement corrective action.

The board agreed with all of our recommendations but did not fully agree with every finding and comment in the report. While it agreed that disciplining physicians and other health care practitioners is a lengthy process, it disagreed with our interpretation of a legislative goal to complete investigations within an average of six months.

The AGO agreed with our recommendations concerning the assurance of adequate staffing in its newly formed Health Quality Enforcement section. Furthermore, the AGO acknowledged that the reasonableness of the current 60-day turnaround period for accusations should be reconsidered.

Introduction

The goal of the Medical Board of California (board) is to assure the initial and continued competence of the health care professions and occupations under its jurisdiction through licensure, investigation of complaints against its licensees, and discipline of those found guilty of violating the law or regulations.

The board comprises three essentially autonomous divisions: the Division of Licensing, the Division of Medical Quality, and the Division of Allied Health Professions. Through the Division of Licensing, the board licenses physicians. Additionally, the boards and committees of the Division of Allied Health Professions license practitioners of other health care professions and occupations, including acupuncturists, hearing aid dispensers, physical therapists, physician assistants, podiatrists, psychologists, respiratory care practitioners, speech pathologists, audiologists, contact lens dispensers, registered dispensing opticians, research psychoanalysts, and spectacle lens dispensers.

Through its enforcement program within the Division of Medical Quality, the board is responsible for promptly responding to complaints against licensees of the board and investigating complaints within the board's jurisdiction. Furthermore, the board is responsible for disciplining its licensees found guilty of violations of the Medical Practice Act or other laws.

According to the board, the number of physician and surgeon licensees in California was 97,545 as of June 30, 1990. Approximately one-third of all California physician licenses are held by residents of other states or nations. The number of allied health licensees

was 58,189. Therefore, the board and the boards and committees of the Division of Allied Health Professions governed a total of 155,734 licensees as of June 30, 1990.

According to the board's annual report for fiscal year 1989-90, the board received 5,145 complaints against physicians and 1,513 complaints against allied health licensees for a total of 6,658 complaints as of June 30, 1990. Of these, the board opened 2,689 investigations and closed 2,533. Also, the board referred 378 cases to the Attorney General's Office and 53 cases to the District Attorney's Office during fiscal year 1989-90.

Enforcement Program

The enforcement program is the investigative arm of the board, under the Division of Medical Quality. It handles all phases of the enforcement process for physicians from the receipt of the initial complaint to the surveillance of physicians on probation. It also handles and investigates complaints on a reimbursement basis for the allied health committees.

At the board's central complaint unit, the enforcement program is currently staffed by medical consultants, supervising investigators, and consumer services representatives. Each of the board's nine regions is staffed by a medical consultant, a supervising investigator, and field investigators. Before July 1990, each region had consumer services representatives to perform preliminary processing of complaints. However, after July 1990, the board established the centralized complaint unit at its headquarters to perform the preliminary steps of processing complaints.

Enforcement Process

The board receives many types of health-related complaints against the board's licensees from a wide variety of sources, along with complaints against chiropractors, registered or vocational nurses, psychiatric technicians, social workers, and osteopathic physicians, all of whom are regulated by other licensing boards. The majority of complaints in our sample, 57 percent, came from

consumers, including patients, relatives of patients, and medical profession colleagues. Twenty-seven percent of the complaints came from various government agencies such as the Department of Health Services, district attorneys, and county health services. In addition, 6 percent of the complaints were initiated by the board itself because, for example, while investigating a case, an investigator obtained evidence that provided the basis for another complaint. Hospitals, which are required to report physicians whose staff privileges have been restricted, contributed 5 percent of the complaints in our sample of closed cases, and insurance companies, which are required to report physicians who pay malpractice awards greater than $30,000, contributed another 5 percent. Appendix A shows the source and disposition of complaints for the complaint cases that we reviewed.

The enforcement process begins with a complaint or a report to the board. The public can register a complaint with the board either in writing or by telephone. A toll-free line is available to the public. Consumer services representatives review all complaints to determine whether there is a probable violation of the Medical Practice Act. A medical consultant reviews complaints at the initial processing stage whenever a quality-of-care issue is involved.

Disposition of Cases

The board usually resolves its investigations in one of three ways: it will close a case without merit, close a case with merit, or pursue discipline. Cases closed without merit may be closed for several reasons. For example, the complaint may prove to be not true, it may lack evidence to support the allegation, or it may be outside the board's legal jurisdiction. The board may close a case with merit and not pursue discipline. Finally, cases may remain open after the board's investigation while the board pursues formal disciplinary action against a physician if there is strong evidence of a violation of the Medical Practice Act.

There are several different outcomes that lead up to the board closing a case with merit and not pursuing discipline. One possibility is that the practitioner may enter the board's diversion

program, which has the goal of rehabilitating physicians impaired by alcohol abuse, drug abuse, mental illness, and/or physical disorders. Alternatively, a practitioner may be required to take a competency exam, after which the case may be closed with merit. The board may also require a third-level review before closing an investigation with merit. In a third-level review, the board's medical consultant and investigator interview the practitioner to educate the practitioner about the errors identified in his or her care and treatment of a particular patient. Finally, the board may close an investigation with merit without having taken any action against the subject. In such cases, the board determines that, although the practitioner departed from standard medical practices, the departure was not serious enough to warrant disciplinary action. The board maintains cases closed with merit for five years.

When the board determines that a practitioner may have violated the Medical Practice Act and the violation warrants disciplinary action, it refers the case to the Attorney General's Office to pursue discipline. The Attorney General's Office will file an accusation against the practitioner's license. Not all accusations go to hearing: the licensee and the Attorney General's Office may propose a stipulated agreement to the board, which the board must approve before final resolution is reached.

The cases that go to hearing may be heard before an administrative law judge, the Division of Medical Quality, a regional Medical Quality Review Committee, or an Allied Health Examining Committee if appropriate, depending on whether the division or appropriate committee wants to hear the case. The administrative law judge will write a proposed decision, which either the Division of Medical Quality or the appropriate allied health board or committee approves, adopts, or alters. If the Division of Medical Quality or the appropriate allied health board or committee does not act within 90 days and 100 days, respectively, of receiving a proposed decision from an administrative law judge, the decision is automatically adopted. In contrast, there is no time frame for the adoption of stipulated agreements. A licensee dissatisfied with the final decision has the right to petition for reconsideration or to petition the court system.

The type of discipline the board administers depends on the nature of the offense. Examples of disciplinary action may include restriction of duties, suspension, or probation. The most severe discipline that the board administers is revocation of a license. From December 1, 1989, through November 30, 1990, the period of our review, the board disciplined 196 practitioners. These disciplinary actions included license revocations.

Scope and Methodology

The purpose of our review was to review the level of unassigned investigative caseload. We reviewed the investigative caseload to determine how long the board takes to process cases. Toward this end, we reviewed the case files for complaint cases that had been resolved from December 1, 1989, through November 30, 1990. Of cases closed without merit, cases closed with merit and no discipline, and cases with merit and discipline, we determined the time the board spent performing preliminary work and investigating the cases. For cases closed without merit and with merit and no discipline, we reviewed the board's methods for resolving the cases.

We generally sampled 10 percent of the cases that had closed in each category from December 1, 1989, through November 30, 1990. We reviewed 180 cases that were closed without merit, judgmentally selecting 150 cases that were filed at the board's Central Complaint and Investigation Control Unit. Additionally, we judgmentally selected a sample of 10 cases from each of three regions. These cases had been closed without merit after having been investigated. To review cases closed with merit, we randomly selected 117 of 1,172 cases the board's regions identified as closed with merit. For our review of cases closed with discipline, we randomly selected 20 of the 196 discipline cases closed during the period of our review.

For cases closed with merit that resulted in discipline, we determined the average time taken to discipline the practitioner. This included determining how long the Attorney General's Office took to develop a formal accusation, how long it took to hold a hearing and obtain a proposed decision from an administrative law judge, and how long the board took to approve a decision. We measured the board's performance against a specific goal that was to be set for January 1992 as outlined in the Business and Professions Code Section 2319(a). We also compared the guidelines of the Attorney General's Office with its performance in processing accusations.

We reviewed the board's handling of cases closed without merit and with merit to determine whether the board's performance was in accordance with existing policies. Additionally, we reviewed some of those policies to determine whether they could be improved.

We intended to determine the volume of calls received, complaints logged, and investigations opened by all offices for the past two years. However, based on reliability tests we performed on reports from the consumer affairs automated complaint tracking system, we determined that the system did not provide a reliable source of information about complaint cases that were ongoing or that the board had closed. In Appendix B, we summarize this information as derived from the board's annual reports. We did not audit the information in the reports.

To measure activity on assigned cases, we reviewed a random sample of cases assigned to investigators as of November 30, 1990. We obtained information on how long cases were held at certain steps of the process. Additionally, we assessed whether the investigator assigned to the cases had performed significant work on the cases since the assignment. Finally, we determined whether the investigator had performed significant work on the cases in the previous 30 days.

To determine whether the board's employee turnover and vacancy rates may affect the board's ability to carry on investigations, we reviewed personnel transactions for the board's enforcement staff, specifically for the personnel in investigator series

classifications. We charted the personnel transactions for the board's investigator positions from July 1988 through the end of December 1990. After recording information on the creation, filling, vacancy, and elimination of the positions, we determined the vacancy and turnover rates.

We tested the reliability of the board's central file system by requesting that the board provide us with files we had randomly selected from lists provided to us. These files should have been in the subject licensee's file.

