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PROTECTING MEDICARE AND MEDICAID PATIENTS FROM SANCTIONED HEALTH PRACTITIONERS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
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PROTECTING MEDICARE AND MEDICAID PATIENTS FROM SANCTIONED HEALTH PRACTITIONERS

TUESDAY, MAY 1, 1984

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, in room 628, Dirksen Building, at 9:32 a.m., Hon. John Heinz, (chairman) presiding.

Present: Senators Heinz, Wilson, Glenn, Melcher, and Bingaman.

Also present: John C. Rother, staff director and chief counsel; Diane Lifsey, minority staff director; David Holton, chief investigator; David Schulke, investigator; Isabelle Claxton, communications director; Jane Jeter, minority professional staff member; Robin Kropf, chief clerk; and Kate Latta and Leslie Malone, staff assistants.

OPENING STATEMENT BY SENATOR JOHN HEINZ, CHAIRMAN

Chairman HEINZ. The Special Committee on Aging will come to order.

Ladies and gentlemen, this morning the Special Committee on Aging will investigate a serious defect in our ability to protect our Nation's elderly and poor from treatment by incompetent and dangerous medical practitioners. The problem stems from loopholes in medicare and medicaid which allow doctors barred from practice in one Federal program or in one State, to switch to another program or to pack their bags and set up practice in another State. We will see today what these loopholes mean to the 50 million Americans who trust medicare or medicaid to finance their health care needs. Because many of these practitioners also treat privately insured patients, this problem is a vital concern to all Americans.

Some estimate that the number of bad doctors is small. Today we will hear estimates that as many as 36 million Americans may receive treatment from unfit doctors each year. But whether the number is large or small is not the point. The point here is that the Government has no power to prevent incompetent practitioners from enriching themselves at the expense of the American taxpayer—even as they prey on the poor, the old, and the very vulnerable.

Let me illustrate how serious and shocking a problem we face with a few case studies that the committee's investigative staff has uncovered:

Dr. S. is a surgeon who performed a series of extensive and dangerous back surgeries on a number of patients. As a direct result of his gross negligence and gross incompetence in the operating room, one

woman died. When he lost his license in California, he took up practice in Michigan and continued to receive Federal reimbursement under medicare and medicaid. It took Michigan 4 years to finally revoke his license. Today, Dr. S. practices medicine in New York State and is still eligible to bill the taxpayer under medicare and medicaid.

Take the case of Dr. T. He said he had graduated from a school in Saigon, Vietnam. Later he changed his story and said he had graduated from a school in Hanoi. Finally in March 1981 he admitted to California authorities that the diploma he had submitted was false.

Dr. T. is a convicted felon, found guilty of submitting a false new drug study to the FDA. He has held a license to practice medicine in at least six States and has surrendered his license or had it revoked in at least three. It is not at all comforting to know that Dr. T. now practices in Nevada and is medicare and medicaid certified.

One final case in this incredible rogue's gallery is the case of Dr. H., who treated patients in 30 or 40 nursing homes and hospitals in California. In a 2-year period, Dr. H. billed medicare for one-half of a million dollars. He was cited by HHS for placing patients' lives in jeopardy, for substandard quality of care, and for billing for services not rendered. Today Dr. H. is banned from the Medicare Program—thank heavens—but he can continue to treat medicaid patients in any State that will recognize his California license.

I am entering additional case examples of sanctioned medical practitioners into the record. Also, a series of articles from the Detroit Free Press dealing with unfit medical practitioners will be inserted into the record.[1]

If any one of these practitioners had lost their driver's license for drunk driving, their names would have gone into a national register and they probably would not be given a driver's license in another State. But the current lack of coordination among States allows these dangerous, criminal doctors to hop from Pennsylvania, to California, to Michigan—to any 1 of the 50 States.

The current restrictions on HHS authority means a doctor can be banned in 49 States and the Federal Government still will pay him for treating medicare and medicaid patients in that 50th State.

That is not what responsibility in Government is all about. It is a dereliction of duty on our part that we in Congress have not given the Secretary of HHS the authority needed to prevent these unfit doctors from continuing to treat federally sponsored patients.

So we must set our own Federal house in order, and we must also ask the individual States to strengthen their cooperation and communication in enforcement.

I look forward to hearing today's witnesses. They are experts in these matters. Their testimony should help us better understand the scope of this problem and what we should do about it.

But before I call on our first witness, I want to recognize the distinguished ranking minority member of the Special Committee on Aging, our friend and good colleague, John Glenn.

Senator Glenn.

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[1] See appendixes 1 and 2.

STATEMENT BY SENATOR JOHN GLENN

Senator GLENN. Thank you very much, Mr. Chairman.

Mr. Chairman, access to quality medical care for our Nation's elderly citizens is an issue of longstanding concern to members of this committee. In recent years, proposals to cut medicare benefits have become an annual part of our budget process under the leadership of the Reagan administration. Concern has grown among committee members that increased cost sharing will impose a disproportionate burden on those older Americans least able to afford it—the oldest, the frailest, and the poorest. I have spoken out about the need to preserve access to necessary health services, and have warned against increased health deductibles which limit access to care.

Preserving the quality of medical treatment given to medicare beneficiaries has also taken on a new importance with the enactment of medicare prospective reimbursement to hospitals. As I said before, while we want inflation reined in, we do not want the quality of health care sacrificed under the guise of cost containment.

Today, we are examining access to quality medical services for our Nation's elderly in a different light. As a result of an investigation being released by the General Accounting Office [GAO] today we have learned that medicare and medicaid patients are being treated in some States by doctors and pharmacists who have been determined by another State, after due process, to be unfit to practice.

The GAO looked at the careers of doctors who have their licenses revoked by my home State of Ohio, as well as by Michigan and Pennsylvania. What the GAO found is that some of these doctors are simply moving on to greener pastures—different States where they set up practice—and are billing Uncle Sam to pay at least part of the cost. They are continuing to participate in the Medicare and Medicaid Programs, a few are possibly finding employment with the Veterans' Administration or other Federal health programs.

Doctors and other practitioners who lose the State licenses do so for serious reasons. According to the GAO, the majority provide substandard medical care, either through malpractice, alcohol and drug abuse, or immoral conduct. Yet the Department of Health and Human Services has no authority to prevent these people from continuing to bill for Federal dollars. A practitioner may be convicted of violating the controlled substances law by indiscriminately prescribing addictive drugs, yet HHS cannot exclude him or her from participating in medicare and medicaid.

GAO cited the case of one doctor whose Michigan license was revoked in 1980 for indiscriminately prescribing drugs, failing to meet minimum standards of care, and immoral conduct with both patient and employee. The doctor simply moved to Florida and continued billing medicare from the sunny South.

However, the issue is much more than Federal dollars going to unfit and unscrupulous medical providers—it is the quality of care being given elderly and poor patients. This is a matter of particular importance to the 3½ to 4 million medicare beneficiaries also covered by medicaid—almost 15 percent of medicare beneficiaries. These "dually eligible" citizens often have little choice in health care pro-

viders. The oldest, the sickest, and the poorest of medicare beneficiaries simply cannot afford to "shop around."

The situation described by the GAO is intolerable. The GAO specifically lists several ways to expand HHS authority to exclude doctors from participating in medicare and medicaid, and to help remedy the current disarray and the licensing of health care professionals. I will actively join my colleagues in working toward the enactment of legislation to implement the GAO's findings. I hope we can introduce it in the near future and see it become law this year.

What can we do about all of this? Well, some time ago, we faced a similar situation in automotive safety where "problem" drivers having lost their license in one State would simply obtain one from another State. As this became recognized as a national problem, the Congress passed legislation to create the National Drivers Register under the National Highway Traffic Safety Administration. States participate in the register by sending information regarding drivers whose licenses have been revoked or suspended. States can then check on the background of individuals seeking a license within the State. The program has been enormously successful.

Surely if we can curtail the number of bad drivers on our Nation's roads, we can take steps to limit the number of unfit health care providers practicing on our Nation's senior citizens. We must insure that the persons we entrust to make life or death decisions are competent and qualified to do so.

Thank you, Mr. Chairman.

Chairman HEINZ. Senator Glenn, thank you very much.

Senator Melcher.

STATEMENT BY SENATOR JOHN MELCHER

Senator MELCHER. Mr. Chairman, not as a medical doctor but as a veterinarian I have had some experience in the licensing of professionals in my profession. I served on the State Board of Veterinary Medical Examiners for a number of years and I am familiar with the procedures. A license to practice medicine is not easily obtained. There are many qualified doctors, medical doctors in this country who are here for one reason or another who have had difficulty in obtaining a license and still have that difficulty. And losing a license after being once obtained, I do not know of any State where that is not a profound determination by that State's authority to cancel out that license. It is preposterous that in this country that there can be medical doctors who have been licensed and who have lost their license in a State and still find it easy or find the opportunity to treat medicare or medicaid patients. It is not that big a problem.

The problem ought to be resolved by legislation that bans those doctors who have lost their license from participating in medicare or medicaid until, if and until they have reinstated themselves at the determination of that particular State's board of medical examiners.

It is not like we are dealing with millions of people, we are dealing with thousands of people and they can be tracked. What is missing in this whole chain of events, sad events, is the fact that we have no

specific law requiring HHS to deny access to medicare or medicaid and, therefore, deny them the opportunity to practice medicine once they have lost their license in a particular State.

I do not go for this idea that somehow doctors who have licenses in several States, if they lose it in one State, that casts a grave shroud over their capability from practicing in any State until they can recover that license in the State wherein they lost it. I think they should be banned from medicare or medicaid treatment of patients and I think that requires a law. I think we are capable of suggesting law and drafting that law. Hopefully, the Senate will follow through with passing it.

Thank you, Mr. Chairman.

Chairman HEINZ. Thank you, Senator Melcher; and thank you, Senator Glenn, both for excellent statements.

Before hearing from our first witness, I am going to insert into the record the statement of Senator Larry Pressler, who unfortunately cannot be with us today due to a previous commitment.

[The statement of Senator Pressler follows:]

STATEMENT OF SENATOR LARRY PRESSLER

Mr. Chairman, I would like to thank you for organizing this hearing on this very important subject. I commend the committee for their fine work in researching this issue and for their concern to protect America's elderly.

Medicaid and medicare beneficiaries are most susceptible to medical practitioners who are unfit to provide medical care. For many years, physicians practicing in one State after having lost their licenses to practice in another State were merely swept under the rug or overlooked. The time has come when members of the medical profession, and we as lawmakers, must accept the responsibility of protecting elderly Americans from the incompetent physician. Too often, medicaid and medicare beneficiaries are elderly members of our society who fall prey to the unfit doctor.

The majority of the residents of my home State of South Dakota live in rural or small town settings, but still receive medical services from very capable personnel. I, for one, want to protect these people from incompetent new physicians who may begin a medical practice in South Dakota.

The more information we can collect and disseminate on this subject, the better prepared our elderly citizens will be to avoid victimization by unfit medical doctors. I think this is an extremely worthwhile use of our time and energy, and look forward to the testimony of our witnesses today.

Senator HEINZ. We are very privileged to have our first witness, Dr. Robert C. Derbyshire at the witness table.

Dr. Derbyshire is not only a distinguished surgeon, he is a well known author. He has trained at Johns Hopkins University, the Mayo Clinic, and the University of Minnesota. He practiced actively for over 30 years.

Throughout his career he has been devoted to correcting the problems with licensing and disciplining of physicians. He has published a book and numerous articles on that subject. Dr. Derbyshire is the past president of the Federation of State Medical Boards and is currently on the National Board of Medical Examiners.

Dr. Derbyshire, we are very pleased and privileged to have you here today.

Please proceed.

STATEMENT OF DR. ROBERT C. DERBYSHIRE, SANTA FE, NM, AUTHOR AND PAST PRESIDENT OF THE FEDERATION OF STATE MEDICAL BOARDS

Dr. DERBYSHIRE. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I feel honored by your invitation for me to appear before your committee.

Today, I shall address the general subject of incompetent, unscrupulous, and unethical physicians who have licenses in two or more States. When actions are taken against them, and I am repeating your wise words, Mr. Chairman, if you will forgive me, when actions are taken against them in one State, they merely move to another and continue their depredations upon the public.

First, I should like to furnish with you a little summary of the problem of incompetence among the medical profession in the United States. In 1976, the New York Times correctly quoted me as stating that 5 percent of the physicians in the United States were incompetent. After the hue and cry had died down about my airing dirty linen or washing dirty linen in public, the medical profession began to take this rather seriously and recently the estimate has been changed, I have changed my estimate from 5 to 10 percent. And I think that the American Medical Association—I am not sure—I am speaking as an individual, not for any organization, I think that they are approaching that figure also.

You may say that that is a very small number, 10 percent of doctors are incompetent, but when you break it down there are some 450,000 physicians in the United States practicing today and if 10 percent of those are incompetent, that makes 45,000 incompetent physicians who are practicing.

Assuming that the average doctor—this is an assumption of a fairly busy doctor—sees 800 patients a year, this means that 36 million patients every year are treated by incompetent physicians.

Now, this does not necessarily indicate mass murder by physicians, I assure you, because as you know many diseases are self-limited. But who knows when these incompetent physicians will fail to recognize a life-threatening disease or to overtreat a minor ailment such as giving penicillin for a cold in the head and causing a death from an anaphylactic reaction.

The situation is serious however when we consider that from 1977 to 1982 the State disciplinary boards as nearly as I have been able to determine, invoked some 1,500 sanctions against physicians. This means that only 0.3 percent of the incompetent physicians were disciplined during that period.

Throughout the years the reason for disciplinary actions have been constant. Narcotics violations have led the list with some 40 to 60 percent and these are followed closely by mental incompetence, fraud and deceit in the practice of medicine and conviction of felonies. And I could go on and on, the list continues.

Having furnished you with this background, I shall now consider the problems caused by failure of States to take action against doctors who have been sanctioned in other States. There are many physicians who for various reasons collect multiple licenses. Consequently, when one State revokes or suspends a doctor's license, he merely moves to

another State in which he is already licensed and continues his depredations.

For the sake of brevity, if not elegance, I shall call these people State-hoppers. An example that comes to mind immediately is that of a doctor who practiced near a State line. His license was revoked in his State for habitual drunkenness, for violation of his probation, and he immediately moved across the State line whose laws were different. And he was followed by his large number of devoted patients and continued his incompetent practice.

Why does this happen? There are several reasons, not the least of which is lack of communication among the boards. The Federation of State Medical Boards of the United States has only partially solved this problem by acting as a central repository for all disciplinary actions. However, the federation has not been completely successful in this effort because many of the States do not report and all the federation can do is go on the information that they have.

The hospitals in general—I am not pointing the finger at anyone, but I have had a lot of experience with this—many hospitals cause complications because they are all too willing to engage in plea bargaining with their underqualified physicians and they will say in essence: Doctor, if you will leave we will allow you to resign from the staff voluntarily, quote, unquote, an excellent method of exportation of problems.

Another problem is distrust among boards. For example, one board revoked a doctor's license for manifest incompetence. The court upheld the board's action. He held licenses in four other States and he immediately moved to Florida where he was licensed. I am not necessarily pointing the finger at Florida, but he moved to a small town in Florida where he practiced for 2 years. For some reason or other, he left there and went to New York where he was already licensed. The New York board knew about his record of revocation of license, and yet he practiced there for 11 months. This makes almost 3 years that this person was traveling from State to State and setting up a practice.

After 11 months, they finally had a disciplinary hearing in New York and the upshot of the hearing was that they thought that the action of the original State was too harsh and so they put him on probation.

Incidentally, the icing on the cake in the original State was they added the complaint which was proven in the hearing that he took advantage of his lady patients.

Still another difficulty involves the lack of uniformity of sanctions. For example, in 1980 four doctors were found guilty of exchanging narcotics for sexual favors. Yet for this crime for which I personally believe a doctor should be forever banished from the profession, three were placed on probation and one was only reprimanded.

In many other States, of course, their licenses would have been revoked. One of these cases ended in a tragedy when a young lady who had been involved died from an overdose of narcotics.

There is a crying need for reform of the State laws. Incredibly, at present only 15 States have laws that would permit the disciplinary board to take action against a physician who has been found guilty of an offense in another State if listed in the original State statute. In fact, in some States the law forbids such action.

However, if all States pass such laws it could help prevent the all too prevalent State-hopping. Medical malpractice is another disciplinary concern touching peripherally on State-hopping. Lawyers and doctors alike are not always certain as to what constitutes malpractice. There is an old English proverb with which you are probably all familiar which says that "every dog is entitled to one bite."

This applies to the malpractice situation of course, but the question arises, when is the first bite so severe as to warrant action to prevent subsequent bites?

Certainly no board would discipline an internist who, for 20 years, had practiced excellent medicine in his community and had never had a malpractice suit against him, if he missed a diagnosis of acute appendicitis, which is easy for the best of us to do.

On the other hand, if a doctor is operating—and this is an actual case—if a doctor is operating on varicose veins and he ligates the femoral artery resulting in high amputation of the extremity of a 34-year-old woman, the board would take a little different view and will make sure that he is not allowed a second bite. Yet he might have multiple licenses permitting him to bungle in another State.

Mr. Chairman, the magazine Hospital Practice recently published a series of articles by me on the general topic: "Medical Discipline in Disarray." I would like to submit these for the record.[1]

In closing my formal remarks, I might add that perhaps a more appropriate title for this series of articles would be "Medical Discipline in Chaos."

Mr. Chairman, I have deliberately kept my remarks brief. I am happy to answer any questions from your committee.

Chairman HENIZ. Dr. Derbyshire, thank you very much for some really excellent testimony. We commend you on your willingness to continue to speak out even if you do not get 100-percent agreement from all members of the medical profession. But I think they are beginning to catch up with you a little bit and they seem to be agreeing with you more that there is a problem.

Let me ask you this: You spoke of the tendency for hospitals to, in effect, plea bargain with physicians so that they resign. The result of that being the exportation of those problems elsewhere.

Could you comment further on the extent of that problem? That is, where by not facing up to a real issue, that it just becomes someone else's problem?

Dr. DERBYSHIRE. I have no figures on that, Mr. Chairman, but having been on the New Mexico Board of Medical Examiners for 31 years, I have been confronted by this problem very frequently; for instance, there was a doctor who was called before the board of the hospital and the hospital staff and accused of incompetence. The staff voted 50 to 1, this was in a fairly small hospital, the staff voted 50 to 1 to expel him. We assume the doctor had a vote, that is why there was the one vote. The New Mexico Board of Medical Examiners established a hearing procedure to show cause why his license should not be revoked for making a false statement on his application. His lawyer obtained a statement from the hospital that he was not expelled at all, that he was allowed to resign voluntarily. So maybe his vote did count.

[1] See appendix 3.

Chairman HEINZ. What I think I hear you saying is that hospitals, medical boards, and others do not want to get into long, protracted legal disputes. And they tend to take the easiest possible way out for themselves and, indeed, it may solve their problem at that hospital or within that State. But the result is that no real solution to the problem has been obtained, the number of people who are sanctioned, as you pointed out, 1,500 in 5 years is very low. And as we will establish here today we have physicians forum shopping the way a lawyer would, but instead they are patient shopping in different States.

Do you believe that State medical associations are doing all they can to insure that the average patient's doctor is a qualified, competent physician? After all, the medical profession is a profession, it has its own standards, proficiency standards higher than nonprofessions, the medical profession should have a standard at least as high or higher than any other profession. And we like to think the best way to assure that is to have people closest to the practice of medicine, that is, on a State-by-State basis rather than all of us who are so wise here in Washington looking over the shoulder of physicians in Alaska dealing with the problem. That is the theory. What is the reality?

Dr. DERBYSHIRE. The local medical societies are doing very little, Mr. Chairman, I regret to say. We still have the so-called curtain of silence. And although that is being partially lifted, the medical societies have very little to do with medical discipline. This is entirely up to the local boards of medical examiners or the disciplinary boards. Three States have the two separated.

Of course you are probably familiar with the scandal that happened in Massachusetts when the—this was in the New York Times I believe some time ago, when this man was convicted of raping a nurse and other faults and given glowing letters of recommendation to another hospital in another city. And the officials there in the other hospital found out what had happened and took the first State to task. And the answer was from an eminent surgeon: Well, nobody pays any attention to letters of recommendation anyway.

Chairman HEINZ. Is part of the problem in getting State disciplinary actions to be more forthcoming that there is a lack of due process protecting doctors against unjustified complaints and is there therefore some reluctance because there is a feeling that doctors do receive a lot of unjustified complaints and that they are unprotected by the law; is this part of the problem?

Dr. DERBYSHIRE. Well, I think part of the problem is fear of lawsuits, of being sued for libel. I just came from San Antonio where we had a discussion on this at the Federation of the State Medical Boards of the United States. I was amazed to find that in only a few States did the law protect the members of the disciplinary board against a lawsuit.

Furthermore, practically none of the States had bureaus of risk protection whereby the—in case there was a suit without malice, that the State would defend the member of the board. This is a serious situation because all doctors are mortally afraid of lawyers and lawsuits, you are aware of that.

Chairman HEINZ. Dr. Derbyshire, one last question.

We are going to hear testimony today, indeed some of us I think feel the same way, that Congress should give the Secretary of Health

and Human Services the authority to have nationwide sanctions on a doctor that loses a license in a single State.

In your opinion, is the losing of a license in an individual State a reasonable basis for excluding participation of a doctor in medicare, medicaid, or other Federal health programs?

Dr. DERBYSHIRE. I certainly do, sir.

Chairman HEINZ. Thank you very much.

Senator Glenn.

Senator GLENN. Thank you, Mr. Chairman.

Doctor, this Federation of State Medical Boards, do they have the capability to do the job for the whole country?

Dr. DERBYSHIRE. This is as it implies, Senator Glenn, it is a federation, a loose federation of all of the State boards. The greatest contribution they have made as far as I know, in the last 75 years, is the establishment of uniform licensure examinations, which is far superior to the way we used to do it before. But they have no statutory authority, they can just advise.

Senator GLENN. I was wondering if they could be the action area for keeping track of this thing like we have from national groups that keep track of a number of different matters.

Dr. DERBYSHIRE. If the States will report, they can do it. But the reporting still is not as it should be.

Senator GLENN. You said in your testimony that, at present, only 15 States have laws to permit the disciplinary board to take action against a doctor who has been disciplined in another State for an offense listed in its statutes. In fact, some States forbid such action.

Dr. DERBYSHIRE. I did say so. That is true. My feeling is that all States should have similar laws.

Senator GLENN. Well, I think so too. How many States would forbid such action? Is that a sizable number of States?

Dr. DERBYSHIRE. I do not know. I got that from the GAO report and they did not give numbers.

Senator GLENN. Where do the incompetent doctors come from? I have not read all of the GAO report yet, but have there been any studies of that? Are there medical schools that are turning out incompetents or are there more foreign doctors coming in ill-trained from foreign schools, do we have any pattern there that would also be worth looking into?

Dr. DERBYSHIRE. I have made only a superficial study and with the help of the American Medical Association I have not been able to determine that disciplinary actions among foreign medical graduates are more numerous than those among American graduates.

Senator GLENN. Are there any particular schools in this country that appear to be sufficiently below level, that are turning out incompetents who are more likely to get disciplined than others?

Dr. DERBYSHIRE. Do you understand I used the term "incompetents" broadly, psychiatric illness, drug addiction, and so forth. I cannot see that there is much difference between the graduate of Harvard Medical School or any of the rest of them. It is widely dispersed and most of these are due to mental illness.

Senator GLENN. You mentioned, I think, that up to 60 percent of these cases may be narcotic related.

Dr. DERBYSHIRE. Yes, sir.

Senator GLENN. Is that correct?

Dr. DERBYSHIRE. That is a pattern that has gone on through the years and by narcotics violations, I mean violations of the law, selling narcotics for resale on the street, drug addiction, that is unfortunately too common among doctors. It has been estimated that 100 doctors will relapse into—or will lapse into addiction every year. That is part of what my estimate of 10 percent is based upon.

Then we have the alcoholics, of course, and they are harder to detect than some of the others because, unfortunately, alcohol is, as you know, a socially acceptable dangerous drug. And so it is rather difficult to get at those people, a lot of them.

What is the difference between a social drinker, a heavy social drinker, and an alcoholic?

Senator GLENN. What is the most common type of sanctions against doctors?

Dr. DERBYSHIRE. All of the States try to rehabilitate these people if they possibly can and by rehabilitation they think if there is any chance at all that this can be done without danger to the public, they might suspend the license for 6 months and insist that the doctor go into some form of treatment. If the case is not so severe, they—the board—will lay down very strict rules for his probation with the hope that he can be rehabilitated and returned to practice as a useful citizen.

But if he violates one term of his probation, he is through. His license is revoked.

Senator GLENN. What difficulties face a doctor who decides to represent his or her profession by sitting on a medical licensing panel? Do they face some problems themselves?

Dr. DERBYSHIRE. They face personal problems, shall we say and——

Senator GLENN. Is that a problem on tooting the whistle on the incompetents?

Dr. DERBYSHIRE. That is right. And you asked me what effect this has. These people usually work for practically nothing, just per diem and travel time, that is about all. A lot of these people are very hard-working, they are in active practice and I can remember one case which we had a hearing that went 5 days and half the night and all of us were practicing physicians, very busy and terribly worried about what we left at home. I do not mean to be crying on your shoulder but that is what a lot of these people have to put up with.

Another thing is if they have served conscientiously on a board, this is no guarantee that they will win popularity contests from their colleagues.

Senator GLENN. Yes.

Half a million doctors or 450,000 in the country is not a large number by modern statistical capabilities that we have.

Do you think that we need—is there additional law needed on this or is there sufficient authority now in Health and Human Services to go ahead and set up a system; do we need additional law, in your opinion?

Dr. DERBYSHIRE. Just State laws, that is all.

Senator GLENN. Do we need a Federal law to take care of this across the whole country?

Dr. DERBYSHIRE. Well, if it would be constitutional—excuse me, I am not a lawyer, but——

Senator GLENN. I am sure it would be constitutional.

Dr. DERBYSHIRE. We could do it by regulation and I am very much in favor of that.

Senator GLENN. Yes; I was just questioning whether we need a new law on the books or whether there is existing authority in HHS now, in your opinion, to do this on your own?

Dr. DERBYSHIRE. As far as I know we need a new law.

Senator GLENN. Thank you.

Chairman HEINZ. Senator Glenn, thank you very much.

Senator Melcher.

Senator MELCHER. Doctor, you recited an old proverb, every dog is entitled to one bite.

As a veterinarian, I would like to put a proviso on there, provided the dog does not have rabies.

Dr. DERBYSHIRE. Oh, thank you, sir.

Senator MELCHER. In my State for a veterinarian you cannot get a license to begin with if you have ever been convicted of a felony. And you lose the license, period, upon conviction of a felony, if you commit a felony after acquiring a license. I assume that is pretty much the standard for medical doctors in all States.

However, the State laws do govern licensing procedures and I assume, doctors, that you have served sometime during your career on a State licensing board?

Dr. DERBYSHIRE. Yes, sir, for 31 years.

Senator MELCHER. For 31 years. And what State?

Dr. DERBYSHIRE. New Mexico.

Senator MELCHER. That speaks for itself on your authority to give us rather expert advice in this field.

However, in one State if a physician has lost his license and attempts to be licensed in another State, that is not going to happen, is it?

Dr. DERBYSHIRE. Will he be licensed in another State? Oh, he can be.

To get back to one of my original examples, the manifestly incompetent doctor whose license was revoked, he went to Florida and then he decided that he wanted to go to the District of Columbia. He obtained a license in the District of Columbia but the authorities finally found out that he perjured himself on his application and they revoked his license. But yet they still let him continue practicing in New York.

Senator MELCHER. He had already had his license in New York, however, right?

Dr. DERBYSHIRE. Yes, sir, and he already had a license in Florida but he decided maybe he wanted to get one in the District of Columbia.

Senator MELCHER. He only obtained that license however on committing perjury?

Dr. DERBYSHIRE. It was revoked on the basis of perjury. Oh, yes, he obtained the license on the basis of perjury, yes.

Senator MELCHER. And that perjury was to the effect that he had not admitted to the revoking of his license in Florida?

Dr. DERBYSHIRE. That is right, in another State.

Senator MELCHER. That is right.

So it is a question of somebody who has obtained, as a graduate for instance, a recent graduate obtained four licenses, perhaps, while he is fresh and can answer all the questions.

Dr. DERBYSHIRE. The record is 12, sir, in my experience.

Senator MELCHER. The record is 12. And then taking advantage of those previous licensures he moved from one State to another in what you call State-hopping?

Dr. DERBYSHIRE. Yes, sir.

Senator MELCHER. Now for us you have answered the Chairman's question on whether revocation of a license was serious enough in your opinion to a ban, that is revoking the license in any State, whether that was serious enough to ban that physician from practicing medicine in the realm of medicare or medicaid from then on and you have answered in the affirmative, you thought it was serious enough.

Dr. DERBYSHIRE. I do.

Senator MELCHER. Now, my question to you is this: How about sanctions? Something less than revoking the license in a particular State but nevertheless a very serious charge and a very serious punishment leveled by that licensing board in that State. Do you believe that while that physician is sanctioned in any State that it is serious enough to ban that physician from practicing medicine on medicare and medicaid patients?

Dr. DERBYSHIRE. I do, sir.

Senator MELCHER. Thank you very much, because I think a Federal law can require just that and I agree with you that I think a law is required and is reasonable.

Dr. DERBYSHIRE. May I add something, Mr. Chairman?

I think that your veterinary board standards may be higher than ours. You said that you could revoke a license for any felony?

In going over these, some of the felonies that have been committed by physicians, everything from kidnaping to armed robbery and so forth, I do not say that there is a crime wave in the profession, but there are a few who cause trouble.

Senator MELCHER. I believe you also mentioned rape and drugs—illegal sale or illegal use of narcotics, and in my State that would be a felony, and I think in most States it would be. Either one would be a felony.

Dr. DERBYSHIRE. But you would be surprised at how few States take action against this. They put the doctor on probation.

What would be the terms of probation? I promise not to rape any more nurses or what? I do not know.

Senator MELCHER. Would probation fall—I would assume that probation fell in the broader category of sanctions.

Dr. DERBYSHIRE. Yes, sir, there are four or five things a State can do. Revocation, suspension, probation, reprimand and the reprimand of two types: private and public where it becomes a public record and the press has access to it.

Senator MELCHER. So in all those instances I would include all of those sanctions. And while they were in effect I would think it appropriate that Federal law prohibit——

Dr. DERBYSHIRE. Well, I was expressing my personal opinion when I said I felt that doctors found their fellow physicians who exchanged

narcotics for sexual favors. I think that such a doctor should be banned from the profession for life, but maybe I am a bit Puritannical, I do not know.

Senator MELCHER. I do not think so.

Thank you very much, doctor.

Chairman HEINZ. Thank you very much, Senator Melcher.

Senator Wilson, if you have any opening statement or any comments you care to make in addition to questioning the witness, we would be pleased to have it. We welcome you.

STATEMENT BY SENATOR PETE WILSON

Senator WILSON. Thank you very much, Mr. Chairman. I commend you for conducting this important hearing. I think that when the Federal Government is spending almost $60 billion on medicare and $20 billion on medicaid, we have abundant reason to be concerned. In fact, we have a duty to be concerned about what appears to be a glaring loophole in State laws that allow those who are really not fit to practice medicine in any State to escape from one only to subject patients in another State to very real jeopardy.

Doctor, let me ask this: It seems that there is no great consistency between the States, to put it mildly from your testimony, and in a number there are inadequate safeguards, but for those States that do take the trouble and who are concerned to safeguard patients from professional incompetents, is there any sort of adequate device possible that will allow a cearinghouse to function to give warning if a physician has lost his license, for example, if he has been revoked in New Mexico and he goes to California and California authorities wish to safeguard their patients, how may they learn of his shortcomings?

Dr. DERBYSHIRE. Well, they communicate with the State in which the offense has been committed, that is the easiest way to do it.

You are talking about clearinghouses, the American Medical Association keeps an extensive file on all doctors from the time they enter medical school until they die. And routinely, we have communicated with the American Medical Association saying: "Has any disciplinary action ever been taken against this physician?"

The AMA has been extremely reluctant, for obvious reasons to me, because of the danger to lawsuits and they have enough lawsuits on their hands as it is, they are reluctant to give this information. But they have relaxed their policies now to the extent that they will say: "I suggest that you communicate with the Louisiana board," or whatever board they know about. And then the onus is on the State board.

Senator WILSON. Suppose California contacted Louisiana, and I do not know that this is the case, purely hypothetical, let us say that they contact State X from which the doctor has come. There is on file no record of disciplinary action but only some record, as I gather is true in some States, that the doctor has voluntarily ceased to practice. Is there no way that they can go behind that rather blank record.

Dr. DERBYSHIRE. Well, if the doctor—this is a euphemism of course—if a doctor finds that he is under the gun too much, rather than go through an extensive hearing and be exposed to much unfavorable publicity he will voluntarily surrender his license. And that is equivalent to revocation, in my opinion, because he is finished.

Senator WILSON. And is it a universal practice among the States that someone who has been practicing elsewhere, and who comes into a new State in order to be able to practice there he has to be licensed by that State. And I assume that they automatically check with the State from which he came.

Dr. DERBYSHIRE. Yes, sir.

Senator WILSON. So that the real problem you think is not with respect to those procedures, it is more with respect to the laxity of the performance criteria of the individual States as it relates to the practice of an incompetent physician there? It is not that the new State cannot find out?

Dr. DERBYSHIRE. They easily can. Sometimes they do not.

May I give an example? A doctor's license was revoked in one State for gross incompetence and he went to another State in which he was already licensed and the State wrote to the secretary of the original State and said: "Will you send us a transcript of the hearing?" This is part of the distrust that States have. You can imagine how thick the transcript was. The hearing lasted 2 days and the secretary sent this promptly. Six months later there was a request from this State: "Will you please send us a transcript of the hearing?"

Now, this is just plain inefficiency as far as I am concerned. The State went ahead and sent it but we have a certain amount of laxness and inefficiency among the boards, I regret to say.

Senator WILSON. You feel I gather from your response to Senator Melcher that with respect to at least the involvement of the Federal Government in terms of our funding that a Federal law that makes requirements is in order?

Dr. DERBYSHIRE. Yes.

Senator WILSON. Thank you very much.

Chairman HEINZ. Senator Wilson, thank you very much.

Senator Bingaman.

Senator BINGAMAN. Thank you, Mr. Chairman.

Doctor, we are glad to have you here in Washington testifying. I appreciate your testimony.

Let me just ask—it sounds like there are a series of problems here. One is boards do not get adequate information with which to properly discipline physicians. Perhaps secondly they do not have the necessary authority and the statutes to properly discipline physicians. Third, they perhaps do not have the necessary competence to keep track of these cases and discipline them. Fourth, they may not have the will because of the problems of living in the profession and not wanting to become unpopular among their colleagues. And I guess fifth, you mentioned that they may have problems in their own liability because of libel actions, that type of thing. You do not have the necessary legal protection.

Can you identify those problems that you believe enter into the difficulties and, if so, can you identify any one that is more in need of attention than the others?

Dr. DERBYSHIRE. Just one? Will you give me two?

Senator BINGAMAN. Go ahead, pick out the top two out of those five.

Dr. DERBYSHIRE. Well, some years ago, not too long ago I conducted a study of all of the State boards and sent out a questionnaire. The main questions were: Is your board adequately funded? No. 2, do you have an adequate number of investigators? And along that line. Eighteen of the 50 boards in the United States said they were not adequately funded, and I am not justifying laxness, you understand that, but as you probably know the highway department can get just about anything they want but then the legislature starts economizing, they cut down on the budget of the small agencies like the board of medical examiners. This is a serious problem.

The second thing is I believe that politics enter into this too much. There is an article on that in this collection to which I referred and I think that there are too many doctors on boards who know the respondent too well and maybe they are friends of his and they take it upon themselves to be advocates for this person, ask him all sorts of leading questions that makes him look good. And I think that that doctor who knows the respondent well or who gets referred work from him should disqualify himself. But there is no law that says he must.

Senator BINGAMAN. Doctor, would it be fair to say that if the information problem was solved some of these others might solve themselves in the sense that if there was a national clearinghouse that listed whatever disciplinary action was taken against any physician by a State board, and that information was not only available to State boards but was public information, would that not cause a board to respond more responsibility?

Dr. DERBYSHIRE. I certainly do.

Senator BINGAMAN. Do you think that would help?

Dr. DERBYSHIRE. Yes, sir; I do. And I do not care whether the computer is connected with the highway, what is it, the drivers' license bureau or anything else. Just as long as they have access to this.

Senator BINGAMAN. So that if the information were there is a central place and if it was public information so that everybody could get a copy, then that would help the problem substantially, in your view?

Dr. DERBYSHIRE. Of course I do not have to tell the ex-Attorney General about the law, but of course we have been warned repeatedly not to report anything until the case is completed, and there has been a court decision if necessary.

You will agree with that, I think.

Senator BINGAMAN. Yes, I will. OK. That is really all I had.

Thank you very much, Mr. Chairman.

Chairman HEINZ. Senator Bingaman, thank you.

Dr. Derbyshire, I want to thank you for some truly excellent testimony. We appreciate your being here. Thank you so very much.

Dr. DERBYSHIRE. I thank you for inviting me, sir, and members of the committee.

Chairman HEINZ. Next I would like to have those witnesses representing the General Accounting Office and the Office of the Inspector General please come forward to the witness table.

We are going to hear first from Michael Zimmerman, the Associate Director of the Human Resources Division of the GAO. He is accompanied by Tom Dowdal, Group Director, Human Resources Divi-

sion and Don Warsing, Evaluator, Human Resources Division of the GAO. These two men are responsible for completing the General Accounting Office report on sanctioned medical practitioners that I have here in my hand.

This report which they are introducing today documents the Government's shocking inability to protect patients at federally-supported health programs from unfit doctors that we just had described to the committee.

In addition, we have with us today Richard P. Kusserow, the Inspector General for the Department of Health and Human Services. In general, it is Mr. Kusserow's office upon which the burden falls to protect Federal beneficiaries and Federal health dollars.

First I would like to call upon the GAO.

Please proceed.

STATEMENT OF MICHAEL ZIMMERMAN, WASHINGTON, DC, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY TOM DOWDAL, GROUP DIRECTOR, HUMAN RESOURCES DIVISION; AND DON WARSING, EVALUATOR, HUMAN RESOURCES DIVISION

Mr. ZIMMERMAN. Thank you.

Mr. Chairman and members of the committee, we are pleased to be here today to discuss the need for expanded Federal exclusion authority for practitioners to help ensure that medicare and medicaid recipients receive quality care.

Our review showed that medicare and medicaid patients are in fact being treated in some States by health practitioners whose licenses were revoked or suspended in other States.

Chairman HEINZ. Mr. Zimmerman, I just want to say for the record I notice you are summarizing your statement.

Mr. ZIMMERMAN. That is correct.

Chairman HEINZ. Your entire statement will be made a part of the record.

Mr. ZIMMERMAN. Thank you.

These practitioners were able to continue practicing under medicare and medicaid because existing Federal exclusion authority does not permit a national exclusion of practitioners who are found by State licensing boards to have failed to meet minimum professional standards. Accordingly, the Federal Government's assurance that medicare and medicaid recipients receive quality care is diminished.

The first part of my statement will focus on the need for expanded Federal exclusion authority. Next, I will briefly discuss the need to include all exclusions and sanctions in HHS's planned information system on sanctioned providers and practitioners. Both of these issues are discussed in our report.

Licensing of health care professionals is a responsibility of the States, and practitioners can hold licenses in more than one State. Medicare and Medicaid Program administrators are responsible for determining that practitioners are licensed in the State where they practice before paying claims for services they provide, normally by contacting the various State licensing boards. When a State licensing

board revokes or suspends a practitioner's license, he or she can no longer legally provide services in that State and the State licensing board makes medicare and medicaid aware of this.

In our review of licensing boards' disciplinary actions in Michigan, Ohio, and Pennsylvania we identified 328 health care practitioners from 6 professions who had their licenses revoked or suspended for 1 year or more, or surrendered them for disciplinary reasons, during the period January 1, 1977, through December 31, 1982. These sanctions were imposed when the practitioners did not meet professional standards because they had problems—such as alcohol and drug abuse—or committed acts such as malpractice, sexual offenses, or drug trafficking.

State boards which are responsible for assuring that practitioners are qualified to treat patients, can sanction practitioners for their actions related to any patient. However, HHS is responsible only for practitioners' participation in medicare and medicaid and can exclude practitioners only for acts committed against these programs and their beneficiaries. Because of these differences, HHS excludes relatively few of those practitioners sanctioned by State boards.

There are also differences in the reasons for State sanctions and HHS exclusions although the reasons for both types of action are serious. Over 70 percent of the HHS exclusion actions were for criminal violations against the programs, such as fraud.

However, 58 percent of the 328 licensing board sanctions in the three States were for problems that affected the practitioners' ability to meet minimum professional standards or to provide quality care.

Reasons for State sanctions nationwide are similar to those in the three States. For example, 61 percent of the actions nationwide reported by the Federation of State Medical Boards during a 4-year period involved problems that affected quality of care as compared to the 58 percent we found in the three States in our review.

The problems that caused the physicians to lose their licenses are serious. However, it is important to note that the problems involved only a small percentage of the Nation's physicians. For example, in 1982 only 1 in 1,000 physicians lost their licenses for disciplinary reasons.

Of the 328 practitioners sanctioned by the three States, 122 held licenses at least 1 other State at the time of the sanction. Having licenses in other States permits sanctioned practitioners to move to another State and continue practicing.

Of these 122 practitioners, 30 corrected their problems, retired, or died. The other 92 had to relocate if they wanted to practice. We were able to trace 49 of these practitioners to other States and found that 39 obtained provider numbers to directly bill Medicare and Medicaid Programs. The other 10 relocated, but did not obtain a provider number. They could be serving Medicare and Medicaid patients in a hospital, clinic, or other institution where the institution and not the practitioner bills the two programs for services provided. We could not determine the whereabouts of the other 43.

Of the 39 practitioners who moved to other States and enrolled in the Medicare and Medicaid Programs, 28 originally lost their licenses because they committed acts or had problems which, according to the State licensing boards, showed that they did not meet minimum pro-

fessional standards. The other 11 practitioners were sanctioned by the States for various criminal activities. Only three of these practitioners were excluded by HHS from participation in medicare and medicaid. This permitted the others to participate in the two programs in other States and, in some instances, commit the same or similar acts.

State licensing officials said the main reason for allowing practitioners to remain active in their States was that they did not know about disciplinary actions in other States. In cases where they were informed and considered the offenses serious enough to remove the practitioners' licenses, they usually were not informed of the other States' actions in a timely manner. In addition, when States are informed, it takes up to 3 years to sanction practitioners because of the procedures they must follow.

Under current law, HHS can exclude practitioners from participation in medicare and medicaid. However, we believe that HHS's current exclusion authority is insufficient in the following instances:

Practitioners who lose their right to participate in medicaid in one State for such reasons as habitual overutilization can continue to practice under medicare in that State or relocate to another where they hold a license and practice under medicare and medicaid.

Practitioners who lose their right to participate in medicare for such reasons as providing inappropriate care can continue to participate in medicaid in any State where they hold a license.

Practitioners who lose their license in one State can relocate to another State where they hold a license and practice under medicare and medicaid.

Practitioners convicted of crimes other than medicare and medicaid fraud can continue to practice under medicare and medicaid.

The kinds of situations when HHS cannot nationally exclude practitioners discussed above involve serious problems. Practitioners have been found unfit to participate in medicare or medicaid in a particular State, or have been found unfit to practice in one State. We believe that to protect all medicare and medicaid patients from practitioners found unfit, HHS needs the authority to nationally exclude them from participation in these programs after reviewing the findings that caused action to be taken against the practitioners. Also, if HHS could sanction nationally a practitioner sanctioned by a State licensing board, it would help eliminate the lag time between action in one State and action in other States where a practitioner holds the licenses.

The Office of Inspector General plans to submit legislation which will expand the current exclusion authority to cover convictions for drug-related offenses and other crimes, and to exclude nationally from medicare and medicaid practitioners excluded from either program for reasons other than a criminal conviction against one of the programs. We are recommending that this legislation proposal be expanded to provide for a national exclusion when a practitioner has been sanctioned by a State licensing board.

HHS is also establishing a reporting system which will include public information on practitioners who have been excluded from Federal health care programs and from other public and private health care payment programs that choose to participate in the information system.

However, HHS is not planning to include initially in this system practitioners sanctioned by State licensing boards.

We believe that to be effective the system should include public information on all practitioners sanctioned by States because they committed acts or have problems that resulted in State licensing boards determining that these practitioners did not meet minimum professional standards.

We are recommending that the information system include all practitioners sanctioned by State licensing boards.

Mr. Chairman, this concludes my statement.

We will be glad to respond to any questions that you may have.

Chairman HEINZ. Mr. Zimmerman, thank you. I am going to withhold questions until after we hear from Mr. Kusserow.

[The prepared statement of Mr. Zimmerman follows:]

PREPARED STATEMENT OF MICHAEL ZIMMERMAN

Mr. Chairman and members of the committee, we are pleased to be here today to discuss the need for expanded Federal exclusion authority for practitioners to help ensure that medicare and medicaid recipients receive quality care. While reviewing how the medicare and medicaid programs operate, we noted that it was possible for medical practitioners—medical doctors, osteopathic doctors, podiatrists, chiropractors, dentists and pharmacists—who held licenses in more than one State, to have one of these licenses suspended or revoked by a State licensing board but relocate and continue to treat medicare and medical patients.

Our review showed that medicare and medicaid patients are in fact being treated in some States by health practitioners whose licenses were revoked or suspended in other States. These practitioners were able to continue practicing under medicare and medicaid because existing Federal exclusion authority does not permit a national exclusion of practitioners who are found by State licensing boards to have failed to meet minimum professional standards. Accordingly, the Federal Government's assurance that medicare and medicaid recipients receive quality care is diminished.

The first part of my statement will focus on the need for expanded Federal exclusion authority. Next, I will briefly discuss the need to include all exclusions and sanctions in the Department of Health and Human Service's (HHS's) planned information system on sanctioned providers and practitioners. Both of these issues are discussed in our report "Expanded Federal Authority Needed to Protect Medicare and Medicaid Patients From Health Practitioners Who Lose Their Licenses" (GAO/HRD-84-53), which was issued today.

BACKGROUND

Licensing of health care professionals is a responsibility of the States, and practitioners can hold licenses in more than one State. HHS administers medicare and medicaid at the Federal level. To participate in these programs, a practitioner must hold a valid State license. Medicare and medicaid administrators are responsible for determining that practitioners are licensed before paying claims for services they provide, normally by contacting the various State licensing boards. When a State licensing board revokes or suspends a practitioner's license, he or she can no longer legally provide services in that State and the State licensing board makes medicare and medicaid aware of this. However, sanctioning action by one State does not automatically result in sanctioning by other States where the same practitioner holds licenses.

Although the specific procedures vary somewhat from State to State, the sanctioning process generally proceeds as follows. The State licensing board becomes aware of a possible problem with a practitioner. The board conducts an investigation and notifies the practitioner of the findings. The practitioner is informed of potential actions and of his or her right to a hearing. If the board decides to suspend or revoke the practitioner's license, he or she has the right to appeal the decision administratively and/or through the courts.

SANCTIONED PRACTITIONERS MOVE TO OTHER STATES AND TREAT MEDICARE AND MEDICAID PATIENTS

Nationwide, relatively few disciplinary actions are imposed by individual States to protect their citizens from being treated by incompetent, unethical, and/or unqualified health care practitioners. In our review of licensing boards' disciplinary actions in Michigan, Ohio, and Pennsylvania we identified 328 health care practitioners from six professions who had their licenses revoked or suspended for 1 year or more, or surrendered them for disciplinary reasons, during the period January 1, 1977, through December 31, 1982. These sanctions were imposed when the practitioners did not meet minimum professional standards because they had problems—such as alcohol and drug abuse—or committed acts—such as malpractice, sexual offenses, or drug trafficking.

State licensing boards sanction many more practitioners than HHS excludes from participation in medicare and medicaid. The boards, which are responsible for assuring that practitioners are qualified to treat patients, can sanction practitioners for their actions related to any patient. However, HHS is responsible only for practitioners' participation in medicare and medicaid and can exclude practitioners only for acts committed against these programs and their beneficiaries. Because of these differences, HHS excludes relatively few of those practitioners sanctioned by State boards. For example, while the licensing boards in Michigan, Ohio, and Pennsylvania sanctioned 328 practitioners in 1977–82, HHS nationwide excluded 335 practitioners from September 1975 through December 1982. Also, only 15 of the 328 practitioners sanctioned by the three States were also excluded by HHS.

There are also differences in the reasons for State sanctions and HHS exclusions although the reasons for both types of action are serious. Over 70 percent of the HHS exclusion actions were for criminal violations against the programs. However, 58 percent of the 328 licensing board sanctions in the three States were for problems that affected the practitioners' ability to meet minimum professional standards or to provide quality care. We found that 189 State sanctions (58 percent) were taken because of such problems as malpractice, alcohol, drug abuse, and immoral conduct which affect quality of care. Seventy-five (23 percent) were due to drug trafficking, drug sales, or violation of the Controlled Substance Act; 29 (9 percent) of the practitioners were sanctioned for criminal acts of private insurance fraud; and 28 cases (8 percent) occurred because of the practitioners submitting false medicare or medicaid claims. Seven sanctions (2 percent) were for other reasons.

Reasons for State sanctions nationwide are similar to those in the three States. Information reported nationally by State licensing boards to the Federation of State Medical Boards for 1979–82 on 1,388 practitioners showed that the reasons for actions taken in Michigan, Ohio, and Pennsylvania are similar to the reasons for actions taken by licensing boards throughout the Nation. For example, 61 percent of the actions reported by the federation involved problems that affected quality of care as compared to the 58 percent we found in the three States in our review.

The problems that caused the physicians to lose their licenses are serious. However, it is important to note that the problems involved only a small percentage of the Nation's physicians. For example, in 1982 only about 1 in every 1,000 physicians lost their licenses for disciplinary reasons.

Of the 328 practitioners sanctioned by the three States we identified, 122 held licenses in at least one other State at the time of the sanction. Having licenses in other States permits sanctioned practitioners to move to another State and continue practicing. Of these 122 practitioners, 30 corrected their problems, retired, or died. The other 92 had to relocate if they wanted to practice. We were able to trace 49 of these practitioners to other States and found that 39 obtained provider numbers to directly bill the medicare and/or medicaid programs. The other 10 relocated, but did not obtain a provider number. They could be serving medicare and medicaid patients in a hospital, clinic, or other institution where the institution and not the practitioner bills the two programs for services provided. We could not determine the whereabouts of the other 43.

When practitioners sanctioned by State licensing boards relocate, we believe serious questions arise concerning the quality of care provided by them to medicare and medicaid patients because there are no assurances that the problems that led to their sanctioning in one State were corrected before they began treating medicare and medicaid patients in other States.

PRACTITIONERS WHO HAVE PROBLEMS PRACTICE IN OTHER STATES

Of the 39 practitioners who moved to other States and enrolled in the medicare and/or medicaid programs, 28 originally lost their licenses because they committed acts or had problems which, according to the State licensing boards, showed that they did not meet minimum professional standards. The other 11 practitioners were sanctioned by the States for various criminal activities. Only three of these practitioners were excluded by HHS from participation in medicare and medicaid. This permitted the others to participate in the two programs in other States and, in some instances, commit the same or similar acts. For example:

—A medical doctor was found to be mentally impaired and unfit to practice medicine by the Michigan Medical Board in June 1978. He surrendered his Ohio license in the same year but moved to New York and received medicare and medicaid payments. In April 1982, New York revoked his license for gross incompetence based on another State's action.

—An Ohio dentist moved to Pennsylvania after he surrendered his license in Ohio because of drug usage and illegal possession of drugs. He participated in the medicare program in Pennsylvania. He also enrolled in the Pennsylvania medicaid program, but received no payments. In August 1983, the Pennsylvania medicaid agency took action to deny all future payments to him based on information received concerning a guilty plea in Pittsburgh to a Federal criminal charge of illegal prescribing practices.

—An osteopathic doctor was licensed in Michigan in 1949 and also obtained licenses in 13 other States. In March 1951, he was convicted of unlawfully selling drugs in Michigan and did not renew his Michigan license but continued to practice elsewhere. In 1964, he was convicted of illegal drug sales in Texas, and many States began taking sanction actions against him. He again obtained a Michigan license in January 1972. In 1982, he was convicted of illegal drug sales for the third time and sentenced to 10 years in prison. Over the years, he worked under a Public Health Service grant, at the Veterans Administration, and as part of a group practice in Michigan serving medicaid patients.

In summary, practitioners sanctioned by State licensing boards because they fail to meet minimum professional standards are moving to other States and treating medicare and medicaid patients. The continued participation of these practitioners in these programs raises serious questions about the quality of care some medicare and medicaid patients are receiving. There is no assurance that the practitioners corrected the problem that caused them to lose their licenses. They can continue to move and practice without correcting their problem until each State where they hold a license individually takes a sanction action against them.

ADDITIONAL AUTHORITY NEEDED AT THE FEDERAL LEVEL TO PROTECT MEDICARE AND MEDICAID BENEFICIARIES

A primary reason why sanctioned practitioners were able to go to other States to practice was that the other States never learned about the practitioners' previous offenses or, by the time they did, many months or years had passed. When States are informed, it takes up to 3 years to sanction practitioners because of the procedures that must be followed and the shortage of personnel to carry out these procedures. Specifically, for the 39 practitioners that we identified as relocating and practicing under medicare and/or medicaid after a State licensing board had revoked or suspended their licenses, as of October 1983, 18 had their licenses suspended or revoked in the other States where they held licenses and 21 still held licenses. The time elapsed between the initial sanctioning action and action by the other States averaged about 2.6 years, ranging from 6 months to 5.2 years. On the average, 3.5 years had elapsed since the 21 practitioners still holding licenses had been sanctioned by the initial State. The range was from 10 months to 8.7 years.

State licensing officials said the main reason for allowing practitioners to remain active in their States was that they did not know about discipinary actions in other States. In cases where they were informed and considered the offenses serious enough to remove the practitioners' licenses, they usually were not informed of the other States' actions in a timely manner. In addition, State

licensing laws may preclude a State from taking action based solely on another State's sanction.

Under current law, HHS can exclude practitioners from participation in medicare for a number of reasons:

—Conviction of a criminal act against medicare, medicaid, or title XX of the Social Security Act (section 1128).
—When HHS imposes a civil monetary penalty for acts against medicare or medicaid (section 1128A).
—Submitting false claims to medicare (section 1128).
—Habitually providing more services than necessary to medicare beneficiaries (section 1862(d)).
—Submitting medicare claims with charges that substantially exceed the practitioner's customary charges (section 1862(d)).
—Providing services to medicare beneficiaries that are of a quality which fails to meet professionally recognized standards of care (section 1862(d)).

HHS has authority to require all States to exclude practitioners from participating in medicaid only when the practitioner is convicted of a criminal act against medicare, medicaid, or title XX (section 1128) or when HHS has imposed a civil monetary penalty on the practitioner for acts against medicare or medicaid (section 1128A). If HHS excludes a practitioner from medicare for one of the other allowed reasons, it is required to notify State medicaid agencies of this but cannot require the States to exclude the practitioner from medicaid.

