The Board of Medical Practice by the Numbers

The members and staff of the Board of Medical Practice understand that receipt of a letter informing one of our licensees that an investigation has been opened is not a happy event. What's to like? The potential for uncomfortable procedures and the possibility of an adverse outcome can cause anxiety for even a confident, skilled, and careful practitioner. And, for most of our licensees, being the target of an allegation that they have made an error or done something wrong is not familiar – licensed medical professionals tend to be people who get things right and do the right thing most all the time. No doubt, receipt of that letter is disturbing, unsettling, or just plain annoying. However, the reality is that the likelihood of a public action is quite low. We're sharing some information about Board investigations and actions from the past five years to allow our licensees to better appreciate how infrequently practice shortcomings lead to public sanctions, understand what are the most likely outcomes when there is discipline, and see the types of practice problems that are most prone to Board actions.

Numbers of Investigations and Actions

Looking back at the years 2011-2015, the Board averaged about 197 investigations per year. The number of investigations fluctuated quite a bit, with the low occurring in 2011 when there were 151 investigations initiated, and a high of 264 investigations opened in 2012. The number of total licensees (including MDs, PAs, DPMs, RAs, and AAs) also fluctuates, but it is generally between 4,000 and 4,500.[1] In rough terms, in a given year the Board may conduct one investigation for every 20 licensees, and in a typical year some licensees are the subject of multiple complaints. Essentially, for a given licensee, the odds of being the subject of an investigation is actually quite low and even if a licensee is investigated, findings and sanctions are relatively rare.

Over the five years, the average of investigations opened each year is about 197, and the average number of cases resulting in discipline or surrender of license was just under 9. Among all those investigated, that yields a rate of roughly one in 22 cases that resulted in an adverse outcome for the licensee. Overall, using the total number of health care professionals licensed by the Board and the average number of adverse actions, approximately one in 500 of our licensees is subject to an action in a given year.

One last statistic of note is the limited number of cases in which public charges are filed against licensees. When an Investigating Committee of the Board reaches a finding that unprofessional conduct has occurred, the process is to seek an agreed-upon solution with the licensee, as opposed to immediately charging the licensee. The vast majority of cases that result in an adverse action are resolved with a stipulated agreement of findings and sanctions. During the five years

[1] Analysis of case statistics is not an exact science. For instance, complaints may relate to events that occurred a year, or two, or more in the past. Thus, there is little point to calculating the ratio of total licensees to total investigations on a year-by-year basis. The focus here, instead, is on averages over the five-year period.

considered in this review, the Board averaged only one case per year in which a licensee and the Board failed to reach an agreement and charges were filed.

Profile of Disciplinary Sanctions

Next we turn to the question of "what happened" in the actions taken by the Board. By law, the options for sanctions are: reprimand, conditions, practice limitations, suspension, revocation, and an administrative penalty of up to $1,000 for each violation. 26 V.S.A. § 1361. Within the category of "conditions," there are some distinct types that we counted separately. Those are the condition for a licensee to engage a practice monitor who must report to the Board and the condition to take one or more Continuing Medical Education (CME) programs. Various other conditions were grouped together.

When looking at numbers regarding sanctions, it should be recognized that multiple sanctions may apply in one case, and that, in the vast majority of cases, the sanctions resulted from negotiation and an agreement as to the sanctions that would be imposed. Appearing in 22 cases, the single most frequent sanction is the *imposition of conditions* (excluding CME and practice monitor). Typically, those conditions would be to do or not do a particular act. For example, a licensee may be required to provide current and future supervisors a copy of the action (alerting them to an area of practice that has been problematic), to participate in the Vermont Practitioners Health Program, or to follow certain laws or regulations applicable to practice (reinforcing the existing standards).

Just after the general category of *conditions* was an *order to complete CME*, with 21 cases featuring that requirement. That is not surprising, given that the Board's foremost goals are protection of the public and promotion of quality practice. Board members strive to make the requirement relevant to the demonstrated practice deficiency or error, and usually ask the licensee to submit a brief report of what was learned.

CME completed to comply with a Board Order still counts toward the requirement for all physicians to complete 30 hours of CME in each two-year licensing period.

Reprimand was the third most frequent sanction, included in 20 cases. In that a reprimand does not require the licensee to do anything, prohibit anything, or take anything from the licensee, it might be viewed as the least severe sanction. However, a reprimand is public and is noted with the public information regarding the licensee.

Revocation and *suspension of the right to practice* are generally regarded as the most severe penalties imposed in professional licensing cases. Between 2012 to 2015, there were 11 cases that resulted in the licensee being suspended or permanently removed from practice, which includes 6 instances in which the licensee agreed to a permanent cessation of practice to resolve the pending disciplinary case.

Appearing 10 times each, the two next most frequent sanctions were the requirement to *engage a practice monitor* and *limitations on the licensee's practice*. When a practice monitor is directed, it is for a specified period and includes periodic reports to the Board. "Practice limitations" refers to prohibitions on a licensee practicing in certain fields (e.g., surgery or medication-assisted addiction treatment) or settings (e.g., no solo practice).

The least frequent form of sanction was *administrative penalty*, or what is commonly thought of as a fine. There were 8 cases with a money penalty, but that option was added only in June 2011, and 2013 was the first time this was imposed. Money collected as administrative penalties can be spent only for education and training for Board members and licensees.

What Leads to Board Actions?

More important than the statistics about investigations and actions is the nature of the issues underlying the cases, as that is the information that gives insight into the matters that most often lead to problems for licensees. Statistics regarding the issues in cases are not precise, as a single case may present multiple issues, with some being the foundation for the action and others quite secondary. However, a review of the actions taken by the Board during 2011-2015 shows a small number of "most frequently occurring" issues.

Prescribing Controlled Substances

The most common problem area is prescribing controlled substances. These issues were present in about one third of all actions. Generally, the shortcomings fell into the category of a failure to exercise care in prescribing controlled substances. The cases were not based on limited, isolated instances of mistakes, but rather on patterns of: failure to document a diagnosis that supports prescribing; failure to make regular use of risk mitigation tools (informed consent documents, patient agreements, pill counts, urinalysis testing, checking VPMS); and failure to address evidence of aberrant patient behavior, such as unexplained urinalysis results or need for early refills. Also, some prescribing cases were based on the fact that a licensee had written prescriptions for controlled substances for themselves or family members, which is against Vermont law and Board rules.

Records Issues

The second most common cause for Board discipline was failure to maintain appropriate records. Within record keeping, there were various shortcomings seen – no record at all, illegible records, and records missing significant amounts of required information. There was a strong association between cases in which there were problems with prescribing of controlled substances and record keeping, with poor records also being an issue in most cases that were based on prescribing practices. A small subset of the records cases was not associated with a particular practice issue, but were cases based on the failure of the licensee to consistently prepare adequate records in a reasonably prompt manner. Maintenance of accurate records is not just an administrative issue. It is true that records are associated with administrative functions such as billing, but on the whole records are a critical component of safe, quality care and must be usable by all health care professionals who may be treating that patient now and in the future, not only the physician or other provider who is rendering the care. Additionally, patients often need records to support coverage for services or access to benefits, and there is a legal obligation for each of our licensees to make records available to the patient promptly upon request.

Quality of Care

The third most frequently occurring basis for Board action was treatment that fell short of the standard of care (and not including shortcomings only associated with bad prescribing or record keeping). These were cases featuring failures in diagnosis and errors made in choosing or executing treatments.

Licensee Substance Abuse and/or Criminal Convictions

A relatively small number of cases were based on a licensee being convicted of a crime, most of which were associated with the licensee's own abuse of alcohol or controlled substances. The

Board strongly encourages licensees who may have a substance issue to make use of the Vermont Practitioner Health Program (VPHP), a program supported by licensee fees and run under a contract between the Board and the Vermont Medical Society. It's available to physicians, podiatrists, physician assistants, radiologist assistants, and anesthesiologist assistants. VPHP assists the Board by coordinating recovery and monitoring for licensees who've had substance abuse issues, but VPHP is also available to those licensees who ask, and when someone approaches VPHP on his or her own, without having had a criminal involvement or other event that brings the problem to the Board's attention, the services are provided on a confidential basis. VPHP's confidential phone line is 802-223-4393.

The Bottom Line

Everyone associated with the Board of Medical Practice shares the view that bringing actions and imposing sanctions is not the goal. The Board is committed to protecting the public, promoting good practice, and supporting our licensees with licensing services and information. However, a necessary part of the Board's mission is to identify and respond to unprofessional conduct. Looking at the number of actions and the nature of the sanctions that result, it is clear that unprofessional conduct is fairly rare among the professionals licensed by the Vermont Board. Even among the small number of licensees who must be sanctioned, the most common measures imposed are conditions, a requirement for specific CME, and reprimand.

So, if you get a letter from the Board telling you that a case has been opened, it's not the end of the world. It's unlikely that an action will result at all, and, in most cases, sanctions are relatively mild. In the end, the Board hopes that all licensees will feel that they were treated fairly and with respect regardless of the outcome of a case.

Vermont Board of Medical Practice
PO Box 70, Burlington VT 05402-0070
802-657-4220
(within VT: 800-745-7371)
Email: AHS.VDHMedicalBoard@vermont.gov
http://healthvermont.gov/hc/med_board/bmp.aspx