Finally, to evaluate the board's public accessibility by telephone, we reviewed the board's procedures for handling telephone calls and called the board's 800 telephone number at eight different times. We also called directory assistance for 12 cities in ten area codes and reviewed the telephone directories for 15 cities or areas in California to determine whether each had a listing for the board's 800 telephone number. We did not test for the volume of telephone calls that come in to the board.

Chapter 1 Investigating and Disciplining Physicians and Health Care Workers Is a Lengthy Process

Chapter Summary

The process of investigating and disciplining health care professionals is lengthy, predominantly involving the Medical Board of California (board) and the Attorney General's Office. The board, the Attorney General's Office, and the Office of Administrative Hearings took an average of 2.8 years from the board's receipt of the complaint until discipline was administered. Effective January 1, 1991, the board was required to set a goal that by January 1, 1992, it would complete investigations within an average of six months. With the current case-processing times, the deadlines and goals that govern the investigation and discipline processes would be exceeded by approximately one year. However, even if the time frames are met, based on current information, it will still take the board, the Attorney General's Office, and the Office of Administrative Hearings an average of approximately 1.7 years to process each case.

The board takes an average of approximately 1.2 years to complete the first segment of the process, from receipt of complaint until end of investigation. Chapter 1597, Statutes of 1990, indicates that the board should establish a goal of completing cases in an average of six months by January 1, 1992. We believe that, based on the board's current performance, the board will not be able meet this goal. We found that investigations take so long because investigators often do not work on individual cases for at least 30 days at a time. Also, included in the time between receipt of complaint and completion of investigation is the time that cases are inactive because they are not assigned to an investigator. Of the 312 cases reviewed, cases were unassigned for an average of 117 days.

The Attorney General's Office, which prepares a formal accusation when the board pursues discipline in the case, set a deadline of 60 days for preparing the accusation. However, in a sample of 324 cases, the Attorney General's Office exceeded its time frame of 60 days to prepare the accusations by 233 percent.

The Office of Administrative Hearings generally meets its 30-day deadline for its segment of the process which is to provide a proposed decision after the case is submitted to the Office of Administrative Hearings. The average time for submission of a proposed decision was 22 days. Finally, the board and the allied health committees and boards were within their 100-day deadlines for the last segment of the process, adopting proposed decisions as final decisions in an average of 90 days.

Segments of the Process

For the purpose of our review, we have separated the process of investigating and disciplining practitioners into five segments. Not all cases go through each of these segments, as some cases are closed after a preliminary review. Additionally, many cases are investigated and then closed without discipline against the practitioner.

The first segment covers the board's receipt of the complaint until the end of its investigation. The board currently has no deadline for completing this step, but effective January 1, 1992, the board will have a goal of completing investigations within an average of six months.

The second segment is the time during which the Attorney General's Office develops an accusation against the practitioner. The Attorney General's Office has set a deadline of completing accusations within 60 days of receiving a request for an accusation from the board.

The third segment is the time during which the board, the Attorney General's Office, and the Office of Administrative Hearings prepare for and conduct a hearing or the time during

which the practitioner and the Attorney General's Office propose a stipulated agreement to the board. Although there are no deadlines for completing this segment of the process, the hearings in our sample took an average of 264 days to complete. We do not discuss this segment further in the report because it is outside the scope of the report.

The fourth segment starts with the time that the case is submitted to the Office of Administrative Hearings after a hearing is conducted until the Office of Administrative Hearings provides a proposed decision on the case. According to the Government Code, Section 11517, the Office of Administrative Hearings has 30 days to provide a proposed decision.

The final segment is the time the board takes to act on a proposed decision. During the period of our review, the board had 100 days to approve the proposed decision or formally decide to not adopt the decision in cases regarding physicians and surgeons. The board currently has only 90 days to do the same. In cases regarding allied health workers, the appropriate allied health board or committee has 100 days to approve the decision. In both cases the decision becomes final without action from the board or allied health committees.

Legislative Background

In 1989, the Legislative Analyst's Office reported that the board had a backlog of 789 complaint cases awaiting investigation as of December 1988. In July 1989, the board was allocated $2.4 million for 18 investigators and 10 other enforcement staff to address the backlog. However, in December 1989, the board still had 870 cases that needed investigation but that were not yet assigned to an investigator. At this time, the Legislative Analyst's Office questioned the board's effectiveness in protecting the public because of the backlog of complaint cases.

In 1990, the Legislature enacted Chapter 1597, which established a time frame for several steps in the process of investigating and disciplining physicians and health care workers. The legislation required the board to set a goal of completing investigations

within an average of six months after receiving complaints. However, the Legislature allowed the board until January 1, 1992, to meet this goal. Additionally, Chapter 1597 indicated that the goal for investigating cases with complex issues was less than one year. Before this legislation, no time frames were legislated for conducting investigations. Effective January 1, 1991, this legislation also gave the board a deadline of 90 days after receipt of a proposed decision for finalizing a decision on disciplining physicians.

In 1990, the Legislature also enacted Chapter 1629, which required the board to eliminate its backlog of unassigned cases. The legislation directs the board to assign all cases as of December 31, 1990. The approval of part of the the board's funding for fiscal year 1990-91 was contingent upon its ability to demonstrate a 15 percent reduction in the board's unassigned investigative case backlog from July 1990 through November 1990.

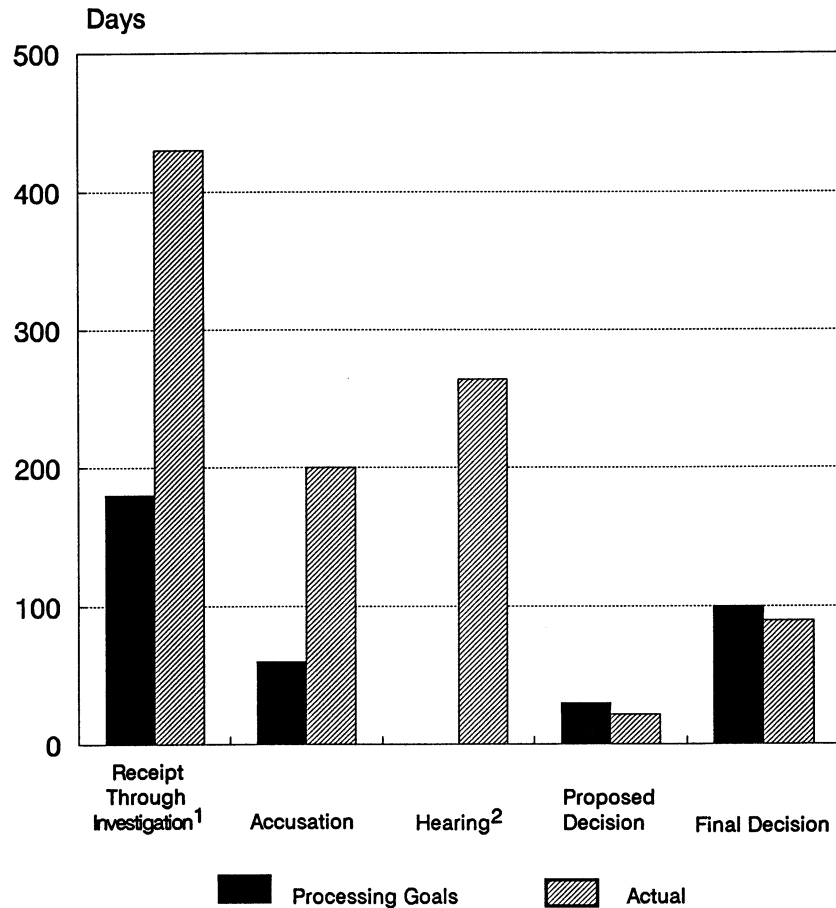
The board has taken steps to reorganize its investigative process in response to its backlog. In mid-July 1990, the board set up a centralized complaint and investigation processing unit at its headquarters. This unit receives the complaints and performs preliminary data gathering for the investigation of the complaint. Additionally, the unit closes the complaints that do not warrant investigation. This function was previously performed at each of the regional offices. Also, in July 1990, the board converted complaint case data files from a limited data processing system to a system that tracks many data elements for each complaint case.

In 1991, the Legislative Analyst's Office reported that the board has reduced its backlog of unassigned investigative cases as of December 1990. Additionally, the Legislative Analyst indicated that the number of cases that have been unassigned for over a year has dropped significantly, to less than 40 cases. However, it also indicated that even with additional staff, there is no assurance that the board will be able to resolve existing complaints and begin meeting the Chapter 1597 goal.

A Lengthy Process

Although not all segments of the complaint process have deadlines, the segments with goals and deadlines, including the six-month goal set for January 1, 1992, total approximately one year. The board, the Attorney General's Office, and the Office of Administrative Hearings took an average of 2.8 years to process the cases in our sample, from the board's receipt of the complaint through the board's final decision on disciplinary action. Of the 2.8 years, 2.1 years were spent on the segments with current deadlines or time frames effective January 1, 1992. The cases in our sample exceeded these time frames by approximately one year. However, even if the board, the Attorney General's Office, and the Office of Administrative Hearings were to meet the one-year time frame, the entire process of investigating and disciplining physicians and other health care practitioners would still average approximately 1.7 years. Of this time, cases are in hearings for an average of .7 years. The board, the Attorney General's Office, and the Office of Administrative Hearings do not have control over the length of time of the hearing. The following chart illustrates the difference between average time taken on the different segments and the current or future time frames for those same segments.

Discipline Process
Goals Versus Actual



[1]This processing goal does not take effect until January 1, 1992.
[2]There is no deadlline for this segment in the process.