We believe that the current practitioner exclusion authority HHS has is sufficient in several respects. Our review of HHS's exclusion authority under medicare and medicaid showed four potential gaps:

—Practitioners who lose their right to participate in medicaid in one State for such reasons as habitual overutilization can continue to practice under medicare in that State or relocate to another where they hold a license and practice under medicare and medicaid.
—Practitioners who lose their right to participate in medicare for such reasons as providing inappropriate care can continue to participate in medicaid in any State where they hold a license.
—Practitioners who lose their license in one State can relocate to another State where they hold a license and practice under medicare and medicaid.
—Practitioners convicted of crimes other than medicare and medicaid fraud can continue to practice under medicare and medicaid.

The kinds of situations when HHS cannot nationally exclude practitioners discussed above involve serious problems. Practitioners have been found unfit to participate in medicare or medicaid in a particular State, or have been found unfit to practice in one State. We believe that to protect all medicare and medicaid patients from practitioners found unfit, HHS needs the authority to nationally exclude them from participation in these programs after reviewing the findings that caused action to be taken against the practitioners. Also, if HHS could sanction nationally a practitioner sanctioned by a State licensing board, it would help eliminate the lag in time between action in one State and action in other States where a practitioner holds licenses.

The Office of Inspector General acknowledges that the Social Security Act does not give HHS this authority. In fact, the Office plans to submit legislation which will expand the current exclusion authority to cover convictions for drug-related offenses and other crimes, and to exclude nationally from medicare and medicaid practitioners excluded from either program for reasons other than a criminal conviction against one of the programs. However, this proposal is too limited, and we are recommending that it be expanded to provide for a national exclusion when a practitioner has been sanctioned by a State licensing board.

HHS INFORMATION SYSTEM ON SANCTIONED PROVIDERS SHOULD BE EXPANDED

Through its Office of Inspector General, HHS is establishing an information reporting system which will include public information on practitioners who have been excluded from Federal health care programs and from other public and private health care payment programs that choose to participate in the information system. However, HHS is not planning to include initially in this system practitioners sanctioned by State licensing boards. We believe that to be effective the system should include public information on all practitioners sanctioned by States because they committed acts or have problems that resulted in State licens-

ing boards determining that these practitioners did not meet minimum professional standards.

We are recommending that the information system include all practitioners sanctioned by State licensing boards.

Chairman HEINZ. Mr. Kusserow.

STATEMENT OF RICHARD P. KUSSEROW, WASHINGTON, DC, INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. KUSSEROW. Thank you, Mr. Chairman.

Like Mr. Zimmerman, if I may summarize my comments now and submit the full text for the record?

Chairman HEINZ. Without objection, your entire statement will be a part of the record.

Mr. KUSSEROW. Thank you, Mr. Chairman.

We are delighted for an opportunity to come before you today and to explore this area of loopholes and gaps in our sanction authority and I know that Margaret Heckler, Secretary of Health and Human Services also shares this great concern as will be evident in my testimony.

The Medicare/Medicaid Programs provide health care to 51 million aged, infirm, and disadvantaged Americans.

Since 1965, there has been an enormous growth in these programs going from $5 billion in 1965 to nearly $80 billion last year. There has been a parallel growth of problems relating to false, fraudulent, or otherwise improper claims being submitted by health care providers.

As part of our effort in the department to step up the campaign against these types of wrongdoers, we have had two major weapons added to the Inspector General's arsenal. This is all a part of an effort to bring together the sanctioned resources of our department to deal with these types of problems.

In the last quarter of fiscal year 1983, Secretary Heckler transferred to our office from the Health Care Financing Administration the authority to suspend or terminate from participation in medicare/medicaid all health care providers who engage in fraudulent or abusive practices.

During the same period of time, the civil money penalties law providing tough monetary sanctions against health providers engaged in fraudulent practices was also formally implemented by the department.

Under these sanctioning authorities, health care professionals engaging in improper practices can be suspended from participation in the Medicare and Medicaid Programs and/or financially penalized. They also provide for termination of agreements between the department and hospitals, nursing homes and other institutions engaging in similar acts.

Under various sections of the Social Security Act as amended, an administrative sanction may be imposed on an individual who:

1. Submits false claims or statements for payment.
2. Submits or causes to be submitted bills or requests for payment containing charges substantially in excess of customary charges.

3. Furnishes services which are determined to be substantially in excess of the needs of the patients.

4. Furnishes services which are determined to be of quality failing to meet professionally recognized standards of health care.

5. Fails to keep adequate medical records to demonstrate the need for services rendered.

In addition, criminal convictions related to either medicare or medicaid are grounds for suspension from those programs.

A provider sanctioned under any of the above authorities is excluded for specific periods of time in almost all cases.

At the end of the period the provider may apply for reinstatement but reinstatement to the program is contingent on our determination that the offense is not likely to recur.

It should be noted that the State and local agencies responsible for licensing or certification are notified of the suspension and are requested to invoke a sanction in acordance with applicable State law or policy.

Since this transfer of the sanction authority to our office 9 months ago, the Office of the Inspector General has imposed 480 sanctions, a figure which is 1½ times the total cumulative sanctions that have been applied in the previous 11 years.

Since the authority has been in existence within the department, we have had a very small amount of sanctioning activity until the last quarter of last fiscal year. We are taking an active role in our department in pursuing criminal investigations and eliminating all administrative loopholes which breed fraud, waste, and abuse.

Pursuant to our civil money penalty authorities, our office has collected also more than $5 million in the last 9 months for recycling to the health care programs.

The civil money penalties law and the new suspension-exclusion authorities are very potent weapons. Coupled with the fact that would be defrauders among the health care providers now face an increased risk of imprisonment, these sanctions should underscore the message that the total resources of our office are massed in an all-out effort to root out those few who would tarnish their profession by preying on our health care programs. That should go a long way to correct the attitudes conducive to fraudulent behavior.

The findings that Mr. Zimmerman presented on behalf of GAO this morning are ones in which we concur. Our staff has had ongoing discussions with GAO during the past year. From the date of the transfer of the sanction authorities to our office we became acutely aware of gaps that exist in our present sanctioning authority. Although the transfer of the sanctioning authorities from HCFA to our office in 1983 represented a major step in the right direction, many gaps in these authorities still exist, some to which GAO has alluded.

For example, we are unable to bar individuals or entities that have demonstrated patterns of fraudulent behavior and have been convicted of defrauding private health care insurors or defrauding other Federal, State, or local government programs.

Take the following case as an example of the concerns we cannot address under existing authorities.

We recently sanctioned a doctor, a nurse, and a coowner of an abortion clinic for submitting false medicaid claims over a 3-year period.

The amount of false claims came to over $2 million. These persons had already been convicted by a State court. The sentence amounted to 3 years probation and restitution of $540,000 for all three. We sanctioned each for a period of 7 years, respectively, from the Medicare and Medicaid Programs. However, the clinic still operates, which was a point agreed to with the State during a plea bargaining session. Because there exists a gap in our sanctioning authority, we cannot stop reimbursement to the clinic except to specific services that we can prove were provided by one of the individuals that we have sanctioned.

There are many other instances that we have found of health providers who have been sanctioned as individuals that are a part of group practices and the group practice continues to bill. We believe that this is a major way in which health care providers can circumvent the sanctioning process during the period of their exclusion or suspension.

Based upon our review of existing authorities, we have begun drafting legislative recommendations for modifications which are needed to plug the remaining loopholes available to abusers of the health care programs administered by our department.

Included in our recommendations are requests for such authorities as the ability to exclude individuals or entities from medicare or medicaid that have been convicted, in connection with either the delivery of health care, or a Federal, State, or local government program, of (1) fraud or financial abuse, or (2) neglect or abuse of patients. We are recommending authority to exclude those convicted of unlawful manufacture, distribution, or dispersing of controlled substances.

Further, we are asking for legislation to exclude those individuals who have been sanctioned for defrauding or abusing the Medicaid Program from participation in the Medicare Program. With respect to civil monetary penalties, we are recommending legislation to permit unified judicial review of the imposition of monetary penalties and medicare and medicaid suspensions imposed under the civil monetary penalty statute; the subpoena power in all civil monetary penalty proceedings, not just in proceedings involving medicare; civil monetary penalties for claims submitted after the date of exclusion from medicare and medicaid pursuant to peer review organization determination; and increased State share of civil monetary penalty awards in order to encourage State investigation and referral of medicaid fraud cases. We are recommending grants of authority to terminate from medicare and medicaid participation providers or suppliers where one or more of its owners, managers, or directors have been convicted of medicaid or medicare-related crimes, or who have been sanctioned either by exclusion from program participation or by civil monetary penalties; exclude persons from participation in medicare and medicaid who are engaged in conduct which violates the anti-kickback provisions of the Social Security Act; exclude any entity that fails to grant immediate access upon reasonable request to the OIG for the purpose of review of records, documents, or other data necessary to the IG in performance of the statutory responsibility; set forth an expressed statute of limitations for civil monetary penalty proceedings; and make several technical clarifying amendments to those statutes granting authority to control fraud and abuse. Finally, I would submit, Mr. Chairman, that there should be a statu-

tory minimum exclusion period of 5 years for individuals convicted of a criminal offense related to our program.

If there are any questions at this time, I stand ready to answer them, Mr. Chairman.

Chairman HEINZ. Mr. Kusserow, thank you very much.

[The prepared statement of Mr. Kusserow follows:]

PREPARED STATEMENT OF RICHARD P. KUSSEROW

Good morning, Mr. Chairman, members of the committee, I am Richard P. Kusserow, Inspector General, Department of Health and Human Services. I am here today to discuss the work of our office regarding the administrative sanction authorities as they relate to the medicare and medicaid programs.

Americans spend over $300 billion a year on health care, annually. It has become this nation's third largest—and most vulnerable—industry. Medicare and medicaid, which together represent the second largest expenditure in the department, next to social security, provide health care to 51 million aged, infirmed and disadvantaged Americans.

Since 1965, federal funding for direct health care service has grown from $5 billion to nearly $80 billion last year. Along with the growth of these two programs has been the parallel growth of problems relating to the false, fraudulent or otherwise improper claims being submitted by health care providers. Stopping health care ripoffs and insuring that scarce funds reach those for whom they were intended, has become the number one priority of the OIG.

In an effort to strengthen the department's ability to protect the multi-billion dollar health care programs, two major weapons have been quietly added to the inspector generals arsenal. These invaluable weapons have helped launch an all-out, long-term counter attack against health care providers who would defraud or abuse this nation's fragile but vital medicare and medicaid programs.

In the last quarter of fiscal year 1983, Secretary Heckler transferred to the inspector general's office from the health care financing administration the authority to suspend or terminate from participation in medicare/medicaid all health care providers who engage in fraudulent or abusive practices. During the same time period, the Civil Money Penalties Law (CMPL), providing tough monetary sanctions, was formally implemented by the department, further empowering the inspector general to take action against health providers who abuse or defraud these programs. Let me add, Senator, that our acquiring such authorities could not have been achieved without your support and the assistance from persons such as you.

Under these sanctioning authorities, health care professionals engaging in improper practices can be suspended from participation in the medicare and medicaid programs and/or financially penalized. They also provide for termination of agreements between the department and hospitals, nursing homes, and other institutions engaging in similar acts.

Under various sections of the Social Security Act as amended, an administrative sanction may be imposed on one who:

(1) Submits false statements or claims for payment.

(2) Submits, or causes to be submitted, bills or requests for payment containing charges substantially in excess of customary charges.

(3) Furnishes services which are determined to be substantially in excess of the needs of patients.

(4) Furnishes services which are determined to be of quality failing to meet professionally recognized standards of health care.

(5) Fails to keep adequate medical records to demonstrate the need for services rendered.

In addition, criminal convictions relating to either medicare or medicaid are grounds for suspension from those programs.

A provider sanctioned under any of the above authorities is excluded for specified periods of time, in almost all cases. At the end of the period, the provider may apply for reinstatement but reinstatement to the programs is contingent on our determination that the offense is not likely to recur.

It should be noted that the State and local agencies responsible for licensing or certification are notified of the suspension and are requested to invoke a sanction in accordance with applicable State law or policy.

Since receiving the sanction authority nine months ago, the OIG has imposed 480 sanctions—a figure which is one and a half times the cumulative sanctions applied in the previous 11 years since the authority has been in existence within the department. The following cases, taken from our files, illustrate some of the crimes that scar this noble and caring profession:

—A physician was excluded for five years after a State Professional Standards Review Organization (PRSO) unearthed a pattern of poor quality of care, overutilization of service and improper record-keeping. The litany of charges against this doctor included: stating that he had performed a full rectal exam and found no abnormalities when, in fact, the patient had had a colostomy and was without a rectum and, noting that a female patient had normal breasts although one had been surgically removed.

—An anesthesiologist, convicted of filing false medicare claims, was also suspended for three years. He defrauded medicare of over $50,000 by inflating the amount of time he participated in operations.

—A psychiatrist, convicted on 20 counts of presenting false claims to medicare and medicaid, was terminated from the Medicaid Program for a 3-year period. She had billed for non-existent patients. She also billed individually for children she met each Saturday at a swimming pool for group therapy.

The OIG is taking an active role both in pursuing criminal investigations and in eliminating all administrative loopholes which breed fraud, waste and abuse. In this role, maximum resources are directed against the criminal and civil abuses occurring in these programs. The new civil money penalties authority provides another sanction tool in these efforts.

In 1981, concerned by testimony that up to 10 percent of all medicare and medicaid claims contain false information, Congress responded by authorizing the Department to develop and implement a program for the administrative imposition of civil money penalties against wrongdoers.

Until enactment of this landmark legislation, the Federal Government was limited to court prosecutions under the False Claims Act or the criminal code to compel restitution of funds illegally or improperly claimed. Criminal prosecutions were often times not forthcoming in many health care provider fraud cases. For a variety of reasons such as clogged court calendars, or insufficient dollar amounts the Department of Justice was unable to exercise its legal authority.

The CMPL was designed to deal with providers who submit bills for items or services not provided as claimed. It hits defrauders where it hurts—in the pocketbook. Over and above any prosecutive action, the Department now has the authority to impose assessments and penalties to recover dollars lost as a result of the submission of false claims. The law permits an assessment of up-to-twice the amount claimed—against any person or organization who knows or has reason to know that items or services were not provided as claimed. In addition, not more than $2,000 per each item or service improperly claimed may also be levied as a penalty. This insures that there is no unjust enrichment of wrongdoers, and that they pay a substantial penalty.

HHS regulations specify that the Inspector General of HHS will make the initial proposal to impose CMPL assessments and penalties. Persons receiving an initial proposal have the right to a hearing, and judicial review of any final departmental determination. Unless a hearing is requested, a person would have no further appeal rights. Hearings are recorded and the parties have the right to be represented by counsel, to present evidence and witnesses, to cross-examine and to present oral arguments and written briefs.

Our office has collected more than $5 million for recycling to the health care programs since passage of this no-nonsense legislation. The following are some recent CMPL cases:

—A doctor in the northeast continued to bill medicaid even after being suspended as a result of a criminal conviction. We recovered overpayments and penalties of approximately $120,000.

—An oxygen supplier in the West was billing for oxygen that was not supplied. We recovered $165,000 for over 2,000 false claims submitted.

—A pharmacist in the Midwest was making claims for payment for services not rendered. Recovery was $56,000. He was also indefinitely suspended from medicaid. His total number of false claims was well over 1,000.

Our office recently conducted a study of convicted medical practitioners and found that they rarely are willing to accept or admit to the guilt of their wrongdoing. Instead, a variety of convoluted rationalizations are routinely offered to

defend their actions. Their only expressed concern had been the possible loss of their license to practice, but even that was often considered a minimal risk compared to the potential payoffs from cheating.

There is the textbook example—one with which I know you are quite familiar—of a well-known cardiologist and author who bragged about filing nearly $1 million in false medicare, social security and workman's compensation claims. He was nabbed through extensive investigative work by our office, convicted on a representative 67 counts of fraud, sentenced to seven years incarceration, five years probation and a $300,000 fine. In a separate civil matter, this same physician and his wife agreed to settle a false claims suit for $500,000. He claimed his "psychopathology" made him fill out phony medicare and medicaid claims.

Unquestionably, the civil money penalties law and the new suspension-exclusion authority are potent weapons. Coupled with the fact that crooked health care providers now face an increased risk of imprisonment, these sanctions should underscore the message that the total resources of our office are massed in an all-out effort to root out those few who would tarnish their professions by preying on our health programs. That should go a long way to correct the attitudes conducive to fraudulent behavior.

The findings presented by GAO this morning are ones with which I can concur. My staff has had on-going discussions with GAO during the past year, and we are fully aware of the gaps that exist in our present sanctioning authorities. Although the transfer of the sanctioning authorities from HCFA to our office in 1983 represented a major step in the right direction, gaps in these authorities still exist.

For example, we are unable to bar individuals or entities that have been convicted of defrauding private health insurers or defrauding other Federal, State or local government programs. Take the following case as a sample of the concerns we can't address under existing authorities.

We recently sanctioned a doctor, a nurse and a co-owner of an abortion clinic for submitting false medicaid claims over a three year period. The amount of false claims came to over $2 million. These persons had already been convicted by State Court. The sentence amounted to 3 years probation and restitution of $540,000 for all three. We sanctioned each for a period of 7 years, respectively, from medicare and medicaid programs. However, the clinic still operates which was a point agreed to by the State during the plea bargaining session. Because there exists a gap in our sanctioning authority, we can not stop reimbursement to the clinic unless we can prove that a service is being provided by one of these three persons.

Based on our review of existing authorities, we have drafted legislative modifications which are needed to plug the remaining loopholes available to wrongdoers of health care programs. Included in our request are such authorities as:

—The ability to exclude individuals or entities from medicare or medicaid that have been convicted: (1) in connection with (a) the delivery of health care, or (b) a federal, state or local government program of any crime related to fraud, theft or financial abuse or with neglect, or abuse of patients; or (2) of unlawful manufacture, distribution, or dispensing of controlled substances.

—The ability to exclude those who have been sanctioned for defrauding or abusing the medicaid program from participation in the medicare program, and vice-versa.

Our full list of recommendations is attached and is being submitted for the record.

In addition, we also support the GAO recommendation that we be able to exclude nationally for an appropriate period of time a practitioner sanctioned by a state licensing board. At the present time, we have no authority to exclude a practitioner from the medicare and medicaid programs on the basis of state licensing board suspension or a revocation of a license, or if the practitioner has surrendered his license voluntarily. There needs to be a nexus between state board action and our authority to exclude a practitioner from medicare and medicaid. We would consider this to be another vital tool in our arsenal of weapons now being used to reduce fraud and abuse in the department's health care programs.

In conclusion, let me say that we plan to make it very difficult and costly for a health care provider to defraud or abuse the medicare or medicaid programs. I know that we have the support of every member of this committee in achieving that goal.

SUMMARY OF RECOMMENDED AMENDMENTS TO SANCTIONING AUTHORITIES

(1) Exclude individuals or entities from medicare or medicaid that have been convicted: in connection with (A) the delivery of health care; or (B) a Federal, State, or local government program, of: (a) fraud or financial abuse; (b) neglect or abuse of patients; or (c) unlawful manufacture, distribution, or dispensing of controlled substances.

(2) Exclude individuals or entities who have been sanctioned for defrauding or abusing the medicaid program from participation in the medicare program.

(3) Exclude an entity from medicare and medicaid where the owners, managers or directors of that entity have been convicted of medicare or medicaid related crimes.

(4) Exclude an entity from medicare and medicaid which fails to make required disclosures that it is owned or controlled by convicted individuals.

(5) Exclude individuals or entities from medicare and medicaid, who engage in conduct in violation of the antikickback provision in the Social Security Act.

(6) Exclude any individual or entity that fails to grant immediate access, upon reasonable request, to the OIG for the purpose of review of records, documents, or other data necessary to the IG in the performance of his statutory functions.

SUMMARY OF RECOMMENDED MODIFICATIONS TO CIVIL MONETARY PENALTIES LAW

(1) Permit unified judicial review of the imposition of monetary penalties imposed under the civil monetary penalty statute, and medicare and medicaid suspensions.

(2) Provide for subpoena power in civil monetary penalty proceedings.

(3) Provide civil monetary penalties for claims submitted after the date of exclusion from medicare and medicaid pursuant to a peer review organization determination.

(4) Increase State share of civil monetary penalty awards to encourage State investigation and referral of medicaid fraud cases.

(5) Add to the type of claims subject to civil monetary penalties claims that a person knew or had reason to know were false and fraudulent.

(6) Provide a six year statute of limitations for civil monetary penalty actions.

Chairman HEINZ. Mr. Kusserow, let me say that I think the last time that you were before one of my committees, I think it was the Finance Committee's joint hearing with the Aging Committee, you were relatively new in your responsibilities as Inspector General of HHS.

Subsequent to those hearings we were able to give you some additional authorities. I understand that the Secretary backed you up with additional enforcement people.

I think your testimony today as well as the record that you have established independently of that testimony illustrates that you have done a very, very good job in cracking down where you now have the authority and I just want on behalf of our colleagues to commend you for the progress you have made, the work you have done and for many of the recommendations you have made here.

I would be remiss if I did not also thank GAO and Mr. Zimmerman, you and your staff for this very comprehensive report. You omitted in your verbal testimony some of the examples that you uncovered here. I thank you for doing that in the interest of time, but I think it is in a sense unfair to you and your staff and the very difficult job they had in successful tracking down literally dozens of people, and several other dozens you were unable to track successfully, not to acknowledge the—not only the careful documentation of each case but to omit, at least on the verbal record, the real horror stories that you have with great meticulousness identified and documented. Perhaps

we will get to some of them a little later. But I do want to focus on one specific issue here.

The principal difference between what you recommend as a set of authorities for the Secretary of HHS and what the draft proposal that you mentioned is that the sanctioning of State boards would not in and of itself be a cause under the Secretary's draft legislation for the prohibition on participation from the medicare and medicaid Program; that is the principal differences as I understand it based on your testimony.

Do I understand you correctly?

Mr. ZIMMERMAN. At the time we looked at the draft, Senator, that was the case. It may have changed since then.

Chairman HEINZ. Mr. Kusserow, have you got anything you would like to say about that?

Mr. KUSSEROW. Yes, sir, Mr. Chairman.

First, let me thank you for your kind comments on the progress we have been making with your encouragement and assistance in the health care programs.

Second, the concern that we have is that we have a number of cases where physicians or other health providers have been convicted of felonies related not only to fraud but also to patient abuse and have been sanctioned by the State societies or by State courts and have situations where they could continue to be permitted to practice on medicaid and medicare beneficiaries with us being basically helpless to do anything about it.

So we would certainly endorse any provision that would allow us to get at convicted providers.

The GAO report goes beyond that and recommends exclusion based on State board sanctions for any other cause, such as impairment of the physician or other health provider. We would endorse that as well.

Chairman HEINZ. Is there any place where you would not endorse the GAO recommendations to us?

Mr. KUSSEROW. No, not at all. I would endorse all of its recommendations. In fact, I would go much further than what they were able to do. They focused on a narrow band of problem areas. I would look at the wider band and try to look at all the loopholes that exist in the sanctioning authorities and take care of those at the same time.

Chairman HEINZ. What would be the principal areas where you would like to go farther than GAO?

Mr. KUSSEROW. One of the problems that we certainly have been having is a tie-up of very expensive resources in dealing with administrative hearings that take place because sanction health providers appeal the period of their suspension or their exclusion.

If a person has been suspended for a criminal conviction, there should be a minimum period of 5 years so that we do not waste the ALJ's time and that of our staff in dealing with it.

Then we have a number of technical problems related to compelling records and testimony and securing exclusions.

So we have submitted, or with your permission, would submit for the record a complete set of all of our recommendations as well as the drafts as they now exist with regards to possible legislative remedies in these areas.

Chairman HEINZ. Senator Melcher suggested that as long as a physician was ineligible to practice by virtue of disciplinary action in a particular State, the sanctions, that is, nonparticipation in medicaid, medicare, should continue to apply. Do you agree?

Mr. KUSSEROW. I believe that if they are not allowed to practice on the population at large, they absolutely should not have any authority or right to practice on beneficiaries in the medicaid or medicare programs at any time.

Chairman HEINZ. With respect to the term of any nonparticipation in Federal programs, why would it be desirable to have a limitation of 5 years or are you not proposing it as a limitation?

Mr. KUSSEROW. Well, I would be proposing it for a felony conviction or conviction of any violation of criminal statute. I think that a minimum period of 5 years should ensue.

Chairman HEINZ. You are saying it would not be limited, 5 years——

Mr. KUSSEROW. It would not be limited to 5 years; it would only be a minimum. It would go from 5 years on up to total exclusion permanently from the program.

There might be mitigating or extenuating circumstances that might cause us to want to consider readmitting them to the program after 5 years back in the program with demonstrated good conduct and competence.

But a convicted provider should be suspended for a minimum of 5 years. We should not be going through expensive hearings to have somebody go from 5 years to 3 years or 18 months to get back into the program after they have been convicted.

Chairman HEINZ. Mr. Zimmerman, I gather you would not disagree?

Mr. ZIMMERMAN. No, Senator, I certainly would not.

Mr. Kusserow is dealing with the problem on a daily basis. He is very close to the technical issues that he is confronted with in trying to administer the program and it sounds to me like he has a problem here that is going to require some type of solution beyond the issues that we considered.

Chairman HEINZ. Very well.

One other question.

When you say, Mr. Kusserow, that you could endorse what the GAO is saying plus some other things, you are speaking for the department in this case?

Mr. KUSSEROW. I cannot speak for the department, but by the statutory authority that set up the Inspector General's Office, I certainly can speak for the Inspector General's Office directly to the Congress on this issue.

But I am confident that Secretary Heckler would agree with us on this point.

On the recommendation that GAO made with regard to setting up a national clearinghouse to keep records of suspended or otherwise sanctioned physicians, I would point out we do not now have the authority to do that. It would require statutory relief to effect that recommendation.

Chairman HEINZ. I have a question that is only somewhat related to the issues we have been talking about. It does have to do with, generally speaking, the prevention of fraud but some unique questions that have arisen under the new DRG, diagnostic-related group system that we

have. It is our understanding that the American Medical Association and some in the physicians community have expressed concern regarding the new physician attestation form now being required for medicare billings to hospitals.

Why is that form being required?

Mr. KUSSEROW. There are a couple of reasons, Mr. Chairman.

First, we heard from Dr. Derbyshire who pointed out that there are a lot of problems in the physician community. Proportionately they represent a very tiny part of that physician community but by the sheer size, nearly half a million physicians, just by the sheer size it is a large problem.

What we had happen a little over a year ago is that the Congress of the United States changed the basis of payment in the hospital setting from a retrospective cost-plus basis to a retrospective DRG——

Chairman HEINZ. Prospective.

Mr. KUSSEROW. Prospective reimbursement system. And when that happened, the documentation that would cause payments changed. Before it was on the cost reports of the hospital; now it is going to be on the basis of diagnostic-related group.

Now, when the physician makes a diagnosis and in fact determines what the diagnosis is which results in the DRG payment.

The new diagnosis form contains a warning statement that says that if you provide false statements on that form, then you could be prosecuted. The Department of Justice advises us that without such a warning statement, we could have a situation where physicians could in fact be falsifying the diagnosis, causing a higher reimbursement rate or higher payment rate, and yet avoiding prosecution.

The concern that some sectors of the medical community have, is that they did not have it for 19 years, why do they have it now. The answer to that is that for 19 years we had a retrospective payment system and now we have a prospective payment system which makes the basic payment system different because it is keyed upon the physician.

Chairman HEINZ. Have you been working with the American Medical Association on that issue?

Mr. KUSSEROW. I have worked with the health provider community with regard to that. We are trying to work out some of their concerns. I have scheduled meetings with them. Some of them are concerned with the language of it, its position on the form, things of that sort.

We will try to work out what we can in resolving the differences and the concerns that they have for their constituencies.

Chairman HEINZ. I hope you work that out because with the new prospective payment system, the administration really turned the old system on its head. As you well know, under part B of medicare, the physician portion of medicare, we have exactly that same kind of attestation. With DRG's being diagnostic-related basic payment system, it is terribly important that those diagnoses be just as accurate for part A of medicare as they have been all along for part B.

We hope that all difficulties will be satisfactorily resolved.

Mr. KUSSEROW. Thank you, Mr. Chairman, that shares our concern.

I do not believe that we can be in a position of removing a control that would permit somebody to engage in fraudulent practices and then not be able to prosecute them later on.

Chairman HEINZ. That is of particular concern because of the change that we have made in the way we reimburse health care. In previous years one could argue that there was no particular need for this type of attestation. Now it is essential to the operation of this program. Indeed, one of the things that I think that every Member of Congress who has studied the DRG system worries about is the incentive in that program to complicate and proliferate diagnoses. In so doing, more money could be obtained for every individual case that comes in the door of the hospital. Without some kind of basic control, neither the Congress nor the taxpayer nor anybody else, including the board of trustees of that hospital and the review organizations will have, it seems to me, the kind of quality management information system and controllership system that everybody I think would agree would be necessary.

So I thank you for your initiative in that area.

Mr. KUSSEROW. Thank you.

Chairman HEINZ. Gentlemen, I have no further comments for any of you. What you have done is excellent.

We thank you all for really excellent work.

Mr. ZIMMERMAN. Thank you, Mr. Chairman.

Chairman HEINZ. Our next panel consists of representatives of the American Medical Association. Dr. John J. Ring is a member of the AMA Board of Trustees. He is accompanied by Ross N. Rubin.

I think the committee, gentlemen, is anxious to hear what the American Medical Association thinks about this problem and what you think should be done about it.

Let me ask Dr. Ring, a medical doctor, to please proceed.

STATEMENT OF DR. JOHN J. RING, MUNDELEIN, IL, MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY ROSS N. RUBIN, DEPARTMENT OF FEDERAL LEGISLATION, AMERICAN MEDICAL ASSOCIATION

Dr. RING. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I am John J. Ring, M.D. I am in the general practice of medicine in Mundelein, IL. I am now and have always been licensed in one State, the State of Illinois. I do not intend to obtain a license in another State. Accompanying me today is Ross N. Rubin, director of AMA's Department of Federal Legislation.

The American Medical Association appreciates the opportunity to testify today concerning the issue of reimbursement under Federal health care programs for health care practitioners who lose for cause a license to practice in one jurisdiction and then relocate to another State where they also hold a valid license.

The General Accounting Office has discussed this matter with the AMA, and we are aware of the concerns expressed in their report regarding continued participation by such practitioners in Federal reimbursement programs and we are aware of GAO's recommendations to address these concerns. The GAO has defined health care practitioner to include doctors of medicine, doctors of osteopathy, podiatrists, chiropractors, dentists, and pharmacists.

The AMA is also concerned that health care practitioners who have been found unfit to practice in one jurisdiction can relocate and practice in another jurisdiction where they hold a license. Such actions by practitioners concern all professionals in the health care field, since such practitioners discredit their professions and the State licensure programs in this Nation. State licensure has been and continues to be a major factor in assuring the high quality of health care available to all citizens.

One positive note about M.D.'s is that the number of physicians involved is relatively few. For physicians, the number of State license revocations, suspensions, and surrenders for cause, relating to fitness of practice, is small. Moreover, in cases of impaired physicians, the advent of programs by State and local medical associations to assist impaired physicians in overcoming their problems and reentering practice diminishes the motivation to simply relocate when a problem is detected.

The AMA maintains a unique database of licensed physicians called the AMA physician masterfile. The masterfile contains independently verified information on all physicians licensed to practice within the United States and includes information such as address, declared practice specialty, medical education, graduate training, board certification, States where licenses have at some time been granted and a record of State licensure actions.

The AMA has a longstanding policy of cooperation with State licensing boards seeking information from the AMA regarding disciplinary actions taken in other States. This is especially important in light of the fact that in many States revocation of a license in another jurisdiction constitutes grounds for sanction. When the AMA receives a request from a State medical board about licensure actions concerning a physician, that information is promptly provided. Unfortunately, some States do not routinely take advantage of the AMA masterfile information. Many States contact the AMA about the files about particular physicians. Today, we provide information that we have to States on request. And I must respond to Dr. Derbyshire's comment that the AMA is reluctant to provide this information because of lawsuits. He is correct that the American Medical Association does not want any more lawsuits.

But we respond to all requests from any State licensing board with information in our files, provided it is verifiable. The State boards however may not request the information from the AMA or they may not know that a physician licensed in another State may have had an action taken on that license.

Because of this processing and cross-referencing problem, the AMA intends to make the information we have available more useful to State licensing boards. When the AMA receives verifiable information concerning a license revocation, suspension or surrender for cause and when that action involves a physician's competency to practice, we will notify the medical licensure boards of all States in which our records show the physician has held a license.

While this committee is particularly concerned with treatment of the elderly under Federal programs, we believe it is equally important that the whole population is protected. It is therefore necessary for

States to take prompt action concerning information regarding practitioners whose licenses are revoked. We are pleased to cooperate in this patient advocacy role.

In light of concern during the mid 1970s about medical discipline laws, the AMA developed model State discipline legislation. This legislation has been distributed to State medical societies for use in improving State licensure laws where necessary. In light of the concern about practitioners who hold multiple licenses, the AMA will update its model State legislation to include suspension, revocation or surrender of a medical license for cause relating to a physician's competency to practice medicine in one State as grounds for disciplinary action in another State.

We will also modify the draft legislation to provide for expedited due process procedures so that a licensure action can be completed as quickly as possible, consistent with constitutional safeguards.

It is also the policy of the American Medical Association to terminate a physician's membership in the AMA, if the physician is a direct member of the AMA, when a license is suspended, revoked or surrendered for cause. For those sanctioned physicians who are members of the AMA through membership in a State medical society, the AMA will advise the State medical society and encourage appropriate action.

We realize that this committee's primary concern focuses on the quality of care for the elderly who receive services under medicare and medicaid.

The GAO report points out that there are significant gaps in authority of the HHS Secretary to prevent a practitioner who has been sanctioned in one State from continuing to participate in Federal programs in other States.

Closing gaps such as these while providing appropriate safeguards and administrative procedures would assist in safeguarding the Medicare and Medicaid Program and beneficiaries in some cases from unqualified practitioners. In the case of license suspension or revocation for cause relating to medical competency, we believe blanket exclusion from participation in medicare and medicaid would be appropriate, regardless of licensure status in other States.

The AMA would support legislation in this area. We would add that appropriate safeguards must be provided in cases of possible exclusion to assure that the original license suspension or revocation occurred for serious reasons relating only ot competency and not merely because of a failure to pay registration fees, to obtain required continuing education credits, or other technical reasons.

Mr. Chairman, we commend this committee and the GAO for highlighting this important issue. As we have discussed, the AMA will be taking affirmative actions to assist in this area. We hope however that the committee's concerns do not overshadow recognition of the important and valid role of the States in licensing and disciplining health care practitioners. Delays are not acceptable prior to license suspension or revocation where the delay results from lack of resources or timely utilization of information. We encourage States to adequately fund their medical licensing programs.

The AMA will be pleased to discuss with this committee and others the development of appropriate legislation to address the concerns of practitioners with multiple licenses who lose a license in one jurisdiction and then relocate to another State where they hold a license.

We would be pleased to answer any questions the members of the committee may have.

Chairman HEINZ. Dr. Ring, thank you very much. And as I understand your testimony, let me commend you for your testimony because it sounds to me that here is an issue on which the General Accounting Office, the Inspector General of the Health and Human Services, myself and I gather the medical profession essentially agree; is not that correct?

Dr. RING. Yes, Mr. Chairman.

Chairman HEINZ. Not only do we agree on the problem, we agree on the solution.

Dr. RING. Yes, Mr. Chairman.

Chairman HEINZ. I should simply declare that the hearing is completed and adjourned, but I have not done that yet. But we are all grateful for favors, large and small. I would not put this in the small category at all.

I also serve as a member of the Health Subcommittee on the Senate Finance Committee, so if any of my questions wander beyond medicare and medicaid, there is a reason for that. And one of the issues that you yourself did touch on here is the overall number of physicians that may or may not be competent to practice medicine.

We had in the testimony offered by Dr. Derbyshire a suggestion that the 500 or so physicians a year who have been sanctioned in some way regarding their license is the tip of a much larger iceberg. That this is one fraction of a percent of all practicing physicians. He suggested that between 5 and 10 percent of physicians for a variety of reasons are not fully competent, in his words, to be practicing medicine. And one of the things that Dr. Derbyshire indicated that I found quite credible, having been a member of the board of several hospitals during my time in private as opposed to public practice, is that it is much easier for a hospital or its medical staff to take a doctor who is not performing well aside and say, "We would like you to leave our hospital, we do not want to get involved in lawsuits and we will not do anything if you will quietly leave," rather than taking more overt action.

How many incompetent physicians do we have out there who are not being subject to the sanctions by virtue of losing or having their licenses suspended?

Dr. RING. I do not know and I do not think Dr. Derbyshire knows either.

The estimate of 10 percent, I as a practicing physician feel may be somewhat high. I do not believe that 1 in 10 of my colleagues is incompetent.

Chairman HEINZ. One in twenty?

Dr. RING. I do not know what the number is but I think it is incumbent upon the medical profession and the State licensing boards to identify incompetent practitioners and see to it that they no longer practice.

You are looking at an incompetent physician right now, Mr. Chairman, if it comes to the removal of a brain tumor. I think I am pretty good at family practice. Incompetence would have to be defined pretty clearly to me and I would have to see some better statistics than Dr. Derbyshire has to come up with a valid estimate.

I might add that I too am on a hospital board and the question that he brought up is a very valid one. Hospitals tend to say: Let us get rid of this problem, we do not want a lawsuit, we do not want this or we do not want that.

The way our hospital approached it is that on all applications for staff privileges at the hospital we require the applicant physician to sign a waiver and actually a directive to other hospitals and other bodies to supply our hospital with all the information that they have. It has been very useful in our hospital. And if you ever get back on another hospital board, Senator, it might be useful in yours.

Chairman HEINZ. I am still on one. They have not defrocked me yet.

Dr. RING. But we have had nice information, good information which we have been able to use.

Mr. RUBIN. Mr. Chairman, if I might add on that. The AMA has been concerned about this for a long time in our model State legislation to encourage the improvement of State licensing. We would recommend that States adopt mandatory reporting requirements for hospital review committees or hospital governing boards, and for physicians who become aware of hospitals, that when a physician becomes aware of incompetent practice, for example, that physician is mandated by State law to report to the State licensing board.

On the other hand, there has to be some protection for those practitioners and we would also encourage States to adopt some type of immunity from legal action where a physician made a good faith report so that somebody is not placed at jeopardy by doing what they think is right, by going to a State board and then winding up being sued for libel when they have made a good faith report.

Chairman HEINZ. Well, that is a problem. It is even sometimes a problem when you bring in expert testimony to get a physician delicensed.

I have talked to a physician here in Washington not too long ago who had to make a trip to Florida to testify regarding somebody they had kicked out of a hospital here. He went down to Florida to testify against him down there. The lawsuits ensuing that that fellow was threatened with were a real concern to him. Unfortunately, the physician in Florida got off with a slap on the wrist.

In any event, I hope you will follow up with your model legislation and get States to attend much more aggressively to this problem. I think we all—I think the American Medical Association has come a long way in the last 5 or 10 years in recognizing that there is a problem. Ten years ago the answer was that there was no problem. Some said, "It could not possibly be 5 percent, it has got to be much smaller than that." Now we are kind of saying, "Well, maybe, maybe between 5 and 10 percent. Who knows?"

One of the things that might help is if States went about recertification. In a sense, Members of Congress get recertified every 2 and 6 years. If it is good for us, why is it not good for members of the medical profession? And by the way, recertification is not foolproof.

Dr. RING. If States feel that is the appropriate role, we would support that.

Chairman HEINZ. How do you feel about it personally?

Dr. RING. I feel favorably. I am a member of the American Academy of Family Physicians and I am a diplomat of the American Board of Family Practice and we are up for recertification every 6 years just like Members of the U.S. Senate.

Chairman HEINZ. Very well.

Let me at this time talk to someone who has not yet had to have his license recertified, he has only been here 3—or 2 years.

Senator Wilson.

Senator WILSON. Thank you, Mr. Chairman.

I apologize for the fact that another hearing claimed my attention and I had to come back in late. I gather in my absence there has been agreement by virtually everybody, including AMA as to the wisdom of some remedial legislation.

Let me just at this point ask one question. When the problem with respect to revocation of a license arises from causes other than professional competence, is there an opportunity for a physician to cure his defect to rehabilitate himself?

In other words, where it is not a function of his competence so much as—well, to pick an example, just to make the point, where he has been careless about paying his dues or something like that, is there an opportunity for the physician to be rehabilitated in his State or if he chooses to go to another State to have his credentials reinstated?

Dr. RING. Usually there is, Senator, and it is the position of the AMA that actions preventing physicians from participating in the Medicare and Medicaid Program should not include failing to pay his license fee by a matter of 7 days.

With regard to other rehabilitative activities, AMA and the State medical societies or strong proponents of impaired physician programs where we can get a physician who is impaired by alcoholism or drug abuse, get him into a program, rehabilitate him and put him back into practice where he will do himself and the community some good.

Senator WILSON. Does the draft legislation have any impact on any of those programs?

Chairman HEINZ. I think, Senator Wilson, in fairness to Dr. Ring, when you say draft legislation, I think he is referring to the recommendations of the GAO.

We do not have as yet, Senator Wilson, any legislation introduced, just a set of recommendations from the GAO to go on.

Dr. RING. I have not seen the legislation. I hope the legislation when it does come would include the concepts that you bring up.

Mr. RUBIN. Senator Wilson, your State of California has probably one of the more progressive programs in that area with a State licensure law that allows for a variety of sanctions rather than an all or nothing termination. It is a recognition of the people in Sacramento that the community and the Federal Government have a large investment in supporting medical education. It has a tremendous investment in their training and that if a sanction less than total revocation of a license can still provide a community resource under supervision after a certain rehabilitation period, possibly a suspension of privileges to write prescription drugs or something like

that, the physician can still be a resource for the community and return to practice.

As an attorney, a loss of a license for me means that I have lost my livelihood, basically, the same thing for the physician. And we commend those States that are progressive enough and try when possible to rehabilitate a physician.

I think Dr. Ring pointed out when there is a physician that cannot be rehabilitated, they are a black mark on the entire profession and we would support them being severely sanctioned.

Senator WILSON. Yes; I have a note here that indicates to me that with respect to the recommendations you apparently expressed what I would anticipate be a normal concern about due process. I do not see that being any problem, though.

Dr. RING. Senator, we see protracted due process as a problem.

Senator WILSON. I am sorry.

Dr. RING. We see protracted due process as a problem, due process which takes 4½ years rather than a couple of months.

Senator WILSON. Has there been any sort of problem of that kind in the States?

Dr. RING. I think there have. There were some examples cited where, while the process is going on, the physician was still in the program.

In Illinois, if I might, Mr. Chairman——

Chairman HEINZ. Please.

Dr. RING. The Medical Society identified rather serious problems in medical discipline and went to the State recommending a rather stringent medical disciplinary act in upping our registration fee from $10 a year to $40, with all sorts of added investigators and of generally tightened up medical disciplinary plan. We have the $40 assessment every year but the State has not seen fit to spend the money and it has not, to the satisfaction of the Illinois State Medical Society, tightened up medical discipline to a sufficient extent. Encouragement of the States is a vital part of this program.

Chairman HEINZ. We would agree.

Senator WILSON. Let me ask this final question:

I represent a State that has a great number of military installations and also an enormous retired military population.

Is it possible for doctors whose licenses have been revoked to enter the military and practice without a license from any State?

Dr. RING. I think that might be possible, although I am only licensed in Illinois and only have been licensed in Illinois, I practiced in two States in one territory by virtue of my service in the military. That is a possible loophole.

Mr. RUBIN. I think you are absolutely right, Senator, it is a Federal constitutional responsibility to protect Federal officers from harassment by States. The decision goes back to the Supreme Court in the 1700's. We understand, though, that the Department of Defense is now initiating programs so that all military physicians and other health care practitioners would be required to be licensed in at least one jurisdiction. But they are doing that on a voluntary basis. States cannot regulate Federal officers.

Chairman HEINZ. And to answer Senator Wilson's concern, if it on reflection turns out to be as real a concern as it is now, I think that it would be possible, Senator Wilson, to draft legislation that says that

any physician that loses eligibility for medicare, medicaid, title V, title XX, would also be rendered ineligible similarly for participation as a physician or providing similar services to the military. I think there is a way to deal with that if indeed it is serious a problem. It can very well be a loophole and I commend you for bringing that to our attention.

Senator WILSON. Thank you, Mr. Chairman.

Thank you, gentlemen.

I have no further questions.

Chairman HEINZ. Senator Wilson, thank you very much.

Dr. Ring, thank you very much for your excellent testimony and also you, Mr. Rubin. We appreciate your attendance.

Dr. RING. Thank you, Mr. Chairman.

Chairman HEINZ. Our final panel consists of Mr. Wood and associates and Mr. Carter.

Would you please come forward to the witness table.

Mr. William Wood is the executive director of the New York State Office of Professional Discipline. He is accompanied by Daniel J. Kelleher, director of investigations; and Ms. Frances S. Berry, director of the National Clearinghouse on Licensure and Enforcement, Council of State Governments, Lexington, KY. Also, Mr. Robert T. Carter who is the counsel for the Kentucky Board of Medical License. I am told that he is involved on a daily basis with the investigations and prosecutions of unfit medical care practitioners.

Together these witnesses should help us better understand the State perspective on this problem.

Mr. Wood, would you please proceed.

STATEMENT OF WILLIAM L. WOOD, JR., NEW YORK, NY, EXECUTIVE DIRECTOR, OFFICE OF PROFESSIONAL DISCIPLINE, STATE OF NEW YORK

Mr. WOOD. Thank you very much, Mr. Chairman.

Mr. Chairman and members of the committee, I am very pleased to appear before you today to discuss the need for a national disciplinary information system covering physicians and other health care professionals.

I am executive director of the New York State Education Department Office of Professional Discipline. My office is responsible for receiving complaints and investigating and prosecuting through administrative proceedings allegations of professional misconduct against 30 professions licensed by the New York State Board of Regents, 500,000 licensees in all. These professions include medicine, dentistry, nursing, pharmacy, psychology, chiropractic, podiatry, and optometry.

In addition, I am chairman-elect of the National Clearinghouse on Licensure, Enforcement and Regulation and cochair of its committee on the national disciplinary information system. CLEAR is an affiliate of the Council of State Governments. It is a voluntary national organization of State agencies involved in licensure, regulation, or enforcement of licensed professionals.

This month CLEAR will publish its first quarterly report of disciplinary actions that had been taken by its subscribing members.

I first became aware of a need for a routine, frequent and comprehensive sharing of professional disciplinary information when, as head of the New York State Attorney General's Education Bureau, I was engaged in the administrative prosecution of a medical doctor who, for a fee of $5,000, agreed to sew synthetic wig fiber into bald men's scalps to give them the appearance of having hair. These victims included many elderly Americans. While the disciplinary proceeding was pending, the physician left New York for Florida where he was already licensed and opened an office there. When complaints about his practice in Florida developed and it was also learned that he was being prosecuted in New York, he left Florida and sought licensure, reportedly, in Texas and then South Dakota. Currently, his whereabouts are unknown. Although he has been revoked in New York, it is possible that he could still be practicing somewhere in the United States.

Another case involved a 63-year-old woman who was left catastrophically disabled after being operated on by a physician who, though legally licensed in Florida, had in a period of 2½ years been previously revoked in New York, Michigan, Nevada, Ohio, and Arizona.

Because of the mobility of many licensed professionals and the fact that many of them maintain licensure in more than one State, it is essential that States exchange disciplinary information, if they are to effectively discharge their responsibility of protecting their citizens' health, safety, and welfare.

New York State's attempt at solving the need for exchanging information before it turned to CLEAR was to periodically mail to every State a report listing all the disciplinary actions that had been taken by the State Board of Regents. However, because many States have autonomous boards for each profession rather than a single agency with responsibility over many professions, such a mailing involves many hundreds of pieces of mail and not just 50.

But, in any event, a number of States followed suit. Nevertheless, even though we were advising every State of New York's decisions, we heard from relatively few States. We strongly feel that a single comprehensive report issued by CLEAR to the States that subscribe will be a giant step forward and win maximum usage.

We agree that the Department of Health and Human Services should be granted additional authority to use State sanctions as a basis for excluding practitioners from Medicare and Medicaid Programs.

However, if such additional authority were granted, but no mechanism existed for the dissemination of such disciplinary information, little purpose would be served. For that reason we support any idea that may lead to a more comprehensive, more efficient system for sharing disciplinary information.

Both the State of New York and CLEAR look forward to cooperation with you in this effort. We will make our disciplinary information system available to the Department and will be happy to furnish any other assistance it may require. And we would be very happy to respond to any questions that you might have.

Chairman HEINZ. Mr. Wood, thank you.

I am going to withhold any questions until we hear from our next witness, Mr. Carter.

Mr. Carter, please proceed.

STATEMENT OF R. THOMAS CARTER, LOUISVILLE, KY, LEGAL COUNSEL, KENTUCKY STATE BOARD OF MEDICAL LICENSURE

Mr. CARTER. Thank you, Senator. Senator Wilson.

I appreciate the opportunity to speak to you today because I think it is important for you to hear from someone who is in the trenches.

I am one of a handful of attorneys employed full time directly by a licensure board to prosecute disciplinary cases. I am here to share some of the experiences in the field of medical discipline that bear upon the issues being discussed.

In my position I have the opportunity to observe and become involved with medical licensure matters in all the States and I can assure you that the problems which I wish to discuss are faced by every State medical board.

The American health care delivery system has its greatest impact on aging Americans because they utilize the system the most. Because they do so, these individuals are those who are most likely to be impacted, directly or indirectly, by the problem in physician licensure and discipline which I have been asked to address.

The problem is the movement from State to State of physicians who have committed acts of misconduct. Time does not allow me to define the problem with any particularity, however, please understand that this problem is complex with many, many nuances. Simply stated, the problem consists of physicians who have been disciplined or who could potentially face discipline, by a State's physician licensure board moving to another State in order to escape its jurisdiction without a restriction or to avoid prosecution in a jurisdiction they are leaving.

Some examples that I am familiar with may be helpful.

Example No. 1. Dr. W. is convicted in Pennsylvania of medicare fraud and his license in Pennsylvania is revoked. After serving his sentence he moves to Kentucky, where he already holds a license, and establishes a practice in a rural part of the State. By the time he is discovered to be in Kentucky and the process of prosecution is begun, a year has passed. Thus, Dr. W., a convicted medicare felon, has practiced over a year, in the State to which he moved without Government scrutinization.

In the following examples I will need to disguise the identity of the individuals and of the States and some of the facts, because these cases are under litigation or investigation presently.

Example No. 2. Dr. X, is an alleged substance abuser who was dismissed from a hospital in State A for inappropriate behavior in the operating room. The doctor was also prosecuted in the same State for misdemeanors involving theft and brandishing a deadly weapon. After the doctor learns that he is being investigated by State A's licensure board, he surrenders his license in that State and moves to State B where he also holds a current license. Thus, he has done what we commonly call surrender and run.

The State of surrender dismisses the case for pragmatic reasons and State B is left with the task of proving misconduct that has occurred in a distant State. Dr. X. continues to practice in State B all during this period, about 2 years. He, like the physician in the previous example, practices in a small community.

Example No. 3. Dr. Y., who practices in a small town in State A, becomes the subject of a major investigation pursuant to allegations of fraud, overutilization, drug abuse, misprescribing, and inappropriate care. Because of the State's enormous investigation workload, the investigation of the doctor is delayed and then, once begun, is lengthy and difficult. In the midst of the investigation, the doctor apparently loads his entire operation onto a truck and heads to State "B," where he presumably has a license, and State A gears back its investigation, again for pragmatic reasons.

Example No. 4. Dr. Z. practices in a village located in State A. He is removed from the staff of the local hospital for alleged gross malpractice in February 1981. In May 1981, he applies for licensure in State B and gives a "no" response to a question on State B's application asking whether he had ever been censured by a hospital. When contacted by State B, State A indicates that the doctor is licensed in good standing, probably because the hospital has not yet informed State A of its action. The doctor practices in a small town in State B for 3 years before the original State notifies State B that his license in that State has been permanently revoked because of incompetence and gross malpractice.

There are many other examples of the problem which could be cited. It is a major concern of the Federation of State Medical Boards of the United States, Inc., which held its annual meeting last week. The representatives of all the States in attendance recognize the need to take corrective action such as:

First, the development in each State of more expedient investigational and prosecutoral apparatus.

Second, the development of laws that not only allow but make mandatory the sharing of derogatory information among State boards, no matter the stage of the proceeding.

Third, the implementation of more thorough scrutinization processes for physicians entering a State.

Fourth, the passing of sterner laws concerning the reporting of misconduct to the licensure boards by physicians, hospitals, and medical societies.

Fifth, the development of laws which give boards personal jurisdiction over licenses thus allowing States to long-arm violators despite the fact that they may have surrendered their licenses.

Medical licensure is a power of the States and should remain with them. The States have been working, with the Federation's encouragement, to pass and implement legislation which will help end this problem that plagues American medicine. However, for a host of reasons, the States cannot move with great alacrity in this area. As Dr. Derbyshire noted, less than 20 States have as yet passed a law that allows for the discipline of a physician in one State if he has been disciplined in another State.

Therefore, the States need help. Perhaps this help could be through the mechanism of the medicare system, such as a provision that would allow for the suspension, under certain circumstances, of the reimbursement rights of any physician who has been disciplined by a hospital, medical society or State board, or who has left a jurisdiction while under investigation. However, such a measure has limitations since a physician could simply begin doing business on a cash basis—as many do—and avoid the effect of such action.

Perhaps a better Federal control would be through the vehicle of the Drug Enforcement Administration's controlled substances permit. This permit must be held by every physician who wishes to utilize controlled substances in his practice and is therefore a very precious item. The problem of interstate movement of offending physicians could be much alleviated if a physician's DEA permit could be restricted if he attempted to leave a jurisdiction either during an investigation or after formal discipline has been imposed by the jurisdiction's licensure board. The law would certainly have to be drawn so as to avoid being "over-broad" but it would not lack for at least one rational basis in fact: Probably over half the investigations conducted by licensure boards involve misconduct relating to controlled substances.

Although time does not allow, this committee should at some juncture consider what actually is the greatest issue facing State medical boards: the foreign medical graduates. Although many of the individuals are well qualified, and let me stress that many are well qualified, many are not. The States have been struggling for years to develop a method of review that would insure the competency of those FMG's who are licensed. The issue is noteworthy here for three reasons:

First, foreign medical graduates appear, from my experience, to present a disproportional number of disciplinary problems, not necessarily things that should be formally disciplined, but discipline problems, especially fraud, although I should stress that this may be due to a cultural adjustment that many of the foreign medical graduates have and local prejudices.

Second, foreign medical graduates, particularly alien FMG's, move from State to State much more often than American trained physicians.

Last, unlicensed, and what I mean by that is those who are actually unable to obtain licensure, foreign medical graduates have a tendency to gravitate to hospitals where they serve as physician assistants and surgical assistants whose services are often paid for, one way or another, by Medicare and other reimbursers.

In conclusion, I hope the committee noticed in the examples I cited earlier that every physician involved moved from a small town in one State to a small town in another State. Small towns today have a high percentage of older Americans. They usually have but one nursing home, one hospital, if any, and very few physicians, sometimes no more than one. They appear to be good places for offending physicians to hide. Some people argue that a bad physician is better than no physician. I do not accept this argument because bad physician care is sometimes a greater threat to the public welfare than none at all.

