



**Testimony of Sidney Wolfe, M.D.
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Committee on Health
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Chairman Catania and Members of the Committee, thank you for the opportunity to present testimony on two critical and long-overdue aspects of the legislation pending before the Council: improving the D.C. Board of Medicine and giving consumers greater access to information about doctor discipline.

I have spent over 30 years studying and, for the past 15 years ranking state medical boards, which are charged with protecting the public by licensing competent medical professionals and disciplining those who endanger their patients. In that time, it has become eminently apparent to me that a medical board can only be as good as the legislature's willingness to allocate the resources it needs to be effective and to be responsible for overseeing the regulation of medical practice in the District. But until your efforts, Mr. Chairman, the Council has failed to take either the funding or oversight responsibilities seriously, a small proportion of the tragic consequences of which was portrayed in a *Washington Post* expose last April. Hundreds of District patients are injured and killed by avoidable medical errors each year, many by repeat offender doctors who despite their failure to meet the standard of care, continue to practice without any restriction, rebuke or penalty—and without their patients knowing that they have negligently harmed others.

This groundbreaking bill introduced as a result of your leadership, Chairman Catania, marks the Council's first real attempt to address the problem of medical negligence through enhanced supervision of the medical profession and increased public disclosure of physicians' disciplinary history. In my testimony I will discuss the provisions of Title I of the bill, which pertain to both the D.C. Medical Board and the on-line physician profile, and make specific recommendations on strengthening these provisions to make them more effective.

MEDICAL BOARD STAFFING AND FUNDING

As I testified before this Committee last May, the D.C. Board of Medicine is currently 30th in Public Citizen's annual ranking of state medical boards in the U.S., which is based on the rate of serious disciplinary actions (revocation, suspension, surrender and probation) taken against licensed physicians. But historically, it has typically languished among the bottom 10, in some years coming in dead last of all 51 jurisdictions. This has not been due to a failure of competence, goodwill or conscientiousness of Board members, so far as I can tell. Rather, the greatest impediment the Board has faced has been a persistent deprivation of resources—serious under-funding, and, for most of this time, not a single full-time staff member.

These deficiencies have made it impossible for the Board to fulfill its obligation to protect the public from dangerous doctors. Over the past 15 years, the Board has taken disciplinary action against only 1 out of 10 District doctors with three or more malpractice payouts, according to Public Citizen's analysis of information reported to the National Practitioner Data Bank. It has restricted, suspended or revoked the licenses of just 15.8 percent of physicians with five or more malpractice payouts. Many of these doctors should probably be put under strict, enforceable probation or restrictions of their practices, and others may actually merit license suspension or revocation. Otherwise, they remain in practice without any sanctions from the board and repeatedly harm hundreds of patients annually. In addition, there have been very few disciplinary actions against most of the 4.3 percent of doctors who account for 47.3 percent of the District's medical malpractice payouts.

Over the past few years, health professionals and consumers across the U.S. have become increasingly vocal in demanding stepped up surveillance of doctor performance to reduce the nationwide epidemic of avoidable injuries and deaths caused by medical negligence. State legislatures and medical boards have complied. From 2003 to 2004, the total number of disciplinary actions taken against doctors in the U.S. climbed 20 percent, according to Federation of State Medical Board statistics, including a 10 percent increase in serious actions.

But, without any full-time personnel it is unreasonable to expect the D.C. board or any medical board to investigate the thousands of complaints it receives annually, make disciplinary determinations, enforce rulings, and generally assert supervisory authority over the medical profession—in addition to licensing health professionals. West Virginia and New Mexico, states with similar numbers of licensed physicians as D.C., have boards that typically rank 10 to 20 places above D.C. in our annual survey. Why? One major reason is that both have full-time executive directors, one or two investigators, a lawyer and two clerical staff.

This is the minimum number of staff the D.C. Medical Board needs to do its job. Happily, the proposed legislation introduced by Chairman Catania provides for this staffing component exactly, both in number and job category. This represents a major improvement that should reap significant patient safety rewards but would be improved upon if there were more than one full-time investigator, as is the case in New Mexico.