Reviewing and Investigating Complaints

In the cases we reviewed, the board took longer than 14 months to complete the first segment of the process by reviewing and investigating the complaints. The period from the receipt of a complaint through its investigation consists of three main components. First, before investigating a complaint, the board performs a preliminary review of the complaint. A consumer services representative reviews the case and puts together

background information for the investigator. Additionally, if the complaint concerns the quality of care a physician or health worker provided, a medical consultant will review the case. The second component is the period between the completion of the preliminary review and assignment to an investigator. The third component starts with assignment to an investigator and ends when the investigation is completed.

To determine the average time the board spends on preliminary reviews of complaints and the average time the board allowed complaints to remain unassigned, we looked at a variety of cases. We reviewed 133 open cases, which is 10 percent of all cases under investigation on November 30, 1990. We also reviewed 180 cases that were closed without merit from January 1, 1990, through November 30, 1990. The board closed at least 2,536 cases without merit during this period. Our sample included 52 of these cases closed without merit that were formally investigated. Therefore, we included them in both the preliminary review average and the backlog average. The remaining 128 cases were closed at the end of the preliminary review and, therefore, are included only in the preliminary review average. Additionally, we reviewed 117 cases that had been closed with merit, which is 10 percent of the cases closed with merit from December 1, 1989, through November 30, 1990. Finally, we reviewed 20 cases closed from December 1, 1989, through November 30, 1990, that resulted in discipline. The board disciplined 196 physicians and health care workers during this period.

Preliminary Reviews

We found that the board took an average of 84 days to perform a preliminary review of the cases. It took more than six months (180 days) to perform the preliminary review for 58 (13 percent) of the 447 cases we reviewed for this test. Although the preliminary review does not include actual investigation of the complaint, the time the board spends on preliminary review is nearly one-half of the six-month goal for completing investigations that will be effective January 1, 1992.

One reason for the board's delay in performing the preliminary review is that it often takes the board a long time to obtain medical records from physicians. In its analysis of the 1991-92 budget bill, the Legislative Analyst's Office reported that physicians take more than a month to four months to submit requested records in 40 percent of the cases. Currently, the board does not have the authority to take disciplinary actions against physicians who do not comply with its request within a certain time frame.

A sizable backlog of complaints requiring medical review contributes to the delay at the preliminary review stage. Once a consumer services representative determines that a medical consultant should review a complaint case, the consumer services representative logs the complaint case with the other cases to be reviewed. We observed the number of cases pending review by medical consultants on several dates. For example, on November 30, 1990, there were 135 cases pending review. From reviewing the log for cases requiring medical review, we found that these cases were with the medical consultants for an average of 24.4 days.

During the period of our review, four physicians worked on an hourly basis as medical consultants. The total medical consultant time charged averaged 19.8 hours a week. The Department of Finance approved funding for a full-time medical consultant effective January 1, 1991. The additional staff allocation to the medical consultant function may reduce the time cases await medical review.

Backlog

Board cases were unassigned and, therefore unworked, for an average of 117 days. The shortest time cases spent unassigned was less than one day, and the longest time was 768 days. Of the 312 cases we reviewed, 70 (22 percent) cases were unassigned for six months (180 days) or longer.

During the period of our review, complaint cases remained unassigned because regional supervisors did not assign a case to an investigator until the supervisor had an investigator who was available to work on an additional case. Complaint cases remained unassigned for long periods because regional supervisors believed their investigative staff were working at maximum caseload capacity. Additionally, the board has been receiving an increasing number of complaints to investigate. As a result, the backlog of unassigned complaints competed with a growing number of new complaints also needing assignment to an investigator.

In December 1990, the board changed its assignment process. In response to Chapter 1629, Statutes of 1990, the board now assigns cases to investigators almost immediately after determining that a complaint requires investigation. We believe that this new procedure will not decrease the time the board takes to investigate cases. Instead, the procedure will transfer time previously considered as backlog time to time a complaint is assigned to an investigator.

Investigation Time

Complaint cases are assigned to investigators for an average of 229 days. We reviewed 52 cases that were closed without merit from December 1, 1989, through November 30, 1990; 110 cases that closed with merit during the same period; and 20 cases that resulted in discipline against the practitioner, also during that period. The number of days the complaint cases spent in investigation ranged from one to 1,374. The board spent six months (180 days) or longer investigating 80 (44 percent) of these 182 cases.

We recognize that the board presently has no legislated deadline for reviewing and investigating complaint cases. However, the Legislature required the board to set a goal of six months, which was to be met by January 1, 1992, for this segment of the process. Based on the results of our review, we believe that, unless the board makes some changes to its operation, it will not be able to reduce its average processing time by the 250 days needed to meet the time frame.

According to the executive director of the board, the board has not been able to complete investigations more promptly primarily because the board has experienced problems in adequately staffing investigator positions. The director indicated that, while the board has received more investigator positions, it has not been able to fill all of these positions because it does not offer a salary that is competitive with other agencies. Additionally, the director indicated the board's ability to complete investigations promptly was affected by the loss of many experienced investigators to other agencies that pay more.

We confirmed that the board experienced a high vacancy rate in investigator positions after receiving 18 newly budgeted investigator positions on July 1, 1989. The board took an average of five months to fill these positions. Because of the high vacancy rate in these new positions, the board lost approximately seven and one-half personnel years of investigator time. The board's vacancy rate for investigator positions averaged 2.9 percent for fiscal year 1988-89, 19.5 percent for fiscal year 1989-90, and 5 percent for the period of July 1, 1990, through December 31, 1990. The average vacancy rate of nearly 10 percent for this 2.5-year period is more than double the most recently calculated vacancy rate of 4.9 percent for all state positions during October 1, 1987, through September 30, 1988.

We also reviewed the board's rate of turnover in investigator positions. Thirteen investigators left their positions between July 1, 1988, and December 31, 1990. During fiscal year 1988-89, the board maintained 57 investigator positions; 3 investigators left, resulting in a turnover rate of 5 percent among investigators. During fiscal year 1989-90, the board averaged 74.6 positions; 6 investigators left, resulting in a turnover rate of 8 percent. From July 1, 1990, through December 31, 1990, the board averaged 73.7 investigator positions. Since 4 investigators left during this period, the turnover rate was 5.4 percent. In comparison, the most recently calculated state turnover rate, covering the period of October 1, 1987, through September 30, 1988, was 4.3 percent.

Investigation Delays

Investigators sometimes do not work on individual cases for periods of at least 30 days. We randomly selected and reviewed 128 of the cases that were open on November 30, 1990, that had been assigned to investigators before November 1, 1990. In 17 (13 percent) of the cases, the investigators assigned to the cases had not performed significant work on the cases yet, even though the investigators had been assigned to the case for 30 days or longer.

Additionally, we found that investigators, in another 27 cases (21 percent) of the sample, had performed substantial work on the cases but had not performed significant work on the cases for the 30 days before November 30, 1990. In some cases, the investigators assigned to the cases indicated that they had not worked on the cases because they had higher priority cases requiring immediate attention.

The Legislature recognized that the board did not always immediately open and take action on complaint cases identified as requiring investigation. Chapter 1629, Statutes of 1990, required the board to eliminate the unassigned investigative caseload by December 31, 1990, by assigning these cases to investigative staff. However, we do not expect that the board will improve its processing time by eliminating the backlog. Instead, we expect that investigators' caseloads will increase, forcing them either to spend less time on each case or to delay working on cases for even longer periods. As a result, we believe investigations will take even longer to complete.

We calculated the ratio of investigators working on investigations to total investigation cases before and after the backlog cases were assigned. In November 1990, when we reviewed activity on cases assigned to investigators, but before the backlog was assigned, the equivalent of approximately 51 investigators worked a combined caseload of 1,394 cases for the board. This is a ratio of one investigator for every 27.3 cases. In January 1991, after the board reported that the backlog was eliminated, the equivalent of approximately 52.6 investigators worked a combined caseload of 1,545 cases for a ratio of one

investigator for every 29.4 cases. Investigators received an average increase in caseload of approximately 7.7 percent when already they were unable to perform significant work on approximately 34 percent of their cases within at least 30 days. In comparison, in 1989, the board reported that investigators in the Department of Justice's Bureau of Narcotics Enforcement maintain average caseloads of 5 to 7 cases; investigators in the Medi-Cal Fraud Unit maintain average caseloads of 8 to 10 cases.

Accusations Deadline Not Met

When the board determines that discipline should be taken against a licensee, the board refers the case to the Attorney General's Office (AGO). The AGO prepares an accusation consisting of the charges against the licensee and returns the prepared accusation to the board for review. After the board approves the accusation, the board, the AGO, and the Office of Administrative Hearings can start the process of conducting a hearing or stipulating the case. An AGO memorandum of May 23, 1989, sets a time frame for preparing accusations. The memorandum requires the AGO either to complete accusations within 60 days of receiving the request from the board or to notify the board that additional investigation is needed. The AGO, on the average, misses the deadline by a significant amount of time.

We reviewed 612 open discipline cases that the board had referred to the AGO through November 30, 1990. The AGO returned 58 cases to the board for further investigation or did not proceed on the cases for other reasons. Of the remaining 554, the AGO prepared accusations on 324 cases, taking an average of 200 days to file these accusations after receiving them from the board. Because the AGO took 200 days to prepare the accusations, it exceeded its time frame of 60 days by 233 percent, or 140 days. In addition, the Attorney General's Office had not prepared the accusation within 60 days for 253 of the 324 (78 percent) cases; it had not prepared 41 (13 percent) within one year. Of the 554 cases that did not require further investigation, as of November 30, 1990, the AGO had not prepared accusations for the remaining 230 cases although the cases had been at the AGO for an average of 231 days.