Mr. Chairman, that concludes my remarks and I would be glad to entertain any questions that you or Senator Wilson might have.

Chairman HEINZ. Mr. Carter, thank you and Mr. Wood both for some excellent testimony.

I would like to divide my questions really into two components.

First, the question of that information system which both of you brought up, Mr. Wood with his work with CLEAR certainly is deeply involved with it. He does point out that the single largest problem is the voluntary nature of people subscribing to the usage of your register.

It seems to me that the logical thing for us to do—I am speaking for myself, I am not in a position to speak for Congress or members of this committee individually—would be as a condition for State participation in medicaid which is a Federal matching fund program to require that States give us information at a minimum of all completed disciplinary actions taken against any of these professions we want to look at it, not just M.D.'s but many of the ones that Mr. Wood has described as well.

There is a difficult line to draw and I sitting here do not know how to draw it. But it is the question of how you handle people who are under investigation and at what point should an alarm bell of warnings go off for medicare and medicaid?

The suggestion Mr. Carter that you make which is providing a meaningful check point so that people do not leave the jurisdiction while they are under investigation sounds extremely helpful to me. And I am indebted to you for the description of the Drug Enforcement Administration's controlled substance permit which might be a very effective means. You point out quite correctly that a large number of these people, as many as half or more are involved with selling phony prescriptions to patients who go out and then get themselves a lot of dangerous substances. I think that is a most practical, ingenious suggestion. And I would also agree with you that in fashioning the way it should work you have got to be careful because you do not want for the wrong reasons to impede someone's travel, although I would like to know just how serious a problem it is. If a physician is under investigation, in what circumstances should he forfeit—not should he not forfeit his controlled substance permit if he is going out of the State?

Mr. CARTER. Well, I will note two things here.

First of all, I find the profession at large, even many of the better physicians, to be somewhat naive, in my experience, about the controlled substance problem. I invite people all the time to come walk with me for a week and be shocked, that there are things going on that are amazing.

The Kentucky Medical Board for instance has provisions that allow for temporary suspension of a license or restriction of a license such as the restriction of someone's ability to prescribe controlled substances during the pendency of an action, but we have to file a complaint first before we can temporarily suspend. Therefore, that does not really correct the problem of what happens during an investigation when a physician is under scrutinization for drugs and he takes off to another State. That is why the States are in kind of a bind because of some limitations in open records laws, and because the States are a

little wary of sharing investigational information not formally entered of record because of the enormous implications of civil rights suits. There needs to be some kind of a national check, especially for people who are involved with drugs.

And I might note this, that the AMA has been part of a program known as PADS, which stands for prescription abuse data synthesis. We are implementing this in Kentucky, it has been implemented in other States, it is a mechanism by which you can identify both regionally and according to physician and drug where the problems are in controlled substances, because I would note to you that invariably the States and cities which have metropolitan areas near borders, this problem crosses State lines all the time and invariably the physician has a license in both States. And before both States can figure it out, the trouble is in both States. That is why I wish—and I think it is unfortunate that DEA has been forced to cut back its staff and its investigations. There is a need for the Federal Government to become a little more active in helping States deal with what I consider to be an interstate problem.

Chairman HEINZ. Mr. Wood, let me ask you: At what stage in the disciplinary practice should a physician, for example—should States and your organization CLEAR be allowed to obtain and disseminate derogatory information on a physician?

Mr. WOOD. I think clearly the safest answer to that question is that the information ought to be disseminated to the public only after there has been a final determination of misconduct, that is, after the licensee has been afforded due process, the opportunity to confront his accusers and to make a defense, and so forth.

However, many States, including New York, authorize their enforcement agencies to share any investigative information they may have with any other proper State agency, so we can share information with other State licensing and enforcement agencies and we can share information with criminal authorities within our State and outside of our State. My feeling is that it is entirely appropriate to share such information as long as the States with whom you are sharing the information recognize that the licensee is entitled to due process; that merely because you have opened investigation does not necessarily mean you are going to be able to establish misconduct on the part of a licensee.

I think an early warning system, where at an early stage of the investigation the information can be shared so that other States are at least on notice that there is an investigation, will result in a better job by all the States in the discharge of their responsibilities.

Chairman HEINZ. So you are saying you would not recommend—well, let me ask and turn it around.

Would you recommend that we, the Federal Government, do exactly that with respect to the people, that HHS be notified of any such proceedings and that without taking any disciplinary action, HHS notify other States?

Mr. WOOD. Yes, I think that would have to be an effective system. I think you would be able to handle that system and that it would be effective and help protect the public.

Chairman HEINZ. Would you agree with Mr. Carter's suggestion that, as I understand it, and maybe he will correct me if I misunderstand it, that we should—while someone is under investigation in a State, in effect restrict their ability by calling their Federal controlled substance permit if he or she moved out of State until that investigation is concluded; does that seem like a good idea to you?

Mr. WOOD. I doubt that—I believe that the courts would not permit you to do that. I do not believe they would permit you to do that until there had been due process afforded that practitioner.

So from a practical point of view, you are going to have to give him an opportunity to respond to charges before you apply any sanction.

Chairman HEINZ. What would you do to avoid the problem of people skipping States before the conclusion of their investigation is reached?

Mr. WOOD. They do not need to be present in a State to bring a disciplinary action to a conclusion. When people leave a State while a proceeding is pending, I think it is important that you conclude your disciplinary action against them, while still affording them due process rights. Obviously, the fact that they have skipped suggests they are not going to avail themselves of such rights. After you have concluded your action, you can disseminate that information to the States, including the States where they may have fled.

Chairman HEINZ. Let me yield to Senator Wilson for any questions. I have taken my time.

Senator WILSON. Thank you, Mr. Chairman.

This may be a naive question, but am I correct in assuming that in New York, disciplinary proceedings or investigations of this kind are not public?

Mr. WOOD. Disciplinary investigations and prosecutions are confidential until they have been decided by the State Board of Regents. Then the hearing, the transcript, the evidence can be made public.

The authority that we have to share them with other enforcement and law enforcement agencies is separate and apart from the general confidentiality that the investigations and prosecutions are afforded.

Senator WILSON. In other words, if you conduct an investigation and conclude that a complaint is not warranted, as a result, no action of a disciplinary kind will be taken, then the case is closed and remains confidential; who could have access to that? Could someone—could your counterpart in California?

Mr. WOOD. Yes, my counterpart in California.

In other words, a responsible State authority that presumably operates under law and recognizes standards of fairness and therefore would not be able to take any adverse steps against a licensee where our investigation had concluded that that person was without fault. We could share that information with other State agencies. We could not share that information with the general public, not with the press, not with professional societies, with individuals who make inquiries to us about the individual. We would not make that information public to those.

Senator WILSON. Mr. Carter, did you want to respond to that?

Mr. CARTER. Yes, I think it should be pointed out here that one of the things that is a problem is the open records and meetings laws. All the States are different. In Kentucky, for example, the minute we file a complaint—now, you have to understand people file grievances

with a board but that does not mean a complaint is going to be issued and the board has to make a probable cause of determination for a complaint to be issued. But once that complaint is filed, the complaint and everything in the record that goes in afterward is just like it would be in a civil or criminal case, and it is open to public scrutiny. All our hearings are open to public scrutiny. This affords the public an opportunity to more or less weigh its own evidence, I suppose.

We, however, do not share information during the course of an investigation. We will discuss generalities like I am doing here, but we will not discuss individuals. That is a decision that has been made that we think is appropriate, based on what we are facing with open records, meetings laws, and civil rights laws.

Senator WILSON. I am a little confused. Mr. Wood has stated that New York, that kind of proceeding would be closed.

Mr. CARTER. That is right.

Senator WILSON. And it is in Kentucky as well; I would think it would be almost everywhere.

Mr. WOOD. No; you would have different systems in different States. So in Kentucky, he is indicating that their State law does not permit a veil of confidentiality to be placed over those proceedings. The same would be true for the State of Florida.

Senator WILSON. So what is closed in your State is open in another?

Mr. WOOD. That is right.

Mr. CARTER. I might note there is a qualification under the revised law that we recently got through the Kentucky General Assembly that would allow us to close the proceedings but only when there is information of personal character about persons other than the charged physician. For instance, patients. It is not a protection for the physician.

Senator WILSON. What remedy is there in Kentucky for a physician who is the victim of a false charge?

Mr. CARTER. You have to understand in Kentucky now we have several—many investigators. We also have physician consultants who review the results of investigations. We have an investigation committee composed of physicians who review all the matters involved in the investigation in closed session and recommend action to the board.

By the time it gets to the board, it has been reviewed by probably 8 to 12 doctors who feel like there is probable cause to file a complaint. That is a safeguard in that regard.

There are also some other safeguards I do not have time to go into today in the new law that will go into effect in July.

But the bottom line is, I do not think that I ever filed a complaint and probably will not that we do not feel like there is serious misconduct and we can prove that case.

Now, technical things have arisen in the course of cases, certainly.

Senator WILSON. What you are saying is that there is a private hearing that precedes a public hearing?

Mr. CARTER. Yes, sir; we do invite the charged physician, especially in serious matters, before the investigation committee so that he will have an opportunity to respond to the grievances that have been made against him before any formal complaint has been issued by the board itself.

Senator WILSON. Mr. Carter, does DEA or does anyone else have any idea of the magnitude of drug offenses by physicians?

Mr. CARTER. Senator, the problem is one of degrees. Serious offenses involve physicians that would require revocation I think are percentagewise small. However, there are numerous problems the physicians have that do not get reviewed or we decline to review them for whatever reason.

Let me give you a good example. Controlled substances, you have a number of people who are—we can identify four types of controlled-substances persons: persons who abuse, persons who deliberately traffic, persons who inappropriately prescribe deliberately, and people who are simply ignorant of pharmacology. Pharmacology has changed so much in the last 10 years it has been very difficult I think for many physicians to keep up. Well, they are not bad parties; they need re-educating.

But I daresay my personal opinion is that probably one-fifth of the physicians in the country could use some retraining in pharmacology. I have physicians who tell me all the time where they get their information is the drug salesman. Well, this is a serious problem and it is not easily corrected by us. It is a serious disciplinary problem in general terms, but it is not worthy of formal complaint. And therefore it does not show up in the numbers of disciplinary cases in the States. But these are problems that need to be corrected if health care is to be extended in an appropriate fashion to the public.

So I think that when Dr. Derbyshire says 10 percent, I think there may be 10 percent that have problems and need review.

Chairman HEINZ. If the Senator would yield for a comment.

The committee, my recollection is, only last year held a hearing on the misprescribing of drugs by perfectly honest doctors but doctors who had become incompetent to prescribe drugs not just because they willfully malpracticed but because, as Mr. Carter has said, things are changed so much. And a study has done in my home town of Pittsburgh, actually in Beaver County as I recollect, that indicated that as many as 40 percent of the doctors really had an inadequate knowledge of pharmacology and we had many real case histories describing how several drugs would be prescribed, there would be side effects from those drugs, more drugs would be prescribed. The end result was that in some cases 15 or 20 prescriptions would have been inflicted on a person and, indeed, the underlying cause had been so obscured by all of the symptoms of the drugs that the patient never really got well and suffered a variety of—the patients suffered a variety of very, very serious problems. This is a very serious problem for the elderly because they end up having the most number of multiple prescriptions. I cannot recollect, Senator Wilson, whether you were here for that hearing but I wanted them and you in case you had not been made aware of it; it is a very serious problem.

I thank you for yielding.

Anything additional?

Senator WILSON. No, Mr. Chairman, I have no further questions of Mr. Carter or Mr. Wood.

Senator HEINZ. I have one last question for Mr. Wood.

Mr. Wood, would you just following up on what Mr. Carter said regarding foreign medical graduates, please briefly describe the prob-

lems you were having in verifying the medical education records of foreign graduated doctors?

Mr. WOOD. We have recently encountered a case in New York State—I am afraid its dimensions go far beyond New York State—and it is a situation where people have presented medical degrees and supporting credentials that reflect that they have completed a medical education, when in fact they have fraudulently obtained those credentials, in many instances purchasing them and paying up to $27,000 for the documents. And in some instances never setting foot on the island where the medical education was offered.

The case that initially came to our attention involved 165 people who had paid $1.5 million to a man named Pedro DeMesones, to obtain fraudulent degrees and credentials. We became aware of these cases during the last 4 months. All of them involve the unauthorized or unlicensed practice of medicine. These cases got a lot of public attention and hospitals in New York have called to our attention people who were graduates of the medical school involved so that now we have 500 active cases involving purported medical graduates who we believe obtained their degrees and credentials fraudulently.

Chairman HEINZ. Did you say 500?

Mr. WOOD. Yes; 500 in New York State.

Chairman HEINZ. Just in New York State?

Mr. WOOD. That is right. There are active investigations in California and Illinois and Massachusetts and a number of other States.

Chairman HEINZ. Time does not permit us to go into it now, but this sounds like a subject for another investigation and hearing by our committee.

I thank you for bringing it to our attention. I would only observe that, as I mentioned in my opening statement where I quoted the case of a doctor, a Dr. "T" who first claimed that he had a diploma from the University of Saigon. When that was checked up on—by the way, it was the University of Saigon, campus of Montpellier University in France, claimed that—oh, no, it was not Saigon, it was up in Hanoi and presumably that it was going to be a little tougher to get the records out of Hanoi, there might be a few CIA operatives still in Saigon, and he did not have to pay anybody for those fraudulent diplomas and he managed to fool a number of people for quite a while. Indeed, he is still fooling people in Nevada, as I remember, yes, he is still practicing in Nevada and he is medicare and medicaid certified, so he is still fooling us. And that he did not have to pay, you know, neither he nor anybody else apparently made any money off that, unlike the 300 people who paid $1 million-plus to that person you mentioned. So this is a significant issue as well.

We thank you both for highlighting it.

Unless there are any further questions from the committee, Senator Wilson, it would be my intention to adjourn.

I want to thank you, Mr. Wood, and I want to thank you, Mr. Carter, for coming considerable distances. We appreciate your testimony. It has been very valuable.

Thank you so very much.

The hearing is adjourned.

[Whereupon, at 12:08 p.m., the hearing was adjourned.]

APPENDIXES

APPENDIX 1.—CASE EXAMPLES OF SANCTIONED MEDICAL PRACTITIONERS

R.C.C., M.D.

Disciplined for illegally selling prescriptions for quaaludes.

--Summary of Practice and Disciplinary Actions--

- Has held licenses in four states (NY, PA, MI, FL).
- License revoked in two states (FL, MI).
- Now licensed in two states (NY, PA).

- Between 12/3/75 and 1/8/76 issues six prescriptions for 30 quaaludes each, to three "patients" (actually Florida Criminal Law Enforcement agents.) Asks the undercover agents what names the prescriptions should be in to avoid issuing too many scripts in one name, and charges agents $60 per prescription.

- July 1978: the State of Michigan serves complaint on him for the Florida drug sales. He moves to Florida.

- Between 2/22/79 and 8/27/79 issues eleven prescriptions to various patients for a total of 660 three hundred mg. quaaludes. The quaaludes were not issued to these persons in the course of his professional practice.

- November 1979, Florida State Supreme Court affirms the felony conviction of selling controlled substances.

- Now licensed in NY and PA.

- As recently as 1982 has practiced in New York, receiving Medicare reimbursement.

- Presently eligible for Medicare reimbursement in PA.

R.C.C., M.D.

DATE: December 3, 1975 through January 8, 1976

JURISDICTION: Florida

EVENT: "...issued six (6) prescriptions for 30 quaaludes each, to three (3) Florida Department of Criminal Law Enforcement agents .... did not conduct a physical examination prior to writing these prescriptions for his patients. In addition, he asked the patients what names the prescriptions should be written in to avoid issuing too many scripts in one name....sold the prescriptions to the agents for sixty dollars ($60) each."

DATE: November 1, 1976

JURISDICTION: Florida

EVENT: Pleads nolo contendere to the criminal charge of "...unlawfully selling or delivering by means of prescription, in bad faith and not in the course of professional practice, a controlled substance".

DATE: May 10, 1978

EVENT: Federal Drug Enforcement Administration revokes DEA registration.

DATE: July 6, 1978

JURISDICTION: Michigan

EVENT: Complaint served on Licensee. Moves to Florida.

DATE: Prior to December 31, 1978

JURISDICTION: Michigan

EVENT: "Notice and Application for Renewal sent to Licensee. There was no response..."

DATE: February 22, 1979 through August 27, 1979

JURISDICTION: Florida

EVENT: "...issued eleven (11) prescriptions to various patients for a total of six hundred and sixty (660), three hundred (300) mg. quaaludes. The quaaludes prescribed...were...not issued to these persons in the course of Respondant's professional practice."

DATE: May 8, 1979

JURISDICTION: Michigan

EVENT: At a Department of Licensing and Regulation hearing on a Complaint, "no one appeared on behalf of R.C.C." The hearing was adjourned "to allow time for a second renewal notice to be sent to the Licensee...there was no response by the Licensee."

DATE: September 7, 1979

JURISDICTION: Michigan

EVENT: License revoked. "... it was established that the Licensee's license to practice medicine in Michigan had been automatically revoked."

DATE: November 21, 1979

JURISDICTION: Florida

EVENT: "The State Supreme Court ... affirmed the felony conviction of the Respondant."

DATE: January 28, 1981

JURISDICTION: Florida

EVENT: License Revoked. The Florida Board of Medical Examiners "ordered and adjudged that the license to practice medicine in the State of Florida of R.C.C., M.D., be and hereby is revoked.

STATUS: ACTIVE.

New York License, Issued 2/25/63; Expires 12/85.

Medicaid and Medicare certified.

Pennsylvania License, Issued 1/06/66; Expires 12/84.

Eligible for Medicare reimbursement.

D.Q.F., M.D.

Disciplined for Unnecessary and Grossly Incompetent Surgeries

--Summary of Practice and Disciplinary Actions--

- Has held licenses in 12 states (CA, CO, IL, IN, KY, MD, MI, MN, MO, ND, SD, VA).
- Licenses revoked in 6 states (CA, IL, MI, MN, MO, NE).
- Licenses expired or voluntarily surrendered in 4 states (CO, KY, VA, and MD (denied renewal due to lack of good character)). Status of license in North Dakota is unclear.
- Now licensed in 1 state (IN).

- Between 2/67 and 8/68 performs six unnecessary and grossly incompetent surgeries on California patients, severely deforming a 16 year old girl's arm in one case. Also cited for injudicious use of antibiotics and unnecessary multiple drug orders, among other charges, in some of these cases.
- Between 2/70 and 10/71 applies for licenses in Michigan, Nebraska, and South Dakota, failing to disclose his California license in the Michigan and South Dakota applications. Each state grants a license.
- From 10/74 through 3/75 works as medical director at G_____ E_____ C_____ S_____ in Michigan. Terminated for falsifying his application and personnel record.
- From 5/75 through 8/75 finds work as medical director at the F___ M____ C_____ in Michigan. Is asked to resign for falsifying his employment application.
- March 1977: A Michigan State investigator is unable to locate Dr. F. after tracing his movements extensively, discovering a false address and sudden departures along the way.
- Now licensed in Indiana.

D.Q.F., M.D.

DATE: July 13, 1960

JURISDICTION: Illinois

EVENT: Granted Illinois license.

DATE: July 16,1960

JURISDICTION: North Dakota

EVENT: "...was granted a license...by reciprocity with Illinois...the Secretary was instructed to hold up delivery of said license until...presented (with) original medical diploma....(Licensee) practiced a few weeks...and then left the State....does not intend to resume his practice...and requests the return of his $100.00 reciprocity fee....request...denied."

DATE: December 19, 1964

JURISDICTION: California

EVENT: Granted license

DATE: February 23, 1967

JURISDICTION: California

EVENT: "...performed on...patient (A.M.) a lumbar laminectomy and excision of the intervertebral lumbar disc....(In April) performed a lumbar spine fusion on said patient....Each of said surgeries was unnecessary and constituted grossly negligent and incompetent conduct....said lumbar spine fusion was performed with no significant X-Ray, or other findings, to support such major surgery....patient received unnecessary and injudicious administration of antibiotic medication while hospitalized...(and) suffered a post-operative wound infection which could have resulted from the injudicious use of said antibiotics."

DATE: March 16, 1967

JURISDICTION: California

EVENT: "...performed a supracondylar osteotomy of the left humerus on his patient, S.T., who was approximately 16 years of age. Performance of said surgery was unnecessary and was grossly incompetent, in that...said osteotomy was performed with grossly inadequate internal fixation which resulted in a severe...deformity and marked decrease in elbow joint motion....There was routine post-operative use of unnecessary multiple drug orders in this teenage patient."

DATE: December 18, 1967

JURISDICTION: California

EVENT: "...performed a lumbar laminectomy on (patient P.N.)....Said surgery was unnecessary and was performed...in a grossly negligent and incompetent manner....The period of conservative treatment before said major back surgery...was inadequate in the case of this patient, who was 60 years old and suffering from degenerative arthritis....There were insufficient indications...to justify performance of the disc surgery....In the course of the performance of said surgrey...a surgical accident occurred in which a portion of a surgical instrument...was broken off and lost...the patient was not advised by respondent concerning said surgical accident, nor was it recorded by him in his operative report."

DATE: January 26, 1968

JURISDICTION: California

EVENT: "...performed surgery upon (L.K.)....Such surgery was unnecessary and its performance was grossly negligent and incompetent, in that....Whereas conservative treatment was called for, respondent proceeded to perform surgery two days following the inconclusive myelographic findings....patient was given multiple medications post-operatively, in the absence of any medical basis for prescribing said multiple medications."

DATE: February 1968

JURISDICTION: California

EVENT: Patient P.N. fell, "sustaining a comminuted undisplaced fracture of the left patella and a right elbow injury. She was hospitalized and four days later respondent performed an open reduction and circumferential wiring of the undisplaced fracture. Said patient wore a cast for over three months and had no post-operative physical therapy....was re-hospitalized in June, and...respondent performed an arthrotomy and meniscectomy. Following this surgery the patient received several months of followup treatment, when respondent left town suddenly. The said surgeries were each and all unnecessary and the conduct of respondent was grossly negligent and grossly incompetent....Respondent provided inadequate physical therapy in this case of an obese patient following two surgical procedures on her knee. After several months of post-operative care respondent sent the patient a letter advising her to seek orthopedic care elsewhere and requesting payment of the surgical fee in full, and refused to release the patient's medical record because her bill was not paid in full."

DATE: August 1968

JURISDICTION: California

EVENT: "...performed a lumbar laminectomy on his patient, N.G., and removed lumbar discs L4 and 5. Performance of said surgery by respondent was grossly negligent and grossly incompetent....Following surgery, there was no relief of the patient's back or leg pain....After approximately three months of post operative care, respondent sent the patient a letter advising her to seek orthopedic care elsewhere and requesting payment of the surgical fee in full."

DATE: February 10, 1970

JURISDICTION: Michigan

EVENT: Applies for Michigan license, "...failed to list notice of his California license" on application.

DATE: September 2, 1971

JURISDICTION: Nebraska

EVENT: Nebraska license granted.

DATE: October 18, 1971

JURISDICTION: South Dakota

EVENT: "...a license was issued by the Board..." as a result of "reciprocity with (licensee's) licensure in the State of Minnesota. In the application...for licensure by reciprocity, he...failed to make any disclosure of having practiced in the State of California, even though his application required such disclosure."

DATE: August 23, 1972

JURISDICTION: California

EVENT: "The California medical certificate...was revoked by the Board of Medical Examiners of the State of California for...unprofessional conduct by reason of gross negligence and gross incompetence...."

DATE: March 10, 1973

JURISDICTION: Minnesota

EVENT: "The Minnesota State Board of Examiners suspended the license of Respondent based upon the Revocation of Respondent's license to practice medicine in the State of California"

DATE: June 1, 1973

JURISDICTION: South Dakota

EVENT: "...voluntarily surrendered his license to practice medicine and surgery in the State of South Dakota, as well as waiving all rights to renewal or reinstatement of such licensure at any future time."

DATE: June 1, 1974

JURISDICTION: Nebraska

EVENT: License revoked. "...acts of gross negligence and gross incompetence (in California)...are due cause for the revocation of his license to practice medicine and surgery in the State of Nebraska....It is hereby adjudged, ordered and decreed...the license...to practice medicine and surgery in the State of Nebraska...is hereby revoked for all time...."

DATE: From October 1974 through March 1975

JURISDICTION: Michigan

EVENT: Works as medical director at G___E___C___S___. Terminated for falsifying his application and personnel record.

DATE: From May 1975 through August 1975

JURISDICTION: Michigan

EVENT: Employed as medical director at the F___M___C___W___H___ in Dearborn. Requested to resign by management for falsifying his employment application.

DATE: October 3, 1976

JURISDICTION: Illinois

EVENT: "...the Medical Disciplinary Board of the State of Illinois ...filed a formal complaint against said Respondent and sent notice of said complaint to the Respondent by registered and regular mail...."

DATE: November 3, 1976

JURISDICTION: Illinois

EVENT: The Medical Disciplinary Board held a "hearing on the complaint filed by the Department...Respondent was not present at said hearing...(although) due and proper statutory notice of the hearing was received."

DATE: December 20, 1976

JURISDICTION: Illinois

EVENT: "...the Director of the Department of Registration and Education...did sign an order that the License of the Respondent...as a physician, be suspended for six months during which period (he) might appear before the Medical Disciplinary Board to offer evidence relevant to (his) future licensure. If (he does) not appear...during that six (6) month period then...license...shall be revoked."

DATE: March 1977

JURISDICTION: Michigan

EVENT: License revoked, based upon California and Nebraska actions.

DATE: March 18, 1977

JURISDICTION: Michigan

EVENT: "The Board requested that an attempt be made to locate D.Q.F., M.D., and personally serve the attached 'final order'...the investigator went to the University of Michigan Campus" and was "advised...that Dr. F. resigned without reason...and left a forwarding address"...the investigator went to the forwarding address, and left a message there, "but to date has not heard from Dr. F.". The investigator went to the L___ H___ Center where "the Administrator...advised that Dr. F. was released...after receiving information from the Board that (his) medical license had been revoked....the only address (the Administrator) had for Dr. F. was 8230 Merriman Road, Romulus, Michigan. Same day, found 8230 Merriman Road, Romulus, Michigan to be a non-existent address....Unable to determine the whereabouts of Dr. F. to serve the attached 'final order.'"

DATE: August 11, 1977

JURISDICTION: Illinois

EVENT: License revoked. "...the Director of the Department of Registration and Education...did sign an order that the license of the Respondent...as a Physician and a Surgeon, be revoked....the order of revocation...will be implemented as soon as possible and practicable as provided by law."

STATUS: ACTIVE.

Indiana license, issued 7/1/65, expires 6/30/84.

M.R.J., M.D.
Board Certified Family Physician Excluded by HHS for:
Unnecessary Services
Poor Quality of Care
Poor Documentation

Summary of Medicare Earnings:

1978 - $27,884

1979 - $32,256

1980 - $48,539

1981 - $31,843

DATE: May 13, 1980

JURISDICTION: DHHS Health Care Financing Administration, Region II.

EVENT: "...a New York County Health Services Review Organization (NYCHRSRO) physician advisor (family physician) performed an on-site visit...and reviewed nine (patients') charts. Based on this physician's findings, NYCHSRO requested written rationale from Dr. MRJ for:

1. The routine performance of physical examinations, chest x-rays, and laboratory testing every six months.

2. The lack of chart documentation concerning breast and rectal examinations.

3. The frequent use of B-12 injections.

4. The use of hormonal drug combinations to treat arthritis."

DATE: Between July 14, 1980 and September 11, 1981.

JURISDICTION: NYCHRSRO

EVENT: NYCHSRO holds a series of consultations and discussions of cases with Dr. MRJ and several expert physicians, including a family practitioner at Dr. MRJ's urging. These physicians verified the previously identified problems.

DATE: September 15, 1981

JURISDICTION: NYCHRSRO

EVENT: NYCHRSRO reaffirms its decision to recommend permanent exclusion from the Medicare, Medicaid, and Title V programs. Forwards recommendation to New York Statewide Professional Standards Review Council, Inc.

DATE: November 23, 1981

JURISDICTION: New York Statewide Professional Standards Review Council, Inc.

EVENT: NYSPSRC forwards recommendation of NYCHSRO to DHHS' HCFA Region II office with statement that NYSPSRC's "...Committee (on Sanctions) agreed with the PSRO that significant deficiencies in the quality of medical care provided by Dr. MRJ included the following:

--Management of patients seriously below acceptable standards of medical care;

--Inappropriate use of pharmaceuticals, including but not limited to: Vitamin B-12 injections, hormones, iron, anti-depressants, and anti-inflammatories;

--Abusive overutilization of services and visits;

--Inadequate chart documentation."

The New York Statewide Professional Standards Review Council also agrees with the PSRO's finding that Dr. MRJ's medical practice is potentially dangerous to the health and well-being of his patients. The Council's recommendation is as follows:

"In the opinion of the Council, the care provided by (him) to federal beneficiaries was flagrantly below acceptable levels of professionally recognized quality standards...Therefore, the Council recommends to the Secretary of Health and Human Services that (he) be excluded permanently from eligibility to provide Title V, XVIII and XIX on a reimbursable basis."

DATE: June 18, 1982

JURISDICTION: DHHS, HCFA, Region II

EVENT: Regional Division of Quality Control's forwarding PSRO "Sanction Report" to Director of Bureau of Quality Control with recommendation "...that Dr. MRJ be excluded from participaton..." in Title V and XVIII, and XIX programs for at least one year or "...until he can demonstrate that the grounds for the exclusion have been removed."

DATE: September 3, 1982

JURISDICTION: U.S. Congress

EVENT: Section 143 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), amending Chapter 11 of the Social Security Act, inadvertantly removes DHHS' authority to exclude Dr. MRJ from the Medicaid and Maternal/Child Health programs.

DATE: June 29, 1983

JURISDICTION: DHHS

EVENT: HHS writes to Dr. MRJ notifying him of their proposal "...to exclude all items and services furnished by you from Federal reimbursement under title XVIII (Medicare) and title XIX (Medicaid) of the Social Security Act for a period of 3 years..." and providing him with an opportunity to submit written arguments as to why he should not be excluded.

November 2, 1983: Dr. MRJ notified of his exclusion from participation in the Medicare program (alone) for a period of three years. The exclusion occurred because Dr. MRJ "...provided services which failed to meet professionally recognized standards of health care; provided services that were not medically necessary; and failed to provide adequate documentation of such medical necessity and quality...At the conclusion of three year period of time or anytime thereafter, you may be eligible for readmission to the programs."

DATE: November 30, 1983

JURISDICTION: DHHS

EVENT: Attorney for Dr. MRJ writes HHS requesting an immediate hearing regarding his exclusion from Medicare program, claiming in part that "irreparable harm is being done to Dr. J. and his patients."

DATE: January 12, 1984

JURISDICTION: United States District Court for the Southern District of New York.

EVENT: Dr. MRJ sues HHS and numerous others, seeking a preliminary injunction preventing HHS' exclusion from being implemented.

F.L.S., M.D.

Disciplined for:
Falsifying of Medical School Diploma
Falsifying Results of Blood Tests
Failing Competency Test

--Summary of Practice and Disciplinary Actions--

- Has held licenses in at least 6 states (AZ, CA, MA, NV, OH, WV).
- Licenses revoked or surrendered in at least 3 states (AZ, CA, OH).
- Now licensed in 1 state (NV).

- March 1981: Admits to California Board of Medical Quality Assurance (BMQA) he misrepresented his educational qualifications. In agreement with the Board, he surrenders his license prior to BMQA's filing of a formal proposed decision. BMQA's accusation is then dismissed, but BMQA retains the right to raise the issues again if he should ever reapply for a California license.

- July 1981: A Federal Grand Jury in California indicts him on ten felony counts. Indictments include multiple counts of submitting to the Food and Drug Administration falsified blood test documents while engaged in human subject research designed to test a new drug approved by FDA.

- October 1981: Convicted of submitting false documents to the FDA. Ordered to pay a $5,000 fine (in lump sum or installments), receives a suspended prison sentence, is placed on five year probation, and is prohibited from practicing medicine unless lawfully licensed. Nine counts are dismissed.

- March 1982: Having admitted the medical school diploma he submitted with his application for licensure in Arizona is false, and having failed a medical competence examination, the Arizona board revokes his license.

- October 1982: The Nevada state board revokes his license based upon the other state and federal actions, but stays the revocation and orders five years probation.

- November 1982: After receiving from the Ohio board two citations (alleging falsified graduation papers and a felony conviction), he surrenders his license to practice in the state.

F.L.S., M.D.

DATE: March 1, 1981

JURISDICTION: California

EVENT: "F.L.S., M.D., admits he incorrectly represented his educational qualifications to practice medicine in the State of California and is desirous of surrendering his certificate of licensure to the Board of Medical Quality Assurance for their formal acceptance. In consideration therefore, upon accepting the proffered surrender herein, the Board of Medical Quality Assurance agrees to dismiss the accusation...prior to the submission of a proposed decision with no prejudice to the board's raising the issues therein in a formal proceeding should F.L.S., M.D., reapply for licensure in California."

DATE: July 9, 1981

JURISDICTION: U.S. District Court, Central District of California.

EVENT: "...A Federal Grand Jury indicted F.S. on 10 Felony counts."

DATE: October 15, 1981

JURISDICTION: U.S. District Court, Central District of CA.

EVENT: "...convicted of the offense of submitting false documents to (the) Food and Drug Administration... as charged in Count Three of Indictment....IT IS ADJUDGED that on Count Three of the Indictment the defendant pay a fine to the United States in the amount of $5,000.00. Imposition of sentence as to imprisonment only is suspended and defendant is placed on probation for a period of five (5) years...and upon the further conditions that defendant (1) pay the fine herein imposed in a lump sum or in installments arranged through the Probation Office; (2) not practice medicine unless lawfully licensed; and (3) take no part in the conduct of any medical research investigation in connection with new drug applications or otherwise....IT IS ORDERED that Counts One, Two, Four, Five, Six, Seven, Eight, Nine and Ten of the Indictment are hereby dismissed....".

DATE: January 14, 1982

JURISDICTION: Ohio

EVENT: "...the Ohio Medical Board issued a citation letter to Dr. S. concerning his alleged falsification of his documents of medical education."

DATE: March 4, 1982

JURISDICTION: Arizona

EVENT: "...Doctor S. admitted that in applying for a license to practice medicine in the State of Arizona he submitted a diploma entitled "Diploma de Doctorate en Medicine et Chirugie", from University of Saigon in Saigon, Vietnam, as evidence of his graduation from medical school and further admitted that he now recognizes said diploma is false. Nevertheless, Doctor S. contended that he did in fact attend medical school at the University of Notre Dame School of Medicine in Hanoi, Vietnam." Doctor S. was ordered to undergo an oral medical competence examination. "A review of the transcript of the oral medical competence examination and the conclusions of the examiners show Doctor S. to be medically incompetent...in that he is lacking in sufficient medical knowledge and skills, in that field of practice in which he engages, to a degree likely to endanger the health of his patients....Doctor S. is guilty of unprofessional conduct and medically incompetent....IT IS ORDERED that the license of F.L.S., M.D., for the practice of medicine in the State of Arizona...be and hereby is revoked."

DATE: April 14, 1982

JURISDICTION: Ohio

EVENT: "...the Ohio Medical Board issued another citation letter alleging a felony conviction."

DATE: October 25, 1982

JURISDICTION: Nevada

EVENT: The state board, "...having duly considered the entire record and proceedings, found the Respondent guilty of the charges in the Complaint, to wit: That Respondent's license to practice medicine had been revoked by another jurisdiction and that Respondent had been convicted of a felony, and concluded that cause existed for the following Order...NOW THEREFORE IT IS ORDERED that Respondent's license to practice medicine in the State of Nevada is hereby revoked; provided however, that the execution of said Order of Revocation is stayed and Respondent is placed on probation for a period of five years beginning with the effective date of this Order."

DATE: November 22, 1982

JURISDICTION: Ohio

EVENT: "the above-named physician voluntarily surrendered his medical certificate to practice medicine and surgery in the State of Ohio..."

STATUS: ACTIVE.

(On probation, must annually demonstrate competence; may not practice obstetrics)

Nevada License, Issued 6/7/76, Expires 12/31/84.

Medicare, Medicaid certified.

D.Y.S., M.D.

Disciplined for Grossly Negligent and Grossly Incompetent Surgeries

--Summary of Practice and Disciplinary Actions--

- Has held licenses in at least 3 states (CA, MI, NY).
- Licenses revoked in at least 2 states (CA, MI).
- Now licensed in New York.

- Between February 1968 and November 1969 performed on three California patients grossly negligent and grossly incompetent back surgeries, resulting in one woman's death.
- About 1970 leaves the country to live abroad.
- October 1973: California's Board of Medical Quality Assurance (BMQA) revokes his license (he is not present at the hearing; represented by attorney).
- March 1976: Michigan reinstates his license. Works in Detroit until December 1976, when he is fired.
- Leaves the country again, spending 1977 in Europe.
- February 1979: Michigan license revoked.
- During 1981, New York is investigating his problems in California and Michigan.
- During 1982, applies for licenses in Kansas and Alaska.

D.Y.S., M.D.

DATE: February 26, 1968

JURISDICTION: California

EVENT: "Respondent has been guilty of unprofessional conduct in that he was grossly negligent and grossly incompetent with respect to his care and treatment of his patient, T.O., as follows:

> "Respondent performed extensive and dangerous surgery, consisting of a bilateral laminotomy and a total laminectomy on said T.O. ....Said surgical procedures were performed by respondent in the absence of physical or other findings to support the said surgery, and respondent thereby subjected his said patient, T.O., to the risk of dangerous and unnecessary surgical procedures."

"Respondent has been guilty of unprofessional conduct in that he was grossly negligent and grossly incompetent with respect to his care and treatment of his patient, R.T. as follows:

> "Without first localizing or verifying the existence of a lesion, or determining the existence of an emergency or indication for a surgical procedure, respondent performed an anterior cervical disc excision and an anterior decompression of the cervical spine and dura upon said R.T.... In performing said surgical procedure...respondent was guilty of gross negligence and gross incompetence in that it did not appear that said R.T. was suffering from any condition which would justify the surgical procedure performed by respondent, and the same constituted unnecessary and dangerous surgery."

DATE: November 18, 1969

JURISDICTION: California

EVENT: "Respondent has been guilty of unprofessional conduct in that he was grossly negligent and grossly incompetent with respect to his care and treatment of his patient, F.P. as follows:

> "Respondent, without prior myelographic or electromyographic or physical findings of sufficient magnitude to warrant a surgical procedure, performed

extensive and dangerous surgery, consisting of an anterior discectomy and anterior decompression of the dura at the C-5 to 6 and C-6 to 7 levels on said F.P.... Respondent was guilty of gross negligence and gross incompetence in the performance of said surgical procedure without myelograhic, electromyographic, or physical findings of sufficient magnitude to warrant such an extensive and dangerous surgery."

DATE: April 19, 1969

JURISDICTION: California

EVENT: "Respondent has been guilty of unprofessional conduct in that he was grossly negligent and grossly incompetent with respect to his care and treatment of his patient, M.D., as follows:

"Respondent caused said M.D. to be admitted...and on April 21, 1969, respondent performed on said M.D. an anterior cervical disc excision, according to the Cloward Technique, with discogram at three levels, a three level Dowel-Cloward Iliac Crest Graft, with three level anterior disc excision and posterior decompresion back to the dura and slightly laterally. During the course of said surgical procedure, respondent encountered a large bleeder at the C4-C5 level and packed it with Oxycel. A dowel graft was hammered home over this Oxycel. The use of Oxycel by respondent under said circumstances during said surgical procedure, and the hammering home of the dowel graft over the Oxycel pack as aforesaid, each constituted acts of gross negligence and demonstrated gross incompetence by respondent. As a direct result of respondent's said gross negligence and gross incompetence in the management of M.D.'s case, she expired on April 22, 1969."

DATE: October 24, 1973

JURISDICTION: California

EVENT: "The physician's and surgeon's certificate heretofore issued by the Board of Medical Examiners to respondent...to practice medicine and surgery in the State of California is revoked, separately and severally as to each of said causes for discipline."

DATE: March 12, 1976

JURISDICTION: Michigan

EVENT: Michigan Department of Licensing and Regulation reinstated Dr. S.'s expired license.

DATE: February 1, 1979

JURISDICTION: Michigan

EVENT: "Licensee, then a Board Certified Orthopedic Surgeon, after a formal hearing before the California Board of Medical Examiners...was determined to have committed acts of unprofessional conduct in that he had been grossly negligent and grossly incompetent with respect to the care and treatment of his patients.... the holding in Maccarato v Grub,...in LeBlance v Lentini...(is instructive):

> "The reliance of the public upon the skills of a specialist and the wealth and sources of his knowledge are not limited to the geographic area in which he practices. Rather his knowledge is a speciality. He specializes so that he may keep abreast. Any other standard for a specialist would negate the fundamental expectations and purpose of a specialty. The standard of care for a specialist should be that of a reasonable specialist practicing medicine in the light of present day scientific knowledge. Therefore, geographical conditions or circumstances control neither the standard of a specialist's care nor the competence of an expert's testimony.

"Licensee being a Board-Certified Orthopedic Surgeon in 1968-1969 is held to a national standard of care and having performed the acts violative of the standard of care in California, he violated minimal standards of care in Michigan....The license to practice medicine in the State of Michigan heretofore issued to D.Y.S., M.D. shall be and hereby is revoked."

Shortly after this action, according to an article in the Detroit Free Press, dated 4/4/84: "S., 55, did not have kind words for the Michigan Board: 'I think they're the biggest bunch of lying, cheating frauds in the world. In spite of the fact that I had good references from Detroit, and in spite of the fact that I was the most super-trained and highly trained man in the entire history of the world, they revoked my license. They should be lined up in front of the AMA building in Chicago and machine-gunned to death and the blood left there for a day.' "

DATE: August 12, 1981

JURISDICTION: New York

EVENT: In response to New York State Department of Health's inquiry into Michigan state action, certified copies of final order sent New York.

DATE: October, 1982

JURISDICTION:Kansas

EVENT: License application denied based on California's action. Kansas notified by Michigan Board about California & Michigan revocations per Kansas Board's request.

DATE: November 19, 1982

JURISDICTION: Alaska

EVENT: In response to Alaska's Division of Occupational licensing request, Michigan authorities sent certified final order of Michigan decision.

STATUS:

ACTIVE

New York license, expires 12/31/85. Eligible for Medicare reimbursement.

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APPENDIX 2.—NEWSPAPER ARTICLES DEALING WITH UNFIT MEDICAL PRACTITIONERS

Detroit Free Press

Volume 153, Number 333 PAGE 1A ON GUARD FOR 152 YEARS Sunday, April 1, 1984

bad doctors/license to err?

First of seven parts

A system whose ills can be fatal

Dr. Weldon Cooke's mistake left a healthy 19-year-old woman dead on the operating table. Dr. Edith Lee is in jail in Texas. Dr. Larry Kompus seduced his severely disturbed psychiatric patients into homosexual relationships. Dr. Dale Williams has been barred from two Muskegon hospitals and sued 10 times.

All four doctors can still practice in Michigan.

Dr. Joseph Rucker Sr. cannot. He lost his license after his botched abortions left two women sterile and resulted in the birth of a baby with a piece of her scalp missing.

But Rucker kept his license for nine years while his case dragged through hearings and into the courts. During the last four of those years, the state paid him almost $1 million to care for Medicaid patients.

After a 15-month investigation of how effectively the Michigan Board of Medicine protects the public against incompetent doctors, the Free Press has found that if you are a patient in Michigan:

- The only thing you can assume from the license on the office wall is that your doctor went to medical school and once passed a test. Licensure — the state's certification that your doctor is competent — does not offer reasonable assurance that the doctor who may have life and death power over you is not on drugs, is not mentally ill, is not unethical and is at least minimally competent.

If you are an incompetent doctor:

- The chances are good that you will never come to the state's attention.
- Even if you do, the state has to produce both expert witnesses and physical evidence to prove your incompetence, much as a prosecutor would have to prove a case in court. Often the state fails.
- Even if the state does bring charges, you will be able to continue treating patients for an average of 2½ years before your case is resolved.
- Even if the board finds you incompetent, you have better than a 50-50 chance of keeping your license.
- And if you lose your license, you have a 50-50 chance of getting it back.

The overwhelming majority of the 20,000 doctors licensed in Michigan are competent. But that is small comfort to the patient who picks one of the few incompetent ones.

National estimates — which vary greatly — suggest that between 600 and 2,000 doctors licensed in Michigan are incompetent.

Yet the Board of Medicine revokes an average of only three licenses a year. Another half dozen are suspended, and three more, of retirement age, surrender their licenses.

By comparison, Michigan has about the same number of lawyers as doctors — but five times more lawyers lost their licenses in 1982. And a disbarred lawyer must wait five years to apply for reinstatement; a doctor need wait only a year.

Of the 74 doctors who lost their licenses in the 1977 through 1982 period the Free Press studied, 30 so far have them back. Twenty-seven others either have retired, at an average age of 77, or set up practice in other states.

In other words, the state forced only 17 doctors of working age out of the profession in six years.

Michigan's problems are not unique, nor does its Board of Medicine compare badly with those in other states. In the last three years, according to the U.S. Federation of State Medical Boards, Michigan has ranked at least in the upper half of states in the number of actions taken against doctors.

Coming up

- **MONDAY:** Why many incompetent doctors will never be caught.
- **TUESDAY:** Doctors who have lost their licenses can get them back — again and again.
- **WEDNESDAY:** Doctors who lose their licenses in Michigan often become other states' problems, and vice versa.
- **THURSDAY:** The drug problem — doctors who take them, doctors who sell them.
- **FRIDAY:** Medical societies, hospitals and malpractice suits also are supposed to help control incompetent physicians. They don't.
- **SUNDAY:** Solutions. The state plans changes. How to find a good doctor, report a bad one and monitor the care you get.

DETROIT FREE PRESS/SUNDAY, APRIL 1, 1984

Three weeks after the death of Pamela Wahl-Arnold, left, the Board of Medicine concluded that Dr. Carol Varner's handling of the case showed Varner, above, was an "imminent threat" to public safety. Wahl-Arnold's brother, William Wahl, of Northville Township, called Varner "just totally inept . . ." and asks, "Why in the hell was she allowed to practice? What protection do you have against bad doctors?"

Doctors practice while wheels turn

By DOLLY KATZ
Free Press Medical Writer

Pamela Wahl-Arnold most likely would be alive today if the state had suspended Dr. Carol Varner's license one month earlier.

Arnold was the victim not only of bad medicine but also of a licensing system that requires an average of 2½ years — and as long as nine years — to investigate, prosecute and decide a case against an incompetent doctor, and then to enforce that decision.

Meanwhile, the doctor is free to treat patients.

Varner practiced from her office near Lansing for five years while the cases against her ground to their conclusions. *(See chart on Page 12A).* The causes of the delay are clear and chronic. So are the results.

Arnold, an office manager for Burger King, showed up at Varner's Okemos office March 19, 1982, with classic symptoms of untreated diabetes. Later testimony would indicate that she had been drinking large quantities of water and was urinating frequently. She was weak, gasping for breath and clutching her stomach in pain.

She had been referred to Varner by a local chiropractor. She could not have known that the doctor examining her had been under investigation by state licensing officials since 1969 for improperly prescribing narcotics, and in 1973 had temporarily

See WAIT, Page 12A

12A
DETROIT FREE PRESS/SUNDAY, APRIL 1, 1984

Licensing board cure is slow and uncertain

WAIT, from Page 1A

lost her license to prescribe narcotics.

She probably did not know that Varner had been kicked off the staff of Lansing's Sparrow Hospital in 1977 for mishandling obstetrics cases — or that Varner was defending herself in two cases before the Michigan Board of Medicine, cases she would lose.

One, filed by the state Attorney General's office in 1981, charged Varner with 20 counts of irresponsible drug prescribing.

The other, which the state filed in 1978 and amended in 1980, charged Varner with incompetent treatment of seven patients, including a woman whose baby almost died during a home birth.

For at least a week before that birth, Carribea Chappel, 25, had symptoms of pre-eclampsia, a potentially fatal complication of pregnancy. But Varner went through with the home birth, arriving without a stethoscope or other basic medical equipment, according to the hearing examiner's findings. She reportedly tried to speed up Chappel's difficult, 21-hour labor by dousing her with vinegar and witch hazel. She performed an episiotomy — an incision to widen the vaginal opening — on Chappel and did not repair it. She prescribed sea lettuce leaf tablets for Chappel's post-delivery bleeding, which continued for five weeks until another doctor removed the retained pieces of placenta that were causing the bleeding.

Free Press Photo

Jacob Chappel, now 5, survived Varner's incompetent treatment.

The baby, Jacob, was rushed to Sparrow Hospital in critical condition and survived a traumatic night during which his heart stopped twice, according to the state charges and his mother.

Questions not asked

The drug charges and her handling of obstetrics cases eventually would cost Varner her license.

But during the snail's pace of the process, Arnold lost her life.

On that March day in her office, contrary to basic medical practice, Varner did not ask Arnold whether she was drinking a lot or urinating frequently, even though Arnold said her throat was dry, drank a cup of water in Varner's presence and excused herself to use the bathroom, the hearing officer found.

Varner did not ask Arnold if she had a history of diabetes. She did not perform the simple urine or blood tests that would have revealed the diabetes.

Instead, Varner concluded that Arnold's rapid breathing signaled an anxiety attack. She made Arnold breathe into a paper bag to slow her breathing.

"Just take it easy," she told Arnold. She gave Arnold a pain shot and a prescription for sedatives, and sent her home, with instructions to come back if she was not better in a few hours.

Three hours later, her friend, Teresa Wood, brought Arnold back, no better. Varner recommended counseling.

That night, Wood called Varner, said Arnold was getting worse and asked if she should take her to a hospital. No, Varner responded, it would just confirm her emotional feelings.

The next morning, Wood could not wake Arnold. An ambulance took her to Sparrow Hospital, where doctors diagnosed diabetic coma.

The diagnosis came too late. Arnold died the next morning, despite emergency treatment.

Varner later claimed she was misled by Arnold's unusual symptoms — although the doctor at the hospital testified he was able to diagnose Arnold's diabetes within 30 seconds.

"I did miss the diagnosis," said Varner, now 59. "I had never before seen a woman in diabetic coma who was alert and wide awake. And she gave such a wonderful history to indicate a severe neurotic."

Both the doctor who signed the death certificate and the doctor who performed the autopsy concluded that Arnold died of diabetes, but Varner insisted that Arnold was a victim of poor treatment at the hospital.

"She didn't die of diabetes," Varner said. "She was drowned. They gave her too much fluid at the hospital. The hospital knew they'd blown it, so they sicced the family on me."

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Doctor an 'imminent threat'

Three weeks after Arnold's death, on April 14, 1982, the Board of Medicine concluded that Varner's handling of the case showed she was an "imminent threat" to public safety. Invoking its emergency powers, the board summarily suspended her license while it considered the charges.

Eight days later, the board issued its decision on the 1978 charges of incompetence in delivering babies and treating gynecologic patients.

Varner's license was suspended for at least a year. Upon reinstatement, she would not be allowed to practice obstetrics for three years.

Had the board's order come 34 days earlier, Varner would not have been able to treat Arnold.

Six months after Arnold's death, the board revoked Varner's license on the basis of the 1981 drug charges.

And last August, the board revoked Varner's license again because of her treatment of Arnold.

The board ordered that the two revocations run consecutively. Because a doctor can apply for reinstatement a year after a revocation, the board's order means that Varner can apply for her license in September.

"SHE KILLED my sister," said Arnold's brother, William Wahl, of Northville Township. "The doctor you depend on was just totally inept. She couldn't even make the basic diagnosis.

"The whole point is, why in the hell was she allowed to practice? What protection do you have against bad doctors?"

The agency that is supposed to protect Michigan citizens against bad doctors is the Michigan Department of Licensing and Regulation, which includes 13 boards that license the state's 170,000 nurses, medical doctors, osteopathic physicians, dentists and other health care professionals.

Like other states' medical boards, Michigan's Board of Medicine licenses new doctors, who have graduated from medical school and passed examinations, and established doctors — like Varner — who can show they are licensed in other states. Varner was originally licensed in Ohio. After the Board of Medicine licenses doctors, it is supposed to make sure they remain at least minimally competent.

In practice, though, the board does not monitor all 20,000 of Michigan's doctors — 4,000 of whom are currently practicing in other states.

Instead, it weighs evidence against those who come to the attention of the Department of Licensing and Regulation because of citizen complaints or because they have been disciplined by a hospital, sued, or investigated by drug agents.

VARNER'S OBSTETRICS case took five years to wend its way through the state licensing system, from June 1977 — when licensing officials learned of the problem — until the board suspended her license in April 1982. The drug case took almost three years.

A Free Press study of 187 cases brought before the Board of Medicine by the attorney general from 1977 through 1982 shows that Varner's cases took longer than average but were not unusual.

In those six years, the average case took 2½ years from the time the doctor came to the state's attention until the board's order took effect.

The process takes so long partly because the Department of Licensing and Regulation is disorganized and underfinanced. But it is also the result of a regulatory system that seems designed more to protect the health care professional's license than to protect the public's health. *(See steps, Page 13A.)*

Delays hurt some cases

Some cases do move swiftly.

The board revoked Dr. Pedro Berdayes' license only 15 days after an off-duty police officer caught him injecting himself with Talwin, an addictive painkiller, in a pharmacy parking lot.

That April 1980 case was handled so quickly because Berdayes' license had been taken away once before, in 1977, after he admitted he was a Talwin addict. The board had restored his full license only three months before the parking lot incident.

Berdayes' first case took three years, slightly longer than average. But many cases take far longer. Dr. Willard Green signed an agreement in 1983, shortly after his 80th birthday, that he would retire when his license expired at the end of January 1984 — almost eight years after Pontiac General Hospital notified the board that his admitting privileges would not be renewed because of poor quality patient care.

Dr. Joseph Rucker Sr. lost his license last year — nine years after the state learned about botched abortion attempts at his Detroit clinic.

Indeed, delay sometimes renders the board's action meaningless.

Eight-year-old Tracey Mallory died of blood poisoning in Traverse City in 1975. Her doctor, Charles McManus, admitted her to the hospital by telephone, never went in to examine her and never diagnosed her illness. By the time the board's 60-day suspension of his license took effect, in 1981, McManus already had moved to Hawaii and begun a family practice.

MOREOVER, A BAD doctor often practices for years before the problem even comes to the state's attention.

Dr. Stanley Lynk's reputation as an irresponsible drug prescriber was well established in Flint by 1976. But the board did not get wind of the problem until 1980, after one of Lynk's patients died of a drug overdose and the attorney for the family notified the board. Lynk, who by then had moved his operation to a room at the Scenic Motel in Grand Blanc, was summarily suspended Sept. 2, 1981.

Some incompetent doctors may never be caught.

Licensing officials do not know about the skin doctor who gave a 61-year-old woman the gruesome disease that helped kill her. In an attempt to treat her herpes infection, the doctor on April 1, 1982, gave her a smallpox vaccination — despite repeated warnings from the manufacturer and the federal government that the outmoded practice is dangerous and has no proven value in the treatment of herpes or any other disease.

At the site of the vaccination on her left arm, the woman developed a small ulcer, filled with dead skin and pox virus, that grew — and grew. By the time Dr. Marc Gurwith, an infectious disease specialist, saw her at St. Lawrence Hospital in Lansing, the ulcer was two inches square. Within a month, another ulcer formed on her left thigh.

