# Physician oversight report cites woeful flaws

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## Criticisms include drug abuse program

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UNION-TRIBUNE STAFF WRITERS

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The process of investigating and disciplining bad doctors is woefully stymied by too few investigators, too little money and needless inefficiencies that delay serious disciplinary actions by 3¾ years on average, according to a report mandated by the state.

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"We're dealing with physicians who practice medicine every day and for whom even one moment of incompetence, impairment or negligence can mean death or irreparable harm to patients," said the report's author, Juliet D'Angelo Fellmeth, an attorney with the Center for Public Interest Law at the University of San Diego School of Law.

Fellmeth added, "Delay in addressing and processing these cases can be disastrous because these doctors are practicing the whole time."

The report also says a diversion program that monitors doctors with a history of drug or alcohol abuse is poorly managed and allows some doctors far too many relapses. This program is so flawed, the report says, that it must be completely overhauled or scrapped.

Thomas A. Papageorge, head consumer protection attorney in the Los Angeles District Attorney's Office, co-wrote the report as a consultant.

Their 364-page report, released last week, offers 65 recommendations to improve and speed up the oversight process. It was ordered by the Legislature after newspaper reports in 2002 pointed to serious flaws in the way the Medical Board of California licenses and disciplines the state's more than 91,000 practicing physicians.

Those articles showed the board didn't give top priority to cases against doctors most likely to cause harm, investigations were needlessly fragmented and meager public disclosure of disciplinary actions allowed physicians' negligence to evade public discovery.

To fix these problems, legislation by state Sen. Liz Figueroa, D-Fremont, in 2002 created an "independent enforcement monitor" to spend two years examining the board's oversight process. Fellmeth was selected to fill that post.

In her report, she blames some problems on "a devastating combination of blows" to the board's funding and staffing, including:

Recent reductions in resources, including the elimination of nearly 50 positions such as its medical director, despite a 60 percent increase in complaints about doctors in the past 10 years.

No increase in the $300 annual doctor license fees, more than 90 percent of the board's revenue, in 11 years. The report recommended that doctors should be required to pay an additional $100.

A 28 percent increase in the cost of investigating and prosecuting cases.

The report devotes substantial focus to lengthy delays, especially the average of 74 days to receive required physician medical records – "the single greatest source of delay" – which is legally required within 15 days.

Fellmeth's report criticized both the board and state prosecutors for an atmosphere of "permissiveness" in which doctors are allowed to delay the process. Despite the heavy caseload, they used the state's subpoena power, enforced with fines of $1,000 a day, only a few times in a year, she wrote.

"Serious delays in record procurement are pervasive in the 1,800-plus investigations handled each year, making it difficult to understand how 19 subpoena enforcement actions and a half-dozen sanction actions . . . are sufficient to address this problem," the report stated.

Among the delays: an average of 60 days to obtain an interview with a physician under investigation.

Finding and getting written opinions from expert medical reviewers, in part because of the low $100 per hour fees the board is authorized to pay, produce further delays, Fellmeth said. By contrast, physicians' attorneys often hire witnesses for $500 an hour.

The report details other inefficiencies that hamper prosecutors and investigators. For example, regulations allow a physician defendant to pick any location for a hearing, regardless of how far the site is from state offices. That requires the state to pay for hotel, hearing rooms and travel expenses for staffers, witnesses and a judge, which eats into the state's medical oversight budget.

And, Fellmeth wrote, many entities that are required to report physician misdeeds and incompetence fail to do so, including insurance companies and courts handling malpractice payouts, coroners dealing with deaths from physician negligence, and hospitals reporting disciplinary actions against their staff doctors.

"Reporting by hospitals, health care facilities and HMOs is one of the most valuable sources of complaints to (the board), and is the greatest area of failure" with only 157 reports in the last fiscal year – one-third of which were made after the medical board had already disciplined the doctor, she wrote.

The Medical Board president, Dr. Mitchell S. Karlan, called Fellmeth's report "excellent" and said the problems she points to are real.

Her suggestions, he said, have already resulted in attempts at change, such as the board being stricter when demanding physician records. "We need to let them know we mean business," he said.

Nathan Barankin, spokesman for the state attorney general's office, called the report "thorough and thoughtful. We know there are an awful lot of problems. And we know there are more things we can do with more money, more authority and more people.

The report will be turned over to a task force and reviewed at upcoming meetings with the primary goal of raising license fees, Karlan said.