The Legislature has recognized that the AGO needs to consolidate its medical cases and provide additional support on board cases. In compliance with Chapter 1597, Statutes of 1990, the AGO established a Health Quality Enforcement Section, which has as its primary responsibility the prosecution of licensees and applicants within the jurisdiction of the board. Before the formation of the Health Quality Enforcement Section, the licensing section of the AGO represented its client agencies, including the board, in all disciplinary actions. In response to this legislation, the AGO has established the new section that is staffed with attorneys dedicated to processing medical cases. The new section is intended to provide ongoing review of the investigative activities conducted in support of those prosecutions.

However, the assistant attorney general in charge of the Health Quality Enforcement Section indicates that the establishment of the new section will not guarantee that the Attorney General's Office will be able to meet the turn-around time of 60 days. He indicates that the number and complexity of cases being received by the board continue to increase substantially, as do the average length of hearings, the average number of days necessary to prepare for those hearings, and the number of cases in which the board is seeking a temporary restraining order. Additionally, Chapter 1597, Statutes of 1990, requires the new section to perform additional new duties for the board, so the attorneys in the new section will not be able to work entirely on filing and prosecuting new cases.

Decision Proposed Within Deadline

Section 11517 of the Government Code requires a hearing officer from the Office of Administrative Hearings to propose a decision within 30 days after the submission of the case. From our sample of 20 cases that resulted in discipline from December 1, 1989, through November 30, 1990, 6 cases had hearings. The remaining 14 cases resulted in an agreement between the licensee and the board without a hearing.

In 5 of the 6 cases that resulted in hearings, the administrative law judge did not take longer than 30 days to render a proposed decision. In the sixth case, the administrative law judge returned a proposed decision in 40 days. On the average the administrative law judge returned a proposed decision 22 days after the conclusion of the hearing.

Decision Made Within Deadline

For the period of our review, Section 11517 of the Government Code stated that when the Division of Medical Quality and the Division of Allied Health Professions do not act within 100 days after receipt of the proposed decision concerning physicians and surgeons, the decision shall be final. The division currently has 90 days to act.

The board is adopting final decisions within these legislated deadlines. In our sample of six cases that resulted in hearings, four cases concerned allied health workers and two cases concerned a physician or surgeon. On the average, the board adopted the hearing officer's decision within 89.5 days compared to the 100-day deadline.

Risk to the Public

Lengthy investigations, delays in filing accusations, and lengthy adjudication mean that physicians and allied health practitioners who may be guilty of violating the Medical Practice Act concerning quality-of-care issues can continue to practice and put the public at risk of harm. For example, a hospital filed a complaint against a physician who was allowed to continue practicing until his case was decided more than six years later. The physician was subsequently given five years probation, including a requirement for additional education. The complaint against this physician was initiated by a hospital that had formally restricted the physician's privileges because the physician mishandled two abortion procedures. The first case resulted in an emergency hysterectomy, and the second patient required immediate and unplanned

assistance by a specialist during the procedure. In another example, a psychiatrist was allowed to continue practicing for almost 4.5 years after a complaint was filed before surrendering his license to the board. The complaint against the psychiatrist concerned gross negligence, incompetence, and excessive prescribing of medications to a patient.

Lengthy complaint processing also hinders the public's ability to select a physician based on his or her record. Because the board cannot make available to the public information about pending complaints or actions against a physician until ten days after an accusation is filed, the public may make uninformed decisions about health care professionals.

Conclusion

Chapter 1597, Statutes of 1990, and policies of the Attorney General's Office establish time frames within which the Medical Board of California and the AGO should process complaints against physicians and allied health practitioners. The total of the time frames equals approximately one year. Based on our sample, the board, the Attorney General's Office, and the Office of Administrative Hearings currently exceed the projected one-year time frame by approximately one year. Even if the board, the Attorney General's Office, and the Office of Administrative Hearings were able to meet each of the goals and time frames, the process of disciplining physicians and other health care practitioners would average 1.7 years. In addition, of the cases we reviewed, we found that the board currently exceeds a processing goal of six months, which is required to be fully effective by January 1, 1992. Taking an average of 1.1 years to complete investigations, the board is currently taking more than twice as long as the goal it will need to meet in January 1992.

The Attorney General's Office attempts to return formal accusations to the board within 60 days. However, in our sample of discipline cases, the AGO returned accusations within an average of 200 days, exceeding its goal by over 233 percent. The longer the AGO takes to return accusations, the longer the public is delayed in obtaining information regarding complaints filed against physicians.

Recommendations

To reduce the time taken to investigate complaint cases and to reduce the time taken to pursue discipline against a health care practitioner,

- The Medical Board of California should seek legislation authorizing it to take disciplinary action against a physician who fails to provide medical records within a reasonable period determined by the board.
- The board should ensure that it has enough medical consultants;
- The board should evaluate its investigators' workload to determine the optimal level, and it should seek staffing levels commensurate with the optimal level; and
- In light of the formation of the Health Quality Enforcement Section, the Attorney General's Office should ensure that the new section is adequately staffed and should reconsider whether a 60-day turnaround is reasonable for the preparation of accusations.

Chapter 2 The Medical Board of California Could Improve Its Handling and Processing of Complaints

Chapter Summary

As part of processing complaints against health care practitioners, the Medical Board of California (board) decides whether a case has merit or does not have merit and closes it accordingly. Although the board may or may not be appropriately closing cases as having no merit, the reasons provided for closing some of these cases is not consistent with the determination that the case has no merit. In addition, the unit's policies regarding supervisorial approval of cases closed without merit as well as its guidelines for referring nonjurisdictional complaints to other agencies are not well-defined and could be improved. Finally, the board does not maintain the central file on its licensees in accordance with law, and its toll-free complaint telephone number is not easily available to the public in all areas of the State.

Accuracy in Case Closures

Section 800 of the Business and Professions Code, which requires the destruction of all information related to complaints found to be without merit, does not define the phrase without merit, nor does board policy provide any definitive guidelines to ensure that cases are identified as being with or without merit in a consistent and appropriate manner.

At least 2,536 complaint cases were closed without merit from January 1, 1990, through November 30, 1990. We reviewed 180 of these cases to determine whether the reasons given for closing the cases provided sufficient basis upon which to conclude that the cases lacked merit.

Thirty-one (17.2 percent) of the 180 cases were closed without merit because the evidence was insufficient, the complaint was withdrawn, or the complainant failed to respond. We believe that the board correctly closed some of these cases without merit. However, none of the reasons cited for closing these 31 cases provide sufficient basis upon which to conclude that the cases lacked merit. For example, the board closed one case without merit, which involved an allegation that a physician misdiagnosed a medical condition. This case may have been closed without merit correctly. However, the reason given was "insufficient evidence" although the investigator had obtained the medical records in the case and the medical consultant had reviewed them before deciding that the complaint lacked merit. Because the board appears to have had sufficient evidence to show that the physician did not misdiagnose the medical condition, the case should have been closed with the reason of "no violation" rather than "insufficient evidence."

In another example, a physician was alleged to have negligently and incompetently treated a patient diagnosed with lymphoma. This case was closed without merit because the complainant did not respond to a request for a signed medical records release form. Although the board may not have been able to investigate the case because the complainant did not respond, it has no basis to conclude that the complaint did not have merit.

We also found that one case from among the 180 cases we reviewed had been closed without merit even though the facts of the case clearly indicate that the allegation had merit. This case involved a physician who, during the investigation, admitted that she had mistakenly written out a prescription for the antidepressant Doxepin when she had meant to prescribe Doxycycline, a drug that prevents Lyme disease. In this instance, the board's conclusion that the case should be closed without merit was inappropriate given the physician's admitted fault in the case.

Accuracy in classifying closed cases as with or without merit is important since, according to law, all cases that the board determines to be without merit are to be purged from licensees' central files

and destroyed. The board has established its own policy for holding records of cases closed without merit for one year after closure before destroying them. In contrast, the board maintains records of cases closed with merit for five years. Therefore, if cases are inappropriately categorized as without merit and destroyed after one year, the board's ability to detect repetitions of negligent acts or other patterns of licensee behavior may be impaired. In turn, the inability to detect such patterns may put the public at risk of being harmed by a negligent or incompetent physician.

Without clearly defined guidelines for closing cases with or without merit, consumer services representatives may inappropriately close cases without merit, and the case files will subsequently be destroyed. In addition to lacking clearly defined guidelines, consumer services representatives may categorize cases inappropriately because some cases do not fit in the two case closure categories presently available. The creation of other categories of closed cases beyond the "with" or "without merit" classifications would allow the board to describe more accurately the status of closed cases. For example, the board could create a category for cases that it could not positively identify as with or without merit. If it retained these files rather than destroying them, the board could access the files if it later received additional complaints against the practitioner.

Some Closures Without Merit Lack Supervisory Approval

The board's desk manual for consumer services representatives, which was issued in March 1987 and is currently being updated, requires that a supervisor approve a consumer services representative's decision to close a case without merit if the complaint is drug-related or involves criminal activity. However, the desk manual does not require such approval when the complaints involve physician negligence or incompetence. Additionally, although the board's chief of enforcement has stated that consumer services representatives should obtain input and guidance from their supervisors before closing cases without merit, he added that some representatives may, depending on their background, make such decisions themselves.

Because the board classifies complaints that allege negligence and incompetence, in addition to those that are drug-related or involve criminal behavior, as representing the greatest potential harm, we believe that supervisors should approve decisions by consumer services representatives to close all such cases without merit. However, the board's files for cases closed without merit do not always include evidence of such approval.

