Oregon
Kate Brown, Governor

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March 8, 2017

The Honorable Dan Rayfield, Co-Chair
The Honorable Elizabeth Steiner Hayward, Co-Chair
Subcommittee on Human Services
Joint Committee on Ways and Means
Oregon State Capitol
900 Court Street N.E.
Salem, OR 97301

Re: Responses to Subcommittee questions of the Oregon Medical Board, March 7, 2017

Dear Representative Rayfield and Senator Steiner Hayward,

Thank you for your time and attention during the public hearing for the Oregon Medical Board (OMB) budget bill, HB 5023. Below are the responses to the questions posed by the Committee members during that hearing.

Question: Please provide a copy of the Medical Board's study on the consistency of Board disciplinary actions.

Answer: Our study was published in the *Journal of Medical Regulation*. Please see excerpt attached.

Question: When does the Board anticipate increasing fees and how do the policy packages proposed for 2017-19 impact the need to increase fees?

Answer: OMB license fees were last increased in 2013. The OMB has been operating efficiently and been able to keep biennial expenses well within our approved budget for several biennia. We've experienced a slight uptick in license applications for fiscal year 2017 over fiscal year 2016. Given current trends in licensee growth and current cash reserves, the OMB projects that license fees will need to be increased in 2025.

The policy packages recommended by the Governor total $643,310. Based on the agency current service level, this represents approximately 1.2 months of operating expense. Approval of the proposed policy packages will not have a measurable impact on the need to increase fees.

Question: Does the agency have any performance data on existing physician wellness programs?

Answer: The Oregon Health Sciences University (OHSU) Resident and Faculty Wellness program was established in 2004 to provide free, confidential counseling and coaching services to OHSU students and faculty. Demand for the services is demonstrated by the program's increasing participation rate. In the last year, more than 20 percent of residents/fellows and 9 percent of School of Medicine faculty participated in the program. The provider team, composed of two psychologists and two psychiatrists (2.25 FTE), currently provides over 100 visits each month. Trainees and program directors report a high level of satisfaction with this wellness program. This program's success demonstrates that the model of care is feasible and valued.

The Lane County Medical Society's Physician Wellness Program, modeled after the OHSU program, was established in 2012. Through January, 2015, the program has served more than 45 doctors in 160 counseling and coaching sessions

In developing resources for the planned wellness program, the OMB has met with OHSU and the Oregon Hospital Association. Both have pledged to provide funds for a statewide program contingent on the OMB funding requested within our policy package 104. The OMB is committed to working with our coalition partners to build a sustainable, self-supporting program that delivers services state-wide.

Please let me know if I can be of any further assistance.

Sincerely,

Kathleen Haley

Kathleen Haley, JD
Executive Director

JMR

JOURNAL of MEDICAL REGULATION

CRITICAL THINKING ON ISSUES
OF MEDICAL LICENSURE AND DISCIPLINE

VOLUME 101
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VOLUME 101, NUMBER 2, 2015

State Medical Boards Self-Examination:
Analysis of Oregon Data 2009–2012

Kathleen Haley, JD; Kimberly Fisher, JD

ABSTRACT: Consistency in the application of sanctions is a desirable objective of medical boards. This paper retrospectively reviews two types of misconduct that regularly come before medical boards: cases involving inappropriate prescribing of controlled substances to self, family and friends and sexual misconduct. To determine consistency in decision-making investigative case files, we reviewed who the complainant was and his or her relationship with the licensee, the conduct alleged and proven, the licensee's response, the licensee's investigative history, the interview demeanor, and other aggravating and mitigating factors. Each case was considered on its own merits. An analysis of this data suggests that the Oregon Medical Board is consistent in applying sanctions.

Introduction

State medical boards are responsible for supervising the practice of medicine and in doing so protecting the public. They license, investigate and discipline physicians and other health care professionals. The Oregon Medical Board oversees physicians, podiatric physicians, physician assistants and acupuncturists.

Because of confidentiality statutes little is known of the investigative and disciplinary decision-making of medical boards. Websites and outreach efforts outlining the processes for investigation have helped the public and licensees understand the framework. However, most practicing physicians and other health care providers have little insight into the inner workings of medical boards. Consistency in decision-making by medical boards offers licensees and the public some measure of predictability and, importantly, a demonstration of fairness.

It is incumbent on medical boards — which hold extensive power over medical practices — to examine their outcomes to ensure that they are effectively meeting goals of public protection. Other goals for disciplinary sanctions include maintaining the integrity of, and public confidence in, the profession; deterring further unlawful conduct; rehabilitating the offender and educating the public. To that end, the Oregon Medical Board undertook a review of investigative outcomes in two subject areas. A four-year retrospective allowed for a varied roster of Board members. We wanted to see whether disciplinary consistency was dependent on specific members of the Board.

Members of the Oregon Medical Board are appointed by the governor for up to two terms of three years each. Over the period under review there was a turnover of eight Board members in a composite Board of twelve members.

Our objective in conducting this research was to determine the extent to which the Board's disposition in cases involving two areas of misconduct was consistent. By consistent we mean that the licensees' misconduct was treated uniformly, which was reflected in their resulting sanction. We also wanted to know if the Board's response to misconduct was tailored more toward rehabilitation, a secondary goal or protecting the public.

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Methodology

Medical boards investigate many cases that do not result in discipline. Due process requires that the Oregon Medical Board be able to prove its case by a preponderance of evidence. If the Board's evidence does not meet that legal threshold, the Board cannot proceed with discipline.

Medical boards investigate complaints under three broad areas of misconduct: unprofessional conduct, incompetence and impairment. Statutes and rules break these broad categories into specific violations

of law. We selected a subcategory of unprofessional conduct, sexual misconduct and a subcategory of incompetence, prescribing of controlled substances inappropriately because these issues are common complaints to medical boards.

Case files for the period under review were retained in hard and electronic copies in the Board's offices. A legal extern had access to the files for an in-depth review. She went through each individual case file with allegations of prescribing of controlled substances to self, friends or family and sexual misconduct with patients for a four year period. A work sheet with each case by name of licensee, the disposition, complainant, specific conduct, and the licensee's reasoning for alleged conduct, concurrent offenses, history with the board, interview and demeanor at the interview, other aggravating factors and other mitigating factors were described.

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The period of review included cases closed in 2009, 2010, 2011 and 2012. One hundred and nine cases were reviewed within the two categories. Of those, 86 cases were forwarded by staff to the Board for disposition. The review examined those 86 cases for consistency. The other 23 cases were reviewed by Board staff but were not forwarded to the Board as there was insufficient evidence to establish a violation of law. Only two of the cases in this review went to a contested case hearing. All the other cases that resulted in discipline were negotiated resolutions or the licensee defaulted.[1]

Results

For complaint investigations involving the inappropriate prescribing of controlled substances to self, family and friends, 38 were forwarded to the Board. Of the 38 cases, 35 involved physicians and three physician assistants. Four cases reviewed by the Board resulted in a finding of no violation of the Medical Practice Act.

When a licensee of the Board was found to have prescribed controlled substances to him/her self, family or friends, the Board directed the medical director to send a letter of concern to the licensee or asked the Board's assistant attorney general to negotiate a stipulated order after the Board moved to discipline. A letter of concern is confidential, advisory in nature and does not constitute disciplinary action. The Board retains letters of concern in a licensee's electronic file. If similar complaints are later brought forward, the Board can refer to earlier letters of concern in taking an action.

The Board consistently employed a letter of concern in the reviewed cases except in cases where there were other factors such as diversion of the controlled substances, evidence of personal substance abuse, prior Board action, concurrent offenses, or criminal activity. In those cases, the Board voted to take discipline and requested the assistant attorney general assigned to the Board to negotiate stipulated orders. A stipulated order is an agreement to practice medicine subject to specified terms such as a requirement for a chaperone; it is also disciplinary and reportable to the Federation of State Medical Boards and National Practitioner Data Bank.

There were sixteen letters of concern, sixteen stipulated orders, one applicant withdrew his application for licensure and one resulted in a corrective action agreement which is remedial and non-disciplinary.[2] In the sole case that resulted in a corrective action agreement it was the physician's first complaint with the Board, and he demonstrated remorse at the interview with the Board's investigative committee. The Board required, and the physician agreed, to take a course in appropriate pain management, receive personal counseling, cease prescribing for family and friends and establish care for himself with a primary care physician.