However, that might be tough to do.

Previous attempts were opposed by the California Medical Association, which represents physicians.

CMA president and San Diego anesthesiologist Dr. Robert Hertzka said doctors are committed to "a strong and functional medical board, and if (the board) can make the case that the dollars are useful, that's fine."

But he cautioned that his organization will not support the writing of what in essence could be "a blank check" for unwise spending.

Hertzka acknowledged that although both sides agree "we can move the ball a little faster," he criticized Fellmeth for writing a "telephone book" that focuses on problems caused by state officials.

"From reading this, one gets the impression there's a mob of hideous physicians leading a trail of horror, . . . doing bad surgery with one hand and not returning phone calls with the other," he said.

In fact, he said, "at any moment, even 3 a.m. on Sunday, one can pick up the phone and call a judge to get an interim order of suspension that will yank that dangerous doctor right out of the operating room."

Hertzka also said that neither the board nor the attorney general's staff take advantage of the tools already available, such as using the $1,000 per day fine for doctors who delay supplying records. "They just don't bother to go to court. We tell them, go ahead and fine the $1,000."

Fellmeth and the Center for Public Interest Law have long been strong consumer watchdogs who keep tabs on state agencies that regulate such occupations as construction contractors, optometrists, lawyers and accountants.

Her report targets what it calls a failure by state prosecutors and medical board investigators to collaborate at the start of a case. Instead, complaints are first investigated by board staff members and, if determined valid for disciplinary action, are then "handed off" to a prosecutor unfamiliar with the case.

She wrote that that system deprives investigators of legal support at critical times. Instead, her report said, the two groups should work together from the start to address legal issues, such as preparing search warrants or subpoenas to prod uncooperative subjects or witnesses.

State law says the Medical Board's part of the investigation should take an average of 180 days before it is handed to the Attorney General's Office for review. In fact, that phase is taking an average of 340 days, and many cases take much longer.

A major chapter of the report is devoted to the Medical Board's drug and alcohol diversion program, in which hundreds of addicted doctors avoid disciplinary action if they agree to five-year monitoring, including random bodily fluid testing, group meetings, work-site observation and often substance abuse treatment and/or psychotherapy.

If they successfully complete the program, the doctors avoid having their problems publicly revealed. They may treat patients while in the program. About 240 are now enrolled.

Fellmeth's review of the files of many of those doctors indicates that all the important monitoring mechanisms are failing, "and may expose the public to unnecessary risk." For example, the report said:

Several dozen doctors had not submitted a urine sample for extended periods.

In 20 recent cases involving relapsed doctors, six had relapsed at least four times before being considered for program termination. One doctor who tested positive for cocaine use in 1998, both cocaine and alcohol use in 1999 and 2000, and admitted to continuing use of alcohol was allowed to stay in the program and treat patients, with only temporary interruptions. It was not until 2003, when the doctor tested positive for methamphetamines, that he was kicked out of the diversion program.

The fluid collection schedule, set by the board for unannounced, random dates, was observed only 40 percent of the time it was supposed to occur because collectors tend to rearrange test dates in a pattern than enables some participants to anticipate when they are least likely to be tested, according to the report.

Delays and gaps in collection of samples indicate that 25 percent of doctors who relapsed were not tested as often as required.

The program claims a 75 percent success rate when, in fact, 663 of 981 participants merely completed the program since it began. There is no required follow-up to assure that those 663 have remained clean, so the board "has no idea whether it is successful in rehabilitating physicians

over the long run."

The CMA's Hertzka said there is no evidence the diversion program causes "disasters involving doctors stumbling back into practice and harming patients." Rather, it gives doctors a chance to kick their habits with professional help, "to get their lives in order while insuring patients are not put at risk."

Sandra Bressler, an association attorney and vice president of regulatory policy, said there has never been a case of a doctor having harmed a patient while in diversion.

"That's not true," Fellmeth countered. In October 2003, according to her report, a relapsed diversion participant who tested positive for two narcotics similar to morphine "overmedicated a patient," missed urine collections and stopped attending required group meetings. Even when those problems came to light late last year, the doctor was not booted from the program until early this year.

Fellmeth reiterated that no one knows the extent of the harm that doctors abusing drugs or alcohol have caused, either to themselves or patients, because those entities that are required to report addicted doctors abusing substances rarely do so.

Fellmeth said the problems cited in her report are all the more striking because many of these faults were spelled out 18 years ago in a series of reports by the state auditor general.