Of the 180 cases closed without merit that we reviewed, 150 were filed at the board's central complaint unit. Of these 150 cases, we determined that 23 (15.3 percent) involved allegations of physician negligence or incompetence or of drug violations but were closed without any evidence of supervisory approval. For example, one complaint we reviewed involved an allegation that a physician's failure to care properly for a graft necessitated surgery and led ultimately to permanent damage to the patient's left hand. Before closing the case without merit, the consumer services representative coded the complaint as a possible violation of the Business and Professions Code, Section 2234(d), which covers incompetence. In another case that a consumer services representative had closed without merit, a pharmacist reported that prescriptions signed by a physician suggested a possible violation of the Business and Professions Code, Section 2238, which addresses violations of federal or state statutes regulating dangerous drugs.

Since cases closed without merit are destroyed one year after closure, if a consumer services representative inappropriately decides to close a case without merit, the board may not be able to determine that a physician has been incompetent or repeatedly negligent. Repeated negligence is a violation of the Business and Professions Code, Section 2234, which covers unprofessional conduct. In turn, a failure to detect a repetition of negligent acts may leave the consuming public at risk of being harmed by a negligent or incompetent physician.

Referral of Complaint Cases

Section 2004 of the Business and Professions Code states that the board's Division of Medical Quality is responsible for enforcing the disciplinary and criminal provisions of the Medical Practice Act. The board's desk manual for consumer services representatives states that complaints received at the board that fall outside its jurisdiction are to be referred to other appropriate agencies. However, the manual provides no instruction for determining whether or not a case is within the board's jurisdiction and, consequently, whether a complaint should be referred to another agency.

Of the 150 cases closed without merit that we reviewed at the unit, 45 (30 percent) were closed by being referred to other agencies. Ten (22 percent) of these referrals were to professional medical societies because the complaints principally involved fee or billing disputes between patients and physicians. Four of these 10 cases were in process at the board for an average of 265 days (8.8 months) from the time the complaints were received at the board until a consumer services representative closed them as referrals. For example, one case involved problems in obtaining a complainant's medical records and alleged overpayment. The board received this complaint on November 21, 1988, but did not refer it to the professional medical society until March 6, 1990, more than 15 months later.

Eight (5.3 percent) of the 150 complaints that we reviewed at the unit were from prison inmates. The board ultimately referred 6 of these complaints to the Department of Corrections and closed the other two without merit, referring them elsewhere. Although the 6 referrals were ultimately referred to the Department of Corrections, the consumer services representatives handled them differently in the steps they took and the time they took to refer them.

Of the 6 referrals, 4 were referred to the Department of Corrections within an average of 22 days, sometimes with the comment that the referral was made because the complaint concerned care rendered in a correctional institution. The other 2 cases were delayed for an average of 319 days. One was delayed while the consumer services representative attempted to obtain

further details about the case and a signed medical records release form from the complainant. This case was ultimately referred to the Department of Corrections with the comment that it concerned a matter outside the board's jurisdiction. Thus, although the consumer services representative in this instance followed correct procedures in obtaining further case details and a signed medical records release form, she ultimately referred the complaint to the Department of Corrections apparently because it concerned medical care in a correctional institution.

Sometimes complaints about fees or billing disputes also allege violations of the Medical Practice Act. For example, one of the 10 cases in our sample that the board referred to professional medical societies involved a possible violation of the Business and Professions Code, Section 725, which covers excessive prescribing or treatment, as well as billing disputes. In this instance, however, the board did not review or investigate the possible violation of Section 725. Rather, the case was simply referred to a medical society as a fee/ethical issue, which was judged not to be within the board's jurisdiction.

The inconsistencies and delays we observed in the board's referral of complaints outside its jurisdiction may affect the public's right to have its complaints addressed by the appropriate agency as well the board's own ability to operate effectively. For example, when the board causes delays in the referral of complaints, the consumer is, at minimum, forced to wait until the proper authority addresses the complaint. Similarly, when the board refers to another agency a complaint that includes allegations that fall under the board's jurisdiction, the consumer's complaint may not be fully addressed.

Central Licensee File Needs Improvement

Section 800 of the Business and Professions Code requires the board to maintain a central file of the names of all its licensees. This file is to contain, among other items, a record of all complaints received from the public as well as insurance settlements and hospital discipline reports filed against licensees, provided such

complaints and reports have not been determined to be without merit and they have not been held without action for more than five years. Complaints that fall into these two latter categories are to be purged from the central file and destroyed. Complaint case files are confidential; however, law enforcement and regulatory agencies may, under certain circumstances, inspect and copy the files.

We found that the board cannot always provide complete case file documentation about its licensees from its central file. During our audit, we requested that the board provide us with a large number of case files for our review. For example, to perform one of our tests, we requested files for 117 cases closed with merit from December 1, 1989, through November 30, 1990. Because these cases were closed with merit less than five years before our test, the files should have been in the board's central file, in accordance with Section 800 of the Business and Professions Code. The board was initially unable to locate within a week's time at least 34 (29 percent) of these case files.

While the board was looking for these files, several of its units were in the process of relocating to new offices. Since some of the case files that we requested may have been among files being moved, we allowed the board additional time to locate the remaining 34 cases after the units had settled into their new quarters. After one additional week, the board was able to locate all or some documentation relating to 33 of the cases and to determine that one file had been purged because the case was closed without merit. However, 2 of the files provided were not complete, and at least 10 of the 34 files were obtained from regional offices of the board rather than from the central file. Furthermore, at least 3 of the case file numbers were not found on the Consumer Affairs System, the board's new automated complaint tracking system. Finally, although one of the files contained the case documents we had requested, case documents for 2 other unrelated cases were in the file as well.

The board's inability to provide some of the case file documentation requested and the board's maintenance of some complaint files at the regional offices indicates that the board does not maintain its central file on licensees wholly in accordance with the code. The board maintains a central file room for complaint cases, which is organized by case number rather than by licensee name. Consequently, all complaint cases against a practitioner are not filed together, nor are they cross-referenced to each other. The board also maintains the Consumer Affairs System, which is capable of tracking individual cases and providing information about all cases the board handles. Together these two systems have the capacity to provide a central file as required by Section 800 of the Business and Professions Code. However, the board has not converted all cases to the new system. Additionally, because some regional offices keep some closed files rather than returning them to the board's central file, the board may have difficulty compiling the full case file for a particular licensee.

Without a complete and reliable central file system of the board's licensees, parties who are entitled to have access to such files may not be fully informed. Additionally, the board may be unable to ascertain patterns of complaints, in accordance with Section 129 of the Business and Professions Code, to ensure that patterns of behavior that may constitute code violations are being recognized.

Telephone Access to the Board

The supplemental budget language for fiscal year 1989-90 appropriated $200,000 of the board's budget for implementing a toll-free telephone number that would facilitate the board's receipt of consumer complaints. The toll-free telephone number became operational on March 15, 1990. The unit has five telephone lines through which the toll-free calls may be channeled. It also has seven lines for its 916 area code numbers. At all times during regular business hours, two employees stand by for calls through these lines on two telephones dedicated to incoming complaint calls. In addition, staff members whose desks are located near these two telephones will answer overflow calls when the regular assignees are busy with other callers.

We called the board's toll-free complaint line to the unit and some direct lines to the board's regional offices and requested advice on the procedures for filing a complaint against a physician. Our purpose was to determine how accessible the board was through the toll-free line and to assess how helpful and accurate the board's operators were. We found that we could usually reach a board operator through the toll-free complaint line. Additionally, in our opinion, the response we received was accurate and helpful. Specifically, six of seven calls made to the board's toll-free complaint number during regular business hours resulted in a connection to a staff member. Additionally, a recent AT&T study of calls made to the board's toll-free number over seven days showed that callers connected with the board 96.3 percent of the time. When we asked about the procedures for filing a complaint, the board's staff informed us that they could send us a complaint form that, when completed and returned, would be evaluated. If warranted, our complaint would then be investigated. One of our seven calls resulted in a busy signal.

When we called two of the board's regional offices and requested help in filing a complaint against a physician, the regional offices both referred us to the board's toll-free complaint number. One of the regions also offered to send us a complaint form. Finally, when we called the toll-free complaint number during the weekend to determine if we could leave a message, a recorded message requested that we call back during regular business hours to file a complaint. Based on the calls that we made to the toll-free complaint number and to the regional offices, we conclude that the board is reasonably accessible through its toll-free complaint line.

We also tested to determine how available the board's toll-free complaint number is through operator directory assistance and published telephone directories. Specifically, we called operator directory assistance in a total of 12 cities in California's ten area codes and asked for the listing for the board's complaint number. The operators in Los Angeles, Fresno, Eureka, and Modesto could not give us the toll-free number although we called operators in these cities at least twice. In addition, the

operator in Modesto could not give us any listing at all for the board. Finally, we called AT&T's directory assistance for toll-free telephone numbers and found that it could not provide the board's toll-free number.

Our review of a judgemental sample of 15 published telephone directories (11 published by Pacific Bell and 4 published by GTE) showed that the board's toll-free number is published in the 3 Pacific Bell directories published since September 1990 that we checked. These directories covered the cities of San Francisco and San Luis Obispo as well as Orange County. Additionally, the 8 Pacific Bell directories published before September 1990 that we checked included at least one board number for complaints although none contained the toll-free number. Three of the 4 GTE directories that we checked contained no listing at all for the board. These three directories were for the cities of Palm Springs and Laguna Beach and for Del Norte County. One of these directories, for Laguna Beach, was published in November 1990 and, therefore, could have included the toll-free complaint number for the board.

Based on our tests of operator directory assistance and published telephone directories, we conclude that the board's toll-free complaint number is not easily available to the public in some areas of the State. Since the purpose of the board's toll-free complaint number is to facilitate the process of making consumer complaints about physicians, the number should be publicized as broadly as possible. If the number is not easily available to some consumers, they may be unable to determine how to file complaints with the board against physicians.