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DOCTORS TRIED to kill the pox viruses with interferon. They tried to cut away the ulcer on her thigh. Nothing worked. The areas of dead and dying tissue spread across her arm and thigh.

Eventually, doctors discovered an underlying cancer that had raised havoc with her body's defense system, permitting the vaccine virus to grow unchecked.

By the time she died last spring, the ulcer on her arm measured about six inches by five inches.

Gurwith said he believes the smallpox vaccine infection contributed to the woman's death. "It certainly made her miserable the last months of her life," he said.

Although Gurwith sent a report on the case to the federal Centers for Disease Control, he would not reveal the doctor's name and says he will not report him to the state.

"I'm certain he'll never do it again," he said. "Secondly, although I consider it malpractice and bad medicine, there are people who do it.

"I'm not sure it's my business to report it, nor do I think the medical board would do anything about it."

bad doctors/license to err?

DETROIT FREE PRESS/SUNDAY, APRIL 1, 1984 12A

One doctor's story: 12 years to revocation

Carol Varner's license was suspended after more than a dozen years of charges of incompetence and indiscriminate prescribing of dangerous drugs. The following chronology is based on hearings, records, testimony and other documents filed in Varner's case.

Key: drug violations | obstetrics-gynecology incompetency | general medical incompetency

Dates when specific actions are taken are set in bold. In some cases, a specific date will combine actions concerning both drug violations and general medical incompetency.

Dec. 29, 1969:
State board of Medicine rquests investigation after pharmacy inspector reports Varner has written several prescriptions for methadone for an 18-year-old man.

April 29, 1970:
Investigator contacts Varner, warns her against indiscriminate prescribing of narcotics. Case closed.

May 11, 1970:
Investigators learn of more prescriptions by Varner for methadone. Another warning.

Aug. 2, 1971:
Three federal drug agents try to make a drug buy. Varner says she's not accepting new patients.

Aug. 16, 1971:
Board of Pharmacy informs Board of Medicine of complaint from a woman who says Varner is prescribing excessive amounts of Seconal and Nembutal to her 39-year-old brother.

Aug. 20, 1971:
Board of Medicine requests another investigation.

Sept. 17, 1971:
Police officer informs state investigator that Varner writes prescriptions for dangerous drugs without seeing patients.

April 5, 1972:
Board member demands to know, once and for all, whether reports about Varner over last two to three years are true.

April 6, 1972:
Investigator gets appointment. Varner puts her hands on his back for 30 seconds, writes prescription for Demerol, a morphine-like narcotic.

April 11, 1972:
Varner writes prescription for investigator for 100 tablets of Lorfine, a painkiller, with no exam.

Dec. 21, 1972:
Attorney general issues formal charges against Varner: prescribing drugs for other than legal and therapeutic purposes.

Feb. 27, 1973:
Varner surrenders for three years her license to prescribe dangerous drugs.

April 28, 1975:
Varner mismanages pregnancy at St. Lawrence Hospital.

July 12, 1976:
Board of Pharmacy reissues Varner's license to prescribe narcotics and other dangerous drugs.

December 1976:
St. Lawrence Hospital suspends Varner's privileges to admit obstetrics patients.

June 28, 1977:
Board of Medicine asks for investigation.

July 6, 1977:
Varner inadequately manages patient's pelvic infection; woman subsequently undergoes partial hysterectomy.

July 7, 1977:
Sparrow Hospital suspends Varner because of years of problems with recognizing pregnancy complications.

July 29, 1977:
Varner attempts home delivery of problem pregnancy (breech baby); infant subsequently delivered by cesarean section by another doctor.

February 1978:
Subpoenas issued for Varner's records.

August 1978:
Varner begins prescribing large amounts of narcotics and other dangerous drugs to patients.

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Dec. 6, 1978:
Attorney general formally charges Varner with 10 counts of incompetence in obstetrics-gynecology cases.

Jan. 21, 1979:
Varner agrees to home delivery of high-risk pregnancy. Arrives without basic equipment. Carribea Chappel, 25, in labor 21 hours. Varner ignores fetal distress. Baby rushed to hospital in critical condition. Chappel bleeds five weeks from retained placenta. Varner prescribes sea lettuce leaf tablets.

March 29, 1979:
Compliance conference with member of Board of Medicine.

Aug. 21, 1979:
Varner's lawyer withdraws from the case.

November 1979:
Varner gets another lawyer.

Jan. 8, 1980:
Hospital pharmacist refuses to fill prescriptions for Varner's patients, notifies state.

Feb. 25, 1980:
Lawyer for Carribea Chappel informs board of her treatment by Varner.

June 10, 1980:
Board proposes settlement: Varner not to practice obstetrics or neonatology; three years' probation. Settlement fails.

Oct. 2, 1980:
Attorney general adds Chappel case to charges against Varner.

Oct. 3, 1980:
First hearing.

Dec. 3, 1980:
Varner's lawyer withdraws; hearing adjourned.

Feb. 5, 1981:
Attorney general charges Varner with 20 counts of irresponsible prescribing of narcotics and other dangerous drugs.

Feb. 19, 24-25, 1981:
Hearings.

July 22-24, 1981:
Hearings.

Sept. 2, 1981:
Hearing.

Jan. 4, 1982:
Hearing.

March 8, 1982:
Hearing.

March 19, 1982:
Pamela Wahl-Arnold visits Varner with symptoms of diabetes. Varner diagnoses emotional trauma, tells Arnold to breathe into a paper bag as treatment for hyperventilation.

March 21, 1982:
Arnold dies of diabetes at Sparrow Hospital.

April 2, 1982:
Hearing law judge issues opinion finding Varner incompetent in obstetrics-gynecology cases.

April 13, 1982:
Attorney general charges Varner with incompetence in Arnold's treatment.

April 14, 1982:
Board, invoking its emergency powers and declaring Varner "an imminent threat to the public health, safety and welfare," summarily suspends her license.

April 22, 1982:
Board suspends Varner's license for a year, followed by three years' probation during which she cannot practice obstetrics.

May 2, 1982:
Varner, now unlicensed, allegedly dispenses a narcotic painkiller to a woman.

May 6, 1982:
Hearing.

May 19, 1982:
Administrative law judge issues opinion that Varner's drug prescribing was incompetent.

May 25, 1982:
Hearing.

June 7, 1982:
Hearings.

June 9, 1982:
Attorney general obtains a court order to stop Varner from practicing without a license.

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July 15, 1982:
Hearing.

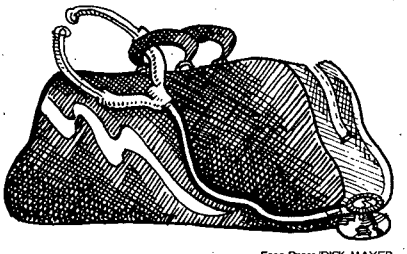
Sept. 11, 1982:
Board revokes Varner's license.

May 25, 1983:
Administrative law judge issues opinion finding Varner incompetent in Arnold's treatment.

Aug. 10, 1983:
Board revokes Varner's license again, orders that the two revocations run consecutively.

Nov. 11, 1984:
Varner is eligible to apply to get her license back.

Seven Steps: How the system works



Free Press/DICK MAYER

The state Board of Medicine, which makes the final decision on a complaint against a doctor, sits at the end of a long, tortuous road that all complaints have to follow through the Department of Licensing and Regulation.

State law, judicial decisions and bureaucracy have endowed the process with the rigor of a court proceeding and the complexity of a Japanese tea ceremony.

Some 250 cases are now scattered through the steps of the system.

1. COMPLAINT ANALYSIS.

Every complaint against a doctor — whether from an individual, a hospital or a law enforcement agency — must enter the system through the Office of Complaint Analysis, which packages it for its journey.

The office reviews the complaint to determine whether any of the charges could be a violation of the state licensing act (fee disputes are not) and sends it to an investigator or, if it alleges incompetence, to a board member for evaluation.

By law, incompetence complaints must be sent to a board member within five days of receipt. In fact, a complaint now spends as long as six months in paperwork at its first stop.

Attorneys, board members and others associated with the department have complained for years about the office's inefficiency. Complaints disappear or are lost. One complaint file, about a doctor who had lost his license to prescribe narcotics, bears this notation: "closed on an unknown date . . . due to an unknown reason."

Licensing officials appointed last year by the Blanchard administration have acknowledged this problem, among others, and have vowed to improve the operation.

"Every time I check into something, it seems to get a little worse," William Howe, administrator of the Department of Licensing and Regulation's Bureau of Health Services, told the Board of Medicine last December.

2. INVESTIGATION

The first investigation of Dr. Carol Varner's activities took three years before a formal complaint could be filed. The second took 1½ years. The third, a year.

Staff shortages are partly to blame. State budget cuts last May reduced the number of full-time investigators from 17 to six — to handle investigations for 13 licensing boards that regulate more than 170,000 health care professionals. Investigators interview witnesses, conduct undercover work, serve subpoenas and collect records. The two investigators in Detroit are handling a total of 120 to 140 cases.

Even when there were 17 investigators, they did not always seem to allocate their time according to the seriousness of a case. The Free Press investigation showed that, except in emergency cases, investigators took each case as it came in, without priorities. An investigator spent almost a year determining that a St. Clair Shores doctor was supervising a physician's assistant without the approval of the Board of Medicine. (The doctor was reprimanded.)

Investigators usually have been trained in law enforcement, not medicine or regulatory law; the civil service hiring guidelines require no specific educational background. No in-service training is provided, but bureau director Howe says he is planning a training program for all employes.

Investigators operate independently of board members and attorneys. In the cases studied by the Free Press, it was the investigators who decided whether and how cases should be pursued. One investigator warned Varner about her prescribing habits and then closed the case against her.

In another case, an assistant attorney general sent memos to investigators beginning in November 1979, asking them to investigate complaints about Dearborn Dr. John Chester Watts' prescribing. The investigators declined to investigate until 1981. Watts' license was summarily suspended in January 1982.

"I would say the single biggest cause of delays is that the board has no control over the handling of the cases and no information about the cases and no records about them," said Dr. James Fenton, a Bay City radiologist who has been a board member for six years and now is its chairman. "We have no power, no authority (over the department employes); we just sit and wait. Even if I know there's a case cooking, I can't get in there and put a torch under anybody.

"We've offered many suggestions and comments. I've gotten into shouting matches with one of the bureaucrats. We're furious with these delays. Sometimes I feel I want to go down and punch somebody in the nose because they're so slow."

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DETOUR: CRIMINAL COURTS

If a criminal case starts, the licensing case usually stops. Everybody benefits except the public.

Prosecutors are glad because they usually don't like to share their information or their witnesses with other enforcement agencies, for fear it will damage chances for a conviction.

Investigators and licensing officials can accept it because their jobs become easier. Because conviction of a felony is ground for license revocation, the state's attorney need only wait for the court to act, then present a copy of the conviction to the hearing officer, and the state's case is complete. Even if no conviction results, the court testimony often still can be used.

Doctors benefit because they can continue practicing.

The public, however, must wait that much longer to find out if doctors like Eugene Jakubowski and Leo Donaldson are fit to practice.

Jakubowski, a former urology resident at Henry Ford Hospital, was convicted in November 1982 of participation in a prescription mill that investigators said poured millions of doses of addictive drugs into the community. Jakubowski, who worked undercover for the FBI after agents caught him, served three months in prison in Lexington, Ky., was released and is on parole in Detroit. He remains fully licensed. The state's challenge to his license, based on the 1982 conviction, is pending before the Board of Medicine.

Donaldson, a surgeon, was charged with second-degree criminal sexual conduct after a woman claimed he molested her while she was a patient at St. Joseph Mercy Hospital in Pontiac on Dec. 15, 1982.

The Oakland County Prosecutor's Office has refused to give state licensing investigators the woman's address and phone number and has suggested they wait to question her until the criminal case is finished. The state is waiting.

Meanwhile, the hospital's teaching faculty has refused to certify Donaldson to take the American Board of Surgery examinations because of his "totally inadequate" performance as a resident, according to minutes of the faculty's Aug. 1, 1983, meeting.

Donaldson, who is black, charges that the faculty's actions were racially motivated and that hospital officials helped concoct the criminal charges in retaliation for Donaldson's civil rights suits against them.

Donaldson is on the staff at Kirwood General Hospital

3. ATTORNEY GENERAL'S OFFICE

A completed investigation goes to one of four assistant attorneys general who handle cases for 22 boards in addition to the Board of Medicine. The lawyer who reviews a case often sends it back to Step Two for more investigation.

A complaint against Dr. Albert Keefer, of Concord, charging him with prescribing massive doses of narcotics for minor problems like gum pain, went back to investigators for another 11 months of investigation after an attorney examined it. Total investigatory time: two years. Keefer, who died recently, ultimately lost his license for six months.

4. COMPLIANCE CONFERENCE.

Once notified of charges, a doctor must be given a chance, at a conference with a board member, to demonstrate either that the charges are a mistake or that the violations were trivial and have been corrected.

Finding a conference date that fits the schedules of the doctor, the doctor's lawyer, the assistant attorney general and the board member can take months. Carol Varner's compliance conference came almost four months after she was charged with incompetence in the obstetrics-gynecology cases.

EMERGENCY ACTION: SUMMARY SUSPENSION

If the doctor's behavior appears to be "an imminent threat to the public health, safety and welfare," the attorney general can ask the Board of Medicine to summarily suspend the license pending a decision on the charges.

In theory, this provision allows the board to protect the public against the most dangerous doctors while the case wends its way through the system.

In fact, "imminent threat" is a slippery concept not easily applied.

The designation is easiest to pin on doctors who have been convicted of crimes. Convictions are unambiguous and easily understood — particularly by judges who might be inclined to strike down a suspension based on the vaguer concept of competence. Preston Ports, a Three Rivers physician diagnosed as a chronic paranoid schizophrenic, won a three-year court stay against the board's 1975 summary suspension.

In practice, summary suspensions are used not necessarily against the most dangerous doctors, but against those whose guilt can be most easily established.

Dr. James Gotham, a neurologist, was suspended from the Harper Hospital staff in December 1981 because he exhibited impaired memory that doctors attributed to a rare neurological disorder. The hospital immediately notified the board of the suspension.

The board did not summarily suspend Gotham as an "imminent threat" until 1½ years later — after he pleaded guilty in U.S. District Court to writing illegal prescriptions for Quaaludes, a much-abused sedative.

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5. NEGOTIATIONS

The conference is followed by informal attempts at a settlement, much like plea bargaining in the criminal courts.

The first two lawyers that Carol Varner hired bargained in succession with the board's lawyer for almost 1½ years before a proposed settlement on the incompetency charges fell through. If the matter had gone directly to a hearing, Varner might never have treated Pamela Arnold.

Dr. Lois Dunegan sparred with the state's attorney for almost three years over charges that her incompetence led to the death of a 19-year-old Lansing area woman. Dunegan operated on Cheryl Burnham after the woman was injured in a traffic accident. The state charged that she failed to detect the woman's internal bleeding, which proved fatal.

By the time the board suspended her license Feb. 8, she had moved to Pennsylvania and a surgeon's job at a hospital there. The physicians who hired her were unaware of the charges against her.

6. HEARINGS

Drawing out hearings for a year or more seems to be almost a fine art for defense lawyers and their clients. Adjournments, reschedulings and other delays can add months to the process.

Varner's eight days of hearings stretched from the beginning of October 1980 to the end of July 1981. Included was a delay of more than two months, when her attorney withdrew from the case and she had to find another.

7. BOARD

At the end of the hearings, the administrative law judge handling the case writes an opinion and sends it to the Board of Medicine, composed of 10 doctors, a physician's assistant and three people not in a health care profession. Writing the opinion can take several months. The opinion on Carol Varner's obstetrics cases came out nine months after the final hearing and two weeks after Arnold's death.

Board members read the opinion and decide whether to revoke, suspend or limit a doctor's license, impose probation or dismiss the charges.

After the board rules, the doctor can move the case into yet another arena: the courts.

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What the state revokes, the courts can restore

By DOLLY KATZ
Free Press Medical Writer

A final order of the Board of Medicine often marks only the halfway point in the process of disciplining a doctor. In the next step, the board is the defendant and the doctor the accuser. A doctor who loses before the board might win in the courts — time, money or license.

If the Board of Medicine had its way, Dr. Robert Sillery would not be practicing today. The board ordered the Grosse Pointe pathologist's license suspended for at least two years. But a circuit court judge overruled the board and restored Sillery's license.

The courts haven't made up their minds about Dr. Norbert Anderson, 54, of East Lansing, but he's in no hurry. He's been practicing three years under a court order blocking his two-year suspension for prescribing 6,700 tablets of a morphine-like painkiller for a drug addict.

Judges ultimately agreed with the board that Detroit physician Joseph Rucker Sr. is incompetent — but not before he earned almost $1 million in Medicaid fees during the four years his case was in court.

One in five physicians whose licenses are revoked or suspended wins a court stay, according to the Free Press investigation of cases before the Board of Medicine from 1977 through 1982.

Court reprieves tend to be long. Once a case enters the courts, it stays there an average of almost two years, the Free Press investigation found. Meanwhile, the doctors continue to practice.

TODAY, four physicians whose licenses have been suspended by the board for alleged irresponsible drug prescribing continue to practice under the shelter of court orders.

One is George Shargel, 69, of Bloomfield Hills, charged with running a prescription mill on E. Seven Mile in Detroit. The board declared Shargel an "imminent threat to the public safety" in 1981 and suspended his license on an emergency basis. Oakland County Circuit Judge George LaPlata restored it provided Shargel give up his license to prescribe narcotics until federal officials decide whether to prosecute.

Court stays also are protecting Anderson; Donald Finch, 65, of Onaway, suspended in 1980 for prescribing massive quantities of narcotics to four patients, and William Stewart, 48, of Union City, suspended last June for overprescribing amphetamines.

State law guarantees the right of court appeal in licensing cases, but does not require stays. Legal tradition and precedent allow stays only if the evidence suggests the appeal will be successful and the board's order reversed.

YET JUDGES often ignore those guidelines when doctors ask for stays.

Rucker's license was suspended in 1979, then revoked in 1980 for a series of bungled abortion attempts that left two women sterile and resulted in the birth of a baby missing part of her scalp.

But Rucker obtained stays allowing him to continue practicing for four years. After Ingham County Circuit Court judges threw out the stays, the Michigan Court of Appeals reinstated them.

"To me, it does not serve the public well when circuit judges grant stays (to doctors) almost as a matter of course," said a Detroit lawyer who often represents doctors.

"A guy with a ski mask walks into a bank and robs it; I have found judges not reluctant to give that person a ton of time. Yet you can prove a physician is totally and completely incompetent, give him a fair (hearing), and the moment he appeals to circuit court, a judge will grant a stay.

"I don't think that's right. It goes back to the notion that doctors can do no wrong."

Judges who grant stays argue that a decision to revoke a physician's license should not be taken lightly.

"You're talking about somebody's right to engage in a profession. You're not talking about something insignificant," said James Giddings, the Ingham County circuit judge who upheld the board's order suspending Rucker's license — four years after the board issued the order.

MOST DOCTORS who take their cases to court gain only time. But doctors won four of the 12 court appeals concluded in the years the Free Press studied.

In two cases — Dr. Jack Marrs, 56, of Muskegon, suspended a year for overprescribing addictive drugs, and Dr. Rolando Mateo, 45, of Detroit, suspended six months for billing for surgery he didn't perform — judges reduced the suspensions to one month because they felt the board had been too harsh. In a third case, a judge ordered a training license restored to a psychiatric resident who had been involved in a cocaine purchase in 1979.

The fourth case was Dr. Robert Sillery, 60, a Grosse Pointe pathologist, who was fired as Oakland County medical examiner in 1981 because the county found he had falsified 919 autopsy reports. In two cases, survivors said they could not collect accidental-death benefits because Sillery listed the cause of death as a rare disorder of the pancreas, when the victims actually were electrocuted.

In 1979, Sillery said Jamie McGrew, 25, died of liver disease. After the body was exhumed, another pathologist found fatal head injuries that his parents had charged were inflicted by a Madison Heights policeman.

Nine months after Sillery was fired, the board suspended his license for two years after finding he had falsified information in an autopsy report on a 17-year-old girl.

Sillery appealed and won. Last December, Wayne County Circuit Judge Robert Colombo, noting the suspension was for what the law calls "a violation of general duty," ruled that standard is too vague. The state plans to appeal.

AS A REACTION to such decisions, state Rep. Wilbur Brotherton, R-Farmington, has introduced a bill to bar judges from staying orders of the Board of Medicine and the Michigan Board of Osteopathic Medicine.

And the state Supreme Court has issued new rules to limit stays in appeals of licensing board decisions. Now a court may order a stay only if it finds that the applicant will suffer irreparable harm without a stay, that the public won't be harmed and that the court probably will decide in the applicant's favor.

But those rules reflect the principles that courts were to have been following all along.

Meanwhile, the readiness with which judges grant stays in such cases led Dr. Norman Rotter to resign from the Board of Medicine two years ago.

He wrote: "It should not take years to determine that a questionable practitioner should not be licensed, only to find out that the decision of this board has no presumptive validity in court and that a revoked license can be restored during a seemingly endless process of appeals and review of our efforts to safeguard the public.

"I was honored to have been chosen, but I cannot serve when I cannot function."

Losers before board, winners in court

Dr. Donald Finch: The Onaway doctor poses with a group of townspeople in 1955, during a fund drive to expand their health center. Twelve-year-old Russell Lee, whose picture is displayed in the photo, died in an accident in 1949, when the nearest doctor was 26 miles away. Finch still practices in the northern Michigan town, under the protection of a three-year-old court stay. In November 1980, the Board of Medicine tried to suspend him 90 days for overprescribing narcotics. One patient received 6,800 tablets of Percodan, a highly addictive morphine-like painkiller, in 16 months.

Dr. Jack Marrs: The Muskegon doctor was suspended by the Board of Medicine for a year for irresponsibly prescribing pep pills and other addictive drugs. The Court of Appeals reduced Marrs' suspension to one month.

Dr. Robert Sillery: Oakland County officials fired Sillery for falsifying 919 autopsy reports. The Board of Medicine suspended his license for two years. A circuit court judge gave it back. Sillery is now in private practice.

Michigan's ranking

How Michigan ranks with other states with more than 10,000 licensed doctors. The national average is 1.98 disciplinary actions per 1,000 doctors.

Rank among all states	No. of doctors	Actions in 1982	Actions per 1,000 doctors
1. Florida	22,258	148	6.65
8. N.J.	15,732	68	4.32
18. Calif.	63,163	144	2.28
26. MICH.	**16,000**	**28**	**1.75**
27. Va.	10,896	19	1.74
29. Md.	13,898	22	1.58
34. Ill.	22,997	24	1.04
36. Tex.	25,298	23	.91
37. Ohio	19,469	17	.87
38. N.Y.	51,590	44	.85
41. Mass.	17,310	12	.69
42. N.C.	10,117	7	.69
43. Pa.	24,864	14	.56

Sources: American Medical Association, Federation of State Medical Boards of the United States. The figures only list doctors who are both licensed by and practicing within a particular state.

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How this story came about

This investigation began almost 10 years ago, when Free Press medical writer Dolly Katz wrote a series of stories that led to state regulation of abortion clinics.

Dolly Katz

At one of the clinics she visited, unannounced and unidentified, Dr. Joseph Rucker Sr. examined Katz, told her she was pregnant (Katz has never been pregnant) and scheduled an abortion. Rucker's assistant was an ex-convict with no medical training whom Rucker allowed to perform abortions.

After the story, the state investigated and eventually charged Rucker with incompetence in three botched abortion attempts. His license was revoked — last year, after nine years of investigations, hearings and legal delays.

The case led the Free Press to examine the state's system of licensing doctors. Using the Freedom of Information Act, Katz studied each of the 205 doctors who came before the Board of Medicine on formal charges from 1977 through 1982 (and eliminated 18 for various technicalities).

For each doctor, Katz developed a chronology of state actions and searched court records for malpractice cases. Then she tried to find each doctor. More than 5,000 documents were copied and assembled for the study. Almost all the statistics used in the series were developed by the Free Press from these documents.

The 15-month study covered the 20,000 doctors licensed by the state Board of Medicine but not the 3,900 osteopathic physicians licensed by the Board of Osteopathic Medicine.

Katz, 38, has been Free Press medical writer since 1970. A native of Cleveland, she is a graduate of the University of Wisconsin. In 1976-77, she was a Nieman Fellow at Harvard.

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bad doctors/the burden of proof

Second of seven parts

The doctor who misdiagnosed the length of a pregnancy, and caused the abortion of a fetus estimated to be seven or eight months along; the pathologist who filed 919 false autopsies; the doctor who has been sued 10 times for malpractice . . .

Free Press Drawing by MOSES HARRIS

... The evidence was not enough

By DOLLY KATZ
Free Press Medical Writer

Six years ago, Dr. Julio Acosta of Detroit attempted an abortion on a Westland woman whom he diagnosed as 18 to 20 weeks pregnant.

He was wrong.

That night, after the woman delivered a live male child, doctors estimated she had been seven to eight months pregnant.

The baby lived four months at Children's Hospital before his heart and lungs failed.

In Michigan, it is manslaughter, a felony, to perform an abortion on a viable fetus — one who can survive outside the womb. Most doctors will not perform an abortion on a fetus older than 22 to 24 weeks, and many will not abort a fetus more than 20 weeks old.

State health officials who investigated the incident called it a "gross error" and recommended that the state Department of Licensing and Regulation investigate. A physician on the department's Board of Medicine who reviewed the case recommended that the doctor be charged with incompetence.

But no formal charges were ever filed. The assistant attorney general who examined the evidence concluded he could not prove incompetence against Acosta, and the case was closed.

Acosta has continued his obstetrics-gynecology practice and is on staff at Grace and Brent General hospitals in Detroit.

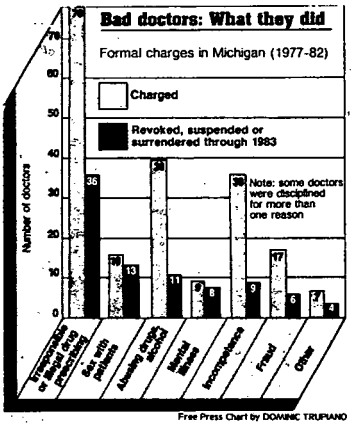
Acosta's case is an example of how difficult it can be to prove a physician is incompetent. And it helps show why the state Board of Medicine each year takes away only about a half dozen of the 20,000 Michigan licenses held by doctors.

Tradition, the law, the uncertain nature of medicine and the

See PROOF, Page 18A

Coming up . . .

- **TUESDAY:** Doctors who have lost their licenses can get them back — again and again.
- **WEDNESDAY:** Doctors who lose their licenses in Michigan often become other states' problems, and vice versa.
- **THURSDAY:** The drug problem — doctors who take them, doctors who sell them.
- **FRIDAY:** Medical societies, hospitals and malpractice suits also are supposed to help control incompetent physicians. They don't.
- **SUNDAY:** Solutions. The state plans changes. How to find a good doctor, report a bad one and monitor the care you get.



Free Press Chart by DOMINIC TRUPIANO

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Over their protests . . .

Dr. Donald Kulper, left, of the state Board of Medicine, wanted charges filed against Dr. Julio Acosta for the attempted abortion of a fetus that turned out to be more than seven months old. The infant survived four months. **Dr. Charles Berger**, right, chief of the state Health Department's division of maternal and infant health, reported Acosta had no explanation for what Berger called a "gross error." But the attorney general closed the case for lack of evidence.

PROOF, from Page 1A

reluctance of doctors to condemn their colleagues make incompetence hard to prove. As a result, many — some national experts say most — incompetent doctors are never charged, and no action is taken against their licenses.

When the board does act, it is nearly always after a doctor already has harmed one or more patients, according to a Free Press investigation of six years of board actions.

Although the board can take action against incompetent doctors before they hurt patients, it has no objective test to spot a problem before it results in injured or dead patients.

Once licensed, doctors — unlike airline pilots, certified lifeguards and others who hold people's lives in their hands — never again have to prove their competence to a licensing agency. Unless a licensing agency acts against them, they can practice as long as they live, in any field they choose, limited only by their own judgment.

The burden of proof that a doctor should no longer practice rests solely with the state.

14 needle marks

It is a burden that often proves too heavy.

The 21-year-old Westland woman came to Acosta for an abortion in January 1978. Acosta examined her, told her she was 18 to 20 weeks pregnant and said he would perform a saline abortion. A salt solution injected into the uterus would cause contractions to expel the fetus.

But what the woman aborted shortly after midnight Jan. 19 was a live baby boy weighing just under three pounds. The infant was rushed from Plymouth General, where he was born, to the intensive care unit for infants at Children's Hospital.

Dr. Ronald Poland, director of the unit, estimated that the woman had been pregnant 30 to 32 weeks — or more than seven months — when she delivered the baby. He insisted that the Plymouth General staff fill out a birth certificate.

The baby had 14 needle marks on his back and shoulders from the saline injections. He had a cyst in his lung, apparently caused by one of the needle punctures.

He lived in the Children's Hospital infant intensive care unit four months, trying to breathe through immature lungs. They finally failed, and he died May 28.

Acosta maintains he did nothing improper.

"Some ladies hide (pregnancy) real well," he said in an interview. "The patient thought she was no further than 20 weeks, so everything seemed to coincide — the history, examination by hand, by me and by the resident physician and somebody else before me. We all agreed she was 20 weeks."

Poland was so disturbed by the incident that he filed a complaint with the Board of Medicine.

Dr. Charles Berger, then medical chief of the state Health Department's Division of Maternal and Infant Health, investigated the incident and reported that Acosta had no explanation for what Berger called a "gross error." Berger also raised serious questions about the examination by the obstetrics resident, who was moonlighting from the hospital where he was in training.

THE ADMINISTRATOR of the Division of Maternal and Infant Health, Jeffrey Taylor, used stronger words in his report:

"It is inconceivable that a woman . . . at 32 weeks could have been mistaken as a candidate for abortion where the fetus should be approximately 24 weeks or under."

Taylor recommended that the case be referred to the state Department of Licensing and Regulation for investigation.

Four obstetricians contacted by the Free Press agreed that a doctor should have no trouble distinguishing between a 20-week pregnancy and a 30-week pregnancy.

"There is a big difference," said Dr. Charles Vincent, associate professor of obstetrics and gynecology and associate dean for admissions at Wayne State University Medical School.

The difference was not big enough for the Department of Licensing and Regulation.

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In a memo, the assistant attorney general who reviewed the case noted that he had no evidence — such as a failure to perform a physical examination — to show that Acosta's care was substandard. In addition, the infant's body already had been cremated, and no scientific tests had been performed to prove that the baby really was 30 to 32 weeks old. Finally, the mother was not willing to co-operate in an investigation.

The assistant attorney general recommended that the case be closed.

His recommendation was opposed strongly by the member of the Board of Medicine who reviewed the case. Dr. Donald Kuiper of Lansing informed department officials that he thought Acosta's treatment was incompetent and demanded that the assistant attorney general file a formal charge.

But licensing officials finally convinced Kuiper that incompetency charges could not be proved. The case was closed in February 1980.

52 licenses pulled

Some state investigations are more successful. In the period of the Free Press investigation — 1977 through 1982 — the state Attorney General's Office filed formal charges against almost 200 Michigan physicians. Fifty-two have lost their licenses.

Yet those 200 cases represent only about 10 percent of the complaints against doctors that the Department of Licensing and Regulation received in those years.

Many of those complaints, of course, were groundless or were disputes over fees, which the state does not regulate. Department analysts consider only about half the complaints they get worth investigating.

Nevertheless, state and national medical licensing experts agree that many incompetent doctors elude them.

"I know who the competent doctors are in my hospital," said Dr. John Fennessey, a Detroit pathologist and member of the Board of Medicine for six years.

Asked if he knows incompetent doctors, he replied, "Yes, I do . . .

"I think there are a significant number who practice below minimal standards and who fail to keep up with trends in medicine, and at the present time, I think medicine in general has not developed an effective mechanism for controlling them."

Nobody knows how many Michigan doctors are incompetent. Dr. Robert Derbyshire, past president of the U.S. Federation of State Medical Boards and, a nationally recognized authority on the problem of medical incompetence, has estimated that five percent of the nation's doctors are incompetent or addicted to drugs or alcohol.

> "I think there are a significant number who practice below minimal standards and who fail to keep up with trends in medicine, and at the present time, I think medicine in general has not developed an effective mechanism for controlling them."
>
> *— Dr. John Fennessey, a Detroit pathologist and member of the Board of Medicine for six years.*

Derbyshire bases his opinion on estimates of mental and physical disability among doctors, rates of substance abuse and studies of negligence in hospital case records.

Other estimates range from three percent to 10 percent. A recently published Mayo Clinic study concluded that the incidence of alcoholism among doctors might be as high as seven percent.

If Derbyshire's estimate is correct and if Michigan has its share of the nation's 24,000 incompetent doctors, then perhaps 1,000 doctors with Michigan licenses are practicing substandard medicine.

But most of these doctors are outside the board's reach. The overwhelming majority never will be charged, because the Board of Medicine would not be able to find them or find them incompetent.

THE BOARD OPERATES under legal constraints that require a doctor be proved incompetent in much the same way that a suspect in a crime is proved guilty.

Evidence of incompetence must be strong enough to convince a hearing officer who knows little about medicine. It must be strong enough to convince the Board of Medicine. And it must be strong enough to convince a court, if a doctor appeals.

Convincing a doctor's colleagues, employers and licensing board of that doctor's incompetence is not enough.

Dr. Robert Sillery was reported to the board by the president of his professional society, the Michigan Society of Pathologists. He was fired in 1981 as Oakland County medical examiner because the county found that he falsified 919 autopsy reports.

Board member James Breneman declared to the board: "Our conclusion was that this was a dishonest pathologist. The intent of the board was to get this guy out of circulation."

But the board's action was overturned in court. A Wayne County judge in December voided the board's two-year suspension of Sillery on the ground that the section of the licensing law he was alleged to have violated was too vague.

Proving incompetence requires expert witnesses, victims' testimony and meticulous documentation of examples of substandard care — which the law defines as failure to conform to minimal standards of practice.

"I am sure there are doctors in private practice who make (grades of) A, B, C and D," said board Chairman Dr. James Fenton, a Bay City radiologist. "But to say that the C-minus physician is incompetent goes a little too far. There are certainly those who are more competent than others."

Ingredients of a case

As a result, the state goes after only the most blatantly incompetent doctors. In practice, that means doctors who already have harmed patients. Those doctors whose level of competence is less clear-cut continue in practice until they retire or until they commit an error obvious enough to allow the state to act.

The same holds true for doctors suspected of mental illness, drug dealing or any of 16 other legal grounds for board action.

Board members finally caught Dr. Bruce Clark in enough irrational acts to justify taking away his license on the ground of mental illness. But Dr. Paul Goodreau, an Upper Peninsula doctor who was kicked off the staff of a hospital for alleged alcoholism, has eluded them. *(See profiles above.)*

A SUCCESSFUL CASE against a doctor requires an expert witness and physical evidence. Attorneys for the board will not proceed without both.

A medical specialist must testify that the doctor's behavior is substandard. If the doctor is accused of mental impairment, a psychiatrist must declare the doctor unfit.

Without a medical expert willing to testify against a colleague, the state has no case. The investigation against Goodreau foundered because local doctors would not testify against him, according to department officials.

"It's easy to find a doctor to say informally that something is incompetence," said Fennessey, a board member for six years.

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"But (at) a formal hearing, it's much more difficult to find a doctor who will do that. A little of it is 'There but for the grace of God go I' approach, and the feeling they may be criticized by some of their colleagues, and the amount of intestinal fortitude, time and effort that's involved in getting yourself up to do it."

GETTING a medical expert is often difficult. Keeping one can be just as hard.

Crittenton Hospital in Rochester had ordered Dr. Theodore Roumell to obtain consultations on all elective obstetrics-gynecology cases in 1980 after the medical staff determined he had used "poor medical and surgical judgment" in two cases. As required, the hospital reported that to the state.

The state licensing division investigated and found a case in which Roumell allegedly had cut a woman's uterus almost in half in a search for an embedded intrauterine device (IUD).

The assistant attorney general who handled the case found a physician who agreed that such extensive surgery was "below minimal standards." Based on that opinion, the state filed formal charges against Roumell.

Roumell countered that the medical records were wrong and that he had made only a small incision in the uterus.

Because the assistant attorney general had no way to disprove Roumell's statement, the expert withdrew his objection, and the state withdrew its charges last spring.

Roumell said the incident is the work of a former priest, whom he would not identify, who disagrees with Roumell's liberal views on contraception and abortion.

"It was a political ploy by a priest," he said. "We have a physician here, a former priest, who has different views about the way women should be treated. This was just one in a series of many things that he has done in an effort to discredit me."

Roumell, 47, has been sued for malpractice four times. One case, brought by survivors of a 36-year-old woman who died of complications a month after a hysterectomy, was settled for $200,000. A second, which claimed that a child had minimal brain damage because of avoidable birth trauma, was settled for $200,000. A third, which involved the death of a newborn, was settled for $38,000. The fourth, on behalf of a child with a facial scar, is pending. Roumell has denied negligence in all four cases.

Physical evidence

Even the most impressive expert witness is not enough for successful prosecution of a case. The physical evidence of wrongdoing must be concrete and strong.

For example, in the state's success-

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ful effort to revoke the license of Dr. Joseph Rucker Sr., attorneys introduced as evidence the skull of a fetus that Rucker had left in a patient's uterus.

In the case against Dr. Dale Williams, the evidence was not impressive enough.

Williams was kicked off the staffs of two hospitals in Muskegon. He has been sued for malpractice 10 times. (He won three and settled seven.) He is being pursued by the state Medicaid program, which wants him to repay $26,170 they say he billed improperly.

His case before the Board of Medicine involved a total of 10 charges of poor record keeping and poor medical care in cases in which at least three patients died.

Two experts testified that Williams' care was below minimal standards.

Dr. Richard Peters, a pathologist at Mercy Hospital in Muskegon, testified that Williams' treatment of a 68-year-old woman who died was "significantly below the standards" of a general practitioner or any doctor. Peters said Williams made three mistakes in treating the woman, who died after a blood clot blocked her artificial heart valve.

"Because of these three errors, this woman didn't make it," he testified.

Dr. Austin Aardema, former chief of staff at Hackley Hospital in Muskegon, testified that Williams' treatment of another patient was "definitely below the minimal practice standards in this community and elsewhere."

BUT EVEN with such testimony, the state could not prove its case. A major problem, according to the assistant attorney general and a board member, was that medical records comprised most of the evidence. The records were so poor that attorneys for the state could not prove that Williams, and not an assistant or another doctor, had committed a particular error. For example, Williams maintains that he "didn't have that much to do" with the care of the 68-year-old woman who died.

Furthermore, as state Board of Medicine Chairman Fenton pointed out, Williams had a lot of support in his community.

Faced with the costs of hearings and depositions, with no certain outcome, the state settled. Williams agreed to take some extra medical courses, a local surgeon agreed to monitor his practice for a year, and the case was closed.

Aardema, now practicing in Ft. Myers, Fla., said of the outcome: "I was extremely disappointed. They had a good case. What (Williams) did is he wore them out; he actually wore them out. There's no excuse for that."

WILLIAMS still runs a clinic in Muskegon that he says handles 50 to 75 patients a day. The other physician at the clinic, Jack Marrs, was suspended by the Board of Medicine in 1980 for irresponsible prescribing of amphetamines and other drugs. Williams testified as an expert witness on Marrs' behalf.

Williams insists his patient care was not substandard. He said the incompetency charges were trumped up by local hospitals, which he said felt threatened by his efforts to reduce hospitalization through innovative payment arrangements with Medicaid.

"Muskegon is a very conservative town," he said. "There was a lot of dissatisfaction with me and the Medicaid proposal in the medical society."

The board's reluctance to proceed without strong evidence is based, at least in part, on its experience in the courts.

At least five times in the last seven years, Michigan courts have ruled that a board action was improper or too harsh, and have canceled or drastically reduced the penalty, as Wayne County Circuit Judge Robert Colombo did in Robert Sillery's case.

Line of incompetence

Some incompetent doctors did not start that way. But they got old, a little less skillful, a little more forgetful and a little less in touch with medical developments. At some point, they crossed over the line from competence to incompetence.

Dr. Benton Schiff, former chief of surgery at the 600-bed Hurley Medical Center in Flint, had never been sued for malpractice — until, at age 65, he performed surgery on a 36-year-old woman who had a goiter.

In attempting to remove her thyroid gland, he accidentally severed or damaged the nerves to her vocal cords. She now talks through a hole in her throat. A jury awarded her $250,000.

Eight years later, in April 1983, the Board of Medicine, on the understanding that Schiff was going to end his surgical practice, agreed to limit his license to prohibit any surgery under anesthesia. Schiff died before the order could be implemented.

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"I'VE SEEN elderly physicians in other (hospitals) who are practicing who should obviously not be practicing, and they're tending to make mistakes," says Dr. John Gilroy, chairman of the neurology department at Wayne State University Medical School.

Fourteen such physicians surrendered their licenses from 1977 through 1982 after their mistakes brought them to the board's attention.

One of them, born in 1894, still was treating patients in Lansing in 1979. Complaints about his prescribing habits had begun to reach the board about three years earlier. One complaint noted that he had bought 12,000 amphetamines in nine months. Another concerned his practice of writing prescriptions for addictive drugs just to get patients out of his office.

The 43-year-old woman he was treating for high blood pressure did not know that. She also did not know that the drug he was giving her, the sedative butabarbital, is ineffective against high blood pressure and had not been used for that purpose for some 20 years.

On Dec. 6, 1979, she developed a severe headache. He told her to lie down. Two days later, she was dead. She had suffered a stroke, a common complication of untreated high blood pressure.

Six months later, the doctor surrendered his license. He since has suffered a stroke and is unable to reply to questions about the incident.

IF THAT DOCTOR had been required to take a periodic competency test to renew his license, his deficiencies might have become apparent before a patient died.

Pilots for commercial airlines must take proficiency tests every year. Lifeguards certified by the Red Cross must renew their training every three years.

But a doctor, once licensed, is considered eternally competent.

Six years ago, the Legislature decided that health care professionals should not have lifetime licenses. They ordered health licensing boards to develop competency tests and to administer them at least every four years as a condition of license renewal.

The tests were supposed to begin by this October.

Instead, a Michigan State Medical Society task force, set up to study competency testing, has concluded that it cannot be done — at least not fairly and economically.

Competency, the task force report concluded, is as hard to measure as incompetency. It includes knowledge, but it also encompasses judgment, technical ability, self-discipline and a caring and ethical attitude — difficult qualities to assess.

"It's almost impossible to measure competency," declared former board Chairman Kuiper, a member of the medical society's task force. "Instead of trying to determine if 20,000 are competent; our idea is focusing on those we suspect a problem with. Let's look at those people we have reason to believe are incompetent."

At the request of the Department of Licensing and Regulation, state Rep. Mat Dunaskiss, R-Lake Orion, has introduced a bill to repeal the requirement for competency testing. Instead, licensing boards would be required to study ways of measuring competency and submit reports to the governor by October.

If the bill passes, the Board of Medicine will be back at square one, trying to assess incompetence.

Competency, the task force report concluded, is as hard to measure as incompetency. It includes knowledge, but it also encompasses judgment, technical ability, self-discipline and a caring and ethical attitude — difficult qualities to assess. "It's almost impossible to measure competency," said Dr. Donald Kuiper, a former chairman of the Board of Medicine and a member of the medical society's task force. "Instead of trying to determine if 20,000 are competent, our idea is focusing on those we suspect a problem with. Let's look at those people we have reason to believe are incompetent."

bad doctors/the burden of proof

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One who was caught . . .

. . . and two who slipped away

Bizarre examination forced the board to act

Dr. Bruce Clark teetered on the edge of insanity for three years while licensing officials watched, aware of his drug abuse and mental illness.

In October 1973, department investigators learned that Clark was taking large amounts of drugs.

On June 19, 1974, a state licensing investigator, the Monroe County prosecutor and one of Clark's physician friends persuaded him to close his office and see a psychiatrist.

Two months later, the three agreed that Clark could reopen his office. But they were so concerned about his behavior that they decided to ask the pharmacist he used not to fill any prescriptions Clark wrote for himself. They also agreed that Clark's employes should be told of his condition and asked not to leave him alone for long periods of time.

"The doctor needs to have people around him," an investigator reported to licensing officials.

Not until Clark committed the following acts in 1977 did the state consider his behavior dangerous enough to invoke its emergency powers and suspend his license without a hearing:

According to the findings of the hearing officer, Clark called one of his female patients and told her to come to his office in Temperance, north of Toledo, ostensibly for an examination related to an injury claim she had filed after an auto accident. He kept her at the office for nine hours while he performed inept magic tricks, made her listen repeatedly to a tape recording of herself describing the accident and performed a bizarre "physical examination."

To begin the examination, Clark removed one of his shoes and socks, tied the shoelace around the woman's arm and had her remove her clothes. He then wrote her name in a circle he drew on her stomach and wrote "normal" on one of her breasts. With a hypodermic needle, he made some 300 bloody needle pricks over her legs, back, stomach, fingers and arms.

Then he held her down on the examining table and sexually assaulted her. She fled when Clark went to buy some batteries for an instrument he needed to continue the "examination."

Clark's behavior with this patient, plus an equally bizarre incident with another patient, and an earlier finding by a psychiatrist that Clark had a brain disorder, was considered enough evidence to permit the summary suspension of his license. After a hearing, his license was revoked.

Doctor keeps license despite going to jail

Dr. Edith Lee claimed she was a dedicated inner-city doctor who regularly drove her Mercedes 450 on 200 or more house calls a day on Detroit's east side.

The state Medicaid program maintained she was a cheat who billed Medicaid for treatment of impossibly large numbers of patients.

Lee is in jail now. Where the state Medicaid program and the state Department of Licensing and Regulation failed, the federal Internal Revenue Service succeeded.

Lee, 59, is serving a year and a day at the Federal Correctional Institution in Ft. Worth, Tex., for filing fraudulent income tax returns.

If proving a doctor incompetent is difficult, proving that a doctor is a cheat can be even harder. Few cases of fraud ever come before the Board of Medicine, and fewer still result in penalties.

Officials in the state Medicaid program, which pays medical bills for poor people, had been trying for years to prove Lee was cheating, and state licensing officials said they had been waiting for a fraud conviction so they could proceed against her license.

In 1981, Medicaid officials demanded that Lee repay more than $1.3 million in alleged improper billings. Two years later, that claim was settled for $328,499, of which $92,000 went to her lawyers.

In 1982, Lee went to trial in Wayne County Circuit Court on Medicaid fraud charges. At her trial, attorneys for the state pointed out that she billed Medicaid for 322 home visits on a single day in 1976.

Assuming she did not sleep that day and spent no time in travel, she would have been able to spend 4.5 minutes with each patient.

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By comparison, a driver for United Parcel Service is able to make an average of 150 to 200 deliveries a day.

The jury deadlocked, 10-2, in favor of conviction. Jurors later said that those opposed to conviction felt that Lee did not intend to cheat the state. The judge declared a mistrial, and a new trial was scheduled. That case is pending.

Meanwhile, Lee pleaded no contest last October to federal charges of income tax fraud.

When she gets out of jail, she will not be able to treat Medicaid patients because she has been barred from the state program.

But she will be able to treat other patients because she is still a physician in good standing with the licensing board. Without a conviction on the Medicaid charges, the chances of an action by the Board of Medicine are slim.

Case lacks colleague who's 'willing to talk'

The Board of Medicine has been following the activities of Dr. Paul Goodreau since 1975 and has been unable to come up with enough evidence to take action against his license.

According to Board of Medicine files, Goodreau, 57, was placed on probation at least twice because of alleged problems with alcohol and finally suspended from Portage View Hospital in the Upper Peninsula. Goodreau maintains that the charges were a smoke screen for local doctors' jealousy of his large practice.

Robert Benjamin, then administrator of the hospital in Hancock, said Goodreau was suspended after he tried to deliver a baby while he apparently was drunk. He has not had hospital privileges since 1978.

But suspension from a hospital is not, in itself, legal evidence of incompetence. The board must find that the doctor's work is incompetent.

Goodreau has been sued for malpractice at least six times. One suit, settled for $45,000, involved the death of a 15-year-old boy, allegedly after Goodreau failed to recognize the seriousness of injuries from a motorcycle accident. Three others were settled for small amounts, and two are still pending.

The state filed a complaint against Goodreau in the case of the 15-year-old boy. But the board dismissed it in December 1977 because the evidence was not strong enough and because Goodreau's colleagues in Hancock felt he was recovering.

"We have situations where there's a lot of smoke, but you can't get to the bottom and find the fire," says Dr. Donald Kuiper, who retired as board chairman in December. "We get a lot of complaints on a few doctors. We look into those, but we're not able to find they're in violation of the law, and therefore we can't do anything."

Later, in response to more allegations from the hospital that Goodreau had a drinking problem, state investigators returned to Hancock but could not find doctors willing to testify. The last investigation was closed last summer.

"Any time an attempt has been made to get information, no information has been forthcoming," said an assistant attorney general who asked not to be named. "We never seem to get anyplace . . . . No one is willing to talk."

Doctor lost his license after woman lost life

By DOLLY KATZ
Free Press Medical Writer

The Michigan Board of Medicine could not save Tammy Dohm.

She would have been 21 this year, probably finished with her accounting studies and perhaps still training horses on her father's 60-acre grain farm near Eau Claire, in southwestern Michigan.

But the Berrien County college freshman died on the operating table, six months after her 18th birthday, of a surgical error.

She was Dr. Weldon Cooke's last surgical mistake. Her death convinced the Board of Medicine to suspend Cooke's license.

THE BOARD KNEW before Dohm's death that Cooke had problems. He had made a surgical error in another case that the board knew about. That patient, a 31-year-old mother of seven, also died.

But the practical need to prove incompetence means that doctors must show a pattern of errors — measured in patient death and disability — before the board can take definitive action.

"Surgical errors do occur," said Dr. Henry Kallet, the board member most closely involved in Cooke's case, in explaining why the board did not take away Cooke's license after his first mistake.

Tammy Dohm's death established a pattern for Cooke.

"How many times can a doctor be allowed to commit the same error?" asked New Mexico physician Robert Derbyshire, past president of the Federation of State Medical Boards of the United States, in a recent issue of the Hospital Practice journal.

Derbyshire described a board-certified surgeon in another state who injured three gallbladder patients in four months:

"His errors had been fatal for all three patients. Eventually, with the discovery of gross blunders in other operations, a pattern of incompetence — at hideous cost to his patients — emerged.

"His certificate was revoked too late. This moved one critic to remark that a license to practice is a license to kill."

A victim and her doctor

Tammy Dohm, left, died on the operating table after **Dr. Weldon Cooke**, right, accidentally punctured a vein during simple exploratory surgery. Her death convinced the state Board of Medicine to suspend Cooke's license. An earlier case, in which a 31-year-old mother of seven died after Cooke performed surgery on her, had not persuaded the board that Cooke shouldn't practice.

LEOLA WILLIAMS' surgery was Cooke's first documented mistake. She underwent surgery June 4, 1975, for removal of an inflamed gallbladder. When he removed the organ, Cooke committed "serious surgical errors" and damaged the duct that carries bile from the liver to the small intestine, the attorney general charged.

Williams went home eight days later but was back in the hospital June 22, with bile draining from her incision. Cooke never properly diagnosed or treated her complications, the state charged. She languished for eight days and died July 4 of massive bleeding.

Her family sued Cooke, the hospital and others involved in the case. The lawyer hired to handle the suit — eventually settled for $195,000 — filed a complaint against Cooke with the Board of Medicine.

The board proposed that Cooke be put on probation for three years, so they could monitor his practice.

Cooke still was negotiating with the board Nov. 7, 1981, when Tammy Dohm came to him for a laparoscopy.

Often called "Band-Aid surgery," a laparoscopy permits the doctor to inspect the pelvic organs with a slim lighted tube. The tube is inserted through a half-inch incision after the doctor inflates the abdomen with carbon dioxide or nitrous oxide gas.

BUT COOKE made two mistakes that led to Dohm's death, the board later would conclude.

First, he used air to inflate her abdomen. Carbon dioxide and nitrous oxide dissolve quickly in the blood; air does not.

Second, he punctured the vena cava, the principal vein that carries blood back to the heart.

An air bubble entered through the puncture, blocked the blood flow and stopped Dohm's heart. She died shortly afterward.

Cooke resigned from the hospital staff that day. Nine months later, he lost his Michigan license.

But he still had his Indiana license, so he signed on as a physician at Indiana State Prison in Michigan City, where he now works.

Cooke, 56, got his Michigan license back last year, with the proviso that, for a year, another surgeon stand in on all his operations.

"Let me just say I have made mistakes," he said. "I'm afraid in medicine, we no longer have the right to make mistakes anymore. I can prove (the Dohm case) was an honest mistake."

In Tammy Dohm's memory, the Michigan Association of Western Horse Clubs has established an annual Friendship Award.

Kallet was asked if the Board of Medicine could have prevented her death.

"I hope not," he replied.

Detroit Free Press

Volume 153, Number 335 ON GUARD FOR 152 YEARS PAGE 1A Tuesday, April 3, 1984

bad doctors/ a second chance

Third of seven parts

Before **Dr. Boleslaw Krawczyk** opened his office in town in 1965, the 1,600 residents of the Fennville area in western Michigan had been without a doctor for two years. The picture above, part of a Free Press story on the town's good fortune, was taken a month after he arrived. Since then, drug violations twice have twice cost Krawczyk him his license — the first time for illegally prescribing them, the second time on an emergency basis for abusing them. (see excerpt from the 1980 suspension order, below). The board gave him a third chance last April.

Coming up . . .

- **WEDNESDAY:** Doctors who lose their licenses in Michigan often become other states' problems, and vice versa.
- **THURSDAY:** The drug problem — doctors who take them, doctors who sell them.
- **FRIDAY:** Medical societies, hospitals and malpractice suits also are supposed to help control incompetent physicians. They don't.
- **SUNDAY:** Solutions. The state plans changes. How to find a good doctor, report a bad one and monitor the care you get.

> IT IS HEREBY FOUND that, based upon said Verified Complaint, the continued ability of Boleslaw Krawczyk, M.D., hereafter Respondent, to practice medicine constitutes an imminent threat to the public health, safety and welfare which requires emergency action; accordingly,

Medicine's revolving door

In state's view, no doctor is permanently bad

By DOLLY KATZ
Free Press Medical Writer

Nurse Ruth Goodsell watched doubtfully that night in September 1978 as Dr. Boleslaw Krawczyk staggered into the Thorn Hospital emergency room, made a mostly unsuccessful attempt to inject anesthetic into a patient's eyebrow and sewed up a cut. More than once, Goodsell saw the needle slip and come "frightfully close" to the eyeball.

Krawczyk's behavior at the Hudson, Mich., hospital, plus the testimony of a patient who walked out rather than allow him to treat her, plus the presence of more than 100 distinctive Talwin injection scars on his body, convinced the state Board of Medicine he was addicted to the painkiller Talwin.

It took away his license in 1981 — just as it had in 1974, when it concluded he illegally was selling prescriptions for amphetamines from his office in the Irish Hills town of Brooklyn.

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Krawczyk, 66, got his license back last spring — just as he did in 1974, after a six-month suspension.