The other major barrier faced by the D.C. Medical Board has been the absence of a dedicated funding source. The board has struggled along for years without any formal budget, reduced to

begging for funds from other parts of the D.C government because the license fees collected from medical professionals go into the treasury instead of to the board. Both West Virginia and New Mexico, again, two relatively successful boards with about the same number of licensed physicians as the District, have been able to use their license fees to fund their operations.

The proposed legislation provides for a minimum licensing fee of \$300 (presumably paid every two years, which is the duration of a license), with the money generated by the fee slated entirely for Board administration and implementation of orders. It must be recognized that since a portion of this fee goes to an outside contractor that administers and processes license renewals, it leaves less money to cover investigation of complaints and enforcement of disciplinary orders. This level of funding is woefully inadequate. In my previous before this Committee, I strongly urged that the fee be set at a minimum of \$500 per year. By way of comparison, West Virginia upped its licensing fee to \$1,000 every two years in July 2004.

I would emphasize again that sufficient staffing and funding are key determinants of a board's success. Arizona, for example, made a big investment in its medical board in the late 1990s following media revelations similar to those in the *Washington Post* series on D.C. area doctors. The investment paid off almost immediately. Arizona surged from 38th place in our state ranking (comparable to where D.C. is today) in 1999, to 5th place by 2001, and became No. 1 among all medical boards by 2003. What this legislation now proposes is the bare minimum contingent of full-time staff, and a budget that will remain inadequate to accomplish the vigorous enforcement of rules, regulations and practice standards that patients should be able to expect.

Other issues not specified in this bill, but that need to be addressed in order for the Board to operate effectively are:

- **Budgetary authority.** Under the proposed legislation, the Board will be relieved from dependence on handouts from other parts of the government for its funding. But the bill is silent on the Board's authority over the budgetary process. The Board is in the best position to determine its own operational needs and priorities, and therefore must have the ability to develop and approve its own budget. The bill should be amended to include such authority.
- **Rulemaking authority.** Some 42 state medical boards have the power to adopt and amend their disciplinary rules, regulations and procedures. The District's medical board is not one of them. Just as the Board should have control over its budget, it should also have control over rulemaking. Currently, the Board can recommend rule changes, but these must be approved by the Department of Health. The Board itself requested greater autonomy in its testimony before this Committee in May 2005. The July 20 report of the Health Committee Taskforce on Medical Malpractice, convened under your leadership, cited "lack of autonomy or independence" as a stumbling block to improved Board performance. I strongly urge the District to look toward the national trend and listen to the recommendations of its own Board and the Medical Malpractice Task Force, and grant the Board greater independence in this area. I will discuss this further in the next section of my testimony.

TIMELY NOTIFICATION OF COMPLAINTS, INVESTIGATIONS, AND DISCIPLINARY ACTION

Title I of this bill requires physicians faced with medical malpractice complaints or out-of-state disciplinary action to notify the Board within 60 days. It further requires the Board to initiate an investigation within 60 days of receiving such notification, and make a final ruling no later than 60 days after commencing its investigation. Finally, the bill mandates disciplinary action against a physician subject to an adverse ruling by the Board.

These provisions are presumably meant to ensure that the Board is apprised of potential performance problems with its licensees, and that it conducts an investigation of every complaint or disciplinary action it receives. While the intent is laudable, it is doubtful that it can be achieved by this bill as now drafted. For example, there is no provision for penalizing a doctor who fails to notify the Board of a complaint or out-of-state action within 60 days. The Board has no duty to seek out errant doctors on its own, nor is there a mechanism established that would enable the Board to detect a doctor who failed to submit the required notification within the required timeframe. There is no oversight specified to ensure that the Board conducts timely investigations. The bill requires an investigation, but nowhere does it require a *thorough* investigation, nor give any guidance on how those investigations should be conducted. Finally, the Board is not required under the bill to verify enforcement of a disciplinary action it takes against a doctor.