Conclusion

During our audit, we found that the Medical Board of California could improve its performance in some areas and that some board policies should be clarified or revised. Specifically, the board classifies closed cases as being either with or without merit. However, these two categories are not adequate to describe all cases that the board closes. We identified 31 (17.2 percent) of 180 cases closed without merit that were closed for reasons (such

as complaint withdrawn or insufficient evidence) that are not sufficient for determining the complaints' merits. Also, the board does not ensure that a supervisor approves decisions by consumer services representatives to close cases without merit, even when the complaints allege physician negligence or incompetence. The board's present policy does not explicitly require such approval, and the board's policies for closing cases without supervisory approval are not well-defined. In addition, although the board requires that supervisors approve closures without merit when the cases are drug-related or involve criminal activity, these closures do not always receive such approval.

We also found that the board's central file on its licensees and its computerized data processing system do not, taken together, comprise a reliable source of historical data and information about complaints filed against board licensees. Thus, the board, its licensees, and other parties who have access rights to the central file may not be able to obtain complete files, which the board is required by law to maintain.

Finally, we found that, although the board is reasonably accessible through its toll-free telephone number, the number itself is not easily available to consumers in some areas of the State.

Recommendations

To ensure that complaint cases are processed and investigated in accordance with its policy and that all policies are well-defined, the Medical Board of California should take the following actions:

- Develop concise and logical guidelines for closing cases with merit and without merit. The board should also consider creating additional closed-case categories to permit more accurate classification of cases for which the two merit categories are inadequate;

- Institute a policy requirement that a supervisor approve decisions by consumer services representatives to close cases without merit for complaints that include allegations of negligence and incompetence; and

- Develop clear guidelines for consumer services representatives for referring complaints outside the board's jurisdiction, including a list of agencies matched to complaint types that should be referred to them as well as time frames for making such referrals.

To ensure that the board has a reliable central file, the board should take the following actions:

- Ensure that it maintains all case files the law requires it to retain in its central file room; and

- Complete the conversion of complaint case data to the Consumer Affairs System so that the central file room and Consumer Affairs System together constitute a central file on board licensees as required by law.

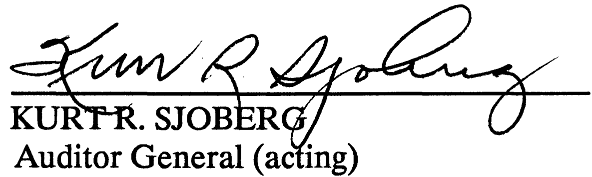
To ensure that the board is easily accessible to all consumers with complaints, the board should take the following actions:

- Ensure that all telephone companies in all cities and counties in the State have a listing for the board's toll-free complaint number; and

- Include listings under both "Medical Board" and "Physician/Doctor Complaint Hotline" in the state government offices' section of the white pages or under "California" in the white pages.

We conducted this review under the authority vested in the auditor general by Section 10500 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,



KURT R. SJOBERG
Auditor General (acting)

Date: April 15, 1991

Staff: Thomas A. Britting, Audit Manager
Kay E. Overman
Arn Gittleman
Charles W. Kilbourne
Thomas Roberson

Appendix A Sources of Complaints

Table A-1

Complaint Sources for 492 Sample Cases Closed by the Medical Board of California December 1, 1989, Through November 30, 1990

Type of Case	Consumer[a]	Agency[b]	Hospitals	Insurance Companies	Medical Board	Total
Cases closed without merit	158 (88%)	11 (6%)	4 (2%)	6 (3%)	1 (1%)	180 (100%)
Cases closed with merit	66 (56%)	23 (20%)	9 (8%)	14 (12%)	5 (4%)	117 (100%)
Cases closed with discipline	57 (29%)	101 (52%)	10 (5%)	4 (2%)	23 (12%)	195 (100%)
Total	281 (57%)	135 (27%)	23 (5%)	24 (5%)	29 (6%)	492 (100%)

Table A-2

Complaint Sources for 129 Sample Cases Assigned to the Board's Regions for Investigation November 30, 1990

Type of Case	Consumer[a]	Agency[b]	Hospitals	Insurance Companies	Medical Board	Total
Cases assigned to regions for investigation	72 (56%)	22 (17%)	8 (6%)	19 (15%)	8 (6%)	129 (100%)

[a]This category comprises patients, relatives or friends of patients, attorneys, physicians, health practitioners, pharmacists, union representatives, and anonymous complaints.

[b]This category comprises any agencies that have referred complaints to the board.

Appendix B Calls Received, Complaints Logged, and Investigations Opened by All Board Offices Fiscal Years 1988-89 and 1989-90

	Fiscal Year 1988-89	Fiscal Year 1989-90	Total
Calls received		(Data Unavailable)	
Complaints logged	6,293	6,658	12,951
Investigations opened	2,658	2,689	5,347[a]

Source: The Medical Board of California provided the data from its annual reports.

[a]There are two reasons for the difference between complaints logged and investigations opened. First, upon preliminary review, a complaint case may be closed without being forwarded for investigation. Second, the board ended each of these fiscal years with a substantial backlog of unassigned cases. For example, the board ended fiscal year 1989-90 with a backlog of 675 cases.

Pete Wilson

GOVERNOR

State and Consumer Services Agency

OFFICE OF THE SECRETARY
915 CAPITOL MALL, SUITE 200
SACRAMENTO, CA 95814
(916) 323-9493

:andards Commission
Consumer Affairs
nployment & Housing
Fire Marshal
Franchise Tax Board
General Services
Museum of Science & Industry
Personnel Board
Public Employees' Retirement System
Teachers' Retirement System
Veterans Affairs

April 11, 1991

Kurt R. Sjoberg
Acting Auditor General
Office of the Auditor General
660 J Street, Suite 300
Sacramento, California 95814

Dear Mr. Sjoberg:

Thank you for the opportunity to comment on your draft report titled A Review of the Processing of Complaints Made to the Medical Board of California (P-049). It is my understanding the Medical Board of California (MBC) will respond directly to your recommendations in the report.

The report's findings are of concern and I want to assure you that the Director of Consumer Affairs and the State and Consumer Services Agency will work closely with MBC to see that appropriate corrective actions are implemented.

The MBC indicates that the Auditor's sample was atypical because it was taken from a period when the Board was converting the complaint records of the Board's existing enforcement tracking system to the Department's new centralized system. While it is correct that the MBC was involved in a conversion effort for the period of May through July 1990, and some resources were devoted to that effort, the conversion would not have had any impact on the investigative staff's ability to process or investigate cases.

Further the MBC may have misinterpreted the Legislative Analyst's report as it relates to the Consumer Affairs System (system) and the problems which some agencies of the department have experienced. The primary point of the Analyst's report appears to be only that there have been delays in implementing three of the enhancements that would give the Boards added functions that do not now exist.

Additionally, the Auditor, under the Scope and Methodology section of the report, indicated that the automated complaint system did not provide a reliable source of information about

cases that were ongoing or that MBC had closed. While the Auditor did not cite the cause of the problem, we wish to point out that in our view the system is reliable but that the converted data is suspect. We have found that many Boards have chosen to correct errors or omissions in their data after the conversion period to ensure an accurate complaint history.

The Board in its response stated that a portion of its backlog was attributed to the denial of its requests for additional investigator person years in fiscal years 1985/86 and 1986/87. During those years the MBC had difficulty justifying the need for additional resources since their data base was somewhat incomplete. The 1990/91 budget includes 18 new positions which were approved largely because the data was finally available to support the request.

Finally, I appreciate the professional approach your staff took in performing the audit. Your recommendations will further strengthen the effectiveness of the MBC's processing of complaints.

If you have any questions or need any additional information, you may wish to have your staff contact Barbara Fitzer at 322-2285.

Sincerely,

PORTER MERONEY
Under Secretary
State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA
1426 HOWE AVENUE, STE. 54
SACRAMENTO, CA 95825-3236

(916) 920-6393

April 10, 1991

Mr. Kurt R. Sjoberg
Auditor General (Acting)
Office of the Auditor General
660 J Street, Suite 300
Sacramento, California 95815

Via: Mr. James Conran
Director
Department of Consumer Affairs
and
Dr. Bonnie Guiton
Secretary
State and Consumer Services Agency

Dear Mr. Sjoberg:

We are pleased to respond to your draft report: A Review of the Processing of Complaints Made to the Medical Board of California, forwarded under cover letter of April 3, 1991, to Dr. Bonnie Guiton, Secretary of the State and Consumer Services Agency.

We appreciate the thoughtful and professional manner in which your staff conducted the review.

While we may not fully agree with every finding and comment in the report, we agree with all of its recommendations, and believe the report accurately documents the status of complaint processing during the period of the audit.

Sincerely,

KENNETH J. WAGSTAFF
Executive Director

KJW/bh

RESPONSE TO AUDITOR GENERAL'S REPORT

Overview

The Medical Board appreciates the efforts of the Office of the Auditor General in conducting this study and reporting findings and recommendations. We welcomed the study. It confirms what we have been saying: The system for disciplining physicians and other health care practitioners is lengthy, both in the elements under the direct control of the Medical Board and in the actions involving the Office of the Attorney General and Office of Administrative Hearings.

Some of the delay can be reduced by adding staff resources and improving procedures. Other reductions in time, such as the two-four month period for obtaining responses to requests for medical records, may require legislation.

While we may not fully agree with every finding and comment in the report, we agree with its recommendations, and we have already taken steps to implement a number of them since the completion of the audit period (November 30, 1990).

Why Has the Process of Discipline Been Lengthy?