For complaint investigations involving allegations of sexual misconduct with a patient, 48 were forwarded to the Board. The 48 cases involved 39 physicians, four physician assistants and five acupuncturists. One case resulted in a finding of no violation of the Medical Practice Act. That case was one of two in our review that went to a contested case hearing before an administrative law judge.

Sexual misconduct, as defined in the Board's administrative rule,[3] includes behavior that exploits the licensee-patient relationship in a sexual way such as sexual intercourse, kissing, inappropriate touching of body parts, and viewing sexually inappropriate materials in a health care work place. Co-worker relationships, sexual harassment, sexual abuse and prostitution do not fall under this definition, unless a patient is involved.

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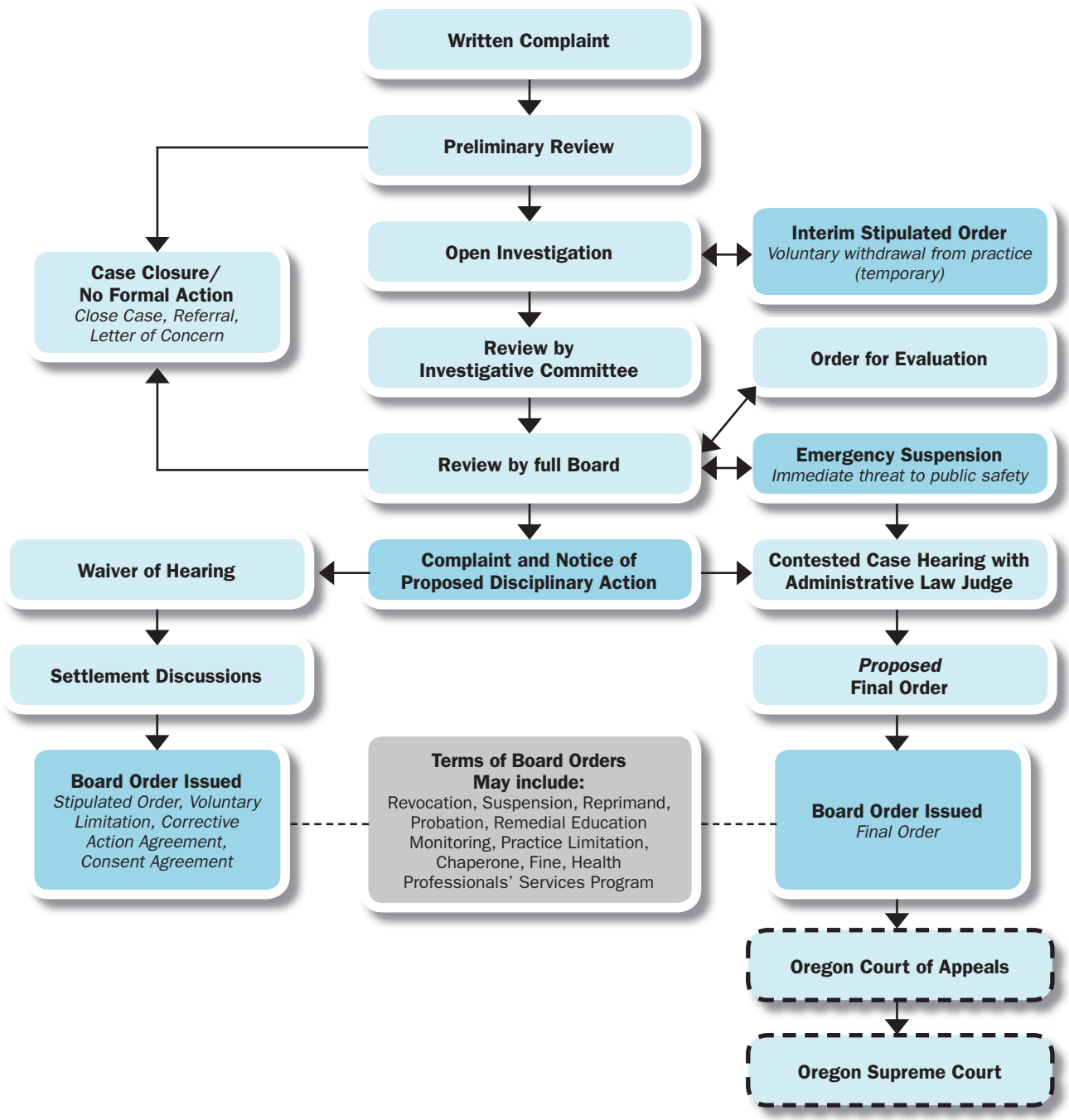
Anatomy of a Complaint