IN THE EYES of the State of Michigan, no doctor is permanently bad. Every doctor whose license is revoked deserves a chance to get it back — and sometimes a second chance, and sometimes a third.

The only exceptions since 1977 have been two doctors who had moved their practices to other states and — to avoid the time and expense of hearings — signed agreements not to exercise their legal right to apply for reinstatement of their Michigan licenses.

In Michigan, a doctor whose license is revoked has at least a 50-50 chance of getting it back, according to a Free Press study of six years of board actions.

Drug addicts and drug dealers, convicted sex offenders, doctors whose mistakes have killed their patients — all have been given back their licenses and told to try again, and again.

Dr. Larry Kompus did not contest charges that he enticed three of his severely disturbed psychiatric patients into homosexual relationships.

The Bloomfield Hills psychiatrist plied one 23-year-old schizophrenic patient with alcohol, drugs and pornographic movies, and took him to hotel rooms in Pontiac and Dearborn. At their last meeting, Kompus bribed the man to retract confessions he had made to other doctors about their sexual

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SECOND CHANCE, from Page 1A

encounters over three years. Under Kompus' direction, the patient wrote to those doctors that he was the victim of hallucinations.

Kompus was later arrested, convicted of attempted criminal sexual conduct and delivery of drugs, and sentenced to one to seven years in the State Prison of Southern Michigan at Jackson. He was paroled after nine months.

THE BOARD OF MEDICINE revoked Kompus' license Aug. 6, 1980, while he was in prison.

Two and a half years later, Kompus convinced the board he had reformed. He got his license back Feb. 28, 1983. The U.S Drug Enforcement Administration, not convinced of Kompus' reform, has declined to give him back his federal license to prescribe narcotics.

Kompus, 45, now practices psychiatry at the Veterans Administration Hospital in Allen Park.

Asked to comment on his treatment by the board, Kompus said: "I think it was very good, and I'm very happy where I am now."

By state law, a doctor whose license is revoked need wait only a year to apply for reinstatement.

By comparison, lawyers — regulated by the Michigan Supreme Court — must wait five years to reapply for a revoked license.

From 1977 through 1982, the Board of Medicine revoked 18 licenses. Eight doctors asked for reinstatement; four got their licenses back.

Six doctors did not apply for reinstatement because they already had moved to other states where they still were licensed. One doctor received back-to-back revocations and is not eligible to reapply yet. Of the remaining three, one still is unlicensed, and two could not be located.

THE BOARD SOMETIMES gives an errant doctor more than a second chance. If a reinstated license is revoked again, the board can give it back again — and again. The Free Press study found that one in five doctors who came before the board had been there at least once before.

Dr. Richard Sundling's long relationship with the board began in 1975, when he was an anesthesiologist at McLaren General Hospital in Flint. While assisting in an operation, he surreptitiously injected himself with Demerol, a morphine-like painkiller. The staff had to find another anesthesiologist to continue the operation.

The board gave him a second chance: He had to give up his narcotics license, but he could keep his medical license.

A year later, Sundling was suspended from University of Michigan Hospital in Ann Arbor for Demerol abuse. The board then revoked his license.

They gave him a third chance the next year, with the provision that doctors at Chelsea Community Hospital west of Ann Arbor supervise him.

A year after that, Sundling admitted he was injecting himself with narcotics. The board, taking emergency action, summarily suspended his license.

The next year, when Sundling asked for it back again, the board agreed to give him a fourth chance provided he switch from anesthesiology to another specialty, such as radiology.

In October 1981, Sundling got a limited license to enter a radiology residency at William Beaumont Hospital in Royal Oak. It did not include a license to prescribe narcotics.

Contacted recently at Beaumont, Sundling said he plans to go into practice on his own soon and will apply for a full license. He has no complaints about the board. "I think they treated me very fairly," he said.

REVOCATION is not the board's only means of stopping a doctor from practicing. If a doctor is deemed an immediate threat to public health, board members can take away the doctor's license on an emergency basis — called a "summary suspension" — and hold a hearing later.

Of 10 doctors judged to have posed such a threat during the 1977-82 period, half are now back at work.

One of them is Dr. Ronald Zajac, an eye doctor whose employes would send his patients home when they decided he was too drugged with cocaine and other substances to treat people.

Investigators found him living with his 74-year-old mother in a house that had no electricity and was heated by burning trash, which covered the floors to a depth of three feet and supported the investigators' weight. The Hamtramck health and fire departments declared the house unfit to live in.

The board summarily suspended his license Nov. 5, 1980.

A year and a half later, the board gave it back but without authority to prescribe narcotics. The board also put Zajac on three years' probation and ordered him to see a psychiatrist twice a week for a year. He since has practiced in the Detroit area but could not be located recently.

The board considers some doctors more salvageable than others and tailors its penalties accordingly. Instead of revoking a license, the board will give a year's suspension to a doctor whom it expects will reform. The doctor still must prove competence to get the license back, but the board is signaling its favorable intent.

(Sometimes, the board considers a doctor so incompetent that it issues a longer suspension, to head off the possibility of the doctor's regaining the license in a year. Three times in six years, the board suspended licenses for 18 months to three years. Two of those doctors were elderly and subsequently retired. The third moved to California, where he now practices.)

IN SIX YEARS, the board has refused to relicense only one suspended doctor: psychiatrist Ali Guner, who persuaded two of his patients to have sex with him as part of their treatment.

But Dr. Arnold Kambly, an Ann Arbor psychiatrist who had an affair with a patient, got his license back despite the objections of his hearing examiner. Kambly, now 67, became sexually involved in 1975 with a 30-year-old woman he was treating for marital problems. She later sued him, and settled for $180,000.

Kambly also ran an adolescent treatment center that closed in June 1980 after the state Department of Social

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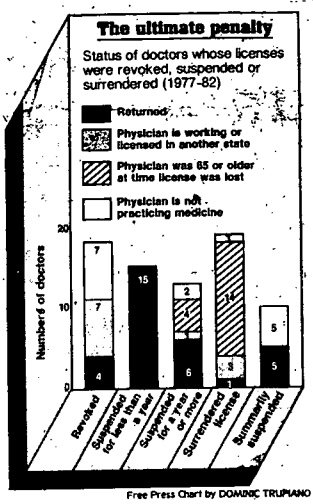

Doctors and their weaknesses . . .

Dr. Larry Kompus lost his license and went to jail for seducing his severely disturbed psychiatric patients into homosexual relationships. He has his license back now, and practices psychiatry at the Veterans Administration Hospital in Allen Park.

Dr. Ronald Zajac's employes would cancel his appointments when he was too drugged with cocaine to see patients. Health officials declared his trash-filled Hamtramck house unfit for human habitation. He lost his license in November 1980, but got it back in November 1982.

Services raised questions about patient safety and moved to revoke its license. Kambly had also been convicted of fraud for billing the government for therapy sessions he never held.

At his 1982 reinstatement hearing, Kambly said that his affair began after the woman's treatment ended, and that the fraud case was based on his policy of billing for missed appointments.

The hearing officer took a dim view of Kambly's defense.

"It has been two years since the suspension, and he shows no remorse for what occurred, which indicates there has been no change in (his ability) to serve the public in a fair and honest manner," wrote Frances Farzley.

The board did not agree. They declared Kambly to be "of good moral character" and gave him his license back Dec. 15, 1982.

Kambly, who has an unlisted telephone number, did not respond to a letter requesting an interview.

Another doctor now considered competent is Weldon Cooke of Berrien County, whose suspension came after two of his surgical patients died.

The first, a 31-year-old mother of seven children, died in Berrien General Hospital a month after Cooke damaged her bile ducts while removing her gallbladder. The second, Tammy Dohm, 18, died on the operating table during exploratory surgery when Cooke accidentally punctured the principal vein from the abdomen to the heart.

Cooke lost his Michigan license for a year, which he spent working as a doctor at Indiana State Prison.

His license was restored in February 1983, after two physicians and the administrator of the Berrien Center clinic where he once worked vouched for him. He is still working in Indiana, although he said at his hearing that he intends to practice in Michigan.

OTHER suspended doctors who won relicensure include Dr. Leo Fuentes of Oakland County, convicted of Medicaid fraud; Dr. Jerome Wisneski of Grand Rapids, who traded drugs for sex, and Dr. Joan Shapiro of Birmingham, who abused drugs.

In 1979, Shapiro twice staggered into the delivery area at William Beaumont Hospital with her hands infected and bleeding from drug injections, and once delivered a baby while she was apparently under the influence of drugs. She is now back on the staff at the Royal Oak hospital. She did not respond to a request for an interview.

Making licensing decisions requires board members to juggle concepts of retribution, rehabilitation, property rights and protection of public safety — not always successfully.

"My philosophy is, we're not here to protect doctors, we're here to protect the public," said Dr. Donald Kuiper, former chairman of the board.

But Dr. Henry Kallet, an Ann Arbor pathologist who has been on the board since 1977, cited other considerations: "The courts have held the license is a valued property, and therefore (the doctor) has a property right.

"Doctors are a driven group, and they tend to rehabilitate themselves. I like bringing people back into the mainstream, but in a gradual manner.

"There has to be some element of punishment with any transgression. If you take away a man's livelihood for a year, that attracts his attention."

Added Dr. James Fenton of Bay City, board chairman: "To take the license away after all that education is a very serious thing, and I like to think those who are suspended would be given an opportunity for rehabilitation."

SUCH CONSIDERATIONS apparently figured in the board's decision to return Dr. Larry Kompus' license.

Kompus showed at his hearing that he had received psychotherapy and had volunteered as a teacher at Detroit's Lafayette Clinic, a well-known psychiatric institution.

The hearing officer, Gregory Holiday, was impressed. He wrote that Kompus "openly and honestly testified about his wrongful conduct. He has expressed sorrow and regret for his mistakes. He regularly attends church with his family. He no longer engages in the wrongful conduct heretofore described.

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"This applicant, and the profession, should be given the opportunity to demonstrate to the public that truly remorseful and rehabilitated practitioners are worthy of the public's trust."

One psychiatrist who examined Kompus, however, sounded a note of caution. Dr. Frank Ochberg, former director of the state Department of Mental Health, agreed that Kompus was competent. But he warned: "There still exists a possibility of temptation and of weakness in this direction."

The board tried to steer a middle course between the doctor's rights and the public interest. Kompus would get his license back, but only for work in supervised settings approved by the board. He would have to continue psychotherapy.

The board has used similar restrictions in restoring other licenses.

The board ordered Weldon Cooke to have another surgeon stand in on his operations for a year and to submit 10 percent of his cases to the board for review. They ordered Joan Shapiro's narcotics license withheld, required random urine tests to detect drug abuse and ordered her psychiatrist to notify the board if Shapiro becomes a danger to her patients.

ATTEMPTS TO BALANCE a doctor's "property rights" against the public's safety have had mixed results.

Most doctors come before the board only once, according to the Free Press study of six years of board actions.

But at least one in five, the study found, are repeaters. And a doctor who falls down again might take a patient or two along.

Patient complaints about Dr. Rolando Mateo have continued for 10 years, despite the board's efforts at reform.

Mateo, a Detroit hand surgeon, first came to the board's attention in 1974, when the Police Department accused him of billing for extensive surgery on two police officers' hands, when they had suffered only minor injuries.

Mateo lost his license for a month.

Seven months after the board issued its order, 30-year-old Mary Shutran injured her left thumb at work when she tried to catch a large roll of paper. Mateo performed two operations on her, three months apart, and billed Fireman's Fund Insurance Co. for extensive tendon and ligament repairs.

When her hand continued to hurt, Shutran when to another hand surgeon, Dr. Robert Larsen, a clinical associate professor of surgery at the University of Michigan. He operated and discovered no evidence of the elaborate repairs Mateo claimed to have done.

Larsen concluded that Shutran originally had nothing more than a sprained thumb, but that the surgeries induced trauma-induced arthritis. To ease the pain, Larsen permanently locked the second joint of her thumb.

Shutran sued Mateo and settled for $40,000.

Asked about the lawsuit, Mateo acknowledged it had been settled but pointed out that a jury decided another patient's suit in Mateo's favor.

WHILE THE STATE licensing division was investigating the Shutran case, another incident occurred at Deaconess Hospital.

In September 1981, according to state records, Mateo admitted a patient to repair an old fracture in the man's left ring finger. By mistake, he opened the middle finger instead and inserted a wire intended to provide traction for the fracture.

When X-rays taken immediately afterward revealed the mistake, Mateo corrected the error. Then he cut up the incriminating X-rays and falsified his surgery report in an attempt to conceal the error. He did not tell the patient about the mistake.

But the operating room supervisor retrieved the X-rays from the wastebasket, reassembled them and submitted them to the hospital administration. Mateo was suspended from the staff for a month.

Charges on the Deaconess and Shutran incidents have been pending before the Board of Medicine since last October. Mateo remains on staff at Deaconess and Holy Cross hospitals in Detroit.

Some licensing officials, noting the gravity of these physicians' offenses and the uncertainty of rehabilitation, do not agree with the board's ideas about reforming doctors.

"I don't feel people are absolutely entitled to a medical license," said a department official who asked not to be identified. "Why should Kambly be licensed? Is the board expected to monitor him and make sure he doesn't take advantage of another woman? What kind of man does that?

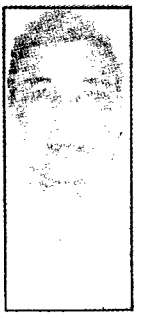
"And Kompus — when does a human become responsible for his actions? Do we excuse all deviation from the law on the basis that this is an emotional disorder?

"Some doctors are not capable of being rehabilitated."

Licensed for lives, but not for drugs

22 years of trouble — and still licensed

A matter of trust . . .



The Board of Medicine doesn't trust **Dr. Abraham Gellar** of Lansing, left, with a narcotics license, and won't allow **Dr. Leonardo Lopez**, right, to prescribe narcotics or other dangerous drugs from his Detroit office. Yet the board trusts both doctors with patients' lives; it has granted them licenses to practice every other aspect of medicine.

By DOLLY KATZ
Free Press Medical Writer

The Michigan Board of Medicine does not trust Dr. Leonardo Lopez of Detroit to prescribe narcotics from his office.

But it does trust him to perform surgery.

That apparent contradiction is the board's solution to the problem of doctors who abuse drugs by sale, prescription or personal use. The board allows many to keep or resume medical practices, but without authority to prescribe narcotics and other addictive drugs.

So doctors the board does not trust to handle dangerous drugs nevertheless are trusted with patients' lives.

Of 86 doctors brought before the board for drug-related offenses from 1977 through 1982, one-third lost authorization to prescribe dangerous drugs, nine permanently.

MOST MICHIGAN DOCTORS have three licenses: a state license to practice medicine, a separate license to prescribe narcotics and other addictive drugs, and a federal narcotics registration.

Some are trusted with only a medical license. One such doctor is Albert Laura of Livonia, charged with selling hundreds of amphetamines at a time to undercover agents. According to an investigator's affidavit, Laura told her he was charging only 50 cents each for tablets that sold for $3 on the street.

The board, in an emergency action, summarily suspended Laura's license March 3, 1977. He was convicted of a drug violation in Wayne County Circuit Court three months later and sentenced to a year's probation and a $2,000 fine.

Seven months after that, the board returned Laura's medical license in exchange for the permanent surrender of his narcotics license.

Laura, 72, still is practicing in Livonia. He said the board's action has not changed his practice. "There are tranquilizers you can prescribe which are not on the list" of narcotics and dangerous drugs, he said.

Dr. Abraham Gellar lost his license in 1973 for selling fake work excuses to autoworkers and for operating a high-volume prescription business a block from the Michigan State University campus. He got it back in 1977, minus his narcotics license.

Gellar, 83, still is practicing in Lansing.

"The whole thing was a frame-up," he said of the charges that persuaded the board to take his license away. "I write a lot of excuses, but I do an honest job."

Lopez was charged in 1977 with illegally selling prescriptions for addictive sleeping pills, sedatives, tranquilizers and amphetamines. A Detroit Recorder's Court judge convicted him of illegally prescribing amphetamines. The board suspended him for six months, then prohibited him from prescribing addictive drugs except in Southwest Detroit Hospital.

Last December, Lopez applied to have that restriction removed. The board turned him down. "I find it hard to consider there is a reasonable possibility this man should ever be given prescribing responsibilities again," Dr. John Fennessey of Detroit told other board members.

Dr. Donald Kuiper, until December the board's chairman, admits to uneasiness over the practice of just limiting the narcotics-prescribing privileges of a doctor who has misused the medical license.

"The whole of medicine is tied up with trust and honesty," he said. "But the current legal system doesn't allow us to do anything more than act on the complaint we have. You've got a doctor over here who is pushing Valium. How can you extrapolate and say, 'You can't take an appendix out'?"

The Michigan Court of Appeals recently rebuked the board for doing just that.

In April 1981, the board suspended Dr. Jack Marrs' medical license for irresponsibly prescribing addictive drugs. The court gave it back, noting that the Muskegon physician is primarily a surgeon and that nobody had impugned his surgical skills. The board, the court concluded, "abused its discretion."

But incompetence or dishonesty in prescribing drugs can be a sign of a more pervasive problem.

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Dr. Maxim Melnik of Detroit gave up his narcotics license in 1972 after he was charged with prescribing Dilaudid, a derivative of morphine, to addicts.

Seven years later, the state accused the 69-year-old doctor of having sexual intercourse with a mentally retarded 18-year-old patient who suffered from cerebral palsy. Melnik did not admit to the charge but permanently surrendered his medical license.

Dr. Carol Varner agreed to give up her narcotics license for three years beginning in 1972, after the board charged her with illegally prescribing painkillers.

By 1982, the state had charged the 57-year-old Lansing physician with more than 30 counts of incompetence in the diagnosis and treatment of disease, the prescription of drugs and the delivery of babies. Her license was revoked after the death of one of her last patients, a 33-year-old woman.

For 22 years, the Michigan Board of Medicine has been punishing and forgiving Dr. Robert Sosa.

Sosa, 58, lost his license in 1962 for stealing from accident victims.

He got it back, then was put on probation for carrying a concealed weapon, and then was barred from prescribing addictive drugs.

Now, he is charged with sexual assault and extortion of a patient.

He remains licensed to practice.

Sosa was working in the emergency room at Bell Memorial Hospital in the Upper Peninsula when he was arrested for stealing money from accident victims' pockets.

He was convicted in July 1962 and put on five years' probation.

Based on that and a theft conviction in Texas, the Board of Medicine revoked his license Oct. 17, 1962.

They gave it back Dec. 11, 1969.

SEVEN YEARS LATER, on a Sunday night in Grand Rapids, Sosa was arrested again. A friend he had been visiting called police and told them Sosa was carrying a gun. Police stopped his speeding car and arrested him after they discovered a .25-caliber automatic.

Community leaders in Belding, the town east of Grand Rapids where Sosa was practicing, rallied to his support before the board. Sosa admitted about 200 patients a year to Belding Community Hospital, said administrator William Stanley. If Sosa were not allowed to practice, the patients would go out of the area for care.

Belding Police Chief William Crystler said the community would suffer if Sosa could not practice.

So the board reprimanded Sosa and ordered the community leaders to send letters to the board every four months for three years, attesting to Sosa's skill.

In 1983, Sosa came before the board again, on charges that he indiscriminately prescribed addictive pep pills to a woman.

The board prohibited him from prescribing addictive drugs for at least six months. That limitation is still in effect.

ON FEB. 8, the Ionia County prosecutor charged Sosa with first-degree criminal sexual conduct, sexual assault and extortion in the case of a 41-year-old woman who claimed that Sosa tried to force her to trade sex for the drugs she needed for her addict husband.

Assistant County Prosecutor Gary Gabry said the woman testified at a preliminary examination that her husband had become addicted to the painkillers Sosa prescribed for a back injury, and she feared he would die without them.

Sosa attacked her at least three times over 2½ years, the prosecutor's office charged. The first time, on May 1, 1981, Sosa forced her to have oral sex, she testified.

According to Gabry, the woman testified that Sosa threatened to withhold prescriptions for Percodan, a morphine-like painkiller, if she resisted his advances.

The woman also was required to give Sosa some of the drugs as a kickback, Gabry said.

Sosa referred questions to his attorney, Douglas McFadden.

"None of that is true," McFadden said of the charges. "The Percodan was prescribed for valid medical reasons."

Meanwhile, Sosa can continue to practice medicine while he awaits a trial date.

Ten doctors, one physician's assistant and three people who are not health care professionals meet monthly in Lansing as the Michigan Board of Medicine to hash out settlements and orders. Attending a meeting in April 1983 are: **Dr. Donald Kuiper** at the head of the table, **Dr. Charles Vincent** (almost totally obstructed at the left of Kuiper), **Dr. James Breneman** (partially obstructed), **Dr. Edward Weddon,** and **Dr. Addison Prince.** On the other side of the table, sitting right from Kuiper, are **Gay Hardy, Dr. Robert Gibson, Dr. James Fenton** and **Dr. Henry Kallet.**

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Compromise is the rule for Board of Medicine

By DOLLY KATZ
Free Press Medical Writer

The penalties meted out to Michigan physicians who violate the licensing act are the product of discussions — and sometimes arguments — among 14 people appointed by the governor.

Ten doctors, one physician's assistant and three people who are not health care professionals meet monthly in Lansing as the Michigan Board of Medicine to hash out settlements and orders.

Often, the settlements are as much a compromise among board members as between board members and doctors in question.

"The board is a microcosm of society," said the former chairman, Dr. Donald Kuiper of Lansing. "I know how certain (members) view certain offenses, and they don't all view them the same way."

Punish or protect?

Last April, the board considered the case of Dr. Avelino Mape of Detroit, who had been convicted of Medicaid fraud in Ingham County Circuit Court in 1981. Mape, a psychiatrist, was accused of seeing patients 10 to 15 minutes each and billing Medicaid for a 50-minute session.

Dr. Henry Kallet, an Ann Arbor pathologist who views economic fraud with particular distaste, proposed that Mape be suspended for three months and, after that, be required to hire a certified public accountant to supervise his billings and, for three years, send a quarterly report to the board.

Most other board members were uncomfortable with the severity of the proposed penalty.

"We're supposed to protect the public, not be punitive," protested Kuiper.

Kallet responded that doctors must be shown that the board will not tolerate economic fraud. "I think we have to be a little punitive," he said.

Dr. Carol Pearson, a psychiatrist, suggested that Mape was performing an important service because few psychiatrists will treat Medicaid patients.

"I don't think Medicaid will accept him to do their work anyway," countered Dr. James Breneman, a Galesburg immunologist.

Last April, the board considered the case of Dr. Avelino Mape of Detroit, who had been convicted of Medicaid fraud in Ingham County Circuit Court in 1981. Mape, a psychiatrist, was accused of seeing patients 10 to 15 minutes each and billing Medicaid for a 50-minute session. Two members who had different views of the case were:

Dr. Carol Pearson, left, a psychiatrist, suggested that Mape was performing an important service because few psychiatrists will treat Medicaid patients. She seemed to agree with most of the other board members who were uncomfortable with the severity of the proposed penalty.

Dr. Henry Kallet, right, an Ann Arbor pathologist who views economic fraud with particular distaste, proposed that Mape be suspended for three months and, after that, be required to hire a certified public accountant to supervise his billings and, for three years, send a quarterly report to the board.

OTHER BOARD MEMBERS said Mape might have been more sloppy than dishonest. His wife apparently was responsible for the accounts, which generally were acknowledged to be a "disaster."

"He did it, and I don't care why — it's fraud," said Kallet. "If he allowed his wife to do it, he's a fool. In any case, he should be disciplined, whether he's a charlatan or a fool."

Dr. John Fennessey, a Detroit pathologist, put in a pitch for leniency. He argued that if the board suspended Mape's license, Mape would not be able to repay the money as promised. "You're talking about $130,000 at nine percent," Fennessey said. "He won't live long enough."

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"The board is a microcosm of society," said the former chairman, Dr. Donald Kuiper of Lansing. "I know how certain (members) view certain offenses, and they don't all view them the same way."

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Kallet was not impressed: "This gentleman was one of the high rollers. He'll live."

But Kallet clearly was in a minority; his proposal was rejected, 7-4.

Dr. Edward Weddon of Stockbridge suggested a lesser penalty: one month's suspension, plus a requirement that a certified public accountant oversee his records.

That proposal passed easily.

"There are some lovely tours of Europe," grumbled Kallet, implying that the board was just giving Mape a vacation.

An easier decision

The case of Dr. Lois Dunegan of Lansing, which came up for settlement in February, provoked less argument.

Dunegan was accused of incompetence in the death of a 19-year-old Lansing area woman injured in a traffic accident. Dunegan's errors, which Breneman described as a "frightening series of events," ranged from failure to get adequate laboratory tests to having a friend with no medical training assist her in the operating room.

"There's no indication that she, in her heart, thought what she did was wrong," Fennessey said.

Dr. Charles Vincent, a Detroit specialist in obstetrics and gynecology, pointed out that Dunegan said she had gotten more training since the incident that brought her to the board's attention.

"The problem is not with the training," responded Fennessey. "The problem is her attitude towards her patients."

Physician's assistant Karen Kotch, who proposed suspending Dunegan's license for a year, said, "What she's done requires at least suspension."

"I would be in favor of revocation at this point," argued Dr. Addison Prince, a Detroit obstetrics-gynecology specialist.

The suspension passed easily, with Prince voting no.

MICHIGAN LAW requires that a physician charged with violating the licensing act be given a chance to talk with a board member and settle the matter before it goes to a hearing.

The member designated by the board brings the proposed resolution to the board for a vote. Most cases are settled that way, to avoid the time and expense of a hearing — although negotiations before a resolution sometimes take as long as a hearing.

Last April, Prince proposed a settlement in the case of Dr. Benton Schiff, a Flint physician charged with permanently damaging the nerves of a patient's vocal cords while trying to remove her thyroid gland. The woman, who lost her voice, sued and won $250,000.

"He's 73," Prince told the board. "This is his first suit in 45 years. He plans to retire at the end of the year; he doesn't want to go out in disgrace. He served his country well. This one mistake he made, getting in over his head, shouldn't be punished too severely."

The board agreed. They unanimously decided to allow Schiff to continue performing surgery until the end of the year but under the supervision of the chiefs of surgery at two Flint hospitals. After Jan. 1, 1984, Schiff was to be prohibited from performing surgery that requires anesthesia.

Before the settlement could be approved formally at the board's June meeting, the issue became moot. Schiff died in May.

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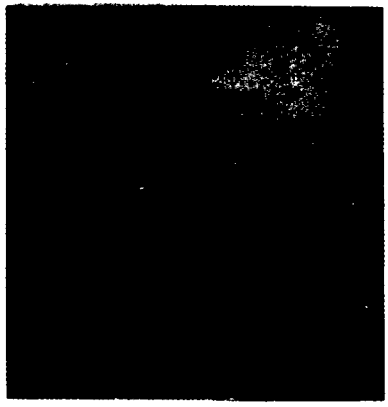
bad doctors/
unwanted exports
Fourth of seven parts



Four days before her death, 19-year-old **Cheryl Burnham**, left, spotted singer Mac Davis at a Lansing area country club and persuaded him to pose with her. The next day, she was taken to St. Lawrence Hospital after a traffic accident where **Dr. Lois Dunegan**, above, operated on her. A member of the Board of Medicine later would call Dunegan's treatment "a comedy of errors, a frightening series of events." Burnham died; Dunegan lost her license in February.

Staying a step ahead

Doctors move to other states to beat the system

By DOLLY KATZ
Free Press Medical Writer

Some of Michigan's worst doctors are no longer Michigan's problem.

They are Wyoming's problem, or New York's problem, or California's problem, or the problems of at least 10 other states where they now work or hold licenses.

They represent a national problem: the ease with which incompetent doctors move from state to state, a step ahead of legal action against their licenses.

Most state boards automatically will license a physician who holds a license in another state. As a result, many doctors are licensed in more than one state.

So a doctor whose license is revoked in Michigan may retain valid licenses in other states.

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Coming up . . .

■ **THURSDAY:** The drug problem — doctors who take them, doctors who sell them.

■ **FRIDAY:** Medical societies, hospitals and malpractice suits also are supposed to help control incompetent physicians. They don't.

■ **SUNDAY:** Solutions. The state plans changes. How to find a good doctor, report a bad one and monitor the care you get.

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OF 71 DOCTORS whose Michigan licenses were revoked, suspended or surrendered in the last decade, the Free Press found that at least 28 remained licensed in other states. The Free Press was able to locate 18 of them.

Since leaving Michigan, at least one of those doctors was involved in the death of a patient, one has killed himself, and one has been charged with using the tools of his trade to murder his wife.

Of course, the traffic goes both ways.

California revoked Dr. Dale Furnell's license in 1972 for performing major orthopedic surgery on five patients who didn't need it, including a 16-year-old girl left with a severely deformed arm. Nebraska revoked his license in 1974. Minnesota followed suit in 1976.

Although California notified Michigan when it revoked Furnell's license, the Michigan Board of Medicine took no action until 1977 — three years after Furnell set up practice in Michigan and 1½ years after a Farmington Hills doctor complained to the board that Furnell was incompetent.

Furnell still is licensed in Indiana.

State medical boards are aware of the problem.

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MOVING, from Page 1A

Their national association, the Federation of State Medical Boards of the United States, routinely circulates the names of doctors whose licenses have been suspended, revoked or limited in any state. But the names are collected in a voluntary, haphazard manner, and many problem doctors never make the list.

Even if a board is alerted that a doctor whose license was suspended in another state is now in its state, it can take years to get the records from the other state, hold hearings and reach a decision. If and when the license in the second state is revoked, the doctor can move to another state.

Michigan contributes its share to this interstate traffic. Following are some examples of practicing physicians who are no longer Michigan's problem.

Dr. Lois Dunegan

Nineteen-year-old Cheryl Burnham was an unwitting participant in what one doctor called a "comedy of errors" directed by Dr. Lois Dunegan.

It ran three days and ended in Burnham's death.

The young woman was injured in a car accident west of Lansing on Aug. 22, 1978. She was taken to St. Lawrence Hospital with severe lung, kidney and liver injuries.

The assistant attorney general's charges depicted the following events at the hospital:

Dunegan, then 34, operated on Burnham. Dunegan's assistant in the operating room was a friend who had no medical training.

During the operation, Dunegan did not put a tube in Burnham's chest to detect and treat bleeding.

Two days later, Burnham rallied enough to sit up in bed and talk with visitors while a nurse combed her long, blond hair. But as undiagnosed bleeding continued and her lungs began to fill up with fluid, she quickly deteriorated.

In those first two days, Dunegan did not order any of the tests that would have diagnosed the internal bleeding. Toward the end of the third day, with Burnham near death, Dunegan finally inserted a chest drainage tube.

But she inserted the tube into Burnham's liver by mistake.

In an attempt to help Burnham breathe, Dunegan tried to put a breathing tube down her windpipe.

But she put the tube down Burnham's esophagus instead.

Burnham died an hour later.

"It's a comedy of errors, a frightening series of events," said Dr. James Breneman, the member of the state Board of Medicine who met with Dunegan in an attempt to negotiate a settlement. "It seems to me no physician should be a part of such a comedy of errors."

DUNEGAN SAID she did not insert a chest tube or order tests earlier because Burnham did not exhibit any symptoms that would have required such measures. She suggested that jostling of the body after death jarred the breathing tube out of Burnham's windpipe and into her esophagus, where it was found. She maintained that another doctor would not have been able to save Burnham.

Dunegan also pointed out that she brought the Burnham case to the board's attention because she felt she had been unfairly treated by Michigan State University, where she was an assistant professor of surgery. The university suspended her patient care privileges about eight months after the incident.

"I was impressed with this physician's willingness to excuse herself rather than recognize a tragic series of events," Breneman commented. On Feb. 8, 1984, the Board of Medicine voted to suspend Dunegan's license for at least a year.

By then, Dunegan had long since left Michigan for a position on the surgical staff of a Pennsylvania hospital.

Dr. Paul Sheridan

Dr. Paul Thomas Sheridan died of a drug overdose at age 36 on an Apache Indian reservation. The public documents of his career portray a good, even outstanding, doctor who used his license to destroy himself.

Sheridan, a Michigan native, came from a large family of achievers. His 13 brothers and sisters earned an impressive number of academic degrees and professional licenses.

Sheridan's performance in medical school was rated superior to outstanding, earning him a residency in orthopedic surgery at Henry Ford Hospital in Detroit.

But drug abuse interrupted his residency. The hospital put him on medical leave in January 1975; he said it was because he had attempted suicide.

Sheridan spent the next four months wandering around southern Michigan, dosing himself with narcotics, barbiturates and amphetamines that he got by writing fraudulent prescriptions. Then he headed west, leaving a trail of arrests, hospitalizations and legal actions.

IN SEPTEMBER 1975, the Nevada medical board charged him with prescription abuse. He surrendered his Nevada license.

In January 1976, he pleaded guilty in California to writing prescriptions for non-existent people and using the amphetamines and barbiturates himself. The court sent him for evaluation to the California Medical Facility, a psychiatric facility for prisoners, and sentenced him to probation.

In July, the California medical board revoked his California license to prescribe narcotics and ordered him to see a psychiatrist.

Michigan refused to renew his license the next year, because of his California conviction and because he lied about it on his license renewal form.

His last job was in an outpatient clinic in the town of Dulce on the edge of the Jicarilla Apache Indian Reservation, on the state's northern border.

"He was a good doctor," said a physician's assistant who worked with him. "He had a lot of experience in orthopedics."

The night of June 5, 1978, he got drunk and apparently injected himself with meperidine, a morphine-like painkiller.

He was pronounced dead at 1:17 a.m. June 6. The doctor who examined him called it an accident.

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Dr. Robert Schmunk

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DETROIT FREE PRESS/WEDNESDAY, APRIL 4, 1984

On July 15, local police in Douglas, Wyo., went to the Schmunk house and found Kay Schmunk, right, unconscious. She died at a local hospital. Two months later, a grand jury charged Dr. Robert Schmunk with pre-meditated murder. Schmunk, the grand jury charged, poisoned his wife with three separate, lethal injections of morphine, methadone and Demerol, a painkiller. The trial is scheduled for next month. Two weeks after his indictment, Schmunk bought an ad in the local newspaper, below.

In his 27 years as a physician, Dr. Robert Schmunk has never been convicted of a crime. But he's been accused of plenty.

In the spring of 1969, three women filed complaints with Mt. Clemens police that, under the pretext of giving them pelvic examinations, Schmunk had sexually molested them. Schmunk denied the charges.

The police notified the Board of Medicine, which warned Schmunk that it would take "stern action" if it received any more complaints about him.

In December 1975, Schmunk was bound over for trial on charges that he had repeated sexual intercourse with his 14-year-old stepdaughter. Schmunk denied the charges, and a jury acquitted him in September 1976.

In May of that year, the Board of Medicine had filed formal charges against Schmunk, accusing him of sexually molesting his stepdaughter and four female patients.

Schmunk denied the charges. His attorney delayed the proceedings for three years with a series of court motions. Meanwhile, Schmunk left the state with his license intact.

After Schmunk notified the board that he had moved away and did not want his license anymore, the board permanently revoked his license in February 1980.

SCHMUNK HAD RESETTLED in the eastern Wyoming town of Douglas with his wife, Kay, 44, and his stepson, William, 14. (The stepdaughter remained in Michigan with her natural father.) He set up a practice in his home.

Twice in the next three years, Schmunk was interviewed by the Wyoming medical board, reportedly on drug charges. Because that board's records and proceedings are secret by law, the subjects of the interviews are unknown.

In the early morning of last July 15, local police called by the stepson went to the house and found Mrs. Schmunk unconscious. Doctors at the local hospital pronounced her dead at 7:30 a.m.

Two months later, a grand jury charged Schmunk with pre-meditated murder. Schmunk, the grand jury charged, poisoned his wife with three separate, lethal injections of morphine, methadone and Demerol, a painkiller.

Schmunk later claimed that he had given his wife non-lethal amounts of the drugs to treat a severe headache, according to court documents.

In a statement to the news media after his indictment, Schmunk denied the charge. To make the $50,000 bond, he put up his collections of guns and ivory. Later, so he could have his collections back, townspeople — including members of his church — put up their homes. The trial is scheduled for next month.

Two weeks after his indictment, Schmunk bought an ad in the local newspaper announcing his continued availability as a family doctor for home care, office care and home births:

"Same location. Same 24-hour availability. Same phone. Same personal care. Anytime, anyone, any need. Commemorating our fourth year."

Dr. Anthony Martinez

Dr. Anthony Martinez made no bones about the service he provided.

Five times, Christine Nicewicz, an investigator for the health professional licensing boards, went to his office in Ecorse, waited her turn and told him what she wanted: two prescriptions, one for amphetamines, one for Valium.

Martinez would pull a prescription pad from the pocket of a white laboratory jacket and ask her name.

Mary Hayes, she would say.

How many Valium do you want, he would ask.

Ninety, she would say.

He would write the prescriptions, take her $10 and warn her to fill them at a different pharmacy each time so the druggist would not get suspicious.

One of Martinez's customers, Nicewicz wrote in her affidavit, was William Kerkes, 19, of Ecorse. Kerkes bought a prescription for 50 Valium tranquilizers Oct. 28, 1977, and bought another prescription two days later for Carbrital, a barbiturate sedative.

The next day, he was found dead in his apartment. The medical examiner said the cause of death was suicide by barbiturate poisoning.

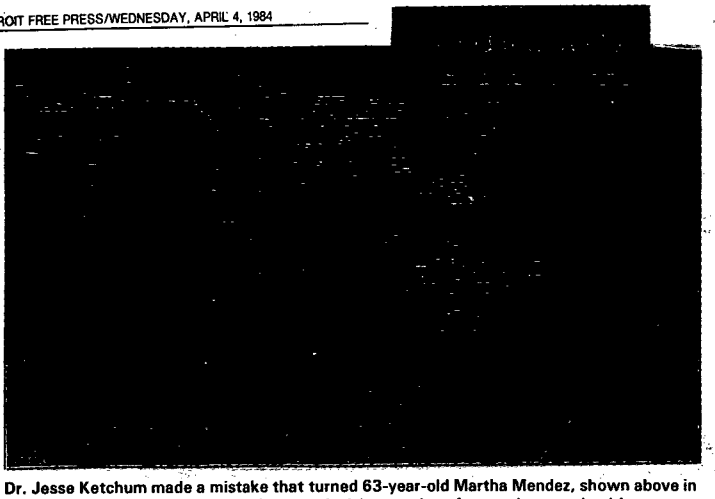
The manufacturer's prescribing information for Carbrital warns: "Carbrital should be prescribed with great caution, or not at all, for persons with suicidal tendencies, predilection for excessive use of medications, or likelihood of becoming drug dependent. Effects may be increased by many drugs, including tranquilizers."

The board summarily suspended Martinez's license Dec. 1, 1977.

Martinez, 60, now practices in Commerce, Calif. The California board suspended him for 60 days, based on the Michigan charges, and took away his license to prescribe addictive drugs.

He did not return four telephone calls.

DETROIT FREE PRESS/WEDNESDAY, APRIL 4, 1984



Dr. Jesse Ketchum made a mistake that turned 63-year-old Martha Mendez, shown above in her hospital bed in a photo taken from a television monitor, from a vigorous, healthy woman into an all-but-dead person whose occasional eye movements provoked disagreement among neurologists about whether they were voluntary. She died Dec. 28, 1981, after 4½ years in a coma.

Dr. Jesse Ketchum wants his Michigan license back. In a sense, it is fitting that he again wants to begin a practice here because Michigan was the first state to revoke his license, in June 1974.

New York revoked his license two months later.

Ontario, where he graduated from medical school in 1943, revoked his license June 3, 1975.

Nevada revoked his license two days later.

Ohio revoked his license April 15, 1976.

Arizona revoked his license a day later.

Yet after he'd lost his licenses in all those places — and served a prison term — he still managed to get a job as a doctor at a Florida hospital.

Dr. Jesse Ketchum

After less than a year on that job, he made a mistake that turned 63-year-old Martha Mendez from a vigorous, healthy woman into an all-but-dead person whose occasional eye movements provoked disagreement among neurologists about whether they were voluntary.

Ketchum's troubles began in 1969, when William Beaumont Hospital in Royal Oak kicked him off its staff for substandard practice of obstetrics and gynecology.

Two years later, 25-year-old Margaret L. Smith of Ypsilanti sought an abortion from Ketchum in Buffalo, where he had moved to take advantage of New York's liberal abortion laws. Prosecutors charged that he tried to perform the abortion by slicing into Smith's uterus; she bled to death.

KETCHUM DENIED the charge, but in October 1973 a jury convicted him of criminally negligent homicide. He was sentenced to a maximum of three years at Attica Correctional Facility.

But Ketchum got a stay while he appealed. Free on $10,000 bond and still licensed in Michigan and New York, he returned to Detroit.

Five months later, three Detroit police officers testified that they caught Ketchum masturbating at the Frisco Theater, an adult movie house on Woodward. Ketchum, who said he was doing research in his role as a sex counselor, was convicted of indecent conduct.

A month after that incident, Ketchum attempted to perform a second-trimester abortion in his Huntington Woods office on a woman who subsequently had to be rushed to William Beaumont Hospital in Royal Oak, where she was admitted in shock.

Based on those incidents and the New York conviction, the Michigan Board of Medicine summarily suspended Ketchum's license. The other states slowly followed suit.

Meanwhile, Ketchum lost his appeals and served a year in Attica prison.

When he was released, in March 1976, he wasn't licensed anywhere in the United States. Florida subsequently refused to let him take its licensing exam.

BUT FLORIDA has a loophole in its licensing law. Residents — doctors who are taking advanced training — don't need licenses in Florida. So six months after his release from Attica, Ketchum got a position as an anesthesiology resident at Jackson Memorial Hospital in Miami.

He was there in July 1977, when Martha Mendez came down to Miami from her home in West New York, N.J., to help her niece, who had broken her leg and was having trouble caring for her family.

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While there, Mendez developed abdominal cramps. She entered Jackson Memorial Hospital on July 26, 1977, to have her gallbladder removed.

Ketchum was the anesthesiologist.

Toward the end of the operation, according to the testimony of one of the surgeons, Ketchum mistakenly gave Mendez straight anesthetic gas instead of a mixture of anesthetic and oxygen. Mendez went into a coma.

She remained in the coma 4½ years, with her care in a nursing home in Jersey City paid for with the $540,000 settlement from Dade County, which owned the hospital, and the University of Miami, which staffed it. She died Dec. 28, 1981.

Because Ketchum was unlicensed, Florida could take no action against him.

Now Ketchum, 66, wants his Michigan license back. As was his right, he requested and received a formal hearing last year. When the Board of Medicine receives the hearing officer's opinion, they will decide whether to restore his license.

When Martin Arnowitz, Mendez's attorney, heard that Ketchum had asked for his license back, he wrote the Michigan board in protest:

"My client was never given the opportunity to choose her anesthesiologist. What do you think her choice would have been had she known the facts about Dr. Ketchum prior to the administration of anesthesia?"

Ketchum did not reply to a written request for an interview, sent to his last known Michigan address. His attorney, Joseph Reid, did not return several telephone calls.

Dr. Ming Hah

Dr. Ming Hah's abortion clinic in Livonia was ordered closed by the state Health Department in 1974 because it was dirty and poorly staffed. The Board of Medicine summarily suspended his license in 1975 for casually prescribing Dilaudid, a synthetic morphine, as a headache remedy.

So Hah moved to Chicago.

There, a Chicago Sun-Times series on abortion clinics identified Hah as the "physician of pain" who performed abortions without waiting for the anesthetic to take effect.

The Illinois medical board revoked his license in 1976, based on Michigan's action. Court delays allowed Hah to continue performing abortions in Illinois until 1978, when the revocation took effect.

So Hah moved to New York.

Though that state's licensing agency knows of his past, Hah remains a physician in good standing there. The Queens address on his license is the same as the address for American Birth Control, an abortion clinic.

ONE WOMAN who remembers Hah well is Rosa Naparstek, a former Michigan lawyer now living in California. Naparstek, who had helped in the battle to legalize abortions, went to Hah's clinic in 1973, a month after the U.S. Supreme Court struck down restrictive state abortion laws.

The night before her operation, she met with friends who had had dangerous, illegal abortions. "We counted our blessings that I could be the recipient of a safe and a legal abortion," she recalled.

Naparstek, then 28, ended up in a hospital with a massive infection that required removal of her uterus, her spleen, part of her colon and the creation of a permanent colostomy, a hole in her side through which fecal waste is passed. A tube was inserted through a temporary hole in her throat so she could breathe. She was in a coma for two months, in the hospital for five.

"When I came to, I had to go through physical rehabilitation," she said. "I couldn't talk, I couldn't walk, I couldn't move."

Rosa Naparstek, left, a former Michigan lawyer now living in California, who had helped in the battle to legalize abortions, went to Dr. Ming Hah's (right) clinic in 1973. She ended up in a hospital with a massive infection that required removal of her uterus, her spleen, part of her colon and the creation of a permanent colostomy, a hole in her side through which fecal waste is passed.

Naparstek sued Hah and, after a two-week trial, settled out of court for $600,000.

During the trial, her boyfriend, now her husband, remarked: "One thing I hope comes of this is that Ming K. Hah will never be around to practice his craft anywhere."

Repeated attempts to contact Ming Hah at his New York office were rebuffed, with explanations first that he was busy, then that he was on vacation, then that he was not the Dr. Hah who had practiced in Michigan, although their birth dates and work histories are the same.

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Dr. Mehmet Kusun Kasal

Dr. Mehmet Kusun Kasal

For four months in 1978, undercover agents for the Michigan Board of Medicine paraded through **Dr. Mehmet Kusun Kasal's** office in Grand Rapids, asking for drugs to make them "feel good:" amphetamines, sleeping pills, morphine-like painkillers.

Kasal gave them what they wanted. He later pleaded guilty to delivery of amobarbital, a sedative.

The doctor, then 55, also propositioned a patient and tried to sexually assault his 19-year-old receptionist, concluded a hearing officer for the Board of Medicine.

A Kent County judge did not believe Kasal's patient and acquitted Kasal of a solicitation charge. Kasal told the hearing officer that he had not assaulted his employe.

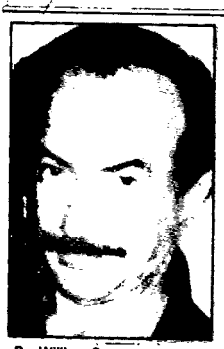
Nevertheless, the Board of Medicine revoked his license in May 1980.

Kasal still had Florida and West Virginia licenses. He went to Wheeling, W. Va., in December 1981. Eight months later, fulfilling a longtime desire to work in Florida, he set up a part-time practice in the small town of Ocoee, near Orlando.

The Florida medical board caught up with Kasal last December and suspended his license.

But he is still welcome in West Virginia.

Dr. William Carranza



Dr. William Carranza

Dr. William Carranza has had trouble with drugs in three states. New York's medical board says it put him on probation for a 1968 federal heroin conviction in Nevada.

When Carranza came to Michigan in 1975, board members gave him a limited license and restricted him to the Redford Medical Center. They relented the next year, granting him a full license.

Then, in 1981, Waterford police, accused him of trying to run his girlfriend over with his car and charged him with felonious assault. Police searched his home and found cocaine.

The assault charge was dropped in exchange for a guilty plea to cocaine possession. A judge sentenced him to 60 days in jail and three years' probation, and ordered him to attend a substance abuse treatment program.

Last August, the board ordered his Michigan license suspended for two years.

The action has little effect on Carranza, who has been back in New York since at least November 1982. He said he's working in the emergency room of a large New York City hospital, but he won't say which one.

Dr. Donald Y. Stewart

In 1969, **Dr. Donald Y. Stewart** performed back surgery on a California woman and killed her in the process, the California Board of Medical Examiners ruled. The board revoked Stewart's license in 1973 for "gross incompetence" in the treatment of the woman and three other people who underwent dangerous, unnecessary back surgery.

Three years later, Stewart asked the Michigan Department of Licensing and Regulation to reinstate his expired license. He paid $85 in delinquent fees, and the department issued a license March 12, 1976.

Three days later, Stewart's resume arrived in the department's office. At the bottom, Stewart had typed that his California license had been revoked "for unreasonable cause — only criticisms were intellectual, not ethical or moral."

MICHIGAN'S REVOCATION machinery rumbled for three years before the board was able to take Stewart's license away. For at least part of that time, Stewart worked in Detroit, performing surgery at small local hospitals.

Now Stewart is in New York, where he has practiced medicine since he lost his Michigan license in 1979. New York's revocation procedures, even more ponderous than Michigan's, have been at work on Stewart's case more than four years, with no decision.

Stewart, 55, did not have kind words for the Michigan board: "I think they're the biggest bunch of lying, cheating frauds in the world. In spite of the fact that I had good references from Detroit, and in spite of the fact that I was the most super-trained and highly trained man in the entire history of the world, they revoked my license.

"They should be lined up in front of the AMA building in Chicago and machine-gunned to death and the blood left there for a day."

Dr. Robert M. Walker

Psychiatrist Robert M. Walker called his Taylor office the Walmor Holistic Clinic, implying a comprehensive attitude toward health care. But the only thing comprehensive about Walker's clinic were the bills he submitted to Medicaid and Blue Cross-Blue Shield.

Investigators who went to his clinic nine times in late 1978 and early 1979 reported that he gave them Valium for the asking. One investigator reported that Walker checked his "aura," told him his heart was going counter-clockwise instead of clockwise, "fixed" the investigator's heart by rubbing his chest and sold him a gold pyramid to wear on his head for treatment of headaches and tension.

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BLUE CROSS and Medicaid charged that Walker spent a few minutes with each patient, then submitted bills for psychotherapy, lab tests and other services they said he never provided.

On May 11, 1981, a Wayne County Circuit Court judge sentenced Walker to four years' probation for Medicaid fraud. Walker also agreed to repay $20,000 to Medicaid and the Blues.

The federal government suspended him from participation in Medicare and Medicaid for four years.

In September 1981, the Board of Medicine suspended his license for two years, beginning in May 1981.

BUT WALKER has not been in Michigan since 1979. He's in California, where he works for the Los Angeles County Mental Health Department, treating patients at the San Pedro Mental Health Clinic.

"I don't care to come back to Michigan . . . Things have been much better for me here."

— Robert M. Walker

"I don't care to come back to Michigan," he says. "I don't like the climate, and I think there's much more learning experiences in California. Things have been much better for me here."

In February 1983, the California medical board filed charges against him, based on his Michigan suspension.

Dr. Bruce Krygowski

The Michigan Board of Medicine considered **Dr. Bruce Krygowski** such a public menace that it invoked its emergency powers to suspend his license without a hearing.

In Ohio, he's a doctor in good standing.

Krygowski, 34, worked in what federal agents called the largest prescription drug mill in the Detroit area. Over two years, the Med-Care Medical Clinic on Schaefer and its successor, United Physicians Medical Center on Six Mile, took in about $2.5 million from the sale of illegal prescriptions for amphetamines, painkillers and other dangerous drugs, the clinic operator told federal agents.

KRYGOWSKI WAS indicted in January 1983 along with 15 other people, including three physicians and a pharmacist. He pleaded guilty to distribution of Talwin, a painkiller. Last fall, he was sentenced to a year and a day in jail, which was suspended, and three years' probation and a $10,000 fine.

Krygowski's plea convinced the Board of Medicine that he was an "imminent threat to the public health, safety and welfare." The board summarily suspended his license Dec. 14.

Krygowski might be an "imminent threat" in Michigan, but in Dayton, Ohio, he is a resident in plastic surgery at St. Elizabeth Hospital. He did not return phone calls.

Dr. Timothy Stern

While **Dr. Timothy Stern** was an anesthesiologist at Dickinson County Hospital in the Upper Peninsula, he wrote fraudulent prescriptions for Dilaudid for himself, according to formal charges filed with the Board of Medicine.

Dilaudid is a modified form of morphine, intended for treatment of severe pain. Like morphine, it is highly addictive and often abused.

Stern would write prescriptions in the names of his father-in-law, who lives in New Jersey, and his father, who lives in New York, the state's attorney charged. In two weeks in July 1979, Stern wrote prescriptions for more than 200 Dilaudid tablets, according to the formal charges.

Four months after the hospital hired him, it fired him.

Without admitting the charges, Stern agreed in November 1980 to surrender his license.

He then moved to Rochester, N.Y., where he opened a pain clinic, treating as many as 40 people a day, usually with anesthetic injections and acupuncture.

The New York state Health Department has decided to file its own formal charges against Stern — the specifics of the charges are secret — but he remains licensed while the case wends its way through New York's intricate disciplinary system.

Detroit Free Press

Volume 153, Number 337 ON GUARD FOR 152 YEARS PAGE 1A Thursday, April 5, 1984

bad doctors/abusers & sellers

Fifth of seven parts

Coming up . . .

■ **FRIDAY:** Medical societies, hospitals and malpractice suits also are supposed to help control incompetent physicians. They don't.

■ **SUNDAY:** Solutions. The state plans changes. How to find a good doctor, report a bad one and monitor the care you get.

Hooked on drugs, protected by silence

By DOLLY KATZ
Free Press Medical Writer

When you have an operation, you know certain risks are involved.

You are probably aware, for example, of the small chance — perhaps three in 1,000 — of a side effect from the anesthetic.

But one risk you probably do not know about is the one in 100 chance that your anesthesiologist is a drug abuser.

That estimate, the product of a survey of anesthesiology training programs, was published last summer in the Journal of the American Medical Association. It is one reflection of a chronic and only recently acknowledged problem in the medical profession:

- Studies estimate that narcotics addiction is 10 to 100 times more common among doctors than among the general population, at least partly because doctors have easier access to drugs. According to the estimates of government and organized medicine, at least one to two percent of doctors abuse drugs.
- A doctor is at least as likely as anyone else to be an alcoholic, according to a Mayo Clinic study that found that seven percent of doctors surveyed were possible or probable alcoholics. If alcoholism among doctors is that common, then 1,400 of the 20,000 doctors licensed in Michigan can be expected to have alcohol problems.

Free Press/MOSES HARRIS

- Dr. G. Douglas Talbott, a drug abuse specialist and director of the Impaired Physicians Program for the Medical Association of Georgia, has estimated that one of every eight doctors in his state has been, is or will become an alcoholic or drug addict.

If the national estimates are valid, the State of Michigan has acted to protect patients from fewer than two percent of the chemically dependent doctors licensed in the state.

IN THE LAST seven years, 31 doctors with drug or alcohol problems have come to the attention of the Michigan Board of Medicine; Seven were alcoholics. County medical society committees that were recently organized to help impaired doctors have identified at least 146 alcoholic or drug-addicted physicians.

The hundreds of doctors who have escaped the board's attention have been protected by what physicians have called a "conspiracy of silence" that includes the doctor, the doctor's colleagues and the medical profession in general.

"The physician-patient denies he is ill, lacks insight into his problem, avoids medical assistance and minimizes his problem outright," the American Medical Association's Council on Mental Health wrote in 1973.

Until recently, organized medicine participated in the deception.

"Physicians themselves provided the most formidable barrier to a resolution of the problem," two physicians on the California medical board wrote in a recent issue of the Journal of the American Medical Association. "Traditionally, the medical profession clung to a code of silent loyalty that either protected or denied the existence of sick, addicted or alcoholic colleagues."

Part of the reason seems to be the belief, shared by recovered physicians and their colleagues, that addicted doctors don't hurt patients.

"I've never really come across a case where (an addicted doctor) hurt a patient," says Dr. Robert

See DRUGS, Page 12A

DRUGS, from Page 1A

Hydrick of Grand Rapids, a member of the state medical society's Impaired Physicians Program for western Michigan.

Hydrick explained that most addicted doctors stay away from patients when they are drunk or drugged.

Hydrick lost his license for a year after he prescribed so many painkillers for a woman that she became addicted. She had to be hospitalized, detoxified and treated in a drug abuse program.

In its findings, the board said Hydrick's patient frequently shared the drugs with Hydrick at their homes.

Hydrick now says he "possibly" was impaired at the time and that he used to drink "a fair amount." But he maintains that the woman implicated him because the Attorney General's Office threatened her.

IN HER STUDY of 100 alcoholic physicians, Dr. LeClair Bissell of New York City noted: "Many of the physicians stated that their alcoholism has never resulted in injury to their patients.

"Although this feeling is often shared by the colleagues of alcoholic physicians, it is a view that is difficult to accept.

"Since alcoholism interferes in so many ways and with such a multiplicity of functions, there can be little doubt that the patients receive a lesser level of care than the physician is able to deliver when he is sober."

The indulgent attitude toward physicians and the "conspiracy of silence" are changing, to a great extent at the instigation of organized medicine. The AMA Council on Mental Health reported in 1972 that it had sent letters to all state medical societies, asking about programs to identify and help addicted physicians.

Twenty-three states had no such program, and three state societies vehemently denied that a problem existed.

Since then, at the urging of the AMA, 40 state medical societies have developed programs for impaired doctors. More than 30 states have enacted the AMA's model legislation, which empowers state licensing boards to act against sick doctors.

Michigan has both a medical society program and a "sick doctor" regulation. Michigan's state and county medical societies have committees of doctors who visit physicians whom they have heard are impaired and try to persuade them to get treatment. The society also has set up a $50,000 fund to provide low-interest loans to physicians who must interrupt their practices to get treatment.

If a doctor agrees to contact a psychiatrist or enter a drug treatment program, the society's role ends, except for informal contact with the informant.

If the doctor refuses, the society's role also ends. Society members do not report the doctor to the Board of Medicine.

"We have no firsthand knowledge of his fitness," says Dr. Douglas Sargent, co-chairman of the Wayne County Medical Society's health and well-being committee. "So our position is the person who has notified us should report" the doctor.

For reasons of confidentiality, the Michigan State Medical Society does not keep detailed statistics on the impaired doctor program. The reports they have received, through the end of 1982, indicate that society members contacted 146 impaired doctors in 28 months. Members say they persuaded 103 to accept treatment; national statistics suggest about 60 will recover. Forty-three refused and presumably continue to practice.

SOME OTHER STATES' medical societies have taken a more active approach.

The Medical Association of Georgia has developed an elaborate two-year treatment program that includes hospitalization, care in a halfway house, "mirror-image therapy" in which the doctors help treat other addicted patients, and aftercare at weekly Caduceus Clubs, modeled after Alcoholics Anonymous. Since the program began in 1976, more than 500 doctors have been treated; more than 300 are back in practice.

Such programs seem more effective than many state licensing boards in protecting patients from sick doctors.

They certainly are faster.

In Michigan, a case before the Board of Medicine takes an average of 2½ years to final resolution. While the case is being resolved, the physician usually remains free to practice.

Dr. Franz Jordan began having problems with drugs as early as 1970, when an Oklahoma court found him guilty of public drunkenness. During his years of practice in Owosso and Boyne City, the Board of Medicine twice investigated him for suspected drug abuse but was unable to find enough evidence to warrant formal charges. In 1977, local doctors concerned about his treatment of patients wrote the board.

In 1978, after Jordan's third hospitalization in a year for problems associated with drug abuse, the board launched another investigation that led to formal charges in 1979.

Jordan was allowed to continue practicing, provided that he submit urine samples and psychiatric reports for two years to prove he was not taking drugs. He reportedly moved to Puerto Rico last July.

The board first heard of Dr. George Stokes in 1978, when Munson Medical Center in Traverse City reported that Stokes had been suspended from the staff because he was drunk when he came to the emergency room to treat a patient. The state charged, and Stokes admitted, that he had been an alcoholic for 10 years.

A year later, when the board issued its final order, Stokes already had entered a treatment program and was recovering. The board simply put its stamp of approval on the program.

Friends of medicine

Most of the larger county medical societies in Michigan have intervention committees to try to persuade addicted physicians to get treatment.

In Wayne County, individuals concerned about an impaired physician can call 567-1640, 8:30 a.m. to 4:30 p.m. weekdays, and ask for the Friends of Medicine. A doctor will call back. Your name will be kept confidential.

If your county medical society doesn't have an impaired physician committee, call the Michigan State Medical Society at 517-337-1351, 8:15 a.m. to 5 p.m. weekdays, and ask for the Impaired Physician Program.

The medical societies can only persuade. The state Board of Medicine is the only agency that can restrict a doctor's practice or revoke a license. To report an impaired physician, write the Department of Licensing and Regulation, Bureau of Health Services, Box 30018, Lansing 48909.

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DETROIT FREE PRESS/THURSDAY, APRIL 5, 1984

SO THE DILEMMA:

Independent treatment is faster but leaves the public defenseless against impaired doctors who refuse or fail treatment and continue to practice.

State board action provides some public protection and control but takes much longer.

Four years ago, the State of California began a program that addressed both needs.

A California doctor impaired by drugs, alcohol or physical or mental illness can apply for entry to the Diversion Program for Impaired Physicians, an arm of the state licensing board.

If, after an interview, the doctor is accepted — and almost all who apply are — any board investigation is halted. An evaluation committee designs a treatment program for the doctor, who might be allowed to continue practicing, sometimes under restrictions.

Although state disciplinary actions are public records, the doctor's participation in the diversion program is confidential; upon successful completion, all records are destroyed.

In 1982, 126 doctors were participating in the program, and 17 completed their treatment. Four years is not enough to measure long-term success, but the program has had some short-term effects, as documented in a letter a graduate wrote to the program director almost two years after beginning treatment:

"It is difficult to comprehend all that has occurred in my life since that evening in late July 1980 when I spoke to you for the first time . . .

"I have progressed from a despairing, depressed individual with no future but continued deterioration and probable suicide, to a productive, competent physician, a reliable and trustworthy friend, and a compassionate and understanding father and husband. I have grown to like and respect myself for the first time in many years."

An addicted doctor who enters a treatment program has a better-than-even chance of recovery, according to statistics from drug treatment centers. Most treatment programs report that 60 to 75 percent of their doctor patients recover.

That is higher than the general population's success rate, which a Mayo Clinic study found to be between 50 and 60 percent.

The Mayo researchers discounted intelligence and education as factors in the doctors' higher recovery rate. Instead, they cited pressure from state licensing boards and hospitals as major reasons for doctors' more favorable outcomes. The threat of losing something as prestigious and lucrative as a medical license is a powerful motivator, they suggested.

The favorable outlook is an encouraging sign for therapists trying to get reluctant doctors to heal themselves.

The directors of Georgia's treatment program wrote, "Perhaps the single most important lesson this program has taught us is that while disabled doctors cannot reach out for help, they will, when motivated with appropriate treatment, demonstrate a high rate of recovery.

"The value of such recovery to the individual physician, his or her family, and community is incalculable."

Three who practiced under the influence

Despite some physicians' assurances that addicted doctors are relatively harmless, Board of Medicine records show that impaired doctors often try to treat patients while intoxicated or otherwise impaired, sometimes with disastrous results:

■ **Dr. Nanette Schneider-Dice** allegedly had sexual relationships with two of her psychiatric patients in 1976 and 1978. One relationship extended over six months; the other occurred while the patient was in the hospital, according to the state attorney general's formal charges filed with the board in 1980.

According to the charges, she was hospitalized for psychiatric care in 1975 and 1977, and was diagnosed as a manic-depressive and an alcohol and drug abuser.

The Grand Rapids psychiatrist was removed from the staff of Forest View Psychiatric Hospital in 1978. But for three years before, the state charged, she continued to treat psychiatric patients despite her impairment.

According to the state's formal accusation, Schneider-Dice diagnosed serious mental disorders without sufficient basis, mixed up her notes and orders, and peppered patient charts with inappropriate comments, such as "Patient dramatic and full of BS" and "(The patient) gave me my diagnosis." She allegedly disrupted a hospital by attempting to conduct a sing-along in the visitors lounge.

After she agreed not to contest charges that she improperly prescribed Valium and sleeping pills for herself, the Board of Medicine dismissed the other charges, suspended her license for three months and put her on probation for three years.

■ **Dr. Ronald Zajac's** employes would cancel his appointments whenever patient complaints and the Lathrup Village eye doctor's deteriorating condition told them he was too drugged with cocaine to finish the day. Once, according to a police interview with his employes, Zajac walked into an examining room and fell on a patient.

Zajac did not contest the charges, and the board took his license away for two years. Zajac was reinstated in November 1982.

■ **Dr. Joan Shapiro** admitted she injected herself with narcotics, including morphine. In April 1979, she appeared in the labor and delivery area of William Beaumont Hospital in Royal Oak, talking rapidly and walking unsteadily, with blood running down her left hand from what appeared to be a fresh injection site. A month later, she appeared in the same condition, her hands swollen and bandaged. Four months after that, she came in at midnight to delivery a baby. She walked unsteadily and suffered memory lapses during the delivery.

The board suspended her license for a year.

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DETROIT FREE PRESS/THURSDAY, APRIL 5, 1984

Doctors who sell drugs face little risk

By DOLLY KATZ
Free Press Medical Writer

Dr. Michael Marshall of Southfield illegally sold prescriptions for 1,200 tablets of narcotics, tranquilizers and diet pills because, he testified, he needed to buy a $14,000 engine for his twin-engine Beechcraft airplane.

The activities of doctors like Marshall have helped make Michigan the nation's largest wholesale purchaser of pep pills, codeine and Dilaudid, a highly addictive morphine derivative. Michigan ranks No. 1 in sales of five of the eight drugs the federal Drug Enforcement Administration regulates most strictly because of their high potential for abuse.

Diet pills like Desoxyn are a particular problem. These drugs, called amphetamines, also are known as pep pills because of their stimulant effect. They are highly addictive, and their usefulness in weight control is, by the manufacturers' admission, questionable.

One-third of the Desoxyn distributed in the United States is sold to hospitals, doctors and pharmacists in Detroit, according to 1982 and 1983 DEA statistics. After it reaches the streets, federal drug agents believe, much of it is shipped illegally to other states.

THAT TRAFFIC continues despite Michigan Board of Medicine regulations intended to strictly limit amphetamine prescription for weight control.

Marshall is one Michigan doctor who got caught. In January 1983 the board suspended his license for at least a year, and a month later, after his conviction on drug charges, a judge sent him to the federal prison in Marion, Ill., where he is now. He already is eligible to apply for relicensure.

But drug abuse experts say most doctors who illegally sell drugs do not get caught.

"We believe a substantial portion of the problem in Michigan is due to a small number of dishonest doctors and pharmacists," wrote members of MOP UP (MDs, Osteopaths, and Pharmacists against Unnecessary Prescriptions), a group of Macomb County health professionals and drug enforcement officials trying to reduce prescription drug abuse.

Dr. Michael Marshall of Southfield, left, is one Michigan doctor who got caught. In January 1983 the Board of Medicine suspended his license for at least a year for selling drug prescriptions, and a month later, a judge sent him to the Federal Prison Camp in Marion, Ill., where he is now. He already is eligible to apply for relicensure.

"The reasons for this growing problem in Michigan can be stated simply: The profit is enormous, the likelihood of being detected is minute, and the likelihood of being successfully prosecuted — with jail or loss of license — if detected is minute."

Since 1977, according to a Free Press study, the Board of Medicine has taken action against 53 of its 20,000 licensed doctors for illegal drug prescribing. Of those, 34 lost their licenses to practice for at least a year.

Over that time, prescription drug abuse continued to grow, according to DEA figures. Since 1978, there have been huge increases in the amounts of stimulants, sleeping pills and narcotic painkillers prescribed and dispensed in Michigan.

In those years, Michigan's wholesale consumption of Dilaudid, for example, increased almost 400 percent. The statistics suggest to drug investigators that Michigan is an interstate distribution center for illegally prescribed drugs.

WHILE THE PROBLEM has been growing, state enforcement activity has been declining.

Until last year, the state Department of Licensing and Regulation paid for six investigators and two secretaries to work with the Michigan State Police's Diversion Investigative Unit, which tries to control illegal sale and use of prescription drugs.

Budget cuts forced the department to eliminate those employes last May. With that funding gone, the unit's staff statewide has been cut in half.

"We're alive, but not really well," said Lt. Joseph Young of the unit's Lansing office. "I had six investigators and a secretary. Now I've got three sergeants and no secretaries; my investigators have to do their own typing.

"Last year, my staff investigated four complaints short of what they did the year before. I don't think they'll be able to keep up. It's just going to catch up with us."

Besides more money, state and federal drug enforcement officials would like to see Michigan enact a triplicate prescription law like the one in Illinois.

Such a law would require three copies of every prescription for addictive drugs — one for the doctor, one for the pharmacy and one for a central state

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agency that could monitor the prescribing and dispensing habits of individual doctors and pharmacists.

"I think if you issued triplicate prescriptions, you'd eliminate anywhere from half to three-quarters of the problem," said John Mudri, diversion control supervisor for the DEA's Detroit office.

The problem of amphetamine abuse prompted the Board of Medicine six years ago to enact prescribing restrictions. Among other limitations, the board's "amphetamine rules" prohibit doctors from prescribing them for weight control to any patient for more than three months in a row.

But the rules seem to have had little effect on the consumption of pep pills in Michigan.

The medical board of at least one state — Wisconsin — has prohibited doctors from prescribing amphetamines for weight control.

"We felt it was a very good rule, and we've had a lot of good luck with it," said Deanna Zychowski, administrative assistant to that board. "I think it shut down a lot of the weight loss clinics where doctors were handing these out. They just kind of folded."

Detroit Free Press

Volume 153, Number 338 ON GUARD FOR 152 YEARS MSE 1A Friday, April 6, 1984

bad doctors/who is watching?

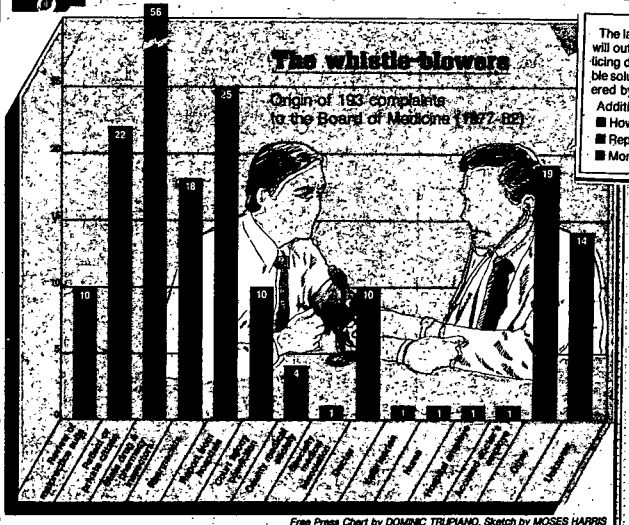
Sixth of seven parts

Coming up Sunday . . .

The last segment of the series will outline the problems in policing doctors and some possible solutions now being considered by the state.

Additionally, we'll advise you:

- How to find a good doctor;
- Report a bad one, and;
- Monitor the care you get.



Free Press Chart by DOMINIC TRUPIANO, Sketch by MOSES HARRIS

Some watchdogs have little bite

By DOLLY KATZ
Free Press Medical Writer

At first glance, bad doctors would hardly seem to stand a chance against all the institutions that are supposed to regulate physicians.

Even if they escape the notice of the state Board of Medicine:

- They can be kicked off the staffs of hospitals
- They can be sued.
- They can be reported to their county medical societies.

BUT DR. DALE WILLIAMS of Muskegon was kicked off the staffs of two hospitals, sued 10 times and disciplined by the Board of Medicine. He's still practicing.

Dr. Robert Posey was reported to his county medical society by another physician. He's still practicing.

Psychiatrist H. C. Tien was dropped from one hospital's staff after other staff members at that hospital refused to work with him because of his extensive use of electroshock therapy. He's now practicing at another hospital and has twice sued the hospital that kicked him off staff.

The institutions that are supposed to police doctors appear much more formidable than they are. Those institutions are profiled on Page 12A.

The medical society . . .

Doctors seldom tell on doctors

Dear Ann Landers: I have two friends whose 14-year-old daughters were sent to the same doctor — one for an injured ankle, the other with a bad cold. He performed vaginal exams on both girls, with no nurse present and without consulting the mothers. This doctor was committed to a mental hospital about 10 years ago. In our town there is no medical society, only gossip from nurses about this particular doctor. What can be done? — Small Town in Nebraska

Dear Neb.: The other physicians in town should report the doctor to the county and state medical societies and to the American Medical Association headquarters in Chicago.

Dear Ann: You're wrong.

Dr. Dale Baker's sister-in-law almost died in 1974 because Dr. Robert Posey failed to recognize her severe internal bleeding. Baker's late-night telephone calls to other doctors saved Marilyn Maynard's life.

Baker reported Posey to the Ingham County Medical Society.

The medical society passed the complaint to the local society of obstetricians and gynecologists. The complaint died there.

Five years later, the state Department of Licensing and Regulation learned of the incident from other sources and added it to the long list of charges filed against Posey with the Michigan Board of Medicine.

In the years since Baker reported Posey to the county medical society, at least eight other women have been victims of Posey's substandard care, the state has charged. One is dead, one lost her baby, and six underwent allegedly unnecessary surgery.

Dr. Robert Posey, above, is now facing charges before the State Board of Medicine that at least eight women have been victims of his substandard care. One is dead, one lost her baby, and six underwent allegedly unnecessary surgery. He was first reported to the Ingham County Medical Society in 1974.

Hearings on the charges are continuing in Lansing.

MANY PEOPLE, like Ann Landers, may believe that the American Medical Association and its local affiliates are the ultimate courts of appeal from substandard care by doctors. They may think that these societies, particularly the AMA, can reach out from Chicago and stop a doctor from practicing.

Even some doctors share those beliefs. In "A Private Practice," a new book describing his ordeal with drug addiction, "Dr. Patrick Reilly" (a pseudonym) worries: "Maybe the medical society in Cleveland had found out. They would pull my license! I would never be able to practice medicine again!"

They can't. Medical societies are political and trade organizations that doctors join if they choose. The societies' strongest sanction is expulsion — which has no legal or practical effect on a doctor's privilege to practice.

Reporting an incompetent or impaired doctor to a county, state or national medical organization is like reporting a bad driver to the American Automobile Association: The organizations might deplore the behavior, but neither is equipped, legally or politically, to deal with the problem.

If medical societies can't stop bad doctors from practicing, they at least might be expected to alert licensing boards.

But they don't. Organized medicine almost never blows the whistle on its members.

The Free Press tracked down the original sources for 187 cases brought before the state Board of Medicine from 1977 through 1982. The cases originated from 193 complaints (in a few cases, more than one person or agency complained to the board about a doctor).

County medical societies filed four of those 193 complaints.

Only one state professional society — the Michigan Society of Pathologists — filed a complaint during the six years.

Individual doctors did not do much better. In six years, 10 doctors stepped forward to charge colleagues with incompetence.

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DETROIT FREE PRESS/FRIDAY, APRIL 6, 1984

The courts . . .

Lawsuits don't stop bad doctors

Malpractice lawsuits, despite their popularity, their numbers and the apprehension they instill in medical circles, do not protect the public from bad doctors.

They do not separate the good doctors from the bad.

They compensate only a fraction of patients injured by negligence.

And they do not drive bad doctors out of business. Doctors who are sued so many times that they can't get coverage simply practice without insurance.

Fifty-seven percent of Michigan's doctors have had malpractice claims filed against them, according to a survey commissioned by the Michigan Insurance Bureau. A national study by the Rand Institute for Social Justice indicates that more than half of malpractice claims are dropped with no payment to the patient.

Partly for that reason, lawsuits seldom lead to formal charges before the Board of Medicine.

MICHIGAN RESIDENTS filed more than 6,000 malpractice lawsuits from 1977 through 1982. But only 10 of some 200 cases that came before the Board of Medicine during that time were based on suits.

It's not that the state doesn't know of the lawsuits. By law, malpractice insurance companies must provide the Michigan Insurance Bureau with detailed information about each claim filed and settled, whether or not the claim leads to a lawsuit. The bureau, in turn, sends the information to the Department of Licensing and Regulation.

But for a year, beginning in November 1982, nobody in the licensing agency was looking at them. Officials said they had neither the time nor the staff to examine 175 claims and suits a month and decide which warranted investigation.

Now they are being examined, by order of licensing officials appointed by the Blanchard administration.

Even when the department has looked at the lawsuits, it has not used many as a basis for formal charges.

Dr. Dale Williams of Muskegon, left, says he can't get insurance anymore because he has been sued 10 times. He won three cases and settled seven. Cheryl Burnham's parents sued Dr. Lois Dunegan, right, after a county prosecutor raised questions about Dunegan's "assistant" in the operating room — a friend of hers who had no medical training.

A malpractice suit or claim is not proof of incompetence, as the high rate of dropped claims indicates.

Even a case that's settled often does not contain enough evidence of incompetence to constitute a licensing violation.

One Coldwater physician's insurer paid $35,000 to a woman who suffered complications from exploratory surgery. An assistant attorney general thought the case was strong enough to bring before the Board of Medicine. The formal accusation charges that the doctor burned a hole in the woman's intestine while trying to cut away adhesions with an electric knife. The woman developed a severe abdominal infection and inflammation of the lungs.

After a hearing, an adminstrative law judge concluded that the state had not proved that the incident was more than an "unfortunate result," which can happen to any doctor, no matter how careful.

NEVERTHELESS, some doctors have more unfortunate results than do others.

A four-year study of 8,000 doctors in the Los Angeles area found that fewer than one percent of them accounted for 10 percent of all malpractice claims and almost a third of all malpractice payments.

Such an enormous burden of claims might be expected to drive the doctors out of business because malpractice insurance companies would refuse to underwrite their high-risk practices.

But nothing prevents a doctor from practicing without insurance.

Dr. Dale Williams of Muskegon says he can't get insurance anymore because he has been sued 10 times. He won three of those cases and settled seven. The latest settlement, approved last October, will compensate a 23-year-old man who limps because Williams allegedly failed to diagnose a hip disorder 10 years ago. The insurance settlement will pay the man $200,000 plus $525 a month for the rest of his life.

Now Williams practices without insurance. He charges that the 10 lawsuits were filed at the instigation of other doctors who felt threatened by his attempts to develop innovative ways of delivering health care to poor people.

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MOST DOCTORS are not sued 10 times, or even twice. Nevertheless, since the mid-1970s, organized medicine has voiced increasing alarm and outrage at the growth in the number of malpractice suits. According to the Michigan State Medical Society, the number of claims filed against doctors has increased 336 percent in the last six years.

Yet malpractice is a much bigger problem than those statistics indicate.

Although a lot of malpractice suits might be frivolous, they are outweighed by the many cases of negligence that never result in a suit. If Michigan is like the rest of the nation, it has nine "silent" victims of malpractice for every one who sues.

A 1982 report by the Rand Corp.'s Institute for Civil Justice estimated that, at most, one in 10 patients injured by negligence files a claim.

"Only a fraction of the stock of potential claims are actually filed," wrote Rand consultant Patricia Danzon. "Very crude estimates suggest that at most one in 10 potentially actionable injuries give rise to a claim."

Why the other nine do not sue is unclear because no one has interviewed them.

Many injured people don't know they are victims. Cheryl Burnham's parents had not intended to sue over their 19-year-old daughter's death. They believed Dr. Lois Dunegan when she told them everything possible had been done to treat Burnham's internal injuries from the traffic accident.

It was only after the Ingham County Prosecutor's Office raised questions about Dunegan's "assistant" in the operating room — a friend of hers who had no medical training — that the Burnhams contacted a lawyer.

"Good manners and a saintly appearance can overcome a great deal of incompetence," said Dr. Thomas DeKornfeld, chairman of the University of Michigan anesthesiology department and head of a committee studying ways to improve state regulation of health professionals.

"I know doctors who are unlikely to be sued because their patients think they're just wonderful."

Fifty-seven percent of Michigan's doctors have had malpractice claims filed against them, according to a survey commissioned by the Michigan Insurance Bureau.

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DETROIT FREE PRESS/FRIDAY, APRIL 6, 1984

The hospitals . . .

Kicked out of one, on to another

A hospital's ability to protect patients ends at its doors. A doctor kicked out of one hospital can simply go on to another.

Sparrow Hospital of Lansing put Dr. Robert Posey on probation and limited his privileges after the Maynard incident *(see story, top left)* and a series of other near misses.

But Sparrow's actions had no effect on Posey's privileges at nearby St. Lawrence Hospital and Ingham Medical Center, to which he subsequently transferred his practice. With the exception of Marilyn Maynard's near-death, the state's incompetency charges are based on incidents that occurred at Ingham and St. Lawrence.

Dr. Dale Williams *(see story, bottom left)* was kicked off the staffs of two large Muskegon hospitals, Hackley and Mercy, on charges of poor care of patients. Three cited in the charges died; another almost died.

But Williams still can admit patients to the nearby 46-bed Heritage Hospital, which he helped found.

Hospitals need doctors to function, but doctors do not always need hospitals.

Dr. Joseph Rucker Sr. of Detroit performed abortions in his own clinic, assisted by an ex-convict with no medical training. In the three years before he lost his license in 1983, Rucker switched to a more general practice and earned almost $1 million taking care of Medicaid patients from his office.

THE DANGERS of keeping incompetent doctors on staff are obvious, but some hospitals have learned that kicking doctors off their staffs also has its perils.

St. Lawrence had to defend itself in court for five years against psychiatrist H.C. Tien.

Hospital officials dropped Tien from the staff in May 1977 after years of turmoil over his extensive use of electroshock therapy, traditionally administered only to severely depressed patients. Before they told him to leave, hospital officials had to hire separate aides and nurses for Tien because the regular staff refused to work with him

Psychiatrist H. C. Tien was dropped from one hospital's staff after other staff members at that hospital refused to work with him because of his extensive use of electroshock therapy. He's now practicing at another hospital and has twice sued the hospital that kicked him off staff. Above he is shown in a picture taken from a book he paid to publish about the use of television in therapy.

Tien used shock treatments to "erase" his patients' undesirable personality characteristics. In the period of confusion that accompanies recovery from electroshock, Tien's patients would be fed chocolate milk from baby bottles, given new names and "reprogrammed" into different personalities.

Tien sued St. Lawrence twice, once after the hospital refused him permission to perform electroshock therapy on certain patients, and again after it revoked his staff privileges. Both suits eventually were dismissed.

Tien still practices in Lansing. He is on the staff at Sparrow Hospital, which does not have electroshock facilities.

"His record at our hospital was clean," said Dr. W. E. Malvonado, vice-president for medical affairs at Sparrow, when contacted by a reporter. "We were not privy to the records at the other institution."

The state later went up against Tien, charging him with 36 counts of exploitation of the doctor-patient relationship, incompetence and misrepresentation. Those charges were dismissed two years later when Tien agreed to be more careful in his financial and patient dealings.

Tien has not responded to requests for an interview.

WILLIAMS took both Mercy and Hackley hospitals to federal court on anti-trust charges. Williams charged that the hospitals got rid of him because they felt threatened by his efforts to reduce hospitalization through preventive medicine.

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WEFT PAGE

U.S. District Judge Richard Enslen denied the hospitals' initial motions for summary judgment. Only after 4½ years of expensive fact-finding procedures did he grant the dismissal, ruling that Williams' professional behavior was "highly questionable" and that his colleagues had "valid medical and professional concerns." Hackley Hospital estimates it spent more than $100,000 on lawyers' fees to defend against the suit.

St. Joseph Mercy Hospital of Pontiac tried to drop Dr. Leo Donaldson from its residency program in December 1982 after he was charged with sexually assaulting a patient. A federal judge ordered the hospital to allow him to complete his residency. Donaldson's racial discrimination case is pending against the hospital, and criminal sexual conduct charges are pending against him.

Dr. Jon Stolte is suing 20 members of the Pontiac General Hospital medical staff who suspended him in 1976, allegedly for using poor surgical judgment. One case cited was an elective tonsillectomy on a pregnant woman who subsequently had a miscarriage. The hospital's non-physician board of trustees put Stolte back on the staff in 1978.

"We have been asked to control our own people on the one hand, and on the other hand when you do, you end up in a lawsuit," said Dr. Robert Segula, one of the physicians named in the suit.

Segula was pessimistic about the future of peer review, the formal process by which committees of hospital-based doctors monitor their colleagues.

"For the good, honest and legitimate physician who is seeking self-improvement, peer review is very much alive," he said. "But the one who really needs it for policing is so protected by the law that (peer review) is in serious danger."

Hospitals do not stand alone in their disciplinary efforts. By law, a hospital must notify the state Department of Licensing and Regulation whenever it acts against a doctor. The state can then pick up where the hospital's action left off.

BUT STATE ACTION is slow at best and uncertain at worst.

Hackley and Mercy duly notified the state Department of Licensing and Regulation in 1978 that they had revoked Williams' staff privileges.

Four years later, the Board of Medicine dismissed most of the charges against him and ordered Williams to get an extra 300 hours of medical education by 1985, a requirement that Williams said he already has fulfilled.

The board did suspend Dr. James Gotham's license — but almost two years after Harper Hospital of Detroit suspended him because of a nerve disorder that impaired his ability to practice medicine safely.

And the board did persuade Dr. Willard Green to retire last January — eight years after Pontiac General Hospital refused to renew his staff privileges because of poor quality patient care.

Although hospitals must inform the state when they take disciplinary actions against doctors, they are not required to inform patients. Even if a patient asks, officials at most hospitals will not say whether the patient's doctor has been put on probation or otherwise disciplined.

"We have been asked to control our own people on the one hand, and on the other hand when you do, you end up in a lawsuit," said Dr. Robert Segula, one of the physicians named in the suit. Segula was pessimistic about the future of peer review, the formal process by which committees of hospital-based doctors monitor their colleagues: "For the good, honest and legitimate physician who is seeking self-improvement, peer review is very much alive. But the one who really needs it for policing is so protected by the law that (peer review) is in serious danger."

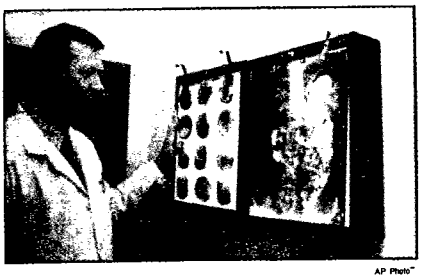
Detroit Free Press

Volume 153, Number 340 ON GUARD FOR 152 YEARS PAGE 1A Sunday, April 8, 1984

bad doctors/what are the answers?

Last of seven parts

Dr. Donald Kuiper, who retired as Board of Medicine chairman in December, would like to see the development of "peer review teams." The teams would be called in when the board received complaints about incidents that could not by themselves be considered incompetence, but that raise questions about a doctor's care. "If the peers were to go out and look at the practice and say, 'We feel for these reasons that Dr. So and So doesn't meet minimal standards,' the board could impose sanctions," he said.



AP Photo

Cures for an ailing system

Michigan seeks to redesign its regulations

By DOLLY KATZ
Free Press Medical Writer

The State of Michigan has a regulatory system designed to protect the public from bad doctors.

Instead, it often seems to protect bad doctors from the public.

"The system doesn't work because it wasn't designed to work," said Dr. Thomas DeKornfeld, chairman of the anesthesiology department at the University of Michigan Medical School.

DeKornfeld is chairman of the Health Occupations Council, a committee asked by the Blanchard administration to help redesign the system of regulating doctors. Friday, the committee gave unanimous approval to its final report on complaints and investigations.

It also submitted preliminary recommendations regarding licensing.

IN THE LAST WEEK, the Free Press has detailed the failings of the system:

- It takes too long. The average case against a doctor takes 2½ years, from the time the doctor comes to the state's attention until the Michigan Board of Medicine's final order takes effect.

- It is too uncertain. Most bad doctors never come to the board's attention. Even among those who do, the stringent requirements for proof and the uncertain nature of medicine ensure that only the most blatantly incompetent doctors are caught and put out of business.

As soon as she took over as director of the state Department of Licensing and Regulation last year, Elizabeth Howe asked DeKornfeld and seven other members of the state's advisory Health Occupations Council to study the department's workings and recommend changes.

"We're aware there are problems, and we're determined to do something about it," said Leo Lalonde, chief deputy director of the department. "We're determined to do the best job we can with the resources we have."

Howe also has encouraged the boards and bureaus in her department to make improvements that do not require legislation or money; some of those are detailed below. Howe's proposed budget for the fiscal year that begins in October includes money to overhaul the department's antiquated computer system and for more employes.

See SOLUTIONS, Page 11A

bad doctors/what are the answers?

SOLUTIONS, from Page 1A

Most of the changes and proposals are designed to reduce the time required to handle a case.

But many of the problems detailed in the Free Press series are caused by the difficulty of proving incompetence unless a doctor has repeatedly and seriously harmed patients. Even then, the state may not be able to amass enough evidence to prove the doctor's incompetence.

The state cannot guarantee patients that their doctors are minimally competent. A handful of lawyers, investigators and licensing officials cannot monitor the quality of care delivered by more than 20,000 doctors and 160,000 other health professionals.

"It may not be possible for a member of the general public to go to a doctor and (be assured) he's minimally qualified," said Lalonde.

NEVERTHELESS, licensing officials agree that much more can be done to ensure that the regulatory system operates quickly and efficiently.

Below are some measures that Michigan and other states have tried or proposed in trying to identify and weed out incompetent doctors. Although none has been completely successful, no one is proposing that the states abandon regulation.

"I think the public needs that protection," said Gay Hardy, chief attorney for the health professions licensing boards. "I don't know how you measure these things. Supposing you save one human life. How do you measure that? What is it worth?"

Problem

The average case that comes before the Board of Medicine takes 2½ years to complete.

Much of the delay is the result of the time required to complete an investigation. Recent budget cuts reduced the number of full-time investigators from 19 to six. They are supposed to conduct investigations for 13 health care professional boards that oversee some 85,000 people. Investigators have had little training and have little contact with the lawyers who will prosecute a case or the board members who will decide whether a defendant is incompetent.

"Right now, the poor investigator goes out and comes back with what he or she thinks is needed," said DeKornfeld. "The board member says this is not really what I need, go back and get some more. Then the board member says this is fine, and the attorney general says well, that's all very interesting, but I can't do anything with that.

"And by this time, a year and a half has gone by, which obviously is intolerable. We can short-circuit this by a factor of many times."

Solution: Howe plans to hire three more investigators in the fiscal year that begins in October. That will bring the investigative staff up to just over half the size it was before budget cuts began a year ago.

Solution: William Howe (no relation to the department director), the new director of the department's Bureau of Health Services, said he has scheduled all employes for in-service education. Board members agree that improving the training of investigators will make them more effective.

Solution: The Health Occupations Council Friday proposed that investigators meet with a board member and an assistant attorney general at the start of some investigations — depending on the nature of the charge and the likelihood of technical or legal complexities — to decide what information is needed. Meetings would then be scheduled to monitor progress.

In New York, medical consultants review incoming complaints to determine what information is needed. After an investigation is completed, a panel of four doctors and one lay person determines whether the case should be sent to a hearing, dismissed or closed with a letter of warning to the doctor.

New York's system, however, is complex and often requires more time than does Michigan's to resolve a complaint.

Solution: The Board of Medicine, which had been meeting only once every two months because of budget constraints, in March began to meet monthly to decide cases. Board members who don't have far to drive to get to Lansing will forgo mileage reimbursement, said board Chairman Dr. James Fenton.

Problem

Licensing fees go to the state general fund, not to the department. This year, the budget for the Department of Licensing and Regulation was $1.3 million less than the department is expected to collect in fees. The Board of Medicine collected more than $1 million; its budget was $629,000.

Solution: If the Legislature approves the department's proposed budget for the fiscal year beginning in October, the department will cut its "parity gap" — the difference between what the department collects in licensing fees and what it gets back for its budget — to about $500,000.

Problem

The department's record systems are chaotic. Very little information is available on computers, and much of the computerized information is inaccurate. For its investigation of the Board of Medicine, the Free Press had to generate statistics from scratch for such basic information as the number of licenses revoked, because the department's statistics were either non-existent or unreliable.

"One of the major problems is they haven't chosen to move into the 20th Century," DeKornfeld said. "Dickens comes to mind, painfully, in some of these situations. This is 19th Century England, with people sitting at big desks writing in big ledgers with quill pens."

Solution: In the next fiscal year, Elizabeth Howe said, the department has budgeted $275,000 to update its computer services. Among other things, the improvements would allow the state Insurance Bureau to send the department computerized information on malpractice suits against doctors, who then could be investigated for license violations. The two agencies have different computer systems.

Problem

The licensing board can take action against only the small number of doctors who demonstrate clear incompetence. It is helpless against the doctor whose practice is marginal but within the law.

Solution: Dr. Donald Kuiper, who retired as Board of Medicine chairman in December, would like to see the development of "peer review teams" of doctors to evaluate borderline doctors. The teams would be called in when the board received complaints about incidents that could not by themselves be considered incompetence, but that raise questions about a doctor's care.

"If the peers were to go out and look at the practice and say, 'We feel for these reasons that Dr. So and So doesn't meet minimal standards,' the board could impose sanctions," he said.

California initiated a variation of that system in 1978. Called the Professional Performance Pilot Project, it authorized regional licensing boards, local medical societies, hospitals, insurance companies and other agencies to identify "marginal" doctors whose level of care was poor but not bad enough to constitute a licensing violation. The agencies would then help those doctors upgrade their skills.

The program flopped and was discontinued in 1982 when the project manager resigned. The problems included lack of participation by the local agencies and a lack of follow-through in dealing with the few doctors identified as needing help.

Since 1979, Maryland has had peer review committees comprised of volunteer doctors who examine a colleague's practice at the licensing board's request. The committees can recommend additional education or other corrective action. Maryland also contracts with the state medical society to conduct its licensing board investigations.

The procedure replaced an archaic law that permitted the state to take action against a doctor only under narrowly defined circumstances, such as conviction of a crime of "moral turpitude."

"We're very satisfied," said a spokeswoman for the Maryland State Medical Association. "We think the word is getting through to doctors that this procedure is in place. I think they're a little more careful."

The Michigan Board of Medicine can order doctors to get additional education or can take other corrective action besides license revocation. Some observers say that the Maryland system adds another time-consuming layer of bureaucracy and that the outcome is the same.

As soon as she took over as director of the state Department of Licensing and Regulation last year, Elizabeth Howe asked eight members of the state's advisory Health Occupations Council to study the department's workings and recommend changes.

Problem

Doctors and medical societies don't report bad doctors to the licensing board. In a six-year period studied by the Free Press, only four of 193 complaints that resulted in formal charges came from medical societies. Only one came from a medical specialty society, and 10 from doctors.

Solution: Some states require medical societies and doctors to report incompetence to a state agency, just as hospitals and insurance companies are required to do in Michigan. After Arizona passed such a law, reports of incompetence quadrupled.

Problem

Judges often delay or overrule board orders to suspend or revoke a doctor's license. A Free Press study found that one in five doctors wins a court stay and that the average length of that stay is two years. A doctor the board has found incompetent can continue to practice while the court decides the case.

Solution: The Michigan Supreme Court issued an order last November reminding judges that they should grant such stays only if an applicant can show that the public won't be harmed, and if the petitioner is expected to win the appeal.

If that doesn't help, said Elizabeth Howe, the Blanchard administration will seek legislation to reinforce the point.

Problem

Michigan has no way to ensure that doctors remain competent after they pass their licensing exams. A doctor, once licensed, never again has to take a competency test.

Solution: Doctors in Michigan and many other states must submit evidence of continuing education along with their licensure fee when they renew their licenses every three years. Michigan doctors have to spend an average of 50 hours a year educating themselves.

But such requirements easily are satisfied by attending a few conferences and by reading medical journals. And the Department of Licensing and Regulation doesn't have the staff to verify the evidence doctors submit.

Furthermore, researchers who have studied the effects of continuing medical education on patient care have not found that it produces any significant improvement.

But until something better comes along, regulators don't want to drop the requirement.

"The real problem is it changes knowledge but not behavior," said DeKornfeld. "Nevertheless, I still believe it would be a mistake to do away with it because even though it doesn't do much, I think it does do something. It's not terribly effective, but not having it would be a step backwards."

The State of Michigan wanted something better. In 1978, the Legislature passed a public health act that included a requirement for the health licensing boards to develop competency tests.

By October, the Board of Medicine is supposed to have developed a competency test to be administered to doctors every four years. But neither the board nor anyone else has been able to come up with such a test.

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DETROIT FREE PRESS/SUNDAY, APRIL 8, 1984

"I can't see how it can be done," said Dr. James Breneman, who studied the issue for the board. "Most medical groups I've talked to feel it's premature to try to measure (competence) and base relicensure on it because some physicians who might be totally competent might be denied relicensure.

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"There are certain practical barriers that exist, too — we don't have the personnel or the money."

At the request of the Department of Licensing and Regulation, state Rep. Mat Dunaskiss, R-Lake Orion, has introduced a bill to repeal the requirement.

Problem

The license granted by the Board of Medicine gives a doctor the right to do anything in the realm of medicine, from psychiatry to brain surgery.

"I'm licensed to do anything," noted former Board of Medicine Chairman Dr. Donald Kuiper. "The only thing that keeps me from doing it is my own good sense and the hospital.

"There's something wrong with our license. It's too broad. I think people ought to be licensed for what they're capable of doing."

Solution: A Columbia University study of doctor licensing recommended that licenses be limited to the area of a doctor's post-graduate training. Many doctors apply for certification from one or more of some 20 national specialty boards, such as the American Board of Family Practice. It would not be difficult to take the next step and pass a law requiring such certification, the study suggested.

Problem

Board members are vulnerable to lawsuits. A doctor who was denied reinstatement because of previous alcohol poblems is suing the board members as individuals. The case is before the U.S. 6th Circuit Court of Appeals on whether board members are immune from such lawsuits.

Solution: A bill in the Legislature, sponsored by Rep. James O'Neill, D-Saginaw, would grant immunity to board members. Licensing director Howe said the measure is likely to be controversial.

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bad doctors/what are the answers?

The complaints pile up, but doctor still practices

By DOLLY KATZ
Free Press Medical Writer

Were it not for a midnight telephone call, doctors say, Marilyn Maynard would have bled to death, surrounded by all the lifesaving equipment of a large, sophisticated hospital.

The doctor who admitted Maynard to the hospital and then, the state charges, left her to hemorrhage, was Robert Posey, 40, a Lansing specialist in obstetrics and gynecology.

Three other doctors who had not spoken to Maynard and got their information secondhand made the decisions by telephone that saved her life.

The incident occurred more than nine years ago. Posey is still practicing, while the complaint against him wends its way through the state's administrative machinery. No conclusion is in sight.

MEANWHILE, at least eight other women have been victims of substandard care at Posey's hands, the state charges. They include Gail Jiskra, whose baby died; Constance MacDonald, who died of cancer, and six women who underwent unnecessary surgery, according to the formal complaint the Attorney General's Office has filed with the Michigan Board of Medicine.

In addition, a 31-year-old woman, not included in the state's case, has filed suit against Posey. Patricia Hiser charges that Posey unnecessarily removed her ovaries, piece by piece, in a series of operations between 1977 and 1982, but left her with the chronic pain he undertook to relieve. Posey has denied negligence.

Posey is one of 27 doctors currently defending themselves against formal charges of misconduct filed by the Attorney General's Office. The doctors are accused of fraud, drug abuse, sexual assault or incompetence. Most, like Posey, will continue to practice during the average 2½ years required for resolution of a complaint to the Board of Medicine.

If the Free Press study of past patterns holds true, the board will find one of those 27 not guilty of the state's allegations.

Dr. Robert Posey, 40, a Lansing specialist in obstetrics and gynecology, is one of 27 doctors currently defending themselves against formal charges of misconduct filed by the Attorney General's Office.

Diagnosis by phone

On Dec. 16, 1974, Marilyn and Charles Maynard learned that six months of tests and of treatment with fertility pills had been successful: Marilyn, 31, was pregnant.

Six days later, Mrs. Maynard awoke with intense abdominal cramps and such severe dizziness that she could not sit up.

She called Posey, who reportedly assured her that the symptoms were merely the uterus "lining up."

A short time later, when Mrs. Maynard tried to stand up to go to the bathroom, she had a seizure and fell unconscious.

Her husband called Posey back, and he directed them to Sparrow Hospital, a 500-bed facility that is Lansing's biggest and most sophisticated hospital. Charles Maynard called an ambulance and raced with his now-conscious wife to the hospital. There, a nurse took Mrs. Maynard's blood pressure and allegedly recorded 80/50, a very low reading (120/80 is normal). Low blood pressure can be a sign of internal bleeding.

The nurse called Posey, who said the condition was not serious and was because of medication he had prescribed for Mrs. Maynard, according to the state's complaint.

"Posey (told the nurse) he would see me the next morning, why not admit me. Then my husband went home," Mrs. Maynard said.

Leo Farhat, Posey's attorney, said Posey was under the impression she had been seen by a doctor. "The male nurse reported things to Dr. Posey which inferred that she had been seen by a physician," Farhat said.

Shortly after Charles Maynard got home, he called Marilyn's brother-in-law, Dr. Dale Baker of Ann Arbor, to reassure him that Marilyn was under observation in the hospital and was all right.

Sixty miles away, Baker listened uneasily to Maynard's description of events. A call to the nurse who had examined her increased his concern.

"It was obvious the patient was in trouble," recalled Baker, an internal medicine specialist. "She was in shock, it sounded like. I remember them telling me when they stood her up to put her in bed, she fainted. And obviously it was because her blood pressure was so low.

"And what alarmed me was that no doctor was going to see her until the next day. I think the chances are the patient would have died (by morning). The whole thing was so bizarre — a hospital as good as Sparrow is, that this could actually be going on."

BAKER CALLED a friend, Dr. Marvin Schrock, an Ann Arbor obstetrician, and described Marilyn's symptoms. Schrock agreed that the abdominal pain, the dizziness and the low blood pressure sounded like a ruptured ectopic pregnancy.

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An ectopic pregnancy occurs when the fertilized egg implants in the narrow Fallopian tube leading to the uterus, instead of in the uterine wall. As the egg grows, it can rupture the tube, causing massive bleeding that is fatal without emergency surgery.

By now it was midnight. Baker and Schrock, conferring by phone about a patient neither had seen, decided to take matters into their own hands. Schrock called Lansing and awakened Dr. Joseph Sheets, chairman of Sparrow's department of obstetrics and gynecology. Schrock related his thirdhand information. Sheets agreed with the diagnosis.

Sheets called Sparrow Hospital, asked the nurse in charge of Maynard's care a few questions, got out of bed and rushed to the hospital.

He went to Maynard's bed, examined her briefly, put her on a cart and called the operating room to prepare for emergency surgery.

The surgery revealed massive internal bleeding. Maynard had lost almost 75 percent of her blood.

"This patient was in critical condition, and it is my opinion that she would not have survived much longer had surgery not been performed," Sheets said in his affidavit to the Board of Medicine.

Maynard did survive. She is now 40, has a seven-year-old son and teaches high school social studies. She is still angry at Posey.

"When my husband and I got done testifying (at Posey's hearing), I was saying I wish I could scream it from the tallest building because I know all these women are still going to him," she said.

"For him not to know it was an ectopic pregnancy, I can excuse. For him not to come to the hospital, I can't.

"Not everybody has a brother-in-law to watch over her."

The death of a baby

Gail Jiskra of East Lansing did not have such a brother-in-law. Her case was the first involving Posey to come to the state's attention, in 1980.

Jiskra, a family counselor, was 30 in February 1979 when Posey told her she was two months' pregnant. As her pregnancy moved into its seventh month, she became increasingly concerned about the swelling that at times made it difficult for her to walk. In the last days of her pregnancy, she developed high blood pressure, protein in her urine and sharp pains under her breastbone — all symptoms of pre-eclampsia, a pregnancy disease that can be fatal to mother and fetus.

Standard texts on obstetrics urge doctors to look carefully for those symptoms — particularly among high-risk patients like Jiskra, who had never borne a child — and to instruct their patients in the recognition of the early signs of pre-eclampsia.

Jiskra said she repeatedly asked Posey about her pain and swelling. But Posey did not recognize or properly treat any of the symptoms nor did he tell Jiskra how to recognize them, according to the complaint.

On July 13, in severe pain, Jiskra tried unsuccessfully to reach Posey, then went to the emergency room of Lansing's St. Lawrence Hospital. There, the Attorney General's Office charges, an emergency room doctor who was not a specialist in obstetrics reached Posey by phone and informed him of Jiskra's high blood pressure (164/104, compared with normal pressure of 120/80) and the protein in her urine.

Despite those findings and her continuing pain, the complaint alleges, Posey agreed with the doctor that Jiskra should be given an antacid and painkillers and sent home. The emergency room staff tried to persuade her to leave.

"And I asked, and my sister asked, had they talked with Dr. Posey, and was he coming in to see me," Jiskra testified. "And they said, yes, they had talked with him, no, he was not coming in because he was in full agreement with what they had decided.

"Then I got upset and told them that I was afraid and I didn't want to go home, I thought there was something really wrong. And they said again it's simply gastritis (stomach inflammation). And that was it. And then we went home."

Farhat, Posey's attorney, said the emergency room physician did not tell Posey about the protein in Jiskra's urine but simply reported that all the tests were negative.

Jiskra's sister, Jill Miller, called Posey twice more that night about Jiskra's severe pain and vomiting, Jiskra testified. Twice more, she said, Posey told them not to worry.

Ninety minutes after the last call, Jiskra suffered a convulsion, was rushed to the hospital and underwent an emergency cesarean section to save her life.

Her baby, Trevor, died nine days later.

A month after Trevor's death, a complaint from Gail Jiskra's mother arrived at the state licensing bureau. As part of their research on the Jiskra case, state investigators inspected court cases and subpoenaed hospital records. Those records revealed at least eight other instances of questionable care, including Maynard's ordeal and Constance MacDonald's case.

CONSTANCE and Donald MacDonald, were hoping to have a brother for their two-year-old, Joshua, within a year when Constance went to Posey in November 1978 about the nodule she'd found in her breast. It was small, round and hard, in the upper portion of her right breast.

Posey testified that he examined the breast manually but did not order other tests because he did not think they were necessary.

"He told me we had some fibrocystic disease in there, and there was nothing to be concerned about," she explained to her lawyer on a videotape made a year later. "I asked him if it was anything that would turn into cancer, and he said no. I was relieved."

At the end of January, MacDonald saw Posey again for a regular exam, and he told her her intrauterine device was imbedded in her uterus, and that she needed an operation to remove it, and exploratory surgery to check her fallopian tubes. MacDonald testified that Posey did not examine her breasts. Posey testified that he did not remember whether he did.

At the end of March, she thought the lump seemed larger and was a little red and painful to the touch. She said she called Posey.

"I told him the lump was larger, sensitive and red," she said. "He told me if it hadn't changed after my next period, to come and see him."

Posey said he recalls no such conversation.

A month later, the lump was more swollen, and the nipple had begun to invert. MacDonald called Posey's office at the beginning of May and asked for an appointment to check her breast. She was scheduled for May 24.

Posey found a "large, fixed breast mass," which was soon diagnosed as an advanced cancer.

Farhat said Posey will testify that the cancerous lump did not develop from the original nodule, but was a different lesion.

"I know the prognosis is not very good," MacDonald said in a videotaped deposition in November 1979, after she and her husband filed a lawsuit.

"I try to maintain optimism, and then the doubts come in. I think about my little boy — what will happen to him if I die before he grows up?"

Constance MacDonald died of cancer seven months later. The lawsuit she and her husband filed against Posey was settled in April 1982 for $200,000.

Questionable surgery

The state's complaint also alleges that Posey performed unnecessary surgery. Five women cited in the complaint each were anesthetized and underwent exploratory surgery that included dilation and curettage (scraping) of the uterus, injection of dye into the fallopian tubes followed by an X-ray study, and examination of the ovaries and uterus with a lighted tube inserted through an incision in the abdomen.

In each case, the state charges, the surgery was not justified by symptoms. Posey maintains it was, Farhat said.

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In another case, the state charges that Posey twice tried to perform exploratory surgery on a woman, allegedly to determine why she was not menstruating, even though the hospital laboratory told him both times a test indicated the woman was pregnant.

The anesthesiologist refused to participate in both attempts because of the danger to the fetus, and both surgeries were canceled. Eight months later, the woman gave birth to a boy.

Farhat said Posey was concerned that the woman had an ectopic pregnancy because two other pregnancy tests came back negative. The exploratory surgery was to rule out the possibility of an ectopic pregnancy, he said.

Every phase of the state's case against Posey has proceeded with glacial slowness. After the Jiskra complaint was received, a year passed before subpoenas for records were sent to the hospitals. Two more years went by while the case was handed down, like a legacy, to four different investigators.

On Oct. 22, 1982, the Attorney General's Office issued its formal charges. Three months passed before the compliance conference on Jan. 22, 1983 — a required meeting in which the doctor has a chance to convince a medical board member that he should not be disciplined.

The last year has been taken up with a court challenge by Posey's attorney on the results of the compliance conference; a pre-hearing conference March 16; adjournments while both sides prepared their cases, and 18 days of hearings in June, September, December, January and February.

More hearings on Posey's case are scheduled this spring. After the hearings, the administrative law judge will write an opinion on whether Posey has practiced substandard medicine.

Then the Board of Medicine must decide whether to discipline Posey. If it disciplines him, he can appeal to the courts for a stay. The courts often take years to render a decision.

Meanwhile, Posey continues on staff at Ingham Medical Center and St. Lawrence Hospital in Lansing. He would not discuss the charges again.

How to complain about a doctor

The doctor's hands shook, and the cut wasn't properly repaired.

A doctor in the neighborhood writes prescriptions on demand for addictive drugs.

The doctor made sexual advances during the examination.

If you are aware of such situations — or if you have other reasons to suspect a doctor is addicted, unethical, negligent or impaired in any way — you can file a complaint with the Michigan Department of Licensing and Regulation.

Anyone — a patient, another doctor, an observer — can file a complaint. You don't have to wait until the doctor has harmed someone; the law defines incompetence as substandard care, whether or not a patient has been injured.

Some problems, however, do not qualify as competency issues.

If the doctor kept you waiting three hours, that may be evidence of a poorly organized practice, but it is not incompetence.

A bill you consider too high is not incompetence, nor can the board do anything about it. But if the doctor billed your insurance company for treatments you didn't receive, that's fraud. Contact your insurance company and the licensing board.

DEFINING WHAT constitutes incompetence is harder than describing what doesn't. The best rule is, when in doubt, report it.

File your complaint in writing, not by telephone. Be as specific as possible about why you think the doctor was incompetent. Give names, dates, places and telephone numbers.

You can file a complaint against any of the 13 licensed health professionals: MD, osteopathic physician (DO), nurse, pharmacist, dentist, psychologist, veterinarian, chiropractor, physical therapist, optometrist, podiatrist, sanitarian and physician's assistant.

Complaints against health professionals should be sent to the Department of Licensing and Regulation, Bureau of Health Services, Box 30018, Lansing 48909.

If a complaint is substantiated, an assistant attorney general will file charges with the appropriate professional board — in a doctor's case, with the Board of Medicine or the Board of Osteopathic Medicine.

You can make an anonymous complaint, but it's less likely to result in board action because the state requires evidence to prosecute a case, and very often the evidence is the patient's testimony and records.

Don't worry about state officials giving the doctor your name. By law, the informant's name is confidential unless and until that person is required to testify at a hearing. If your testimony isn't needed, your name won't be released. About two-thirds of cases are settled without hearings.

You can refuse to testify, and you can withdraw your complaint at any time. But your refusal to testify may mean the state cannot proceed against an incompetent doctor. The state had to withdraw formal charges against a Redford physician accused of sexually assaulting a patient after the woman refused to appear at the hearing.

IF INVESTIGATORS are unable to substantiate your complaint and charges are not filed, your name never will be released. In its investigation of more than 200 cases, the Free Press came across numerous instances in which doctors and their lawyers demanded names of informants. The demands always were refused.

State law also protects informants from lawsuits by the accused doctors.

Contacting the local medical society about an incompetent doctor is, for the most part, a waste of time. A medical society has no power over a doctor's license, and often will not even forward your complaint to the state licensing board.

A doctor who is abusing alcohol or other drugs may be a special case. Many county medical societies have abuse committees that try to get addicted doctors into treatment. The Wayne County Medical Society's committee can be reached by calling 567-1640, 8:30 a.m. to 4:30 p.m. weekdays, and asking for the Friends of Medicine.

But these committees have no coercive power, and if they fail to persuade the doctor to get treatment, the doctor's patients will remain in jeopardy.

— by Dolly Katz

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How to choose a doctor

For many people, picking a doctor is a stab in the dark: You get a name from a friend or a telephone book and hope for the best. If you're lucky, you'll never know if you picked correctly because a serious situation will never arise.

Although no method of finding a good doctor is foolproof, the pointers outlined below can improve your odds considerably.

Newcomers to a town often are told to call the county medical society for names of doctors. But all you'll get will be names from an alphabetical list of members.

A better source is other health professionals who have worked with the local doctors.

Gail Jiskra lost her first baby and almost died under the care of Dr. Robert Posey, who now is defending himself against incompetency charges before the Michigan Board of Medicine. When she became pregnant the second time, she followed a doctor's suggestions in her search for an obstetrician.

His advice: Call the labor and delivery floor of a large hospital that has an intensive care unit for infants. Ask the head nurse to recommend some obstetricians. Call the head nurses on the other shifts and ask them, too.

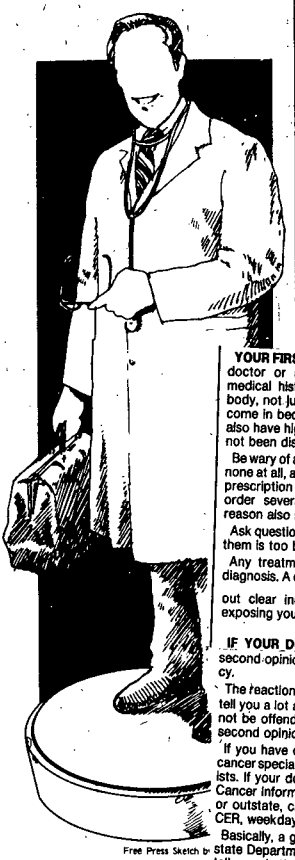
Although Jiskra suffered from the same disorder in her second pregnancy as in her first, she gave birth to a healthy son, Jonathan, now three years old.

THE SAME PROCESS can be followed with other specialties.

Several researchers have done studies to find out what distinguishes good doctors from bad doctors. They found that, in general, your chances of getting good medical care are best if you have a doctor who:

- Is board certified. A board-certified doctor has taken at least three years of additional training beyond that required for a license, has at least two years of experience and has passed a rigorous test administered by one of more than 20 national specialty boards. If you want a family doctor, for example, look for one certified by the American Board of Family Practice. If you're uncomfortable about asking the doctor directly, look on the office wall for a board certificate, or go to the library and look in the Directory of Medical Specialists.
- Teaches.
- Is on the staff of a hospital affiliated with a medical school, or a hospital that has a residency training program.
- Works in a group practice. Solo doctors have no one looking over their shoulders or asking questions and no one at hand to ask for a second opinion or help out in an emergency.

If you have a particular concern, such as a chronic disease or a problem pregnancy, ask the doctor how it will be handled. Ask what would happen if the doctor were out of town, and about his availability on weekends and after hours.



Free Press Sketch by

YOUR FIRST EXAMINATION will tell you a lot. The doctor or an assistant should get a complete medical history and should examine your whole body, not just the part that hurts. You might have come in because your throat hurts, but you might also have high blood pressure or diabetes that has not been discovered.

Be wary of a doctor who does a cursory physical or none at all, and wants to send you off quickly with a prescription or an injection. A doctor who wants to order several expensive tests for no apparent reason also should raise suspicions.

Ask questions. A doctor who is too busy to answer them is too busy to be your doctor.

Any treatment should follow logically from the diagnosis. A doctor who prescribes antibiotics without clear indications of a bacterial infection is exposing you needlessly to the risk of side effects.

IF YOUR DOCTOR recommends surgery, get a second opinion unless the situation is an emergency.

The reaction to a request for a second opinion will tell you a lot about your doctor. A good doctor will not be offended and may even suggest seeking a second opinion before you ask.

If you have cancer, you need to be treated by a cancer specialist, and probably by a team of specialists. If your doctor can't refer you to one, call the Cancer Information Service of Michigan. In Detroit or outstate, call the toll-free number 1-800-4CANCER, weekdays from 8:30 a.m. to 4:40 p.m.

Basically, a good doctor has a clean record. The state Department of Licensing and Regulation can tell you whether formal charges are pending against a physician, the nature of those charges and whether a board has ever taken disciplinary action. Write to the department's Bureau of Health Services, Box 30018, Lansing 48909.

— *Dolly Katz*

APPENDIX 3.—MAGAZINE ARTICLES, "MEDICAL DISCIPLINE IN DISARRAY," WRITTEN AND SUBMITTED BY DR. ROBERT C. DERBYSHIRE

Medical Discipline in Disarray

Obstacles to Enforcement of Discipline

ROBERT C. DERBYSHIRE *New Mexico Board of Examiners*

This is the first of several articles by Dr. Derbyshire to be published in the coming months.

"Some people say that money is not the object in life, but I say the only object is money." This outburst, coming from a so-called disciple of Hippocrates, was addressed to a hotel manager in the presence of several guests. It gave rise to an investigation by a state board of medical examiners into the professional practices of a husband-and-wife team of psychiatrists that was destined to last for several years.

In 1956, two physicians, whom I shall call John and Jane Doe, established a psychiatric practice in a western city. Three years later, the secretary of the licensing board received the following complaint:

The manager of a local hotel called Dr. John Doe to treat one of his guests for acute alcoholism. His high blood alcohol level and a sedative administered by the doctor caused the patient to lapse into a stupor, so that he was unable to pay the doctor for his visit.

The next day, having reached a reasonable state of sobriety, the patient complained to the manager that the doctor had extracted $83.00 from his wallet as his fee for services. However, the doctor had left a receipt on the dresser to avoid any possible accusation of theft. A repetition of the complaint resulted in the confrontation between the manager and the doctor and the latter's loud affirmation of his philosophy of the practice of medicine.

The members of the board of medical examiners, untutored in the law, thought that the doctor's extraction of his fee from the wallet of an unconscious patient was grossly unethical conduct and grounds for the revocation of his license. But counsel for the board disagreed. He pointed out that although he considered the doctor's conduct in bad taste, the money had not been stolen. To which one cynical board member replied: "The moral to this tale is that if you are going to roll a drunk, leave a receipt." As to the conversation in the hotel lobby, counsel thought that this could be dismissed as hearsay evidence since the manager refused to testify at a hearing or to lodge a formal complaint.

Meanwhile, a number of other complaints about the Does were submitted to the board, mostly by telephone. Many of them concerned overcharging and the use of crude methods to collect fees. Although the licensing board had neither the authority nor the desire to regulate physicians' fees, it did have the responsibility to look into the many complaints. Counsel for the board and its secretary therefore invited Dr. John Doe and his lawyer to meet informally with them. After frank discussion, all agreed that the doctor was too preoccupied with money, and he promised to change his approach.

The results of the conference were successful, temporarily at least, and there were no more complaints for several months.

However, in 1959 the husband-and-wife team established a mental health clinic, duly advertised in the telephone directory, causing outrage among members of the local medical society.

Once again complaints began to pour into the office of the licensing board, many coming from members of the medical society. The board secretary answered all of them, but when asked if they would be willing to testify at a hearing, the complainants were never heard from again. Additional grievances unrelated to money now came to light. One involved the disclosure of a

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Dr. Derbyshire is Secretary-Treasurer of the New Mexico Board of Medical Examiners. He is a Past President of the Federation of State Medical Boards of the United States.

Robert C. Derbyshire

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professional secret, but the patient refused to pursue it because of fear of publicity. Another stemmed from verbal abuse by Dr. John Doe of a newspaper reporter's wife. She had consulted him because he had advertised that he would carry out an initial examination for $10.00. He began the interview by berating her for presuming that she could obtain any help for such a ridiculously small sum. Counsel for the board now believed that action could be brought on the basis of unprofessional conduct.

Counsel and the secretary assumed that the reporter and his wife would understand the necessity for her to testify at a hearing. But they soon learned how mistaken they were when, in a letter to the board, the husband said: "I feel my wife and I have discharged our responsibility to society by reporting the malpractice my wife encountered. We cannot, of course, make a career of correcting this problem. We feel it is the responsibility of the medical association and the state board of medical examiners to properly and adequately supervise the medical profession." Had the journalist never heard of due process in the course of his career? Furthermore, the board secretary soon learned that the reporter was not alone in his ignorance; he received a curt note from the president of the state medical society asking: "Just when are you going to revoke the licenses of these two doctors?"

During 1965 and 1966 the number of complaints against the Does continued to mount, but now, for the first time, a few of the complainants indicated that they might be willing to testify. The board counsel interviewed all of them in an effort to evaluate the evidence.

Now a new pattern of the Does' practice emerged. They had changed their specialty from psychiatry to endocrinology and were self-styled experts in the treatment of hypoglycemia. Every patient who consulted them had this condition, regardless of the fact that in virtually all cases laboratories reported normal blood sugars. In some instances there were no laboratory tests at all. One patient alleged that Dr. John Doe had said that tests were unnecessary in many cases; he would often make the diagnosis by examining the palms of the patient's hands. And so, at last, by painstaking investigation and long interviews with prospective witnesses, counsel was able to build up charges of fraud against these doctors. He also learned that the doctors' method of treating hypoglycemia was the intravenous injection of whole adrenal cortex extract, called Eschatin, which long ago had been found to be almost inert.

Finally, on April 26, 1967, some eight years after the original complaints, the two doctors were summoned to a hearing to show cause why their licenses should not be revoked or suspended on the basis of fraud in the practice of medicine.

In due time a hearing was held. It lasted five days and the better part of a night, the proceedings being dragged out by the defense attorney, who asked each question of every witness many times. The board members were all serving without pay. Some were extremely concerned about patients they were having to neglect. During one recess they crowded around counsel, imploring him to try to put a stop to the endless harassment of witnesses. But counsel was firm in his contention that if he tried to shorten the proceedings in any way, counsel for the respondents would claim, in his appeal to the courts, that he had violated his client's rights. And so the hearing dragged on.

Finally, the board members voted unanimously to revoke the licenses of both doctors. Defense counsel then appealed the decision to the district court, which reversed the decision on the grounds that the evidence before the board was not clear and convincing, that the decision was not supported by substantial evidence, and that, in revoking the licenses, the board acted arbitrarily and capriciously. The board then appealed to the state supreme court, which overruled the lower court. In so doing, it reaffirmed a former decision to the effect that the trial judge cannot substitute his judgment for that of the board. The court affirmed the action of the board in ringing tones: "The record in the instant case supports the board's decision by clear and convincing evidence, and the decision of the board is neither unreasonable, arbitrary, nor capricious."

A triumph for justice? Yes, but some two years had elapsed between the final decision of

the state supreme court and the revocation of the licenses. During this time the Drs. Doe had been allowed to continue to prey upon the public on the basis of a stay order of the district court against the board. By that time, 10 years had elapsed since the original complaint.

This case illustrates several obstacles to medical discipline. First is the widespread ignorance of due process among many so-called educated people, including physicians. This relates to the readiness of people to make accusations and their refusal to follow through. Second is the confusion of potential witnesses between medical ethics and the law. A third obstacle to the enforcement of discipline in many cases is harassment of witnesses and board members by the defense attorney.

Judges of lower courts may reverse board decisions, believing that they follow the easy course and hoping that the boards will drop the charges.

Still another lesson emerges from this dreary tale. All of the board members were conscientious public servants as well as busy medical practitioners. When the hearing was scheduled, they had no idea that it would be so prolonged and that it would cause them to be absent from their practices for almost a week. Such long, drawn-out proceedings are common in such cases, with the result that many highly qualified physicians refuse to serve on disciplinary boards.

The Courts

The courts constitute still another obstacle to medical discipline. Unfortunately, there are timid judges who live in fear of being overridden by higher courts. Furthermore, judges are all too ready to issue stay orders, often ex parte. Judges of lower courts may reverse board decisions, believing that they follow the easy course and hoping that the boards will drop the charges. However, a determined board will not do so and will appeal to higher courts, which will frequently uphold their actions.

Where laws allow only a review of the record, the court will not permit the introduction of new evidence except under unusual circumstances. Nevertheless, a favorite ploy of the overcautious judge is to remand the case to the board for a rehearing, having been persuaded that the defense did not have an opportunity to present important evidence. In a recent case, an unusually persuasive lawyer, representing a physician who had been denied a license on sound legal grounds, induced the judge to remand the case. At the second hearing, during which not a shred of new evidence was presented, the board capitulated and granted the doctor a license. Let us hope that the action does not eventually haunt the board.

How frequently do the courts overrule the decisions of the boards? In 1967, the Law Department of the American Medical Association published its valuable "Disciplinary Digest."[1] This contains a collection of court decisions from 1902 through 1966, numbering 251 cases. The courts ruled against the boards in only 30%, a fairly good record, considering the obstacles they must overcome. During the 11-year period from 1969 through 1979, the courts supported the boards in 55 of 79 cases (70%). Thus, the proportion of reversals has remained constant over the years.

In four of the reversals during the 1969–79 period, the decisions of the courts were based on technical errors. For example, in one instance, the order denying a license was signed by the president of the board, who had previously disqualified himself. In another, a license was canceled without notice or a hearing. In the third, the final order of the board contained no findings of fact, and there was no evidence of willful violation of the Medical Practice Act. In the fourth case, the board failed to give the physician a hearing, assuming that they could revoke the license purely on the

basis of a court record! In reviewing the cases described, one can only conclude that the carelessness of the boards and their attorneys can be another obstacle to medical discipline.

Another important obstacle to the enforcement of discipline is the practice of the courts in many states of issuing ex parte stay orders against the boards.[3] That is, after the board has revoked or suspended a doctor's license, the defense attorney promptly obtains an order from the judge temporarily reversing the action of the board until the court can hear an appeal. Moreover, the attorney for the board does not have an opportunity to present the board's side of the question. No matter how dangerous the practices of the appellant doctor may be, his lawyer might convince the court that it was all a misunderstanding and it would be detrimental to the health of the community to deprive its citizens of his healing skills. Such orders can remain in effect for many months until the case has finally been decided by the court. Regardless of the final victory of the board, this can be of secondary importance during the period that a reputedly incompetent physician may be allowed to prey upon his patients. For example, a physician who was alleged to be grossly incompetent was allowed to practice under an ex parte stay order for 22 months pending appeal to the state supreme court. Granted, the court upheld the revocation order of the board; during the long interim period, however, his ability to continue his practice resulted in the death of four patients and the maiming of several others. One can only wonder how soundly this particular judge slept at night. Or was he oblivious to the results of his misdirected authority?

Lack of Resources

Another impediment to the proper policing of the medical profession is lack of adequate resources. In 1969, the American Medical Association appointed a committee to investigate the problem throughout the United States.[3] An important conclusion of the committee: "Most boards of medical examiners are inadequately financed to do the job they would like to do." This sweeping statement, unsupported by data, led me, in 1978, to address the following question to all of the boards: *Does your board have adequate resources to carry out investigative and disciplinary procedures?* I received answers from 46 boards; 18 said they did not have adequate resources. In these states the administration of discipline is severely hampered. The problem is directly attributable to state legislators, many of whom take great delight in pointing accusing fingers at the deficiencies of the boards, while refusing to grant them sufficient funds.

Organized Medicine

In the enforcement of discipline, organized medicine constitutes two types of obstacles:[4] The first stems from the reluctance of members to become involved, often called the conspiracy of silence; the second stems from the resistance of members to support needed reforms of the medical practice acts in the legislatures.

Particularly disturbing to members of medical disciplinary bodies is the pettifogging defense attorney who knows that his defense is weak and, as a result, makes every effort to thwart justice by attempting to catch the board in a technical error. One of the favorite tricks of these lawyers is to disqualify certain members of the board and then to subpoena them as witnesses for the defense. When these witnesses are on the stand, the lawyer will try so hard to discredit them that they, instead of the accused doctor, appear to be on trial. Unfortunately, such tactics sometimes succeed.

The Hospitals

Medical staff members and hospital administrators are in an excellent position to aid in the enforcement of discipline since they can observe the daily performance of their colleagues. But are they doing the job? In attempting to answer this, I directed the following question to the secretaries of the licensing boards: *On the whole, do the hospitals in your state cooperate with the board in enforcing discipline?* The answers: *Yes*, 28; *No*, 13; *Undetermined*, 1; *To some extent*, 1. While the number of affirmative answers is not a cause for rejoicing, at least

the majority of hospitals are willing to help. However, the hospitals all too often shield their delinquent and incompetent doctors, not only by failing to report them, but also by actually concealing their misdeeds. A glaring example of this was the case of a physician addicted to narcotics, whose habit had been known to the hospital authorities for at least a year. They also knew that he had caused his wife to become addicted. Yet who was the last person to find out about it? The local member of the licensing board, who gained this information entirely by accident.

...hospitals all too often shield their delinquent and incompetent doctors, not only by failing to report them, but also by actually concealing their misdeeds.

Then there is the case of the doctor who is a favorite of the hospital administration and medical staff. He is the life of every cocktail party. But one of his failings is his habit of going directly from the party to the hospital, where he often acts in an irresponsible manner. For some time his minor errors are covered up by friendly nurses or fellow physicians. Moreover, as his drinking problems increase, he no longer confines his imbibing to parties but becomes a steady drinker at home. The hospital authorities continue to tolerate him, regarding his liking for the bottle as merely a foible. But the day finally arrives when someone fails to cover him, with a resulting disaster. Does the board find out about it? Probably only by chance, as the hospital has devised a do-it-yourself rehabilitation program, which may be only partially or temporarily successful. What this doctor needs is to face the disciplinary power of the board, with the real threat of loss

of license.

When these cases came to light, I was struck by the ignorance of the physicians on the staff concerning the Medical Practice Act and the functions of the board. The doctors deliberately protected their colleagues against the disciplinary body because they thought that if the board summoned them to a hearing, they would surely lose their licenses. They were totally ignorant of alternatives, such as probation, a penalty more frequently imposed than suspension or revocation.

The hospitals also hamper the enforcement of discipline by their widespread practice of plea bargaining. When the derelictions of a staff member become too serious, so that he is about to be called before a disciplinary committee, the authorities will say: "Doctor, if you will leave town, we will accept your voluntary resignation from the staff, and there will be no derogatory information on your record." Or the offender, aware that he is headed for trouble, will resign before the authorities can bring charges against him. When that doctor applies for a license in another state and encounters on the application form the frequently asked question *Has a hospital ever taken disciplinary action against you?* he can honestly answer *No.*

Another example of the exportation of problems recently came to light in a state in which the board was about to revoke a doctor's license because he was accused of falsely giving a negative answer to the previous question. The board had good reason to believe that a hospital had removed him from its staff. In fact, they had learned that the vote to expel him was 51 to 1. (We assume that the doctor had a vote.) But despite the vote, the hospital trustees had allowed the doctor to resign "voluntarily" from the staff.

Hospital authorities who attempt to engage in do-it-yourself rehabilitation programs for their wayward physicians must realize that no matter how noble their intentions may be, any restrictions they might place upon a physician apply only in the hospital. The staff member can continue his dangerous practices in his office. Or, worse still, the doctor can become a member of the staff of a so-called fringe hospital, one of the many in the country that is more interested in filling its beds than in the quality of its staff members.

Still another obstacle to the enforcement of medical discipline is the reluctant district attorney. Consider a hypothetical case, based upon a composite of actual events. A physician so freely prescribes narcotics to a known addict that the victim dies from an overdose. Among other incriminating evidence are a bottle partially filled with Demerol tablets and a postdated prescription for the same.

The licensing board has obtained its information from the office of the medical investigator and from the investigating narcotics agents. But the evidence cannot be released to the board without the consent of the district attorney, who thinks that he might bring criminal charges against the doctor. However, he is reluctant to do so as the doctor is very prominent in the community and has many influential friends. Besides, election day is approaching and so begins a long delay while the district attorney vacillates between campaign speeches. When he finally decides not to prosecute, after an unduly long delay, the position of the board is weakened since the defense attorney can say, with some justification: "This doctor can't be as dangerous as the board claims since the law enforcement agency would take no action against him."

One can conclude that the obstacles to medical discipline are many and formidable. By no means do I intend to justify laxity on the part of the disciplinary boards, no matter how exasperated the members may become. However, the united efforts of the state legislatures, the medical societies, the hospitals, and the disciplinary boards can overcome many of them.

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Medical Discipline in Disarray

The Incompetent Physician

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This is one of several essays by Dr. Derbyshire to be published in the coming months.

For many years, the medical profession was most reluctant to recognize the existence of the incompetent physician. The following personal experience illustrates this. In 1965, the Judicial Council of the American Medical Association commissioned me to write an article entitled "What Should the Profession Do About the Incompetent Physician?" The result was an unsensational, critical study of the three most important agencies that should monitor the incompetent physician: the state and local medical associations, the hospitals, and the licensing boards. I found all of them deficient. In the article, which appeared in *JAMA*,[1] I made seven recommendations.

Did I say the article was unsensational? The public press thought otherwise. To my dismay, I found my name on the front pages of most of the important newspapers in the United States. Excerpts of the article appeared under such lurid headlines as "Unfit Doctors Are Concern" and "Is Your Family Physician Starting To Slip?" I was besieged by telephone calls and letters from reporters, fellow physicians, and members of the public. The AMA received many calls from irate physicians across the country whose refrain was, "Why did you allow publication of this article? Who is this person who dares criticize the medical profession in public?" I received poison-pen letters from many more. On the other hand, there were several commendatory letters in my mail, mainly from faculty members of medical schools. Apparently, this was the first time that a physician had openly condemned the sweep-it-under-the-rug approach.

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In 1973, I again ventured into the lion's mouth when I accepted another invitation from the Judicial Council to present a paper, "Medical Ethics and Discipline," before the National Congress on Medical Ethics in Washington, D.C. My talk was widely publicized, partly through the efforts of the AMA, which arranged for radio and television interviews. In addition, the public press by no means ignored it. Later it, too, was published in JAMA.[2] Nevertheless, it created scarcely a ripple in the medical profession, although some of my statements concerning incompetent physicians were much stronger than those in the first article.

Apparently, during the nine years between the two publications, a decided change had occurred in the attitude of physicians toward self-criticism. How can we account for this? There are several answers. For example, as a result of pressures from legislators and the public and the continuing malpractice crisis, the profession had finally realized that incompetence is a real problem that can no longer be concealed from the public, despite the protests of some die-hard physicians.

On the other hand, there are some thoughtful physicians who recognize that the days of so-called self-policing of the profession may be nearing an end. If physicians do not effectively police themselves, who will? The answer: the federal government. Even now physicians are not really facing the problem of professional incompetence—but they have made a beginning. The tools exist, although many doctors still use them sparingly.

The Extent of the Problem

In 1976, *The New York Times*[3] correctly quoted me as saying that 5% of doctors in the United States are incompetent. Roger Egeberg, then with the Department of Health, Education and Welfare, independently arrived at the same conclusion. Translated into more dramatic terms, at that time more than 16,000 physicians did not deserve a license. Today the figure is 22,500.

My estimate of a 5% incidence of incompetence was by no means a figure plucked from thin air. It was an educated opinion based on available data. For example, some 16,000 or more physicians will become alcoholics during their professional careers. At least 100 doctors succumb to drug addiction every year. In addition, there are the countless victims of mental and physical diseases as well as those who gradually sink into professional obsolescence because of failure to keep up with advances.

Although many physicians, as well as the AMA, took exception to my estimate, not all of them were hostile; several wrote to me saying that they considered my figure entirely too low and that 10% would be more accurate. Two years later, the AMA conceded that from 4% to 5% of physicians were incompetent.

What Is Professional Incompetence?

Before discussing incompetence, we must define "competence" in the context of medical practice. In 1974, the AMA's Coordinating Council on Medical Education appointed a committee to study the continuing competence of physicians. I concur with the committee's definition: "Physician competence is the function of an array of attributes which compose a pattern of effective activity directed toward the health and well-being of people as individuals or as groups."[4] The committee identified three essential dimensions encompassing knowledge, abilities, and judgment. Abilities include communication skills, self-discipline, work habits, and professional attitudes. Clinical judgment was defined as "the capacity to apply the appropriate knowledge, abilities, and skills at the right time."

Granted that medical competence depends on many factors, I suggest that, from the practical viewpoint, there are at least four common varieties of incompetence. In order of frequency, they are mental, professional, physical, and that stemming from ignorance or stupidity. Regardless of the factors involved, incompetence prevents the physician from rendering safe, up-to-date care to his patients. Of these, mental incompetence is so important that I shall deal with it separately in this discussion.

"Professional incompetence" is a broad term meaning that the physician is unable to care for patients satisfactorily because of such failings as faulty judgment, unreliability, unavail-

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ability, and professional obsolescence. Avarice may be the underlying factor in some of these instances.

Physical incompetence should pose no problem, but in many cases, the profession is not dealing with it properly. This is true partly because by law licensing boards can grant unrestricted licenses only. However, a licensee might have a physical handicap that is an impediment to competent medical practice, especially in cases of emergency; for example, he or she might be incapable of carrying out cardiopulmonary resuscitation. Some physical handicaps may be easily concealed at the time of licensure.

Ignorance or stupidity should not be a problem since all physicians educated in North America are graduates of accredited schools. Unfortunately, to paraphrase George Orwell, some schools are more accredited than others. Although graduates of schools outside the United States and Canada undergo a careful screening process, they often have inferior clinical experience. Further, many older physicians are not as learned as they should be.

One of the simplest problems in the field of medical discipline is dealing with the physician who has been convicted of a felony. The offense is listed as a cause for action in almost all of the state medical practice laws. In sharp contrast is the problem of professional malfeasance because it is often not clear-cut; before a disciplinary board can take action, the accused physician must display a pattern of incompetent behavior—a policy that is admittedly dangerous to the public but is mandatory before the board can initiate action. Moreover, if the board does conduct a hearing, it is confronted with a parade of expert witnesses whose sole claim to expertise is their friendship with the accused doctor. When pressed, they will say, "No, I probably wouldn't have done it that way, but the doctor selected an acceptable form of treatment. There is certainly more than one way of treating this condition."

Occasionally, a doctor will make such a glaring mistake that the action is indefensible. This reminds me of the actual case of a doctor who, in performing an operation for varicose veins, ligated and divided the femoral artery

and, as a finishing touch, injected the distal end with a sclerosing solution. This resulted in a high amputation of the patient's leg. It is difficult to call this anything but bungling and manifest incompetence. To make matters worse, further inquiry revealed that the surgeon had been drinking and gambling until a late hour the night before the operation. In less dramatic cases, physicians and disciplinary bodies are understandably reluctant to condemn a colleague for a single error.

Another question pertaining to incompetent surgeons is: How many times can a doctor be allowed to commit the same error? For example, I asked several highly qualified surgeons how many common bile ducts they would allow a surgeon to injure in the course of his career. The consensus: not more than one. But even such an obvious error may be difficult to prevent. I know of a board-certified surgeon who injured three common ducts in four months. His sins were compounded by his inability or unwillingness to face his errors, which had been fatal for all three patients. In fact, he concealed his errors for several weeks. Eventually, however, with the discovery of gross blunders in other operations, a pattern of incompetence—at hideous cost to his patients—emerged. His certificate was revoked too late. This moved one critic to remark that a license to practice is a license to kill.

Professional incompetence is not limited to surgeons, although the mishaps in other specialties are usually less dramatic. Consequently, much more time may be required to reveal a pattern of incompetence in an internist, for example. I know of one who has a long series of missed diagnoses of appendicitis and gallbladder disease. Although he has settled some of the resulting malpractice suits out of court, the licensing board has so far looked the other way.

Protection of the Public

What is the profession doing to protect the public against the incompetent physician? The first safeguard is the initial evaluation of physicians for licensure. The boards scrutinize them by both examination and investigation of their credentials. Despite this screening process, the granting of a license is assurance of minimal competence only. Most states license doctors as physicians and surgeons, presumably capable of treating all known and some unknown ailments. If a doctor wishes to specialize, he must meet additional requirements, including three or more years of training in an approved hospital. Important in the evaluation of specialists is certification by a specialty board. Although such certification is voluntary and the boards do not claim to endow physicians with miraculous healing powers, it is an indication of excellence rather than of minimal competence. It also guarantees to the public that the certified specialist has met strict educational requirements and has passed an additional examination.

Since most newly licensed physicians are graduates of accredited medical schools and postgraduate programs, assurance of initial competence, although minimal, presents few problems. Of equal importance, however, is assurance of continuing competence throughout the individual's career. How can the profession assure the public that the physician who received his license 20 years ago is still competent? Until 1971, physicians received lifelong licenses. No matter how obsolescent they became, they could continue to practice in the same old way, and many of them did.

The situation began to change when New Mexico became the first state to pass and implement a law requiring continuing education to maintain licenses in good standing. Other states followed suit, so that eventually 26 required periodic fulfillment of continuing education requirements for relicensure. (Colorado recently repealed its law.)

Enactment of these laws has by no means met with universal approval by the medical profession. Opposition has been based on abhorrence of compulsion, doubts that continuing education improves patient care, and claims that the laws were hastily passed without regard for the quality of continuing medical education. Moreover, many physicians claimed it was too expensive. The AMA has opposed mandatory continuing education from the beginning, piously maintaining that it is not necessary since doctors keep up voluntarily. One AMA president,[5] in roundly condemning the

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process, said, in part: "So it seems to me that compulsory CME resembles many of the nostrums conceived in Washington, D.C., in that as a remedy it is timely, convenient, and probably wrong." He probably has never seen the mountainous accumulation of unopened journals on the desks of many physicians.

More and more studies are refuting the argument that continuing education does not favorably influence physician behavior. In fact, I have a bibliography of more than 50 articles, most of which document the benefits of continuing education. In view of this, the opponents have shifted their attack, claiming that *mandatory* continuing education does not improve patient care.

Among the effects of continuing education laws has been a burgeoning of educational offerings and, on the whole, improvement in their quality. As could be expected, there has been some exploitation of physicians by the educational hucksters. But discriminating physicians can find many programs that will fulfill their needs without forcing them to declare bankruptcy. As for the disciplinary effects, I can speak only for New Mexico since many of the laws are of such recent origin that it is not yet possible to draw conclusions. In New Mexico, 256 physicians have lost their license since 1971 for failure to meet the requirements. Of these, 73 resided within the state.

Even the most ardent advocates of continuing education do not claim that it offers absolute assurance of continuing competence. However, they do believe it is a step in the right direction and that it might ward off the specter of compulsory reexamination for relicensure.

I have dwelt at some length on the opposition to relicensure, coupled with continuing education, to make the point that some reforms in medical discipline have come about in spite of organized medicine—which should be leading the way.

Meanwhile, efforts are under way to devise other methods of assessing the continuing competence of physicians. The specialty boards apparently agree that lifelong certification is just as undesirable as lifelong licensure. In 1973, the American Board of Medical Specialties adopted a resolution that voluntary, peri-

odic recertification of medical specialists become an integral part of all medical specialty programs. In 1974, all of the 22 boards then in existence endorsed the principle of recertification. By the end of 1978, five boards had conducted recertification procedures, and several more had submitted plans for approval by the American Board of Medical Specialties.[6]

Since original board certification is voluntary, the same applies to recertification. But voluntarism may soon become a euphemism, as a result of some subtle and unsubtle pressures. For example, the American Board of Surgery has decreed that all certificates issued after 1975 will bear a notation that they are valid for 10 years only. Moreover, in the *Directory of Medical Specialists*, the dates of certification and recertification are included after the physicians' names.

Hospitals also have responsibilities in assuring the continuing competence of their medical staff members. They are in an ideal position to detect incompetent physicians since staff appointments are made on an annual basis in all institutions accredited by the Joint Commission on Accreditation of Hospitals. Presumably, this gives the authorities the opportunity to assess the performance of all staff members before renewal of privileges. But how many hospitals seriously review the performance of their staff members annually? Very few, I'm afraid. But another problem arises concerning the many "fringe" hospitals in the United States that are not accredited and do not wish to be. And then there is the problem of the large number of physicians who have no hospital affiliation. How can one assess their continuing competence? One method would be to evaluate them by the number of malpractice suits they have lost every year.

Several other methods for the assurance of continuing competence of physicians—most of them depending on peer review—are theoretically excellent but far from ideal in actual practice. For example, some authorities have placed reliance on the Physicians' Service Review Organizations (PSROs) established by law. The intent of this law was twofold: to control the quality of medical care and to stem the soaring cost of medical care. However, in most states, the PSROs have been preoccupied with cost control to the exclusion of quality control.

H. G. McQuarrie and D. J. Breaden,[7] in appraising methods of assessing continuing competence, discuss examination, peer review, continuing education, and patient satisfaction. Noteworthy is the last—a recommendation that I have not encountered elsewhere. The authors suggest that this approach is feasible through the licensing boards, which have complete files on all physicians, including complaints. However, they refer to the experience of the California Board of Medical Quality Assurance, which found that most of the complaints were not disciplinary or quality issues but reflections of patient and doctor discontent as a result of poor communication and fee disputes. Other boards have had the same experience.

The liability insurance companies also can play an important role in protecting the public against incompetent physicians. In the 20 states in which medical associations have formed their own companies, the insurers continually observe the performance of the insured doctors. If a physician loses many malpractice cases, further insurance can be denied or premiums can be increased. In addition, the insurers can place restrictions on the performance of certain procedures.

Although medical incompetence is not rampant in the United States, incompetent physicians pose dangers out of all proportion to their numbers. We can be thankful that many diseases are self-limited, so the problem has not resulted in mass murder. It is encouraging that the medical profession is gradually beginning to deal with medical incompetence.

The Impaired Physician

I am discussing this kind of incompetence under a separate heading because medical societies, disciplinary boards, and legislatures are making special efforts to deal with it. Since the term "impaired physician" means different things to different people, a definition is in order. I herewith endorse that of the Florida "Sick Doctor Law," which defines a sick doctor as "a physician who is unable to practice medicine with reasonable skill and safety to his patients by reason of illness, drunkenness, excessive use of drugs, narcotics, chemicals, or any

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type of material, or as a result of any mental or physical condition."[8] The term "impaired physician" in general use today broadens the definition.

Before 1965, there were few studies of psychiatric illness in physicians. For many years, both the public and the profession regarded the alcoholic doctor with tolerant amusement, provided he did not do too much harm. This is exemplified by the true story of a beloved physician in a small town in the West who was often incarcerated because of his alcoholic rampages. In a serious emergency, however, a hurry call would go to the sheriff requesting the release of the good doctor to care for the patient. Never during his long career did either the medical society or the licensing board so much as threaten him with disciplinary action.

Recently, however, attitudes have changed. During the 1970s more than 110 articles appeared in the U.S. and British literature dealing with mental illness among physicians, for the most part manifested by suicide, alcoholism, and drug addiction. Why the sudden interest in the subject? There are several reasons, not the least of which is the recent information explosion in medicine. In the not too distant past, the family doctor had little to offer his patients but kindness and sympathy. Today, however, the physician must possess so many technical skills and so much knowledge that there is little room for error. Consequently, even slight impairment of the physician can prove disastrous. Furthermore, in this age of public accountability and the fading godlike image of the physician, patients will no longer tolerate incompetent physicians.

The state legislatures, licensing boards, and organized medicine are approaching the problem of impaired physicians with varying degrees of success.

The Legislative Approach

For many years, state licensing boards have been concerned because they have been able to act only after professional incompetence has been proved, often at the expense of the patient. We now have laws that go a long way toward correcting this situation.

In 1969, the Florida legislature passed a bill, known as the "Sick Doctor Act," sponsored by the Florida Medical Association and the Board of Medical Examiners. According to J. Nesbitt,[9] assistant state attorney general at the time, until then the state licensing boards were powerless to protect the public against incompetence or inability of the physician to practice medicine safely unless he had committed an act predicated on fault.

The Florida law now states that if the Board of Medical Examiners has due cause to believe that a physician is impaired, it will have the authority to compel him to submit to a mental or physical examination, or both, by physicians designated by the board. Failure to submit to such examination will constitute admission of the allegations unless such failure is due to circumstances beyond the doctor's control. Another section provides for implied consent to submit to such examination on the part of all licensed and registered physicians. The law allows the board to impose a variety of penalties, ranging from revocation of a license to reprimand. The examining committee reports to the board, which is not bound to follow its recommendations.

The Florida law has served as a model for the 20 other states that have passed impaired physician laws. Some of them give the boards power to restrict a physician's practice to a sheltered environment, in addition to the usual sanctions. Another important feature of the legislation is the authority of the board to take emergency action. In a few states, the laws provide for appointment of the examining committees by the state medical associations if the involved doctors are members.

Since the Florida Board of Medical Examiners has had more experience than any other board, it is able to report the largest number of actions: 147. In addition, I have been able to collect figures from eight other states, adding up to a total of 336. The table on page 46 gives a composite picture of actions taken under the laws to date.

It is important to note the number of licenses that have been reinstated without restrictions. Although the rate of rehabilitation is only 27%, the effort is worthwhile. Furthermore, many of the 84 physicians still on probation may eventually be returned to unrestricted practice. I

was unable to learn the rate of recidivism.

The impaired physician laws have definite limitations. For example, they are only partially effective in the case of alcoholics. Because alcohol is a socially acceptable albeit dangerous drug, drinkers experience varying degrees of impairment. The thin line between heavy social drinking and addiction is difficult to define. Moreover, since most laws provide that the board must give the doctor ample notice of examination by the committee, the alcoholic, unless he is out of control, has time to dry out and appear before the committee clean, well-dressed, and alert. I know of one alcoholic doctor who presented himself to a psychiatrist as directed by the board. The psychiatrist reported that the doctor admitted to having had problems with alcohol in the past but had completely overcome them. Just a few weeks after his examination, the physician committed suicide by ingestion of a combination of alcohol and barbiturates.

There are safeguards the authorities must observe when they invoke the impaired physician act. They must beware of witch-hunts. One can only speculate as to how many of the unsubstantiated charges were inspired by malice.

Impaired physician laws are especially effective in dealing with elderly physicians in advanced stages of senility. Because rehabilitation is out of the question, we might spare them the embarrassment of a formal hearing by demanding voluntary surrender of license.

The Medical Societies

According to a recent press release from the AMA, 40 state medical associations now have programs to help impaired physicians. (Unfortunately, the AMA implied that the primary aim is to help the physicians rather than to protect the public.) An important objective of these committees is early case-finding. The societies believe that if they can identify a physician in the early stages of addiction, efforts at rehabilitation will stand a good chance of success.

The program of the Medical Association of Georgia is a model. I am indebted to Douglas Talbott for giving me the details of this program, of which he is the moving spirit.[10,11] The Disabled Doctor Plan for Georgia, inaugurated in 1975, is based on two major premises: 1) The disabled doctor, for psychological reasons, is usually unable to reach out for help. 2) Fellow physicians who would help the disabled doctor must take the initiative, being careful to use a sincerely compassionate, nonjudgmental approach.

Summary of Actions in Nine States Under Impaired Physician Laws

Revocation of license	28
Suspension	84
Voluntary surrender	28
Action pending	12
Probation	84
Reinstated	88
Charges not substantiated	14
Total	336

The main objectives of the Georgia plan are to identify doctors who are disabled because of their addiction to or abuse of drugs, including alcohol; to persuade as many of them as possible to seek treatment voluntarily; and to provide a means for dealing with doctors whose disabilities have been recognized but who refuse to complete a course of treatment. Although the committee has no legal powers, it makes recommendations to the Board of Medical Examiners when its efforts have failed. If treatment has been successful, the committee stands ready to help the disabled doctor to resume practice. The results of the Disabled Doctor Plan for Georgia are shown in the table on page 48.

It is noteworthy that of 644 doctors who were deemed to be impaired, 321 returned to practice, a rehabilitation rate of 49%. This is in sharp contrast to the 27% rehabilitated under the impaired physician laws. However, one cannot help being concerned about the total of 184 physicians (29%) who refused treatment, broke their contracts, or underwent repeated treatment. If one regards these as failures, the results are not nearly so impressive. Did the Board of Medical Examiners deal with them? Apparently, it missed many because, according

to its reports, the board took only seven actions because of drug addiction between 1976 and 1979. This leaves a large number of physicians who fell into the cracks, an ever-present danger. The recidivism rate is remarkably low; this is bound to increase with the passage of time.

What are the reasons for the success of the Georgia plan, as compared with the discouragingly low rate of rehabilitation under the impaired physician laws? The usual explanation is that the committee of the medical society is successful in early case finding whereas the Board of Medical Examiners deals mainly with hard-core addicts.

Other states have different plans. In Washington there is no element of coercion. The Ohio Medical Association has adopted a modification of the Washington system, depending on gentle persuasion and reporting to the licensing board only as a last resort.

Commendable as the efforts of the medical associations may be, they are thwarted in their efforts in the nine states that by law require physicians to report to disciplinary bodies any information indicating that a doctor may be medically incompetent. Thus, a conflict has developed in the states that have reporting laws—the medical societies being powerless to help impaired physicians. This has caused bitterness on the part of many physicians, who refer to them as "snitch laws." There is a continuing debate between those who favor the handling of impairment by the medical associations and those who believe in the strictly legal approach. Because it is inconceivable to me that many state medical societies have the

Results of Georgia Disabled Doctor Plan

Contacted and assessed	644
Refused/inappropriate treatment	115
Entered treatment	529
Returned to practice	321
Currently in treatment	31
Repeated treatment	30
Broke contracts	39
Deceased	10
Follow-up not reported	98

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dedication or resources to match the excellence of the Georgia plan. I favor the disciplinary approach through the licensing boards. I agree with George Palmer,[12] former executive director of the Florida Board, who said: "The conclusion of the board is that with sick physicians, you have to get their attention with the loss-of-license threat."

Prevention

Obviously, the best method of dealing with physician impairment is by prevention. How to accomplish this is the question. Preventive measures should extend all the way back to the colleges and universities. Many impaired physicians should never have been admitted to medical school in the first place. However, no matter how sound the judgment of admissions committees, their decisions are based on general impressions and test scores rather than on scientific methods. It is encouraging that much research is now in progress in an effort to predict the future success or failure of medical students in the practice of medicine. Of prime importance is the development of methods to identify the applicant who might eventually become mentally impaired. C. B. Thomas has made a start in this direction in her precursor study of a cohort of 1,337 Johns Hopkins medical students, in whom she could define traits that might be predictive of future trouble, such as drug addiction and suicidal tendencies.[13]

Also promising is the work of L. C. Epstein and his associates in predicting emotional problems of physicians.[14] Given appropriate information, their study suggests, a clinician can identify a subset of medical students at high risk for suicide. Of 33 cases assessed "blindly," the observer was able to identify all of the suicides on the basis of the test results.

Another preventive measure is firmness of medical school authorities in dealing with troubled students. All too familiar is the impaired physician who was nursed through medical school by a psychiatrist who discovered, too late, that the student was absolutely unsuited to practice medicine. An example recently came to my attention when I told the dean of a highly respected medical school that the licensing board had revoked the certificate of one of his graduates because of drug addiction and depression. The dean replied, "I am so sorry. I remember this person well and was always afraid he would have trouble since he had serious psychiatric problems all through medical school."

Despite all of our efforts, the impaired and incompetent physician will always be with us. It is encouraging, however, that legislators, licensing boards, and medical societies have recognized the problem and are dealing with it by various methods. There should be no conflicts among these agencies; they can work together, never losing sight of the fact that the primary duty of all is the protection of the public.

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Medical Discipline in Disarray

Malpractice, Medical Discipline, and the Public

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As a result of the continuing malpractice crisis, attorneys for plaintiffs are uncovering an ever-increasing number of incompetent, negligent physicians. There is a concomitant increase in the number of complaints directed to licensing boards from angry citizens, who demand that they revoke licenses because of physician malpractice or incompetence. This is oversimplification of a complex problem. The boards are confronted with an old English proverb: "Every dog is entitled to one bite." Some of my friends who are defense attorneys frequently quote this. Applied to the medical profession, the question becomes: How many malpractice actions should a board allow physicians before taking action against them? When is the "first bite" so grave as to warrant disciplinary action?

In my view, the boards should judge each case on its own merits; it is not possible or desirable to have an inflexible policy. For example, an internist who missed a diagnosis of acute appendicitis in a young man, with resultant peritonitis and many other complications, is sued by the patient and has to pay a large settlement. Should the disciplinary board take action against him? No. An investigation reveals that he is a highly qualified, competent physician who has never been sued for malpractice during his career of some 20 years and that there is no pattern of negligence. Furthermore, appendicitis can be difficult to diagnose.

On the other hand, an otolaryngologist in the course of removing nasal polyps also removes generous portions of frontal lobes, and the patient dies within 24 hours. In this case the board, regarding this as evidence of manifest, gross incompetence, demands disciplinary action to protect the public against further mishaps. The board places the doctor on probation without waiting for the filing of the inevitable malpractice suit. This summary action is based in part on an investigation that reveals a pattern of substandard practice elsewhere, which had not been divulged to the board when he was licensed.

Both the public and the medical profession may well remember the so-called malpractice crisis of 1975, resulting in soaring insurance rates and strikes by doctors. Although no longer regarded as a crisis, the problem of malpractice continues to smoulder and at any time it could again reach crisis proportions. In fact, several experts say that another storm may soon break.[1]

I shall not attempt to analyze the whole problem of malpractice, since others have already done so. I shall discuss only the increasingly important relationship between malpractice and medical discipline. Although many physicians are so acutely aware of the daily risks of incurring malpractice suits that they no longer enjoy the practice of medicine, they must admit that such threats can act as a deterrent to incompetence and unscrupulous medical practice.

Oddly enough, the medical practice statutes of only 16 states specifically cite malpractice as a cause for disciplinary actions. The laws of four states mention malpractice alone, and those of 12 specify gross malpractice or repeated malpractice. The laws of a few other states list gross negligence or carelessness in the practice of medicine as grounds for action. In only one state, Nevada, does the law

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define its terms unequivocally: "Gross malpractice means malpractice where the failure to exercise the requisite degree of care, diligence, or skill consists of 1) performing surgery or otherwise ministering to a patient while the physician is under the influence of alcohol or any controlled substance; 2) gross negligence; 3) willful and consistent use of medical procedures considered by physicians in the community to be inappropriate or unnecessary in the cases where used."

The reference in some statutes to repeated malpractice brings us back to the "one bite" doctrine. The detection of repeated malpractice can be difficult because many cases are settled out of court and no official records are available to the boards. This obviously calls for corrective legislation. In 1983 the New Mexico legislature amended the medical practice act requiring all insurance companies that write malpractice policies to report all settlements of malpractice cases—whether made in or out of court—to the board of medical examiners. Very few other states have such laws.

In view of the questions raised thus far, it is not surprising that very few disciplinary actions result from malpractice. Of a total of 2,503 board actions that took place from 1969 to 1976, only 16 were for malpractice or its variants. But this situation may be changing. For example, of 1,817 actions reported to the Federation of State Medical Boards of the United States from 1977 through 1979, 34 were for malpractice, incompetence, or negligence. Twenty-six resulted in revocation of licenses.

The *Report of the Secretary's Commission on Medical Malpractice*, published in 1973, disclosed much valuable information, some of which may have been unpalatable to physicians.[3] For example, the commission concluded that an important reason for the malpractice problem is that there is malpractice. It found that 45% of all closed claims in 1970 resulted in payment either by way of settlement or verdict. The report stated: "The inescapable fact is that most malpractice claims would never be filed if the patient had not been injured in the first place." The commis-

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sion members agreed that licensure and medical discipline are related to malpractice and that more effective programs of licensure and discipline cannot but have a favorable impact on the incidence of malpractice.

The American Bar Association also has become concerned about the relationship between medical malpractice and medical discipline. The *Report of the Commission on Medical Professional Liability* recommended that all malpractice judgments be reported to state boards.[3] Conceding that there is no necessary relationship between conduct that makes a physician liable for malpractice action and conduct that mandates disciplinary proceedings, the commission suggested that malpractice judgments could in some cases serve as an early warning signal to the boards.

Another concern of the ABA commission is the problem faced by medical institutions and organizations in trying to obtain disciplinary information from other hospitals, review committees, and medical societies. I share in this concern, which I discussed in "Obstacles to Enforcement of Discipline" (HP, October 1983). I know of only one state that asks for information regarding previous malpractice suits on application forms. If other states were to become equally concerned, this information might constitute grounds for denial of a license or, at least, for investigation of the circumstances of each suit. That suit-prone doctors are undesirable additions to the medical community is borne out in a study by S. Ferber and B. Sheridan.[4] In a four-year period, they found, 46 (0.6%) of 8,000 physicians in the Los Angeles area accounted for 10% of all claims and 30% of all payments made by insurance plans, and the average number of suits for each of these doctors was 1.25 per year.

One doctor, applying for a license in a second state, was invited to meet with the board because of some information it had received concerning his practice habits. In the course of the interview, the board learned that the doctor had many malpractice suits pending against him. When asked the exact number, the doctor replied, "I don't know, possibly 10 or 15. I count this as part of the cost of

doing business." And this was a board-certified orthopedic surgeon with an excellent educational background! His cavalier attitude toward his patients indicated either an extremely callous attitude or a sick mind. Needless to say, the board denied him a license. A disturbing commentary on the system is that the board obtained its information purely by chance.

Another example of the relationship between malpractice and discipline is the case of the notorious Dr. John G. Nork of California, who was held liable for wantonly negligent medical practice. On the witness stand, Dr. Nork admitted that he had bungled an unnecessary operation on a young man, presumably for a ruptured intervertebral disk; the patient was awarded $3,710,447. Dr. Nork also admitted that he had negligently and needlessly maimed at least 30 other surgical patients. Despite these publicized catastrophes, he was never challenged by the hospital, the medical staff, the local medical society, or the state licensing board. The details of Dr. Nork's depredations were brought to light when his third malpractice suit was tried in the court of Judge B. Abbott Goldberg of the Superior Court of California. In a 196-page memorandum of decision, Judge Goldberg told of at least 50 additional surgical procedures that were "unnecessary, bungled or both." He took the Sacramento County Medical Society and the California Board of Medical Examiners severely to task for their failure to discipline the orthopedist.

An astounding feature of the Nork case was the means by which he was exposed. His falsified notes had led the hospital authorities to believe that he was an excellent surgeon whose patients seldom suffered complications. They did not have the curiosity of Edward Freidberg, an attorney for one of the litigants against Dr. Nork, who discovered a contradiction between the doctor's discharge summary and the nurse's notes of the same date. Nork's notes stated that the patient was doing well postoperatively and would be seen routinely at the office after returning home. The nurse's note indicated that the patient had awakened in the recovery room with the same "appalling" symptoms he had had before. The case was eventually settled out of court.

By persistent digging, Freidberg uncovered a pattern of fraudulence in Dr. Nork's records, as well as dishonest dealings with the patients to whom he recommended surgery. Both the public and the press were incensed over the fact that the Board of Medical Examiners did not revoke his license until February 22, 1970—almost two years after investigations had begun.

That some of Dr. Nork's colleagues were aware of his shortcomings was evidenced in a conversation I had with one of them, who said: "We tried our best to help Dr. Nork."

If the medical profession does not improve its methods of self-discipline, the words of Judge Goldberg might prove frighteningly prophetic: "Licensing of persons to practice medicine in itself furnishes no continuing control with respect to a physician's professional competence and therefore does not assure the public of quality patient care. The protection of the public must come from some other authority—the court. The beneficial effect of malpractice litigation in improving medical performance has been established by the evidence presented in this case."

Another effect of the malpractice problem on discipline is becoming evident in some hospitals. Because of the increasing number of suits against these institutions, it is perceived that it is in the best interests of all concerned for the medical staff and the administration to work together to improve medical care. For example, a surgeon has had a series of disasters involving operations on the stomach, one or more of which have resulted in suits against the hospital as well as the surgeon. The hospital authorities would certainly show poor judgment if they did not carry out a complete investigation of the performance of this surgeon and impose suitable restrictions on his activities. A few states have laws requiring hospitals to report restriction of privileges of staff members to the licensing board. Although the board may take no action, believing that the hospital is adequately protecting the public, there is a record of the physician's inadequacy and the board can follow

any development of a pattern of incompetence.

A by-product of the malpractice situation, related indirectly to medical discipline, is its deterrent effect. It is sad but true that many physicians practice more carefully than they did in the past because they have one eye on the potential litigant. This is not entirely beneficial in that it has given rise to the widespread practice of "defensive medicine," which inevitably increases the cost of medical care—often unnecessarily. However, it may save a physician from appearing before a disciplinary board.

One of the most cogent arguments for the deterrent effect of the malpractice threat was advanced by W. B. Schwartz and N. K. Komesar: "The negligence system makes a great deal more sense if it is understood primarily as a means to deter careless behavior rather than to compensate its victims. By finding fault and assessing damages against the negligent provider, the system sends all providers a signal that discourages future carelessness and reduces further damages."[5]

A recent addition to the disciplinary armamentarium is the doctor-owned liability company. There are 30 such companies, born of the desperation resulting from the mounting cost of insurance premiums and the refusal of many companies to write professional liability policies. Before their withdrawal from the malpractice field, commercial carriers placed few restrictions on the physicians they insured. They were concerned chiefly with whether the practitioners were duly licensed. However, the physician-owned companies carefully scrutinize all applicants in order to assess the possible risks, paying particular attention to the physician's qualifications and experience. Gone are the days of on-the-job training. If the applicant's sole claim to proficiency is that he has assisted in a few cases, the insurance company will say, in effect: "Operate upon aneurysms if you like, doctor, but we will not insure you against any risks."

Many of these physician-owned companies maintain close contact with the licensing boards and are informed of any disciplinary actions related to incompetence. Rash indeed is the physician who undertakes a procedure for which the company has denied him insurance coverage. The strictness of some of the doctor-owned insurance companies is illustrated in a statement by Dr. Joseph D. Sabella, president and board chairman of the Doctors Insurance Company of California. His company can provide coverage more cheaply because of stringent underwriting practices, he said, noting that it turns down about one of every six applicants.