A number of significant factors have contributed to the time required to complete discipline during the period reviewed by the Auditor General:

1. Denial of added investigator positions requested by the Medical Board for fiscal years 1985-86 and again for 1986-87, based on increases in incoming complaints and investigations. For the first of these fiscal years, the Medical Board asked for four additional investigator positions. For the second, the Board asked for six added investigator positions. Both requests were denied during the budget review process when our figures regarding the growing number of complaints and investigative cases were not accepted.

   Denial of these added resources deprived the Medical Board of <u>18 additional investigator person years</u> through fiscal year 1988-89. The Legislative Analyst identified a backlog of 853 cases as of December, 1988. In retrospect, the entire problem with the backlog of unassigned investigative cases experienced by the Medical Board might have been prevented with a timely

augmentation of the Board's budget with the investigator positions requested during 1986-87.

For fiscal year 1989-90, the Medical Board received an augmentation of 18 investigator positions, confirming our contention that we needed the <u>18 investigator person years</u>. By this time, the Board had been forced to prioritize the cases assigned to investigators on the basis of the seriousness or potential seriousness of the alleged violation in relation to consumer safety.

2. The Board experienced considerable delays in filling the newly authorized investigator positions because the salary for its investigator positions lagged behind those of other State departments recruiting for new investigator positions. The Auditor General's report points out that the Board lost the equivalent of <u>8 person years</u> of investigator time due to investigator staff turnover and recruitment problems. This exacerbated the backlog of unassigned cases, which peaked at 914 in December, 1989.

The State Personnel Board to approved a new investigator class series and adjustment to Department o Consumer Affairs investigator salaries by an average of 10% on April 9, 1991. This should improve the Board's ability to recruit and retain investigators.

3. The careful prioritization of cases beginning in 1988 dramatically increased the percentage and number of completed cases referred to the Attorney General's Office for formal action starting in fiscal years 1988-89 and continuing since that time. This increase, coupled with the increase in completed cases from the added investigator resources, virtually overloaded, and substantially increased the backlog of cases at the Attorney General's Office over a relatively short period of time.

In 1987-88, we referred 217 cases to the Attorney General. In 1988-89 we referred 343. In 1989-90, we referred 378. This represents an increase of 74% over a two year period.

As of July 1, 1989, there were 400 of our cases at the Attorney General's Office. By December, 1990, this had

grown to 600 cases. This rapid increase, which occurred in part during the period of the Auditor General's study, represents part of the reason for the long time lines for action reported for the Attorney General's Office.

In short, our process of prioritization of cases and our added resources have overwhelmed the Attorney General's Office with cases.

4. We continue to experience an approximate seven month delay in the conduct of formal hearings, (scheduled by the Office of Administrative Hearing). This contributes substantially to the overall time required to complete a disciplinary action.

Some of these factors are within the administrative control of the responsible agency. There are other factors, such as the delays in obtaining requested medical records, reported by the Legislative Analyst in her analysis of the 1991-92 budget, which are currently beyond the control of any of the agencies involved in the disciplinary process.

Action By The Medical Board

We have taken the following action to reduce the time required to complete discipline since completion of the audit in November, 1990:

1. Eliminated the backlog of unassigned cases which had created an average delay of 117 days before investigations could begin.

2. Increased the medical consultant hours spent in the screening of complaints in the Central Complaint Unit. This reduced the time for this review from the 24 day average reported by the Auditor General, to an average of 7 days.

3. Provided analysis of past levels of Board expenditures for Attorney General services, and on the number of cases referred, to the Attorney General's office for use in assessing need and justifying additional resources.

4. We are assessing optimal caseloads for investigators and identifying added resources that may

be needed to allow us to complete investigations (for non complex cases) within an average of 180 days from the date a complaint is assigned to investigation. (A recommendation similar to the Auditor General's was contained in the Legislative Analyst's analysis of the 1991-92 budget and we will be reporting in response to that budget analysis on April 15, 1991.)

We are also assessing the staff resources needed to complete all investigations within an average of six months from the date of receipt of the complaint (the Auditor General's interpretation of Chapter 1597, Statutes of 1990). We believe, however, that the law should be clarified that the six month average applies from the date a complaint is determined to warrant investigation, and to exclude complex cases, for which the goal is one year from the decision to investigate.

5. We are improving our policy and procedure manual for employees in the Central Complaint Unit to provide clarification of the processing steps for complaints and of supervisors' responsibilities to review and sign off on decisions regarding complaints considered without merit if the cases involve negligence or incompetence.

6. We have taken steps to ensure that our central files are complete and available to all parties entitled to have access to them.

7. We will continue our efforts to assure that telephone companies in all cities in the State have a listing for the Board's toll free complaint number. Further, we will request that all phone companies instruct information operators to give the number to consumers.

The Period of the Audit Was Atypical

Unfortunately, due to time constraints, the Auditor General selected the period January 1, 1990, through November 30, 1990, for their audit. We do not dispute their selection of the audit period, however, this study period was clearly atypical of Medical Board operations for several reasons:

1. The audit period started with the Medical Board having a backlog of about 914 unassigned cases and ended with a backlog of about 125 cases. As a result, the audit case sample and the processing time lines reported by the Auditor General included the processing delays caused by the backlog of unassigned cases.

2. During the months of May through July, 1990, the Medical Board transferred its complaint intake function (including staff and vacant positions) from nine regional offices to a central location in Sacramento. Thirteen positions were transferred from the regional offices to Sacramento. The unavoidable delays in the processing of complaints during this transfer is reflected in the sample used by the Auditor General in reporting processing time lines.

3. The Medical Board implemented the Department of Consumer Affairs Phase II computer case tracking system starting in July, 1990. The problems that agencies have experienced with this system are noted by the Legislative Analyst in her analysis of the 1991-92 budget. The processes of training staff, converting existing files, and working through the initial problems with the Phase II computer system also had an impact on the timely processing of complaints received during the period of the audit.

Taken together, these factors had a profound impact on the process and timeliness of handling incoming complaints and assigning cases to investigation during the period of the audit. (1)* We believe the reduction of the backlog alone, will continue to influence statistics on total elapsed time from receipt of complaint, to completion of investigation, through the end of 1991.

Responses To Specific Report Findings

Six Month Investigation Completion Goal

The Auditor General's report refers to Chapter 1597, Statutes of 1990, which requires the Board to adopt a goal for completing investigations within an average of six months,

*The Office of the Auditor General's comments on specific points in this response begin after the Medical Board of California's response.

effective January 1, 1992. The Auditor General's Office interprets the goal to apply to all investigations, including complex investigations, and interprets the goal to apply from the date a complaint is received by the Medical Board to completion of an investigation.

We disagree with this interpretation, however, we can understand the basis for more than one interpretation, and we will be seeking legislation to clarify this provision.

In August, 1988, the Division of Medical Quality adopted a goal of six months for the completion of investigations from the date a case is assigned to an investigator. We believe the legislation (SB 2375- Presley) which established a goal for completion of investigations intended to incorporate this policy.

In the final version of the bill, however, the specific language referred to completion of investigations within an average of six months "from the receipt of complaint to the completion of an investigation". The language further states "notwithstanding subdivision (a)" (referring to the six month average), "the goal for cases which, in the opinion of the Board, involved complex medical or fraud issues or complex issues or financial arrangements should be no more than one year to investigate."

We interpret these provisions to mean, in brief, that we shall adopt a goal of completing non-complex investigations within an average of six months, and a goal for completing complex investigations within one year.

Since only 40% of complaints received become formal investigations, we do not believe the six month average was meant to apply to all incoming complaints. We will, however, seek legislative clarification of the language regarding the six month average.

We are working with the Office of the Attorney General toward a uniform definition of a complex case. We believe that as many as 30 to 35% of investigative cases opened will meet the definition of complex as outlined in general in Chapter 1597. The number and percentage of complex cases has increased due to prioritization of cases beginning in 1988, and to the careful screening of cases by the new Central Complaint Unit beginning in

July, 1990. We believe cases identified as complex should not be included in the calculation of the six month average as has been done by the Auditor General's office. We believe the standard that should be applied to complex cases is the goal of completion within one year.(2)

"Risk to the Public"

We agree that the standard process of complaints review, investigation and adjudication is lengthy. The report states that the public "can be at risk" during this process. We do not disagree with this risk potential. We must point out, however, that practitioners who present a clear, imminent danger to the public are not handled through the standard process. In such cases, the Board intervenes immediately to obtain a temporary restraining order to prohibit him or her from practicing.

Comments on Specific Recommendations in the Report

We agree with each of the recommendations made by the Auditor General and want to comment on several of them:

1. We agree that complaint file documentation should show supervisor review and approval for all cases involving quality of care issues closed without merit. Beginning March 1, 1991, the supervisory staff in the Central Complaint Unit was increased to allow for supervisory review of all cases closed with and without merit. It should be noted, however, that those cases closed without merit by a consumer services representative, identified in the audit review, did have a review by a medical consultant who recommended closure without merit.(3)

2. The audit report states that thirty one (17%) of the 180 cases sampled were closed because the evidence was insufficient, the complaint was withdrawn, or the complainant failed to respond. It states that these cases may or may not have had merit, however, none of these reasons for closing a case provide sufficient basis upon which to conclude that a case lacks merit. Additionally, one case from among the 180 cases

reviewed had been closed without merit even though the facts of the case clearly indicate that the allegation had merit.

We currently receive approximately 7,000 complaints each year. We cannot pursue matters where the complainant either fails to respond to our request for information/clarification or withdraws the complaint and we have little or nothing else to go on. These are the types of complaints that are justifiably closed without merit. On the other hand, if we are provided enough information by a complainant to bring into question the performance of a practitioner, we will pursue an investigation even though the complainant ceases to cooperate.(4)

3. The report found that we failed to refer non-jurisdictional cases to the appropriate agency in a timely and uniform manner and failed to sort out cases that may involve two issues, i.e., fee dispute and excessive prescribing/treatment, before referral to another agency.