The point I am trying to make is that, while setting mandatory deadlines to ensure that malpractice complaints are acknowledged and investigated may be a good idea, this is really only the tip of the iceberg—an isolated component of a multifaceted problem. It is not possible for us, sitting in a room drafting legislation to think of all the aspects of the disciplinary process that require fixing, and even if we could, we would not necessarily come up with the right solutions. Setting deadlines may increase the quantity of actions, but it says nothing about the quality. Rather than taking a patchwork approach that focuses on the most obvious flaws in the system but most certainly misses other, perhaps more critical concerns, a better strategy would be to treat the process holistically, and in such a way as to incorporate input from all interested parties. This means using broad-brush language to outline the procedure for developing disciplinary rules, but leaving the details to be filled in by the Board, with guidance from physicians, administrators, consumers and others. I, therefore, recommend that the bill be amended to remove this provision and replace it as follows:

1. As mentioned previously, give the Board authority to adopt its own disciplinary rules and procedures with continuing notification of the Council to ensure that the legislature remains engaged and has the ability to conduct responsible oversight.
2. Require the Board to go through a public rulemaking process. This would create a mechanism for integrating expert and layperson contributions into the final product, thereby enhancing quality, comprehensiveness, and getting all parties to buy into the system.

ON-LINE PHYSICIAN PROFILES

A robust oversight system with vigorous enforcement of disciplinary measures and public disclosure of physician disciplinary history are two sides of the same coin. The first ensures that doctor performance conforms to the highest professional standards, the second empowers patients by giving them information they need to make the best choice when selecting a care provider.

We agree with the general topics listed in Section 103, part (d) for inclusion in the Medical Board's new web site, and appreciate the Chairman's very good recommendations here. However, there are important details concerning various disciplinary and other actions against doctors that are entirely missing or not spelled out, there is no clear statement that all information on the site has to be verified, not self-reported and, in addition, there are no requirements to ensure the user-friendliness of the site. We offer the following suggestions for improvement:

Hospital Privileges: The bill includes "loss of hospital privileges" but does not include restrictions on hospital privileges, the latter is included in information present in the National Practitioner Data Bank (NPDB). The criterion for inclusion of restrictions in the NPDB is those restrictions that are more than 30 days in duration. The same should apply to information on the medical board's web site. The cause for either the loss or restriction of privileges should also be included along with the order from the hospital detailing the loss or restriction of privileges.

Malpractice claims settled or adjudicated with payouts: The implication of this language is that all malpractice payouts should be listed as part of the doctor's profile on the site. The language should be more explicit that this would include even one payout for a doctor and that the dollar amount of each payout should be specified. Not mentioned in the bill is a requirement that the cause for each payout be specified, as it is in the NPDB. We believe that is needed as well.

Medical Board disciplinary actions against the licensee: Merely requiring disciplinary actions by the Board or the Mayor to be listed is not enough. We believe that details about the cause of the action along with the details of the action, as well as a complete copy of the medical board order and a summary of the order concerning the action, should be required as part of the web site. There is also no requirement that disciplinary actions taken against a District licensee by another state must be included. This is especially important if the physician has been disciplined in another state but not in the District; but it should be included in all cases.

Federal actions against the licensee: The legislation is silent about any requirement for Federal actions, including the loss or restriction of a Drug Enforcement Agency narcotics license, Medicare/Medicaid exclusions or other actions or actions by the Food and Drug Administration against clinical investigators. All of these sources of information are on government web sites and are easily accessible to the Board.

Criminal convictions: As with the above categories, the section on criminal convictions should include details as to the cause of the conviction.

User friendliness of the site: The information about each physician should be in a searchable data base in which the doctor's name could be entered. In addition, it would be extremely useful to the user if the search could also be done by medical specialty, hospital affiliation or, less importantly, by license number. Other elements to improve user-friendliness would be to state on the home page that the site includes District and out-of-state disciplinary actions, hospital actions, Federal actions, malpractice payouts and criminal actions and to further state the number of years that these actions are retained on the site.

Other topics for inclusion in the web site: State statutes and rules for MDs; an on-line complaint form for patients or others to file; a consumer FAQ (frequently asked questions) or a similar explanation of what's on the site. In addition, more consumer-friendly info such as whether the physician takes Medicare, Medicaid and which health plans are accepted would be helpful to patients.

Funding for the site: Unless there is a specific provision in the legislation for funding for personnel and software/hardware for the site, it will not likely happen or, if it does, it will be very inadequate.

Thank you for the opportunity to testify on this important legislation. I will be happy to answer any questions.