Given that sexual misconduct is a broad category encompassing actions ranging from inappropriate texting to intimate relations, the Board used a variety of resolutions depending on the facts of the case. If the case involved texting a patient with content that was personal rather than professional or other minor issues and there were no other aggravating circumstances, the case was closed with a letter of concern. Other examples of letters of concern include circumstances that involved a sexual relationship that took place before there was a physician-patient relationship, or when the physician-patient relationship was terminated for a reasonable period before intimacy. The Board sent thirteen letters of concern, three applicants withdrew their applications for licensure, and two corrective action agreements resulted. The two corrective action orders involved acupuncturists.

When a licensee engaged in a sexual relationship with a patient, the Board most often negotiated a stipulated order. In 30 of the 48 cases a stipulated order was agreed to by the parties. In 11 of the stipulated orders the health care professional agreed to retire or surrender the license. Three resulted in a revocation of license and two agreed to a revocation which was stayed with other terms.

Terms of the stipulated orders ranged from chaperones to a period of suspension, depending on aggravating and mitigating factors. Standard terms included a period of suspension from practice, probation, a course in sexual boundaries, a reprimand and a fine. Factors which were considered as aggravating or mitigating included vulnerability of the patient; patient credibility (in these cases, the Board offers alleged victims an opportunity to talk with Board members prior to issuing any statement of charges); reputation of the licensee; credibility as determined by history with the Board and demeanor and awareness of boundaries as determined at the interview with Board members; prior board history; concurrent offenses; harm to the patient; and remorse.

In 16 or slightly more than half of the stipulated orders, at the outset of the investigation the Board either voted for an emergency suspension or the Board and licensee agreed that the licensee would step out of practice with an interim stipulated order, pending completion of the investigation into the allegations. Both have the effect of requiring the health care professional to immediately cease practicing medicine.

Our research found that three of the 86 Board reviewed cases resulted in anomalies. Anomalies for purposes of our study were generally outliers wherein the sanction differed from that of other cases with similar fact patterns. In two of the three cases the sanction was less severe; however, in one case involving sexual misconduct the sanction was more severe because the physician exploited a particularly vulnerable patient. In this case the Board imposed a ten-year probation in addition to the standard terms of a stipulated order.

Discussion

This analysis suggests that the Oregon Medical Board makes consistent disciplinary decisions in the two areas under review. While the board does not use a disciplinary matrix, members consider specific mitigating and aggravating factors when coming to consensus on the outcome of a case.

In addition, this research found that the Board tailored the terms of its stipulated order to the proven conduct and rehabilitation. Case analysis demonstrated that there was a reasonable progression in the Board's response to licensee behavior and accountability to the public was paramount. For example, in one case the Board initially sent a letter of concern to the licensee for inappropriately hugging patients. When the behavior continued, the Board negotiated a corrective action order that included prohibitions, chaperones and a boundary course.

It is critical that as regulatory bodies with significant impact on public health, medical boards engage in self-examination. Electronic investigative and disciplinary records make this type of research more accessible. The results of studies such as ours are useful to licensees and their attorneys, boards, and state policy makers. ■

About the Authors

Kathleen Haley, JD, is the Executive Director of the Oregon Medical Board.

Kimberly Fisher, JD, was a legal extern at the Oregon Medical Board. She is currently a law clerk at a Portland, Oregon law firm.

References

1. Oregon Medical Board; *Anatomy of a Complaint.* Accessible at: www.oregon.gov/omb/Investigations/Documents/anatomy-of-complaint.pdf.
2. Corrective Action Agreements are not disciplinary orders and are not reportable to the national data banks (e.g., National Practitioner Data Bank and Federation of State Medical Boards) unless related to the delivery of health care services or a negative funding of fact or conclusion of law. They are public agreements with the goal of remediating problems in the Licensees' individual practices.
3. Oregon Administrative Rule (OAR) 847-010-0073(3)(b)(G). Accessible at http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_847/847_010.html.