The failings of the medical profession in self-policing are many, and I have cited only a few examples related to malpractice. For many reasons it is extremely difficult to protect the public against negligent, incompetent physicians. It is unfortunate that the profession must place so much reliance on outside agencies to weed out incompetent doctors. However, if their efforts are successful, the number of doctors reported to disciplinary boards should diminish. If liability companies were required by law to report all settlements, the boards could detect patterns of malpractice and take appropriate disciplinary action. If the courts and insurance companies and the fear of malpractice become the most important disciplinary weapons in medicine—distasteful as the idea may be to physicians—so be it.

Some Public Attitudes

As noted, angry citizens frequently complain to medical disciplinary boards and demand that they revoke a doctor's license forthwith. Many of these complaints are based on allegations of malpractice, regardless of whether the allegedly injured person has won a judgment against the physician. In no small part because of the widespread reporting of medical "miracles," many people believe that the failure of the doctor to restore them to perfect health constitutes malpractice. Of course, no prudent physician will guarantee a perfect result from any procedure. Moreover, many members of the lay public do not realize that a board cannot summarily revoke a doctor's license unless there is convincing evidence presented at a formal hearing.

However, some boards deserve the criticism

directed against them. Investigative reporters for three major metropolitan newspapers—*The Miami Herald*, *The Chicago Tribune*, and *The Cleveland Plain Dealer*—have made extensive studies confirming this. Although some of their allegations are sensational and unsupported by clear evidence, many are true.

A campaign against licensing boards was launched by *The Miami Herald* in 1979 in a series of articles attacking Florida physicians in general and the Florida Board of Medical Examiners in particular for their lax disciplinary procedures and the reluctance of physicians to report their errant colleagues. The editor published all the articles in a special reprint entitled *Dangerous Doctors...A Medical Dilemma*.[6] On the cover is a lurid color picture of two doctors, one clutching a whiskey bottle, the other with both hands full of medicine bottles, presumably containing dangerous drugs. The authors attacked the Board of Medical Examiners and its executive director, Dr. George Palmer, whom they called "the product of a past generation." Although many of the articles were sensational and consisted mainly of anecdotal evidence, they did point to many reasons for lax discipline—such as defects in the medical practice laws, an understaffed, underfinanced state board, and a court system that often reverses board actions and allows the doctor to continue to practice pending appeal.

In one article the authors stated that patients often will not file charges against physicians, fearing embarrassment and possible publicity. "Those who aren't embarrassed file malpractice suits," noted the author, who observed that the state medical board records only the total number of malpractice suits against a given physician. "It doesn't receive the disposition of the cases, and it rarely acts against a doctor purely because of his malpractice record." Another article recounts the case of Dr. James G. Robertson, 18 of whose patients sued him for malpractice in the course of 10 years. The board was never able to learn the outcome of the suits because they were all settled out of court.

The editor in a concluding comment stated that Florida's laws are too lenient and that the Board of Medical Examiners has neither the will nor the resources to stop dangerous doctors. He made several recommendations, the first of which was to fire Dr. Palmer. Another was to make malpractice insurance mandatory, because "a doctor too incompetent to obtain malpractice insurance is too incompetent to practice."

Largely as a result of the *Miami Herald* exposé, the Florida legislature enacted laws providing for complete reorganization of the licensing board, with a lay person as director.

In February 1980, *The Cleveland Plain Dealer* published seven articles attacking the Ohio Board of Medical Examiners for laxness in discipline. Like *The Miami Herald*, *The Plain Dealer* collected the articles, all written by one reporter, Walt Bogdanich, in a special reprint entitled *The Weak Pulse of Medicine's Enforcer*.[7] The series contains its share of horror stories, but attempting to be fair, Bogdanich attributed some of the faults of the board to inadequate legislation.

He also addressed the malpractice problem, writing in his introduction: "The medical board often never learns who the dangerously incompetent physicians are because Ohio, unlike some other states, doesn't require that malpractice settlements be reported to the board." He contrasted the Ohio board with that of Michigan: Although Michigan has fewer doctors than Ohio, its board has 24 investigators, whereas Ohio's has only seven. He noted also that Michigan has eight investigators responsible for sifting through malpractice cases in search of incompetent doctors. Quoting a prominent malpractice attorney, Bogdanich pointed out that even if Ohio passed a malpractice reporting law, the state's dangerous doctors might not all be identified, since insurance companies often make payment before a suit is filed. The point is well taken: In cases of blatant malpractice, the insurer will offer to pay the patient promptly—before he retains an attorney, who no doubt could obtain a much larger settlement.

In the editorial summarizing the series, the editor expressed his concern in his opening paragraph: "The 10-member Ohio Medical

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Board has done a shockingly poor job of policing the medical profession. Ohio lags far behind other states in providing for an effective medical licensing board able to guarantee a high level of professionalism." In addition to recommending many legislative reforms, he sharply criticized the lax policies of the board—for example, inadequate supervision of doctors on probation. He reiterated the recommendation that all malpractice actions be reported to the board. He seemed to agree with my "one bite" doctrine, although he expressed it differently: "A malpractice suit is not necessarily evidence of incompetence, but several such suits are worthy of further board investigation into competency."

That the *Plain Dealer*'s articles did not fall on legislators' deaf ears is borne out by the prompt introduction of bills designed to reform the medical practice laws.

The Chicago Tribune, in May 1982, attacked the Illinois Department of Registration and Education, the agency responsible for protecting patients from "bad" doctors.[8] Written by several reporters, the articles introduced the subject with the statement: "Illinois's record of disciplining bad doctors is one of the worst in the nation."

One article in the series, "Doctor Sued 14 Times But No State Hearing," is devoted entirely to malpractice. A survey of more than 3,000 malpractice cases in Cook County found that many physicians have been sued repeatedly without action being taken by the Department of Registration. For example, the *Tribune* reported that "94 doctors are defendants in at least two pending malpractice suits each, 29 are defendants in three suits each, five are defendants in four suits each, five others are defendants in five suits each or more. Only eight of the 133 doctors have been called for hearings by the state. Those hearings were not prompted by the malpractice suits."

The Illinois state legislature responded to the *Tribune*'s criticism by enacting corrective legislation in July 1982; this was supported by the state medical society. Among other reforms, the law now requires hospitals, courts, medical societies, and professional liability

insurance companies to report any actions against physicians to the Department of Registration and Education.[9]

Another article on the relationship between malpractice and discipline and the failure of licensing boards to take action appeared recently in *People Weekly*.[10] There was the usual recitation of horrors relating to malpractice. The article continued: "The examples are graphic but hardly unique demonstrations of the unwillingness or inability of authorities in the United States to lift the licenses of MDs who have been negligent, incompetent, or even criminal." The authors concluded that the cause of the problem is that there is no central body policing the medical profession; instead, regulation is carried out on the state level and the standards are often confusing and contradictory. The authors apparently overlooked the Tenth Amendment to the United States Constitution providing for states' rights, which guarantees that licensing is a police power not delegated by the states to the federal government.

Discussion and Conclusions

The public is becoming more and more aroused by the repeated failure of medical disciplinary boards to take action against physicians for alleged or proved malpractice. Many citizens, in their rage, seem to believe that a single real or imagined act of malpractice should result in immediate revocation of a physician's license. Many people, including some physicians, do not understand that the board cannot summarily revoke a doctor's license for proved or alleged malpractice or any other reason without due process.

I have referred to three series of newspaper articles and to another article in a popular magazine. In the past I have repeatedly urged state legislatures to amend medical practice acts to compel physician liability companies to report all settlements against physicians to the licensing board whether they are settled in or out of court. The three newspaper series made the same recommendation. The magazine article suggested a national clearinghouse for malpractice actions. I go so far as to say that this would be unconstitutional, although my statement may be open to challenge.

The fact remains that the boards can take no actions against doctors who have been declared guilty of malpractice if they have no way of finding out about them. I also maintain that no board should take action against a physician for a single mistake, particularly if his past record has been spotless, regardless of public pressure. If boards revoked the license of every doctor on the basis of one mishap, the glut of doctors in this country would soon become an acute shortage.

So far there has been little connection between malpractice and medical discipline. Because the public and the state legislatures have been aroused, I predict that medical disciplinary boards will soon be forced to view the problem much more seriously.

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Politics and Discipline

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A licensing board has several disciplinary hearings pending, some of which involve complex problems of professional behavior and medical ethics. Obviously, those issues demand consideration by board members who are mature in judgment and experience. Suddenly, the governor, for reasons of his own, dismisses the entire board, replacing it with political appointees, none of whom have had any experience in dealing with disciplinary matters. The new members have hardly had time to study the medical practice act and, at best, have only vague ideas about due process. Is it any wonder that they will have extreme difficulty in arriving at just and correct decisions?

That is by no means an extreme example of the mischief that a powerful, politically motivated governor can create. It has happened in the past and will be repeated in the future as long as medical licensing boards are dominated by politics and therefore subject to the whims of a governor.

The medical disciplinary process is influenced by politics—from the appointment of board members through the granting of licenses, the conduct of hearings, and the resulting decisions. In addition, there are some tangential political issues that deserve consideration. For example, the problem of the poorly qualified foreign medical graduate is still with us. The politicians in the state legislatures have certainly not helped to solve the problem, particularly in the states bordering on Mexico. Legislators are often extremely sensitive to the influence of United States citizens of Latin American extraction who want to have their friends and relatives from south

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of the border licensed, regardless of their qualifications. They would have the boards lower their standards for that purpose, and sometimes they are successful. There also has been political pressure from physicians whose children have not been able to gain admission to U.S. medical schools and have studied in Mexico. With the help of the AMA, they have been able to have those students admitted through the back door, bypassing some of the usual requirements, such as the examinations of the Educational Commission on Foreign Medical Graduates. Since some states will still not accept the students, considerable confusion has prevailed.

How are licensing board members appointed? Let us count the ways. In all but five states, the governor appoints them and they serve at his pleasure. In Maryland, North Carolina, and Alabama, the members are elected by the state medical associations. In New York, the Board of Regents of the Department of Education appoints them, while in the District of Columbia the commissioners select them. In 14 states the governors must limit their appointments to names on lists of candidates submitted by the medical associations. In 10, they must consider such recommendations but are not bound by them. Thus, in only 21 states do the governors have unrestricted appointive powers, with or without the approval of the senate.

As the licensing boards are legally constituted departments of the state governments, it is difficult to understand why organized medicine should have any place in the appointment of members. Those who advocate requiring governors to select members only from lists submitted by the medical associations claim that they, being authorities on the attributes of physicians, would thereby remove the selection process from the political arena. They forget, however, that there is such a thing as medical politics, often on the ward heeler level.

As long ago as 1969, I wrote: The medical societies are by no means always likely to recommend the most qualified people for appointment to boards. Frequently, they ignore professional and educational attributes, endorsing some faithful political stalwart who has worked his way up in the councils of his or her society. I know of one case in which the first choice of the governing body of a medical society to fill a vacancy on the board was a graduate of an unapproved medical school—this, despite the fact that the law specifically provided that all members must be graduates of approved medical schools. While the above might be an unusual situation, I seriously doubt that there has been much improvement in the process.[1]

How do the state executives view those laws? Apparently they have expressed few protests. I know of one governor, however, who bitterly resented the influence of the medical society, considering it a usurpation of his appointive power. But to date, neither he nor any other governor has formally challenged the constitutionality of those laws.

Another objection to the political influence of the medical societies is the tendency of the appointees to believe that the primary function of board members is to represent their constituents rather than to act primarily as protectors of the public. That is often reflected in the conduct and attitudes of board members after they have been appointed. Pressures from members of the local medical societies often influence their actions.

The situation in the three states in which the medical associations elect the board members is far from typical. It is most unusual for a professional association to select the members of a government agency. Because of that, one might assume that the associations have continuing influence over the boards. They deny that. Nevertheless, if a board member does not perform in accordance with the wishes of the association, he will have no chance of reelection. Furthermore, this question arises: If the societies directly elect board members, does that empower them to remove board members before the expiration of their terms?

In one state, Indiana, there is open recognition of politics; the law states that of the

seven board members, no more than four may be of the same political party. In another state, in which the governor must appoint members from lists, the medical society made an honest effort to select able, knowledgeable physicians, without concern as to their political affiliations. The governor returned the list, complaining that it contained no Democrats, women, or members of minority groups. In other words, his attitude was, forget about professional qualifications. It is much more important that they be politically acceptable.

In states in which the governors have unrestricted appointive powers, they have often paid off political debts by appointing physicians of questionable ability. It is indeed difficult to understand why membership on a disciplinary board is a political plum, especially if the appointee takes his or her duties seriously. The physician should regard the appointment as an opportunity to perform an important public service.

Politics also can enter into the disciplinary process in the form of conflict of interest. For example, a prominent and able otolaryngologist is a member of a licensing board. Of necessity, he depends largely upon referrals from fellow physicians to build and maintain his practice. Suddenly, he is confronted by a dilemma: A physician who is one of his most important sources of referrals is summoned to a disciplinary hearing. What does the otolaryngologist do? Ethically, he should disqualify himself from participation in the hearing. But does he? He may or may not, as there is no law that says he must. If he does not disqualify himself, consciously or unconsciously he will act as an advocate for the accused physician instead of as an impartial judge.

Another example of conflict of interest is that of a board member who holds high office in a state or national medical association. He must serve two masters: First, as an influential member of organized medicine, his allegiance is to the interests of the members of the profession. Second, as a board member, he must be dedicated to serve the public. That problem was illustrated by a disciplinary case

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heard by five board members. The defense attorney justifiably pointed out that two of the five were past presidents of their state medical society, while a third was the incumbent president. Although the attorney lost the case on appeal, his objection was well taken in view of the fact that the local county society had forced his client to resign.

With no intent to justify the state of affairs described, I can offer an explanation. Usually officers of medical associations attain their positions of influence and prominence by hard work, no matter how misdirected one might consider their loyalties. Consequently, their colleagues—as well as some governors—are inclined to think that they can offer valuable services in another capacity.

Another potential political problem in medical discipline is the desire of many board members to be liked. They are reluctant to take any action that might alienate them from their colleagues or the public. They do not realize that a truly dedicated board member can win few popularity contests. Whatever decisions they make will elicit criticism from either their fellow physicians or the public. Some will castigate the members for being too lenient, others for being too harsh. Usually their severest critics will know little about the details of the cases. The conscientious board member will not allow such criticism to sway him; he performs his duties to the best of his abilities with every effort to be fair. We can only hope that members of disciplinary boards will eventually develop the necessary dermal thickness to protect them from the various pressures brought to bear upon them.

One of the most serious miscarriages of justice occurred when a board, bowing to political pressure, administered a mere wrist slap in the form of probation to a physician whom they had found guilty of an unforgivable breach of professional conduct—the exchange of narcotics for sexual favors. When asked the reason for such leniency, the board president explained that he and the accused physician practiced in the same small town. The president added that the local physicians had brought great pressure to bear against him, urging him to be lenient. That is another example of the misconception that the president of a board is responsible to his local colleagues rather than to the public.

Equally serious is the political pressure from public officials, ranging from members of Congress to local officials. This is particularly abused in behalf of the unqualified applicant for licensure. Many such frustrated physicians, on the advice of local politicians, will appeal to members of Congress, who, in turn, will write letters varying from requests for information to allegations that the board is depriving their constituents of much needed medical care. How can those great statesmen know that the physician in question is qualified? Aren't they bowing to political pressure, disregarding the safety of the public?

I know of the case of one unqualified doctor who was sponsored by the political powers of a small town. Because of a shortage of physicians, real or imagined, they had gone so far as to build an office for him without learning whether he would be able to obtain a license. A delegation of citizens, including the mayor and the president of the local bank, descended upon a bewildered governor to protest the action of the board and demand that he override it. The governor, a fair-minded man, asked the board secretary to provide him with more information. He was informed that not only was the doctor unqualified but that he had been convicted of a felony in another state and was guilty of perjury in making a false statement on his application form.

Politics might even influence the conduct of disciplinary hearings. I have mentioned the example of the otolaryngologist and his referrals. Other influences can be more subtle. When such hearings are conducted by a board rather than by a hearing officer, the members have a chance to question witnesses, including the respondent. Because of personal friendship or indebtedness for favors received, a board member may feel that he

should act as an advocate and protector of the accused physician and ask leading questions designed to place the doctor in a favorable light. Furthermore, his advocacy can be extended to the deliberations of the board after the hearing.

Hospitals are also able to exert political influence, for the most part negatively. One of the most difficult problems confronting disciplinary bodies is posed by physicians who, because of their tremendous influence in both the hospital and the community, feel that they are above the law. Many of us are familiar with the incompetent physician who, because of his personal magnetism, has a large and devoted following. Even though his chief claim to competence is his skill as a confidence man, he is immune to disciplinary action by the hospital authorities or anyone else. Because of his large practice, he is able to fill many hospital beds and to refer patients to his colleagues. Nothing short of a catastrophe would bring him to the attention of the board. Such a doctor exemplifies the worst kind of medical politics to which the hospital is a party. The following account of an actual case exemplifies such a situation.

A 35-year-old mother of four healthy children, the daughter of a surgeon in another city, was nearing the end of her fifth pregnancy. The patient had recently moved to a large city, where, at the advice of a friend, she placed herself in the hands of the leading society doctor, whose charm and winning bedside manner had won him a large following of loyal patients. I shall call him Dr. S.

Despite the fact that Dr. S. had bungled many cases in the hospital, his colleagues were always willing to cover up his mistakes because he was in a position to refer many patients to them. Furthermore, he was on excellent terms with the hospital administration; he was a member of the board of the hospital, and his financial contributions were so generous that he was one of the leading angels of the institution.

And now to return to our expectant mother.

Robert C. Derbyshire

One Sunday afternoon she began to bleed so alarmingly that a neighbor took her to the emergency room of the hospital where Dr. S. worked. The patient had had placenta previa with her preceding pregnancy that necessitated a cesarean section, so that she was practically able to diagnose her own condition. A nurse called Dr. S., only to learn that he was at a country club and could not be disturbed. After over an hour a resident who happened to look into the emergency room had the patient transferred to surgery immediately. He called another staff physician, who performed a cesarean section. The infant was dead, but with the help of four transfusions, he was able to save the mother's life. Because he was an ethical physician, the substitute returned the patient to the care of Dr. S. the following morning.

On the fifth postoperative day, the patient developed progressive abdominal distention, nausea, and vomiting, which soon became stercoraceous. While Dr. S. made rounds twice a day, his visits were made at the doorways of his patients' rooms, where he waved hello and told them, "You're doing fine," never so much as laying a hand on the patient.

Meanwhile, this patient's abdominal distention became progressively worse. Finally, on the seventh postoperative day the distention was partially relieved by complete disruption of her incision. A nurse called Dr. S., who did come in to see the patient but said, "This is not an obstetric problem; it's a surgical one. I am going to call Dr. T." By some quirk of good fortune, he called an excellent surgeon, who found that the cause of the distention was mechanical intestinal obstruction. He corrected it and did a secondary closure of the incision.

In a later conversation with the surgeon, the patient's father asked, "Why did Dr. S. call you?" Dr. T. replied: "Oh, he frequently calls me to clean up his messes."

Later, at the insistence of her husband's family, the patient consulted a lawyer about the possibility of suing Dr. S. for malpractice. The lawyer upbraided her for even considering suing such an outstanding member of the medical community and refused to listen to her story. She later learned that the lawyer was the doctor's attorney and his close personal friend.

This medically incompetent but politically powerful physician was shielded by both the hospital and his colleagues. His influence even extended to a representative of the legal profession. (Incidentally, shouldn't the lawyer have immediately told the patient that he could not take her case because he represented the doctor?) Unfortunately, there are still too many physicians of Dr. S.'s ilk at large.

From the foregoing, one might conclude that I believe all physician members of boards are so weak as to be swayed by political pressure. That is not true. I strongly believe, however, that members who have had close social or professional relationships with alleged miscreants should voluntarily disqualify themselves from disciplinary hearings.

Attorneys and legislators have made suggestions as to how to improve the conduct of hearings. One of the most important is that hearing officers conduct them and present their findings and conclusions to the board members, who can then weigh the evidence dispassionately, disregarding the histrionic tricks of attorneys. Presumably, the members would have little or no prior knowledge of the cases, thus minimizing political influence.

Another possible solution has been advanced by Harris Cohen of the U.S. Department of Health and Human Services, long an implacable opponent of regulation of the health professions by their own members.[2] He advocates complete reorganization of all licensing boards, so that they would be composed entirely of persons who have no self-interest in the regulated professions. His ideal board would be composed of persons who are experts in the fields of education, public health, economics, health care administration, manpower, and consumer advocacy. It is noteworthy that this board would not include

any experts in the field of medicine. Presumably, the board could call on physicians to testify as expert witnesses.

Would Cohen's ideal board be any more resistant to political pressure than one composed of a majority of physicians? I think not. In fact, such a board, because of the members' lack of medical knowledge, would be bewildered by pressures from different directions. Some witnesses would testify that the accused physician is not only a great healer but a benefactor of mankind. On the other hand, there would be equal pressure from persons who believe that the board should not have granted the doctor a license in the first place. Just as in court, I believe that a doctor should be judged by a jury of his peers. It is not unreasonable to demand that such a jury disregard all political pressures.

Sunset Laws

The state legislatures are now taking a renewed interest in the operations of all boards, including those regulating medicine. A relatively recent trend was initiated in 1976 in Colorado. After a study of all state boards and commissions, legislators concluded that many of the so-called regulatory boards were merely serving the professions and trades they were supposed to regulate, with little or no concern for the interests of the public. They found also that the lawmakers exercised little or no oversight regarding departments of the state government.

As the result of those studies, the Colorado legislature enacted what became known as the sunset law, which limits the tenure of all regulatory agencies to six years, at the end of which they no longer exist. To be reactivated, a board must submit to a hearing before a legislative audit committee and prove that it is operating in the interests of the public and is not primarily concerned with the welfare of the regulated profession.

Thirty-three other state legislatures soon followed Colorado's lead by enacting their own

sunset laws. The purpose of the hearings is typified in one of the laws, which states: "The agency shall have the burden of demonstrating a public need for its continued existence and the extent to which an amendment of the agency's basic stature may increase the efficiency of the administration or operation of the agency."[3]

Licensing boards included under the provisions of the sunset laws range from those for physicians to those for embalmers. Although the sponsors of regulatory boards claimed that the boards were established to "protect the public interest," for all practical purposes, they soon became satraps, ruling their own professions as they chose, accountable to no one but the governors—who usually ignored them after appointing the members.

While their abuses of the public trust were not as flagrant as those of some other boards, those governing physicians were not above primary concern with protecting the interests of the profession. For many years, at least two licensing boards limited the number of doctors admitted to practice, a condition that sunset laws have helped to eliminate.

A series of articles in the *Miami Herald*, to which I referred in a previous article, caused the Florida legislature to make drastic changes in the medical practice act under the sunset law. Some of them were by no means favorable to the medical profession: For example, the file on a licensee is no longer confidential 10 days after probable cause for a hearing is determined. That could endanger the reputations of physicians even though they might eventually be exonerated of any wrongdoing. For all practical purposes, the new law reduces the board of medical examiners to the status of an advisory body, as all authority is vested in a central agency with a nonmedical director. Another section invokes penalties against doctors who refuse to provide patients with itemized bills at their request. That seems to be an attempt to legislate medical ethics.

The most objectionable feature of the revised Florida law is a section, suggested by the press, requiring doctors to post signs in their offices notifying patients where and how to lodge complaints of inadequate care. Furthermore, a complaint might call for a subpoena demanding the names and addresses of all the doctor's patients. Search warrants could be issued for clinical records, certainly a violation of the confidentiality of the doctor-patient relationship. Obviously, the Florida legislature had overreacted in its effort to correct the disciplinary deficiences of the board of medical examiners. However, the medical profession struck back with its own political pressure. As a result, the legislature recently repealed the section of the law requiring physicians to post signs in their offices, and it modified the requirement that doctors disclose information from patients' records to the extent that they cannot do so without the patients' consent.

The question now arises: Will other state legislatures follow Florida's lead? In how many states will they consider the disciplinary process so deficient that they will impose such stringent controls? Because of widespread distrust of the medical profession, it is likely that some legislators, prodded by their constituents, will rise up in indignation. Moreover, legislators are increasingly suspicious of regulation of professional bodies by their own members. While sunset laws in some states have resulted in only minor changes in the medical practice acts, to date no legislature has eliminated a medical board.

Lofty as the motives of the supporters of sunset laws might have been, I can state from personal experience that political considerations can enter into enforcement. In fact, the whole sunset concept may prove to be a political farce. In New Mexico, which has a law modeled on that of Colorado, I (as secretary of the board of medical examiners) was required to complete a 45-page questionnaire in preparation for the sunset hearing. That involved many hours of work and seriously interfered with the work of the board. Some of the ques-

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tions were so vague and riddled with jargon that they were unanswerable. However, I went to the hearing fully prepared. I was able to give a complete report on the board's budget, expenditures, and disciplinary actions, as well as an explanation of the examination system. The committee grilled me for an hour and a half, at the end of which the members, with a notable lack of enthusiasm, voted to continue the life of the board for six years more.

The secretary of the chiropractic board followed me on the witness stand. He had not even begun to complete the questionnaire, he knew nothing about his budget or how the board's money was spent, and he seemed totally unfamiliar with the operation of his board. After only 10 uncomfortable minutes, the chairman excused him with thanks; the committee then voted unanimously to continue the board for six years more, with no suggestions as to how it might be improved. That was not surprising; in many states, chiropractors have more political power than does the medical profession.

The only result of the sunset hearings in New Mexico was the recommendation that one consumer representative serve on each board. That is not unreasonable, as the boards are public bodies and the public should be represented on them.

In spite of political influences, sunset laws have great potential for improving medical discipline. Properly administered, they can hold the boards accountable for primary concern with the welfare of the public. If physicians persist in the belief that they alone can best police their own ranks, more and more legislatures will demand proof of that.

Discussion

In using the words "politics" and "politicians" in a broad sense, I am aware that I have raised many more questions than I have answered. I am enough of a realist to understand that it is impossible to eliminate all political pressures that can interfere with the medical disiplinary process. The members of the disciplinary boards must be firm in their resolve to resist the many pressures brought to bear upon them. The inclusion of nonmedical persons on medical boards can be helpful, provided the governor appoints them because of their known ability rather than as a reward for party loyalty. An unanswered question is, How many nonmedical persons should be members of those boards? In most states having lay members, there is only one. That has evoked the charge of "tokenism" by many critics.

Despite their ignorance of the technicalities of medicine, lay persons can provide valuable assistance in matters of policy. In addition to acting as watchdogs over the boards, reporting real or imagined abuses to the governor, they are in a position to present the viewpoint of the consumer. They certainly should not constitute a majority on the boards. While I am not in a position to present a complete analysis of their attitudes, I have learned from talking to several medical board members that in matters of discipline, lay members are inclined to be more lenient than the board physicians!

I feel that the proper authorities to enforce medical discipline are the peers of the alleged wrongdoer. But because of outside pressures, many of them are not properly protecting the public. The answer to the problem is the appointment to medical disciplinary boards of strong, fair-minded men and women who are also leaders of the profession. Idealistic? Yes. But it is at least possible for us to approach the ideal.

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Medical Discipline in Disarray

Offenders and Offenses

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My object all sublime
I shall achieve in time—
To make the punishment fit the crime.
—W. S. Gilbert, *The Mikado*

This could serve as a theme song for medical disciplinary boards, although the members would probably fail to share the optimism expressed in the second line. The boards have four main options in imposing sanctions against medical offenders: revocation of license, suspension, probation, and reprimand. In addition, they have the duty to deny license for cause. Simple, isn't it? All the board must do, having satisfied itself of the guilt of the accused physician, is to select one of the above penalties and its work is finished. But members of disciplinary boards often spend hours agonizing over the responsibility of imposing the proper penalty. They may be torn between their compassion for a fellow physician and their duty to the public.

Because the primary responsibility of the boards is to protect the public, they must first decide whether the sanctions they impose will accomplish this. For example, if the board members decide to place a physician on probation, will they be able to monitor him or her closely enough to provide such protection?

Before they decide that an offense warrants no more than a wrist slap as a reprimand, they should ask themselves: Is this sufficient to induce the respondent to mend his ways? If there is doubt, probation seems more appropriate.

From extensive studies of the medical disciplinary process over many years, I have found many inconsistencies in penalties assessed for identical offenses. This may in part reflect the need for judging each case on its own merits. In some cases, extenuating circumstances might warrant leniency. However, I have found many cases involving serious offenses in which leniency was absolutely inappropriate.

Granted that disciplinary powers reside within the individual states, many of their actions can affect the whole country because of the relative ease with which physicians holding multiple licenses can move about. Although reporting of actions against physicians has increased, there is need for greater improvement. Too many state boards remain ignorant of actions taken against licensees in other states. This is but one cause of the disarray of medical discipline in the United States.

One frequently heard suggestion is that there be a central repository of data on disciplinary actions against doctors. For many years there have been two organizations that collected that information—the American Medical Association and the Federation of State Medical Boards of the United States. Until recently, inquiries to the AMA were fruitless—no doubt the AMA refused to divulge such information because of fear of lawsuits. Recently, however, it has relaxed its policy to the extent that it will refer a question about a doctor's professional and ethical standing to the appropriate state board.

The Federation of State Medical Boards of the United States, with a national office in Fort Worth, Texas, is making a determined effort to gather and disseminate information about disciplinary actions to all of the states. To date, the results have been only partially successful, but they are improving. Most of the information for this article was obtained from the federation and from replies to questionnaires directed to state boards. A few state boards send notices of their actions to all the other boards in the country as well as to the AMA and the federation.

Another advance in the disciplinary process

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is the amendment of 15 state laws to include a clause recommended by a committee of the Federation of State Medical Boards.[1] Cited as an additional cause for discipline is "the suspension or revocation by another state of a license to practice medicine based upon acts by the licensee similar to acts described in this section. A certified copy of the record of suspension or revocation is conclusive evidence thereof." In practice, however, in many cases the action of the original state has been modified or ignored.

In 1980, a typical year, I found records of 30 disciplinary actions that were based on earlier actions in other states: Of those, 19 were the same, 5 were more severe, and 6 were less severe. It is understandable that if another state board previously placed a doctor on probation, the state in which he is currently licensed would be inclined to revoke his certificate. The authorities might look at the record and decide that the original action was too lenient. If there is additional unfavorable information, the board welcomes the opportunity to rid the state of this undesirable practitioner.

Less understandable is why a state board would impose a less severe penalty. In some cases, the first board revoked the doctor's license but the second state merely imposed a period of probation. A striking example of that occurred before 1980. A state board revoked the license of a physician for gross and manifest incompetence and for taking liberties with his women patients. The court upheld the decision of the board, stating that the record showed clear and convincing evidence. The doctor then transferred his activities to another of the several states in which he held valid licenses. The authorities of the second state requested a copy of the hearing transcript, which was promptly delivered. Six months later, another copy was requested, as the board had lost the first one. Again the first board obliged. After another 11 months, the second state board held a hearing. The physician's defense was that the board of the first state revoked his license because of a political alliance between the board secretary

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and the chief of staff of the hospital in which the doctor had practiced. The board of the second state accepted that "explanation" and placed him on probation under the mildest of terms.

Another example is the case of a doctor who wrote many narcotics prescriptions, knowing that the drugs would be diverted to the street. The board of medical examiners managed to revoke his license as he was on his way to a federal penitentiary to serve a five-year sentence. He was released for good behavior after three years; then, with a valid license in another state, he promptly went to work in the emergency room of a large hospital.

Crimes and Punishments

Through the years, the most common disciplinary action has been probation, revocation being second. During a three-year period (1980–1982) I found 1,655 definitive actions, or an average of 551 a year. Eight states reported no actions. I singled out 1980 for detailed analysis. During that year the boards took 549 disciplinary actions. The boards revoked 126 licenses, and 43 more physicians "voluntarily" surrendered theirs. (For all practical purposes, we can say that the total number of revocations was 169.)

Most licensing board members are compassionate people—often too compassionate—who sincerely want to help their troubled colleagues. As revocation of a license is likely to be a final action that forever places the offender beyond the pale, board members can agonize for hours before invoking this sanction. However, some offenses do not cause such agonizing appraisal; for example, board members find sexual molestation of children so heinous that they will revoke the offender's license without any qualms. But what about the doctor who is accused of making sexual advances to adult patients? How often do patients encourage this? Or are some of the accusations figments of wish-fulfillment dreams? The doctor who is entrapped by a seductive patient must have been extremely naive if he did not examine her in the presence of a chaperone.

Suspension of a license may be a punitive action or one that is imposed pending further investigation. For example, the board might suspend a physician's license for a definite period on condition that the doctor obtain help for a drug or alcohol addiction in an institutional setting. When a doctor is placed on probation, the terms are carefully spelled out. If the respondent violates any of the terms, the board will revoke the license. That seems fair enough. Yet, in 1980, I found four cases in which the boards did not revoke the licenses but merely extended or modified the terms of the probation.

One form of probation is restriction of a license, so that the physician can practice only in a state hospital, usually a mental institution. This applies mainly to impaired physicians, but in some cases professionally incompetent physicians are so restricted. Presumably, this will enable the physician to practice only under supervision. The idea is good, but the supervision might leave much to be desired.[2]

The mildest of all sanctions is the reprimand. There are two types of reprimand—private and public. The first is an informal warning to the physician that more drastic action will be taken if he does not mend his ways. Public reprimand becomes part of a public record to which the press has access.

I shall not attempt to analyze every offense listed in the 1980 report but will confine this discussion to some of the more serious ones, pointing out variations and inconsistencies in the penalties invoked.

Felony convictions. There are certain offenses that should entail automatic revocation of licenses. The felonies for which physicians have been convicted include kidnapping, armed robbery, and murder, as well as larceny and falsification of records. One would think that the only thing the board would have to do would be to hold a revocation hearing before the offender is incarcerated and that revocation would be the only appropriate penalty. In 1980, 59 physicians were convict-

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ed of felonies. The boards revoked the licenses of 25 and another four "voluntarily" surrendered theirs; thus, 29 of those criminals were cast out of the profession. Included in the list were 24 cases of unspecified moral turpitude; the boards placed 12 of those doctors on probation, corresponding, in most cases, to the suspended sentences imposed by the courts. The boards suspended the licenses of two felons, implying that at the end of the suspensions they would be placed on probation.

Some examples of extremely mild disciplinary actions taken against convicted felons follow: A doctor pleaded guilty to grand larceny in circuit court. The only penalty imposed by the board was public reprimand. Another mild penalty, private reprimand, was imposed upon a physician who was convicted of common law misconduct, a crime involving moral turpitude. Another board administered a private reprimand to a doctor who pleaded guilty to four counts of mail fraud and false statements.

The imposition of probation for felonies is also disproportionately mild in that context. A board placed a physician on probation for conviction of a felony, namely unlawfully prescribing hypnotic drugs and causing them to be dispensed. Another board placed a doctor on probation because he was convicted of a crime involving moral turpitude, dishonesty, and corruption in the course of his practice. In addition, he prescribed controlled substances for nontherapeutic purposes or in exchange for sexual favors.

Another felony, income tax evasion, deserves special consideration because of widespread disagreement among disciplinary authorities as to the proper penalty to invoke, if any. There are those who claim that boards should revoke the licenses of all such offenders because conviction of such a crime indicates a serious character defect that makes the doctor unworthy to practice medicine. On the other hand, some contend that it is a crime not related to the practice of medicine and, therefore, little or no action is indicated. I found a case in which a physician pleaded *nolo contendere* to federal income tax evasion. The board's penalty? Public reprimand.

The record also abounds with cases that could be classed as felonies if brought to trial. Some of them involved fraud, making false statements to government agencies, and other equally serious offenses. The penalties meted out by the boards were just as inconsistent as those for convicted felons. I shall cite one example of inconsistency involving two doctors under the jurisdiction of the same state board. In the first, the board sent a letter of reprimand to a physician for "Failure to use reasonable care and discrimination in the administration of drugs, and failure to employ acceptable scientific methods in the selection of drugs or other modalities for the treatment of disease. Selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes. A departure from, or the failure to conform to, minimal standards of acceptable and prevailing medical practice, whether or not actual injury to a patient is established." In the second case the wording of the complaint was identical to that in the first with one addition: "Lacking good moral character." The board revoked the license of the second physician. I am unable to understand this inconsistency. The moral character of the physician who was merely reprimanded also seemed to have deficiencies.

Problems with drugs. Year after year, the leading cause for disciplinary action has been violation of the controlled substances laws. Of 549 actions in 1980, 245 (44%) were for that offense. Many of the charges were for prescribing narcotics for other than therapeutic purposes. Most of those physicians were placed on probation; in some instances, the boards later discovered that the drugs were for the personal use of the physician. When the offending doctors were not convicted of drug-related crimes, there was considerable variation in the penalties imposed by the boards. In some cases the boards showed extreme leniency. For example, one board officially reprimanded a physician for indiscriminate prescription of narcotics and for pre-signing prescription blanks so that his assis-

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tant could prescribe medications. Other boards revoked licenses for the same offenses.

For the purposes of this discussion, two categories of narcotics offenses will be considered. The first consists of 179 physicians who were not convicted of felonies but who were prosecuted by the boards for violation of the laws or for indiscriminate prescribing. The actions taken against those offenders consisted of: probation (81), revocation, including voluntary surrender (50), suspension (26), reprimand (9), and cancellation of narcotics permits (4). In addition, nine physicians voluntarily surrendered their narcotics permits.

One will note that probation was the most frequently imposed sanction in those cases. The boards also usually demanded that the doctor surrender his narcotics permit. Revocation was invoked in the most flagrant cases or when the probationer had violated the terms. Although there is considerable variation in the penalties assessed, there is more consistency in this context than there is with respect to other offenses. The nine cases of reprimand only are puzzling. In most of them the offenses seem to be just as serious as in others, but those physicians may have been very early offenders. Most cases of suspension were followed by probation. The periods of suspension varied widely, two lasting as long as a year. The periods of probation also were inconsistent.

The second class of narcotics offenders, numbering 66, includes physicians who diverted drugs for their own use. Forty of those doctors were physically addicted, while the others used the drugs but were not proved to be addicted. We might call them abusers who, if not stopped, could end up as addicts. The penalties invoked were probation (36), revocation, including voluntary surrender (13), suspension (15), and reprimand (2).

The cases of many put on probation were heard under impaired physician laws. In a previous essay in this series, I pointed out the discouragingly low rate of rehabilitation. However, except in the cases of hardened addicts,

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most of the boards believe in efforts at rehabilitation. The two reprimands apparently were imposed on doctors who were on the verge of serious trouble. One involved a physician who was furnishing narcotics to his addicted wife. That tragic situation is, unfortunately, all too common. Although it is a violation of medical ethics, it does not violate the law.

There are other inconsistencies, partly because there is little uniformity among the medical practice acts of the various states. For example, I know of cases in which physicians' licenses were revoked for incorrigible addiction to alcohol or narcotics; the doctors then moved to a neighboring state in which they were already licensed. In the second state, the usual penalty for such offenses is cancellation of narcotics permits. Some states do nothing. This, then, gives rise to the phenomenon of "state hopping." Some physicians seem to collect licenses, often having five or six.

Sex offenses. Stories of physicians who have sexual intercourse with patients under the guise of psychotherapy abound in the public press. An increasingly common cause for disciplinary action is the exchanging of narcotics for sexual favors.

In 1980, 24 physicians were found guilty of sex offenses. Surprisingly, the boards imposed a mild sanction—probation—in 12 cases. The boards revoked the licenses of the other 12. Here, again, there were great inconsistencies. One physician lost his license for having sexual relations with patients. In another case, with an identical finding, the doctor was placed on probation for three years.

In the same year, there were four cases involving doctors who exchanged narcotics for sexual favors. In my opinion, that unquestionably calls for revocation. Yet, all four were placed on probation. There was one case that ended in tragedy because a state board had merely placed a doctor on probation for the offense. Several months later the board summoned the doctor to another hearing because it had reason to believe that he had violated the terms of his probation. He had continued the sex-for-drugs relationship with the same patient, even though his permit had been cancelled. This time the board revoked his license—after the young woman had died from an overdose.

If a board has revoked a license, does that mean that the doctor can never practice again? He can periodically apply for reinstatement. During a rehearing, the same parade of character witnesses, plus a few more, will vouch for the fact that during the period of revocation the physician has led an exemplary life, entirely devoted to good works. Many of them claim to have become deeply religious and have their ministers present eloquent pleas to the board.

From personal experience, I can say that the boards usually regret it when they restore the licenses. I remember one doctor who served five years in the penitentiary for kidnapping a child. The doctor came from a wealthy, politically powerful family in another state. Eventually, an almost entirely new board ruled that the doctor had paid her debt to society and voted to restore her license. The secretary, who distinctly remembered all the details of the doctor's crime—such as giving the child a large dose of phenobarbital and leaving her overnight in an unheated cabin in the dead of winter—prevailed upon the other members to make her reinstatement contingent on her passing a qualifying examination. She failed.

Two states that revoked licenses ruled that the transgressors would be forever barred from practice. Whether their actions were legal, I cannot say, but the respondents have not contested the ruling in court.

Professional incompetence. Because I discussed this issue in detail in a previous essay, I mention it here only in passing. In 1980, the boards took action against 30 incompetent physicians. Many of the charges were for gross incompetence, and there was wide variation in the penalties—from short periods of probation to revocation. Incidentally, I found a case in which the board did not subscribe to the doctrine of the "first bite." It revoked a doctor's license for gross incompetence because he took almost four hours to perform a

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vasectomy and in the process severed the patient's urethra.

Alcoholism. Dependency on alcohol constitutes one of the most difficult problems facing disciplinary bodies. Board members have difficulty in detecting the faint line between heavy social drinking and alcoholism. The situation is further complicated by the fact that, unlike narcotics, alcohol is a socially acceptable, yet dangerous, drug. In most of the 36 cases, the boards placed the doctors on probation, usually preceded by suspension. However, licenses were revoked in three cases apparently involving hopeless drunks.

Other offenses. There were 14 cases involving aiding and abetting illegal practices. Two physicians left presigned narcotics prescriptions in their offices to be used by physician's assistants or nurses. Another doctor was found guilty of fraud because he had introduced a person who had never attended medical school as a doctor and allowed him to operate in his clinic. The sanctions in all of those cases? Probation. Did the punishments fit the crimes?

Discussion

Lack of uniformity is not confined to medical boards. Similar variations have been reported in state court proceedings. In one state, persons sentenced for automobile theft stay in prison an average of 41 months, nearly three times the average of those convicted of rape. In other states, courts are not nearly so lenient toward rapists, who are sentenced to long prison terms. The reason for the discrepancies is that justice is administered under 50 different jurisdictions.

The foregoing account supports the conclusion that the whole system of medical discipline is in disarray. The greatest faults, in addition to indifference on the part of some of the authorities, are failure to report disciplinary actions and lack of uniformity in the imposition of penalties. The problems affect not only individual states but the whole country, in view of the ever-present license collectors and their freedom of movement from state to state. Even though the boards must judge each case on its merits, aren't certain offenses—such as sexual abuse of patients and felony convictions—as serious in Maine as in California? Until there is national agreement concerning these matters, we shall never achieve the ideal of Mr. Gilbert's Mikado: "To make the punishment fit the crime."

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Medical Discipline in Disarray

What Is Unprofessional Conduct?

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The disciplinary codes of the medical profession stem from the medical practice acts of the various states, all of which enumerate causes for disciplinary actions. Many of the laws as well as *A Guide to the Essentials of a Modern Medical Practice Act*,[1] published by the Federation of State Medical Boards of the United States, place those causes under the general heading of unprofessional conduct. Some add dishonorable conduct. The lack of uniformity of those laws causes one to wonder just what unprofessional conduct is. The hodgepodge of laws and regulations that has evolved over the years confuses members of disciplinary bodies and the public alike.

From a study of the various medical practice laws, I found a bewildering pattern of inconsistency. One might think that all of the states would be able to agree on definitions, but they cannot. The closest approach to uniformity applies to two offenses listed in the laws of 48 states, namely, fraud in applying for licensure and violations of the controlled substances laws. Those offenses are closely followed by habitual overuse of drugs and alcohol in 39 laws. From that point on there is a steady decrease in the frequency of offenses listed under unprofessional conduct until we reach fee splitting, mentioned in only 10. Surely, the buying and selling of patients is unprofessional conduct in the extreme and no one should tolerate it. A possible explanation is that such an offense is very difficult to prove. After all, it is highly unlikely that a fee splitter would pay his referring physician by check.

Some 200 punishable offenses are enumerated in the 50 state medical practice acts, and the number is slowly but steadily growing. One of the latest additions is contained in the law of California and makes a physician guilty of unprofessional conduct, and at risk of losing his license, if he does not carefully spell out to a patient with carcinoma of the breast the various treatment alternatives. Needless to say, it has not been welcomed by the many California physicians who believe that it represents legislative intrusion into the practice of medicine—and so it does.

There is great variation in the number of offenses listed in the individual state laws. One statute, that of Nebraska, lists 34; at the opposite extreme is the statute of Nevada, which lists only four. *A Guide to the Essentials of a Modern Medical Practice Act* enumerates 19 offenses but adds the proviso that state boards "not be limited because of enumeration." In other words, the intent is not to require state boards to adhere slavishly only to enumerated acts. Others may be added, e.g., conduct unbecoming in a person licensed to practice medicine. Some state laws incorporate that proviso; it can be important as well as controversial, as we shall see later. One might assume that the laws containing a large number of offenses have been amended in stopgap fashion to plug loopholes discovered by clever defense attorneys.

An offense calling for revocation or suspension of a license in one state might be ignored or unrecognized in another. But shouldn't there be uniformity in the definition of unprofessional conduct? Shouldn't a crime involving moral turpitude, for example, be as heinous in Oregon as in Maine?

One of the most important reasons for disciplinary action, listed in the acts of only 15 states, is suspension or revocation of a license based on actions also enumerated in the laws of another state. Some laws add that a certified copy of the record of suspension or revocation is conclusive evidence thereof. That might

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afford considerable protection against the "state-hopper." However, the passage loses much of its potential effectiveness if not included in the statutes of all states.

Twenty-three state laws still list the performance of criminal abortions as unprofessional conduct, despite the U.S. Supreme Court decision of 1973.[2] The authorities continue to prosecute a few doctors for performing abortions under improper conditions or beyond the time limit set by the court.

One effect of the 1973 decision was to empty the prisons of the convicted abortionists who had helped to swell the ranks of the inmates. Meanwhile, doctors who had been imprisoned for the offense are applying for licenses in states other than those in which they have been convicted. When asked why they do not wish to return to practice in their original states, they reply that they will have a better chance of redeeming themselves if they move to states in which they are unknown. That is understandable. Some state boards will grant licenses presumably because they believe that those doctors have already been absolved of their misdeeds. Other boards are refusing to license them; those boards contend that the physicians knew at the time that they were committing crimes and therefore are not of good moral character. As far as I know, none of those doctors has challenged the boards in court.

Unprofessional conduct includes two items related to felonies: conviction of a felony (in 34 states) and conviction of a felony involving moral turpitude (in 23). I have listed them separately because they are so designated in the laws and because there is controversy about them. For example, a board held a hearing on the case of a doctor who, when stopped by the police for driving 70 miles per hour in a small village with a speed limit of 30 miles per hour, was found to have a large amount of marijuana in his car; presumably, he had been smoking the weed while driving. The court fined him $2,000 and placed him on probation for a year. The board called on him to show cause why action should not be taken against him for unprofessional conduct. The defense of his lawyer rested upon an old law, forgotten by most people (including the board's attorney), that action could be taken only if the crime involved moral turpitude. The action of the board? Dismissal of the case because of a loophole in the law.

An extreme example of failure of a board to take action against a physician guilty of a felony is the following: A physician was drag racing on a busy street in a fairly large city. Police estimated his speed at 70 to 80 miles per hour. At an intersection, he struck another car broadside, killing the driver. At a preliminary discussion by the board, the physician's uninvited lawyer took the floor and presented a compelling argument based on the fact that the offense did not involve the practice of medicine; the board, by a close vote, decided to take no action against him! That is incomprehensible to me. Moreover, the doctor's plea that he had been so seriously injured that he would be crippled for life convinced the court to impose only a stiff fine and probation. The board members who voted to allow that killer to keep his license were probably swayed by the flood of letters from his colleagues stating that he was a great doctor and begging for mercy. In fact, some of the letters threatened that action would be taken against the board members if they disciplined the doctor.

Conviction of a felony of the second type, one involving moral turpitude, is a different matter. *Webster's Third New International Dictionary* defines it as "inherent baseness or vileness of principle, words, or actions"; it is also defined as "depravity." Simple? Not exactly. Defense attorneys have argued that the disciplinary body must *prove* that the accused physician is morally depraved. However, such cases can be simple, as exemplified by the anesthesiologist who committed sexual outrages on his unconscious patients.

At first glance, one might be surprised that mental illness is listed as a cause for action in the laws of only 27 states. However, if we add the 21 states that have impaired-physician laws, we cannot say that the problem is ig-

nored. Since there are many physicians who maintain that drug addiction is a real disease, contained in the victim's genes, one might argue that labeling mental illness as unprofessional conduct is stretching a point. Unfortunately, many board members adopt a judgmental attitude toward those unfortunate people, which does not help in their possible rehabilitation.

Because of the long-established sacredness of the doctor-patient relationship, it is amazing that only 24 laws specify as a cause for action the willful betrayal of a professional secret. Secrecy not only protects the patient but is an integral part of the relationship.

A prohibition of the prescribing of narcotic or hypnotic drugs for other than accepted therapeutic purposes is included in the laws of only 18 states. One explanation is that members of some medical societies think that the licensing board will try to tell them how to practice medicine. They feel that Big Brother will be constantly looking over their shoulders as they write prescriptions. Such objections are ridiculous; no authorities will criticize a doctor who prescribes drugs for proper indications. Those laws are designed to prevent reckless prescribing; secondarily, they can protect physicians against demands of addicts.

I have not tried to analyze all of the 200 offenses listed as unprofessional conduct in the state medical practice acts. It is not necessary to go further to show that there is no agreement among the states as to the definition of unprofessional conduct. The advocates of states' rights who contend that their laws are designed to apply to their particular localities do not seem to realize that many such laws have nationwide implications.

No doubt, 90% of the physicians in the United States practice medicine competently and ethically. For them, definitions of unprofessional conduct are unnecessary except as guides to proper legal practice. The laws are most important when dealing with the estimated 10% of unethical, unscrupulous, and incompetent physicians. (Readers, please note

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my increased estimate.) Although a crime wave has not struck the medical profession, the disciplinary bodies must constantly be on guard against errant physicians. If the states could only reach agreement on what constitutes unprofessional conduct and revise their laws when indicated, the task of the disciplinary boards would be made easier. Although I have long been a staunch advocate of states' rights, I conclude that medical discipline must transcend local boundaries if it is to be effective. Somehow there should be universal agreement as to the definition of unprofessional conduct.

Enforcement of the Laws

In all but three states, the licensing boards are charged with enforcement of medical practice laws. The exceptions are Washington and Maryland, which have separate legally constituted disciplinary committees, and New York, where the Board of Medical Examiners acts only in an advisory capacity to the Board of Regents, which makes final decisions.

Understandably, many questions and complaints arise both from the public and from the medical profession with regard to enforcement of the laws. Most do not involve violations of the statutes. Physicians accuse their colleagues of unethical conduct, and patients complain about excessive fees, real or imagined rudeness, or refusal of the physician to talk to patients or to family members. Although many complaints are not within the province of the boards, in the interest of public relations and their obligation to help people, the boards should answer complaints and direct people to the proper authorities, usually the grievance committees of medical societies. New York law requires that the board answer all complaints, so that it has been necessary to assign a full-time person to that task.

Regardless of the apparent misconduct of a physician, it does not follow that he has violated the law—the main concern of the disciplinary body. Many people fail to understand that and join the ranks of critics who claim that the boards do nothing. In that regard, a word concerning the charging of excessive fees is in order. Although it can be a serious problem, it is listed as unprofessional conduct in the laws of only three states. The other states have not included it in their statutes for several reasons, not the least of which is the potential danger of the disciplinary boards' setting physicians' fees. Moreover, many regard that as the intrusion of the law into private business.

There is widespread misunderstanding with regard to the relationship of unethical conduct to unprofessional conduct as spelled out in the laws. The Supreme Court of Colorado clarified the issue when it ruled, "The law does not punish one for the mere violation of professional ethics as such any more than it would expatriate a citizen for breaking the rules of a lodge, church, or club. It is only when the infraction attains the proportion of a breach of legal duty that the law is offended. When it reaches that stage, as here alleged, the abstract question of ethics is merged into law."[3] Thus, according to that decision, the members of the medical profession can seldom depend on disciplinary bodies to enforce the principles of medical ethics. It is high time that the medical societies assume the responsibility.

No one has ever been able to write a perfect law and certainly not a perfect medical practice act, particularly since most have been designed to cover as many offenses as possible. It is impossible to foresee and define every action that should call for disciplinary measures. The courts have reversed decisions of licensing boards because the particular derelictions were not listed in the laws as unprofessional conduct. A notable exception was a ruling of the Supreme Court of Kansas in the case of *Kansas State Board of the Healing Arts* v *Foote*.[4] The essentials of the case follow.

John J. Foote was graduated from Harvard Medical School in 1938. After completing an

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voke a license on the basis of extreme incompetency and in so doing here the board has not unlawfully created a new ground for revocation." The common sense shown by the court is gratifying. Of course, extreme incompetence constitutes unprofessional conduct. We can only hope that the court's decision will stand as a landmark that will prevent similar delays in administration of justice.

Despite the importance of the Kansas decision, defense attorneys continue to challenge the boards whenever an alleged offense is not specified in the law. As far as I know, such efforts have been unsuccessful.

Another favorite defense is that the law is unconstitutionally vague, especially when the charges are based on unprofessional conduct or conduct unbecoming a licensed physician. Such defenses are not usually successful, since the board will have other evidence to uphold its stand.

With regard to enforcement of medical practice laws, board members have long been disturbed by the multiple roles they must play. For example, one or more board members might investigate a physician and submit their findings to the board. If the board decides to hold a hearing, some members may act as investigators, prosecutors, judges, jurors, and executioners. Those concerns were laid to rest by a United States Supreme Court decision in 1975.[5] The Wisconsin Board of Medical Examiners suspended the license of Duane Larkin because he had permitted an unlicensed physician to perform abortions and had been found guilty of fee splitting. Larkin appealed to the district court, which, in reversing the action of the board, said in part, "The state medical examining board did not qualify as an independent decision maker and could not properly rule with regard to the merits of this case presented to the district attorney."

The Wisconsin board ultimately appealed to the United States Supreme Court, which made the following decision: "The initial charge or determination of possible cause and the ultimate adjudication have different bases and purposes. The fact that the same agency makes them in tandem and that they relate to the same issues does not result in a procedural due process violation." The decision was written by Justice White, and the court unanimously approved it.

Imperfect as the system of law enforcement may be, it is gradually improving, sometimes with the help of the courts. However, the rate of improvement is maddeningly slow. Much of the problem is due to the disarray of medical discipline exemplified by the inability or unwillingness of disciplinary boards to agree on a definition of unprofessional conduct. The disciplinary authorities can do much toward developing a uniform definition. A suitable starting point could be a study of the Federation of State Medical Boards' *A Guide to the Essentials of a Modern Medical Practice Act.* The federation, admittedly an organization without legal authority, could help create order out of the present chaos by working with the National Conference of Commissioners on Uniform State Laws in an attempt to more clearly define unprofessional conduct. If the two groups could produce a suitable document, the boards could then present it to their legislators with the hope that they would pass suitable amendments to the medical practice acts.

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