We agree that in some instances, complaints involving more than one issue may have been referred as non-jurisdictional without consideration of matters that would fall within our jurisdiction. It has never been our intention to simply dismiss complaints that we should handle. Again, with the addition of new supervisorial staff in the Complaint Unit and revision of the consumer services representatives' manual, there will be more checks and balances as well as safeguards in place so that instances of this type will not reoccur.

The Audit Was Professional

We express our appreciation for the professional manner in which the Auditor General's staff carried out their review. Further, we appreciated the opportunity to discuss preliminary findings and recommendations with the Auditor General's staff and to provide clarification regarding the disciplinary program and specific cases reviewed during the study.

Comments

The Office of the Auditor General's Comments on the Response From the Medical Board of California

(1) The board cites three reasons why its operations during our study period were atypical. We disagree with the board's contention that the period of review from December 1, 1989 through November 30, 1990, was atypical for the following reasons:

1. While we agree on page 17 of the report that the board has reduced the backlog of unassigned cases, this reduction simply shifted the backlog from one point in the process to another point in the process and does not affect the overall time it takes to process a complaint from receipt until end of investigation. As we point out on page 20 of the report, the assignment of the backlog means an increase in investigator caseloads when the investigators are already unable to work on approximately 34 percent of their cases.

2. The board indicates that the centralization of the consumer services representative function contributes to the delays in processing complaints. However, when the centralized complaint unit was formed in July 1990, the board already had a complaint backlog of 675 cases pending assignment to investigation. The delay caused by formation of the central unit would not affect the processing times of those 675 cases that were in the backlog because the central unit handles only incoming complaints.

3. The State and Consumer Services Agency clearly refutes the board's position that conversion to the Consumer Affairs System had an impact on the investigative staff's ability to process or investigate cases.

② We believe that Chapter 1597, Statutes of 1990, specifically Business and Professions Code, Section 2319, is clear in indicating that the board shall set a goal of completing investigations within an average of six months after receipt of the complaint and that the maximum time to investigate complex cases should not exceed a year.

③ The board's statement is factually incorrect. The board indicates that the cases in our review did have a review by a medical consultant. However, the board provided us with evidence that a medical consultant reviewed only 4 of the 23 cases. Furthermore, as we point out in our report, there was no evidence, even in these 4 cases, that the case closure had been approved by a supervisor.

④ Our point is that if the board does not have enough information to pursue specific complaints, the board does not have enough information to know that there is no merit to the complaint. Accuracy in the closing of cases is essential because cases closed without merit are required by law to be destroyed. When complaint information is purged and destroyed, the board loses the ability to detect patterns of complaints against a health care practitioner that may be essential to building a case against a health care practitioner.

State of California

Department of Justice
110 West A Street, Suite 700
San Diego, CA 92101

Memorandum

To : Kurt R. Sjoberg, Auditor General (Acting)
Office of the Auditor General
660 J Street, Suite 300
Sacramento, CA 95814

Date : April 11, 1991

File No.

Telephone: ATSS (8) 454-5431
(619) 324-5431

From : Robert L. Mukai
Chief Assistant Attorney General
Office of the Attorney General - San Diego

Subject: Response to Auditor General Report No. P-049

The Office of the Attorney General appreciates the opportunity extended by the Auditor General's Office to respond to that portion of the Auditor's report, entitled "A Review of the Processing of Complaints Made to the Medical Board of California," which pertains to the Office of the Attorney General. We concur in the recommendation pertaining to this office which states:

> "In light of the formation of the Health Quality Enforcement Section, the Attorney General's Office should ensure that the new section is adequately staffed, and should reconsider whether a 60-day turnaround is reasonable for the preparation of accusations."

Staffing

SB 2375, enacted by the Legislature to improve the efficiency of the physician discipline system of the Medical Board of California, established the Health Quality Enforcement Section as a new organizational unit within the Department of Justice. The primary responsibility of this new section is to prosecute disciplinary proceedings against licensees within the jurisdiction of the Medical Board, and to provide ongoing review of the Board's investigative activities. Pursuant to that mandate, this office has staffed the HQE Section with "experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions" against licensees of the Board.

This office agrees with the Auditor General's recommendation that it ensure the HQE Section be adequately staffed. The section's future staffing needs will be identified upon analysis of the current and projected number of cases received from the Medical Board. While the number of cases received from the Medical Board increased dramatically commencing in fiscal year 1988-1989, the increase in the Attorney General's budgeted staff for Medical Board cases did not match the new workload, and the HQE Section has continued to operate in the current fiscal year in an

understaffed condition. As noted, the numbers of cases referred to this office for filing and prosecution has increased markedly over the last three fiscal years and is projected to continue to increase. The recent and continuing increase in the number of investigators employed by the Medical Board suggests that an accelleration in the rate of projected increase can be expected.

Turnaround Period Evaluation

This office also specifically concurs in the recommendation that the reasonableness of a 60-day turnaround period for preparation of accusations against Medical Board licensees should be reconsidered. Establishment of a realistic and meaningful turnaround schedule for the handling of disciplinary cases is receiving attention consistent with its importance to the integrity of regulation of the medical profession.

Several years ago, prior to the separation of the functions of the present Health Quality Enforcement Section, the Licensing Section, within which these functions were performed, established a goal of 60 days within which it would take action on each investigation file received from its client agencies, including the Medical Board. The action taken could include the filing of disciplinary action (an Accusation), a request for further investigation, or, occasionally, a determination that no action be taken. If further investigation was needed, the 60-day target date was extended until the requested information was received.

Commencing during the 1988-1989 fiscal year, and continuing in each fiscal year thereafter, a dramatic increase in the number of cases received by the Licensing Section from the Medical Board has been witnessed. During this period the Licensing Section was not able to meet the 60-day goal with respect to those cases.

Assessment of a reasonable turnaround period must recognize that most administrative hearings in Medical Board cases are now relatively complex and lengthy proceedings in which respondents are represented by skilled defense attorneys.[1] Because of the circumstances in which the new HQE Section came into existence, section attorneys are currently obliged to spend the greatest part of their time in hearing or preparing for those hearings. Since the actual trial of cases typically requires the full attention of attorneys involved in the proceedings, the overall

---

1. The average gross negligence, violation of drug statutes, or sexual abuse case against a physician now takes approximately 2-3 weeks of trial time, as well as at least one week to prepare for the trial. For example, since January 1, 1991, attorneys in the HQE Section in San Diego have already spent the equivalent of 26 weeks in trial, not counting preparation time.

ability to review and file new cases is substantially reduced by current hearing calendars.

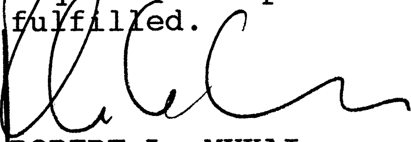
A further factor relevant to the length of the turnaround period is the increase in the number of cases in which a Temporary Restraining Order must be sought in superior court, in addition to the filing of an Accusation before the Medical Board. SB 2375 also provides an additional method (interim suspension order) to obtain emergency relief against physicians who constitute an imminent danger to the public health, safety and welfare.

Additionally relevant to the reasonableness of turnaround time is the requirement of SB 2375 that the Attorney General perform new duties for the Medical Board.

> SB 2375 requires a Deputy Attorney General from the HQE Section be "frequently" available on location at each of the working offices at the major investigation centers of the Board to provide consultation and related services and engage in case review with the Board's investigative and medical advisory staff.
>
> SB 2375 also requires the HQE Section to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations. This mandated task will require the section to totally evaluate the complaint and intake procedures of the Medical Board, including the Board's Central Complaint and Investigation Control Unit in Sacramento. The section must determine what uniform standards and procedures currently exist, who is making decisions to close cases prior to or during the investigation stage, whether the reasons for closing investigations being properly documented, and what role the HQE Section should play in the decision making process.
>
> SB 2375 also requires the HQE Section to assist the Board in designing and providing initial and in-service training programs for staff of the Board, including but not limited to, information collection and investigation.

The Office of the Attorney General recognizes the need for improvement in the over-all efficiency of the disciplinary process in Medical Board cases, and has embraced the challenge presented by SB 2375 and the effort to enhance protection of the public through its role in the statutory implementation. As an acceptable turnaround standard is being established, the HQE Section is currently striving to increase efficiency in filing and prosecution of cases, and thus improve substantially the performance reflected during the period covered by the Auditor

General's report.[2] Once initial staffing requirements have been stabilized and a realistic standard has been set, it is this office's intention to ensure by all reasonable means that the requirements placed upon this office by SB 2375 will be fulfilled.



ROBERT L. MUKAI
Chief Assistant Attorney General

---

2. Current operations include the following practices:

New cases are evaluated by a Supervising Deputy Attorney General and given a priority evaluation. Cases that have a direct and immediate impact on patient care (usually death or serious injury) are given the highest designation (Urgent). To provide public protection, these cases are prosecuted first.

Cases categorized as routine that do not require medical expertise (typically including instances of out-of-state discipline or criminal conviction) are assigned to experienced paralegals for preparation of administrative pleadings. The section will attempt to increase and utilize the expertise of the paralegals in the pleading of "routine" cases.

Supervising deputies meet regularly with HQE deputies to review progress in diminishing the assignment backlog of each deputy. Reassignments of cases are made as necessary to ensure that urgent and serious cases are handled as expeditiously as possible and that existing backlogs are reduced.

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps