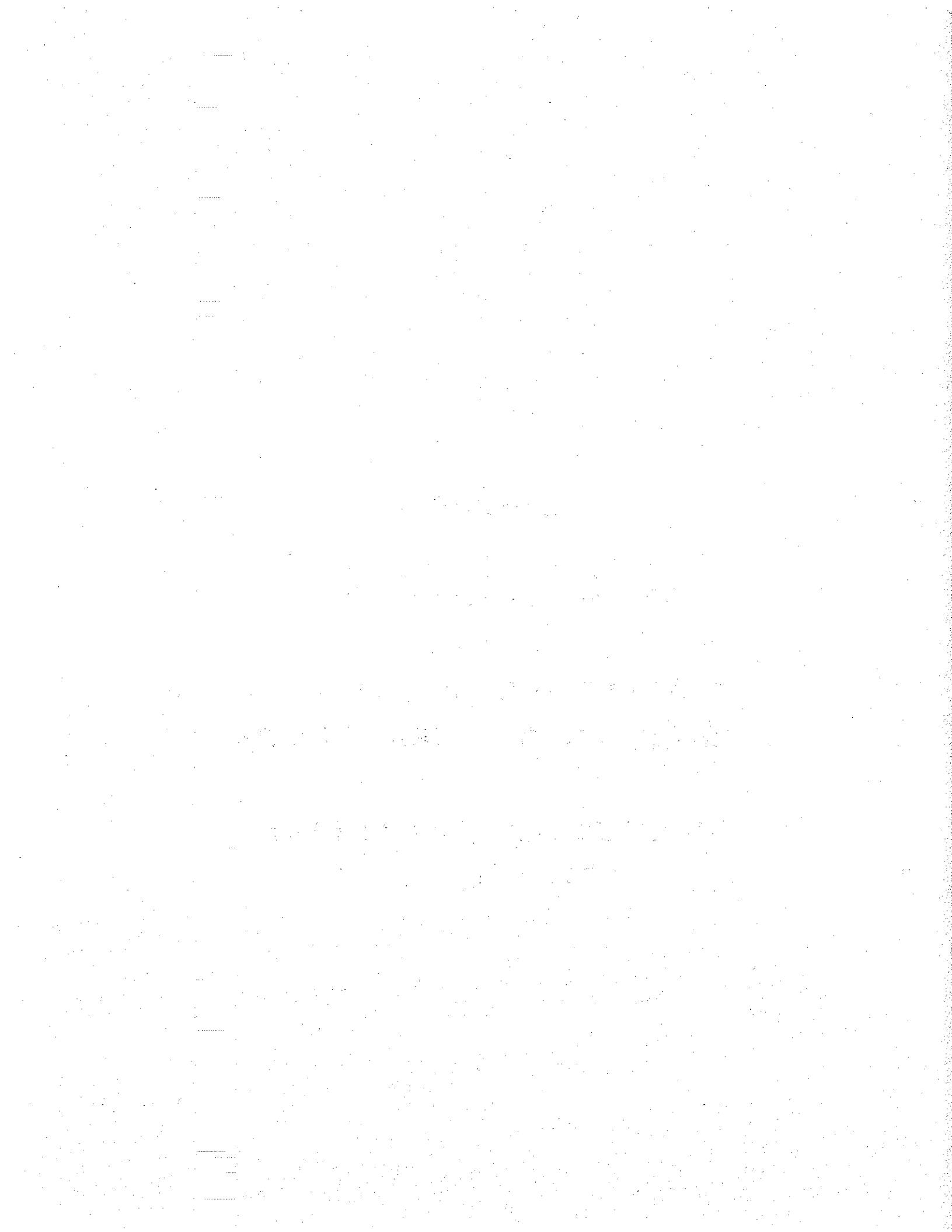
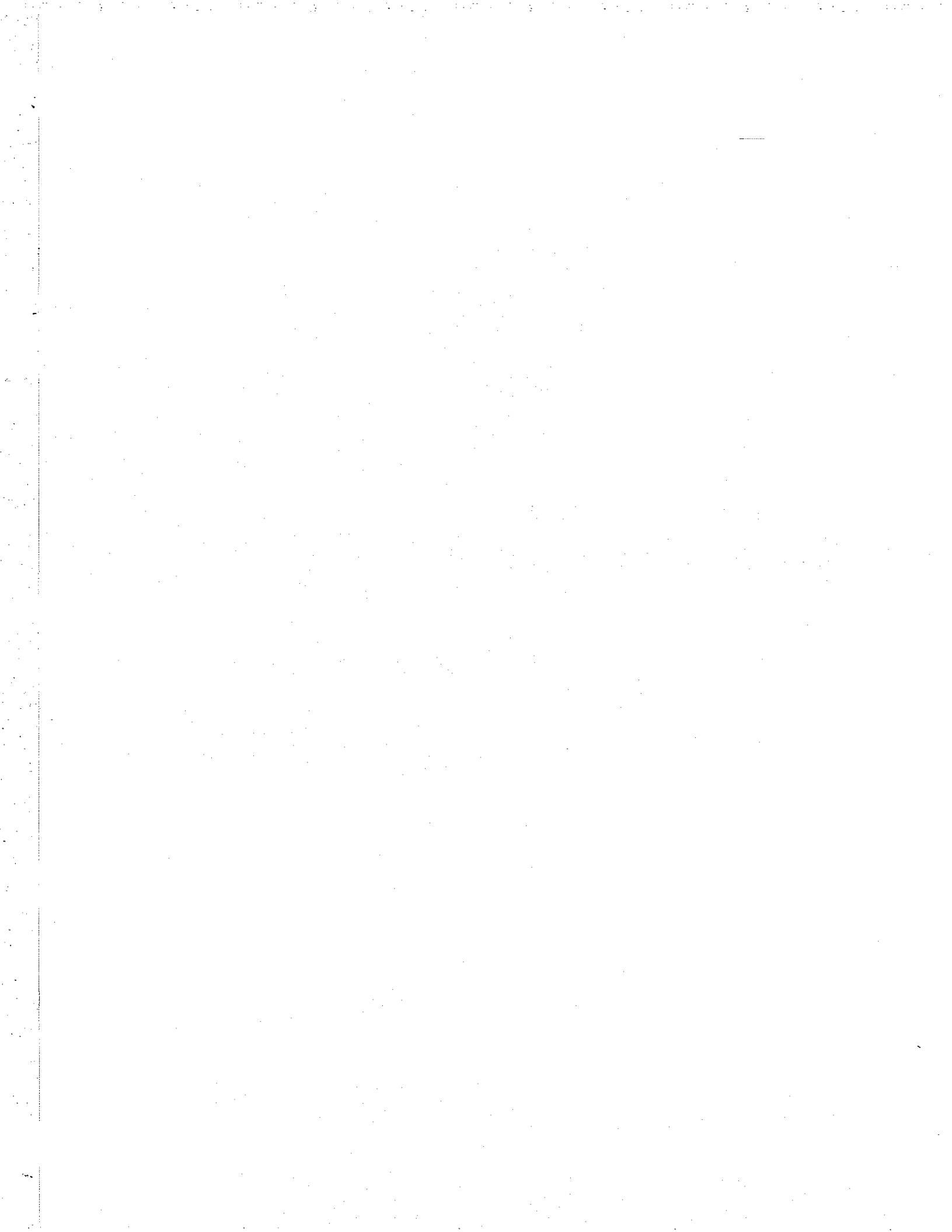


REPORT
and
RECOMMENDATIONS
of the
STATE OF NEW JERSEY
COMMISSION OF INVESTIGATION
on
IMPAIRED and INCOMPETENT
PHYSICIANS





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COMMISSION OF INVESTIGATION

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October, 1987

TO: The Governor and the Members of the Senate and the General Assembly of the State of New Jersey

The New Jersey State Commission of Investigation submits its Report and Recommendations on Impaired and Incompetent Physicians pursuant to *N.J.S.A. 52:9M-10*. The investigation was conducted under *N.J.S.A. 52:9M-2*, which authorizes the Commission to investigate the faithful execution of the laws of the State, the conduct of public officials and any matter concerning the public safety.

Respectfully submitted,

Henry S. Patterson, II, Chairman

James R. Zazzali

Barry H. Evenchick

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REPORT AND RECOMMENDATIONS OF THE NEW JERSEY STATE COMMISSION OF INVESTIGATION (SCI) ON IMPAIRED AND INCOMPETENT PHYSICIANS

Introduction

The State Commission of Investigation emphasizes at the outset the fact that an overwhelming majority of New Jersey's 28,766 licensed physicians are honorable, competent and caring professionals. The SCI also acknowledges that New Jersey's medical licensing agency, the State Board of Medical Examiners (BME), has a national reputation as one of the toughest disciplinarians of deficient physicians. Moreover, the Medical Society of New Jersey (MSNJ) has led the nation in the development of programs for impaired physicians. In fairness, the Commission notes these facts at once because it hopes that this report's findings and recommendations will lead to constructive reforms without unduly alarming a public that is—as noted—well-served by most practitioners.

That said, there are nonetheless problems with incompetent and impaired physicians in New Jersey, as well as in the United States as a whole. This report is intended to focus on the systemic problems of medical incompetency, to identify rather than quantify them and to propose effective corrections of them. Indeed, no one knows precisely how many physicians are problem physicians because of a lack of reliable data—but no one also would question the ominous threat to patients that such doctors pose wherever they are practicing. It has been variously estimated that between 3 and 16 percent are impaired—that is, unable to properly or safely practice medicine because of alcoholism, other drug abuse, mental illness, senility or a disabling physical condition.

A Dangerous Minority

Drug Abuse Dominant

As this inquiry's focus suggests, the relatively small percentage of physicians who are impaired constitutes a potentially lethal minority. And, according to the SCI's findings, the impairment problem most threatening to the public is chemical abuse.

Leading medical journals have estimated that as many as 10 percent are incompetent—that is, lacking sufficient knowledge, skills or judgment to adequately practice medicine.

It is important to emphasize that impaired and incompetent persons exist in other professions and occupations. This investigation has concentrated on the medical profession because its successes and failings have a more direct and immediate effect on the public than other professions.

The Commission discovered at the outset that, despite its deficiencies, the existing system for coping with incompetent and impaired physicians is more advanced than the programs governing other health care professionals in New Jersey. The SCI urges, therefore, that this report be utilized as a guide for improved procedures in the regulation of all health care practitioners. Wherever possible, recommendations in this report that are applicable to physicians and surgeons should also be adopted for such other health care licensees as medical residents, clinical interns, podiatrists, chiropractors, midwives, nurse midwives, hearing aid dispensers, acupuncturists, dentists, ophthalmic dispensers and technicians, nurses, optometrists, orthoptists, pharmacists, physical therapists, psychologists and radiologic technicians. Indeed, such an approach would comport with the Legislature's stated policy, embodied in *N.J.S.A. 45:1-1 et seq.*, of encouraging uniform investigative, enforcement and disciplinary powers and procedures.

Foreboding this view were the results of a 1984-85 survey reported by the *New England Journal of Medicine* in September, 1986, in an article entitled "Psychoactive Drug Use Among Practicing Physicians and Medical Students." This report of a random sampling of 500 doctors and

504 students revealed that 59 percent of the responding doctors and 78 percent of the responding students had used, or misused, drugs at some point. In these two groups, 10 percent of the physicians admitted they were currently using drugs at least once a month, and 3.3 percent had chemical dependence histories, while 5.2 percent of the students had been or were chemically dependent. The medical student responses in particular led the authors of the article to conclude that "perhaps for the first time, appreciable although small proportions of persons entering medicine have histories of extensive drug use and dependence." Overall, the report concluded, the study demonstrated a need for more concern than presently exists about the risk of drug misuse in the medical profession.

Dr. David I. Canavan, medical director of the Impaired Physicians Program (IPP) of the Medical Society of New Jersey (MSNJ), testified before the SCI that physicians were at no greater risk of impairment than the general populace—except for drug abuse.

He estimated the impairment rate among physicians at 16 percent, as against 15 percent for the general population. He said a breakdown of impaired physicians would indicate that 10 percent were alcoholics, 3 percent were otherwise chemically dependent and 1 percent each were psychotic, mentally ill or physically disabled. He enlarged on the problem of drug abuse during questioning by SCI Commissioner James R. Zazzali:

COMMISSIONER ZAZZALI: As to chemical dependency, is it fair to say that chemical dependency among physicians is substantially higher than in the population as a whole?

A. I would say it's higher. I have trouble with "substantially" higher. Let's say 2 percent of the general population is abusing drugs, and let's say physicians [are] 3 percent; that's 50 percent more . . . I think the reality is that it's probably maybe 50 percent or maybe 100 percent more prevalent in the health professionals than it is in the general population.

Canavan said his estimates represented the extremes of available figures, were based on a liberal definition of what constitutes impairment and were intended to encourage early recognition of problems. Whatever the actual figures, the Commission believes that the incidence of impair-

ments among physicians is at least as great as among the general population. However, because of the direct relationship between doctors' work and patients' lives and well-being, the Commission regards as extremely alarming the prospect that so many physicians may be impaired to some degree.

The Commission's review of numerous case histories of chemically dependent physicians revealed particularly significant health risks for both doctors and patients. (Chemical dependence is a primary disease characterized by the compulsive use of mood-altering drugs, including alcohol). Chemically dependent physicians interacted poorly with patients and, of course, neglected them when under the influence. Mental clouding destroyed the professional judgment of such doctors, who often overdosed, incurred frequent job changes, suffered accidents due to intoxication, developed hepatitis and other diseases and sometimes committed suicide. Moreover, those doctors who sought to reverse the plunge in careers and personal lives faced a long and difficult challenge. In too many cases, according to available records, they relapsed. If they abused several substances, persistent use of one generally prevented full recovery. Continued close supervision and long term aftercare for at least several years appeared necessary in many cases. Total recovery generally resulted only after long periods of inpatient treatment.

The SCI's review of case histories of medical impairments at the BME and IPP revealed a deleterious impact on unsuspecting patients that can only be described as shocking. Although the BME and the medical profession have attempted to more adequately recognize and deal with the dilemma, the Commission's probe revealed that far more drastic reforms must be imposed in order to protect patients from physicians whose impairments have not been officially identified, and who thus continue in unrestricted practice as a public menace.

Incompetency and Malpractice

Incompetence and its byproduct negligence are specifically cited in the statutory definitions of the evidence upon which a medical malpractice case can be based or a disciplinary action can be taken against a medical licensee. It can be assumed, therefore, that any review of medical malpractice cases will in all likelihood reflect incompetence in

some form, if not alone then as the result of an impairment or as the cause of neglect, or both. That medical incompetency in whatever form has drastically increased in New Jersey was indicated by a report of a special committee of the State Supreme Court in early 1983. This report showed that, although malpractice cases involving physician defendants at the time represented little more than 1 percent of all cases filed in Superior Court's Law Division, that amount represented a growth rate about 12 percent greater than the growth rate for all other types of law suits. Between 1983 and 1986, about 4,800 malpractice suits against physicians were filed. The SCI conducted a review of these cases at the Administrative Office of the Courts. Although perhaps 20 percent of the cases resulted in settlements or judgments in favor of patients, relatively few of the doctors involved were subjected to any kind of BME discipline for any reason, much less for incompetency. Indeed, a 1985 report by a New Jersey Insurance Department task force showed that of 322 BME disciplinary actions between 1980 and 1984, only seven dealt with any form of incompetence.

The SCI's review of the files at medical malprac-

Data Sharing Too Restrictive

The BME's methods of identifying physician impairment and incompetency are inadequate, a deficiency for which the Board alone cannot be blamed. The sources from which complaints and other data should emanate, to provide a base for the BME's actions, are a hodgepodge that can be variously characterized as unreliable, covert, dissembling and even hostile. Paradoxically, these sources include health care professionals, hospitals and insurers which themselves supposedly require a more cooperative sharing of information vital to the public health and welfare. Other important actual and potential sources of information about impaired or incompetent doctors include other doctors, law enforcement agencies, concerned patients, licensing authorities in other states, various systems of peer review and quality assurance, medical societies, lawyers, the New Jersey Department of Health and the judiciary. Unfortunately, the BME has not kept statistics concerning sources of complaints. It was, therefore, impossible to assess their relative value as data accumulators or producers. It was abundantly clear to the SCI that most of the sources

tice insurance companies and at New Jersey Superior Court revealed startling evidence of physician incompetency that has never been subjected to inquiry by the BME. Since many of the examples cited in this report have not been exposed to any official or public scrutiny under the existing system of restricted disclosure and investigation, the doctors involved will be referred to anonymously. The SCI is, meanwhile, in the process of determining whether there are any legitimate objections to disclosure of identities and underlying information to the BME under the present system. The Commission urges the attorney general to seek such disclosures, in court if necessary, on behalf of the BME.

It should be emphasized here that the SCI's recommended reforms would improve the regulatory and disciplinary authority and capabilities of the BME and give it and its investigative arm access to whatever information is necessary to effectively deal with impairment and incompetency. The recommendations would, of course, sharply increase the responsibility of the health care community as a whole for coping with these problems.

have provided far less information than they are capable of providing, and should provide, in the public interest.

It was not surprising, therefore, to find that strikingly few BME actions originate as a result of referrals by medical societies, peer review systems, hospitals or other health care facilities, physicians and malpractice insurers.

Mandatory Reporting Ineffective

A particularly significant reason for the dearth of problem referrals to the BME is the weakness of the laws that are supposed to mandate such reporting. It must have been obvious to the lawmakers that society's interest in protecting individual life and health justifies compelling members of the health care community to live up to their moral responsibility to report situations which pose a risk to patients. Yet this legislative intent has never been fulfilled.

What laws exist are not only too limited in range—affecting only malpractice insurers and health care facilities—but, in the case of hospitals,

rife with loopholes that permit them to avoid compliance with little or no risk of punishment. The results of hospital disciplinary proceedings were clouded by subterfuge as administrators and medical staffs contrived to control problem cases within a hospital or professional medical setting. In the case of insurance company reporting, the SCI found that the law permits them to withhold information directly indicating incompetency—in an excessive concern for liability—by focusing attention on rote reporting of voluminous, untimely and often meaningless paid claims. Overall, non-compliance with so-called statutory reporting mandates represents a truly dangerous threat to public safety. Not only must such laws be drastically strengthened but also they must be expanded to impose foolproof mandatory reporting requirements on physicians themselves and other licensed health care individuals.

Voluntary Official Reporting Fails

Despite the development of strong statutory and judicial disclosure protections, physicians and other medical professionals have demonstrated a pervasive reluctance to voluntarily report incidents of incompetency and impairment to the BME. This failure to promote a voluntary reporting system among medical peers has been, in the Commission's view, a primary reason why a number of incompetent or impaired doctors has been able to continue life-threatening medical practice from hospital to hospital and from state to state.

Ironically, the initial effort to encourage voluntary reporting followed a formal recommendation in 1981 by SCI Commissioner Zazzali, then attorney general, that legislation be enacted to require all health care professionals to report impaired and incompetent physicians to the BME. The Legislature rejected that proposal but did pass a law, *N.J.S.A. 45:9-19.1*, to encourage voluntary reporting, effective in 1983. This law exempted from liability any person who, in good faith and without malice, provided information to the BME involving physician misconduct. The law was designed to complement another law, *N.J.S.A. 2A:47A-1*, which provides that anyone "who falsely and maliciously and without probable cause makes a complaint . . . of unprofessional conduct against a member of any [licensed] profession . . . shall be liable" for exemplary or punitive damages.

New Jersey's judiciary has demonstrated its strong support for voluntary disclosure by health care professionals who are concerned about the conduct of colleagues. A New Jersey Supreme Court decision in 1986 held that a professional seeking disclosure of the identity of a person who complains about his conduct to a licensing board must first be able to show that the complaint was maliciously filed and without probable cause, that the investigation ended in his favor and that he was harmed by the complaint. *Grodjesk v. Faghani*, 104 N.J. 89, 102 (1986). Again, in March, 1987, the justices unanimously held that reports to supervisors of wrongdoing by workers at state institutions enjoy a conditional or qualified privilege against defamation suits. *Fees v. Trow*, 105 N.J. 330, 339 (1987). So long as the reports are made to someone with a "corresponding interest" in the information (such as another member of a health care team) and are not "motivated 'primarily' or 'chiefly' by ill will," as determined "essentially on notions of practicality and common sense," the Supreme Court appeared to encourage trial courts to grant summary judgments in defamation suits in favor of reporting defendants.

Further reinforcement of the statutory shield for physicians who disclose apparent misconduct by colleagues came in January, 1987, from the Appellate Division of Superior Court in *Bainhauer v. Manoukian*, 215 N.J. Super. 9 (App. Div. 1987). The appellate panel on this occasion held that a "special interest" privilege protects physicians against defamation actions for expressing to appropriate officials sincere concerns about a colleague's abilities. The Court described the rationale for its ruling:

Each physician within a hospital community has a significant and obvious interest in the professional qualification, skill and competence of every other health-care professional rendering services within that community and particularly those with whom he or she works directly. The welfare of patients, the reputation of the hospital, the physician's own ability properly to treat and protect patients, and the physician's own professional reputation are all implicated. Moreover, the public relies on the professional judgments of the hospital community to assure it of the professional skill, qualification, and competence of the medical staff it provides and to take whatever steps are appropriate to that end. . . .

It is therefore not only the physician's self-interest but also the public's interest which demands that hospital staff physicians be free to express themselves openly and without fear of reprisal when matters directly affecting the quality of health care are involved.

Indeed, we regard such expression as, at the least, a moral duty of each physician. In any event, we have no doubt that an individual physician's significant interest in his own reputation produces a lesser weight on the balance scale than the aggregate of the public and private interests served by encouraging physicians to speak out when, in their professional judgment, a colleague's skill and qualification are questionable. (215 *N.J. Super.* at 37-38).

Despite state law and the supportive judicial opinions cited above, voluntary reporting by physicians about other physicians' professional behavior has seldom occurred, according to the Commission's inquiry. One witness said such reporting was "almost nonexistent" and he and others explained why with candor. For example, BME Executive Director Charles A. Janousek testified under questioning by SCI Deputy Director Robert J. Clark:

Q. I take it that you have concluded that the level of voluntary reporting by peers is not adequate?

A. I'd say also almost nonexistent. Being with the Board for ten years and seeing a possible increase in the level of information that the Board receives about impairment still does not in any way equate to that 10 to 15 percent of impaired practitioners that's out there. There's got to be a lot more that the Board doesn't know about and someone knows about.

Q. Do you think the [concern about] legal repercussions is merely a red herring, . . . in other words, is that the real concern?

A. Just from being around for ten years, I just think there's a lot of people out there that know that physicians are impaired and choose to ignore it for whatever reason.

Dr. Floyd J. Donahue, a BME member, elaborated on Janousek's testimony:

The biggest problem in reporting incompetence is brotherly love amongst the physicians. Three or four years ago, without naming names, a very prominent physician in the State of New Jersey was thought to be doing unindicated surgery. . . . [It] was judged by his hospital staff that this was a fact. They were unable to discipline him and it took the outside . . . peer review group to turn him in to the [BME]. It took close to five years to get a [disposition] by the Board to declare this very prominent physician to be incompetent. So it's hard for doctors to turn in other doctors because medicine is not a perfect system; it's an art. So for me to call another doctor incompetent is very difficult.

A similar theme was sounded by Dr. Michael B. Grossman, vice president and former secretary of the BME:

I don't think doctors fail to report [impaired physicians] because of the liability issue. I think they fail to report them because of collegiality. . . .

The voluntary reporting dilemma thus confronting the medical profession has other ramifications. In the absence of a statute prohibiting disclosure, physicians have a legal and a moral obligation—based on liability case law, professional self-interest and ethics—to report to appropriate authorities that a patient poses a threat to public health or safety. In such cases, including those in which a colleague is the patient, health care professionals are required to set aside their usual obligation to keep medical information about patients confidential. For example, the American Medical Association (AMA) Council on Ethical and Judicial Affairs has stated, "The obligation to safeguard patient confidence is subject to certain exceptions, which are ethically and legally justified because of overriding social considerations." Certainly, doctors who know about a patient problem that could lead to injury of an innocent third party could be held civilly liable for resulting harm if they did not tell authorities.

Paradoxically, a form of health care reporting that would be appropriate is officially discouraged. A federal statute prohibits alcohol and drug abuse programs that receive federal money from revealing the names or other information about participants without a court order, even confidentially to authorities charged with preserving the public safety. The SCI urges that this stat-

ute be amended so that when public health and safety are involved, timely disclosures can be permitted and even mandated in the case of health care professionals participating in such programs.

The SCI has concluded that statutory and case law protections, as well as moral obligations, have failed to inspire physicians to report to state officials the transgressions of their colleagues. Lack of aggressive enforcement of the weak statutory reporting requirements that do exist, as well as a tendency to look the other way—to assume that compliance is occurring despite evidence to the contrary—are other basic deficiencies. For instance, although Dr. Edward W. Luka, immediate past president of the BME, somewhat hesitantly endorsed mandatory reporting, his testimony at the SCI indicated an unwarranted willingness to assume that reporting laws were being obeyed. Under questioning by Counsel Clark and SCI Commissioner Paul Alongi, Luka gave these views:

Impaired Physicians Program

Development and Structure

The SCI has found that the medical profession is far less reluctant to report wayward colleagues to state or county medical societies than to the BME with its statutory powers to revoke or suspend licenses as well as to issue them. The societies, which are organizations that doctors may join if they choose, have no licensing authority. Their strongest sanction is expulsion, which has no legal or practical effect on a physician's practice. Since they serve as guardians of the medical profession's traditional privileges, they provide a repository for complaints that, while praiseworthy, is more self-protective than public health and safety warrants.

In recent years the amount of information about impaired physicians coming to the attention of the Medical Society of New Jersey (MSNJ) has multiplied dramatically while the flow of such information to the BME has remained negligible. This larger role for the MSNJ resulted from the development of its Impaired Physicians Program (IPP). Primarily because of this project the MSNJ has won national recognition for attempting to deal with the problem of impaired physicians (despite operational and policy deficiencies which will be reviewed later).

Q. *Given those circumstances, the Board having [sufficient] resources and processes, would it be appropriate that there be a mandatory reporting law for health care professionals?*

A. I would have to study that, but I think, yes, in general, I would agree with that principle.

Q. *Are you satisfied right now that there is adequate reporting of physicians that pose a threat to patients by health care professionals and by hospitals?*

A. Well, the hospitals, we have to assume that they are fulfilling their legal obligation [under their separate reporting statute]. I think that—I have no experience to tell me otherwise right now.

COMMISSIONER ALONGI: Is there anyone checking to see that the hospitals are following their legal obligations?

A. Not that I know of, sir.

With the official support of its national organization, the MSNJ began to develop its state program in 1977. By 1979, when it became operational, an Impaired Physicians Committee (IPC) of volunteer physicians was at work in three regions. By late 1982 this committee with its part time supervision had been replaced by the expanded IPP Program, which the IPC serves in an influential advisory capacity.

Dr. Canavan, a physician with nearly 30 years of experience in the field of chemical dependency, was hired by MSNJ as the full time, salaried medical director of the IPP in September, 1982. The first in the country to become a full time IPP director, Canavan had been a volunteer with the IPC during its first three years. In addition to Canavan, the IPP employs a full time assistant director, Rev. Edward G. Reading.

From the outset the program has been open to any medical doctor, whether or not he joined the MSNJ. In addition, the IPP serves osteopathic physicians, medical residents and medical students, as well as family members of clients. An occasional referral to the IPP is also made by the Veterinary Medical Society.

The IPP identifies, confronts and refers for treatment physicians impaired by alcoholism, drug abuse, mental illness, senility or disabling injury or disease. A rehabilitative, non-punitive program, it is served by a network of volunteer physicians, IPC members, support organizations, treatment facilities and testing centers.

Are Patients at Risk?

IPP clients who are deemed to have their impairments under control are allowed to practice—sometimes with restrictions—while their progress is monitored. Patients, who in virtually all cases are unaware of their physicians' impairment histories, unwittingly face a risk that these impairments will manifest themselves during treatment. Canavan testified at the SCI about whether the program imperils patients:

- Q. *Is it fair to ask a patient to bear the risk, no matter how remote, that a physician taking care of that patient will have a relapse?*
- A. What you're saying, in a sense, is that if any doctor has ever abused alcohol or drugs he should not be allowed to practice medicine again because there is no way a doctor can go back to practice without patients bearing the risk that the doctor may have a relapse. That's a reality you have to deal with. I think that's an injustice to all concerned, that there is no other way to do it except to ask patients to bear that risk, and I think with a carefully documented program of recovery in place, the risk is minimal.

See, part of the problem is that we talk about the risk among those physicians who have been identified. What we overlook is the tremendous risk that exists to the public among the physicians who have not been identified. I like to say when I'm going back to get a doctor back on the hospital staff, "The devil you know is not the guy you have to worry about, it's the devil you don't know. This is the guy whose problem is known to you now. You can set up safeguards, you can set up restrictions, you can set up monitoring and supervision which give you fairly good assurance that this guy is going to be safe to practice. You have got a significant part of your staff here who is currently in trouble that you don't know about, that are a much greater risk to your patients."

There are failures. We don't succeed with all of our cases. There are guys who, despite our efforts, don't get well. We have a limited staff and a lot of clients, and part of the problem is that when you have a lot of people to follow, it makes it a little bit more difficult to do the initial confrontations, and when you're involved in a lot of confrontations it's hard to stay on top of the people you're following. So there are shortcomings, but I have to say that with all its failures and shortcomings, we are still light years ahead of where we were five years ago.

As in the past, at least half of the 13 members of the IPC, the program's advisory group, are physicians with at least two years of continuing recovery from alcohol or drug abuse. Canavan explained how such recovering committee members have helped the program:

Those people tend to be ideal committee members because they are much more knowledgeable and understanding about the disease and they are not deceived by the denial of the client. They recognize that these guys are caught up in their own denial. It takes a lot of time to do this.

The IPP's annual budget is approximately \$250,000. All but a third of its funding is provided by New Jersey's two major medical malpractice insurers, the Medical Inter-Insurance Exchange and the Princeton Insurance Company. The balance comes from the MSNJ, the New Jersey Society of Osteopathic Physicians and Surgeons and the New Jersey Veterinary Society.

Program participation is free except for urine testing fees and the cost of inpatient care or detoxification. In most cases these costs are covered by individual health insurance policies. (Health service corporations in New Jersey are required by law to provide coverage for the treatment of alcoholism). A Treatment Loan Fund—financed by pharmaceutical companies, other benefactors and an annual raffle—makes loans at 3 percent interest to assist participants with family expenses, malpractice insurance premiums and other costs not covered by health insurance. There is no government funding.

IPP's Investigative Incapacity

Contrary to a formal report to the BME on July 8, 1981, that the program had enlisted more than 100 clients in the previous year and a half,

Canavan told the SCI that only 21 doctors had participated. He recalled that a lot of statements were made during the first months of the program "that were not based on reality" and that as an original activist, "I would challenge those numbers." A more reliable accounting, however, during Canavan's tenure as director—from September 9, 1982 through September 7, 1987—showed that the IPP had 383 clients, including seven veterinarians. Reviewing program records, the SCI counted an additional 35 files, including some for individuals designated by the IPP as "not impaired" or "inadequate documentation."

The review of the IPP case files produced evidence that the IPP has never had the ability to thoroughly investigate many potential patient-threatening problems that have been brought to its attention. Not counted in either the SCI's or the IPP's tabulations were some 40 physicians who were identified in a so-called "prospective clients" folder as having been the target of one or another allegation of impairment or incompetence. This folder consisted primarily of numerous slips of paper with cryptic notations, dating from the present time back to the days when the IPP was a part time endeavor. The allegations concerning the 40 physicians were recorded on brief phone messages and handwritten notes without written indication of IPP inquiries, if any. The complaints included drunkenness, overprescribing to a drug addict, poor judgment and performance, psychiatric problems, drug abuse, sexual involvement with patients, indiscriminate prescribing, discontinuance of insurance coverage because of adverse claims experience, senility and misdiagnosis.

Most Clients Are Coerced Into the IPP

The IPP has always regarded confidentiality as its cornerstone. This policy is understandable where it is realistically believed that a physician volunteers for rehabilitation that he would not otherwise have sought except for the promise of confidentiality. However, the Commission has determined that only a small number of such physicians approached the IPP without outside pressure. Indeed, the policy has served to shield from detection those who have failed their legal or moral obligations to report physicians to the BME. The vast majority of clients entered the program because of external pressures from hospitals, colleagues, patients, law enforcement authorities or

other health care professionals, as Canavan testified:

Its been found that very few people go into treatment programs willingly. There has to be some sort of coercion, and so the coercion is the leverage used to coerce people to go into treatment. Now, the good news of that is that the experience over the years has shown that enforced treatment is just as effective as voluntary treatment, but it has a very decided advantage in the sense that you can get enforced treatment much earlier in the disease than voluntary treatment.

Admittedly, those who become IPP clients are warned by the IPP that failure to abide by the conditions imposed by the program will result in a referral to the BME. Physicians entering the IPP are sometimes required to sign a contract that they understand they will be reported to the BME if they break its terms. Others confronted by IPP officials at the request of third parties may be referred to the BME if their impairment is confirmed and they refuse to enter the IPP. However, an IPP referral to the BME must first survive a bureaucratic obstacle course. If the IPP's medical director decides that a client should be referred to the BME, he makes a recommendation to an executive subcommittee of the IPC. If this subcommittee affirms the recommendation, it is reviewed by the Board of Trustees of the MSNJ. No referral occurs unless the Board of Trustees concurs.

A brief memorandum, dated November 1, 1982—prior to the effective date of the reporting laws in 1983—summarizes in ambiguous terms the present working relationship between the BME and the IPP. The memorandum allows the IPP to "intervene, treat and rehabilitate impaired physicians *in confidence*, as long as the welfare of the public is not in real jeopardy." The memorandum continues, "As soon as it is apparent that there is real jeopardy to the public welfare, [a] physician should be reported to the [BME] for appropriate action." The ambiguities in this document suggest that the BME was willing to waive its responsibility to determine itself what constitutes medical jeopardy to the public.

Regardless of the reporting obligations of the IPP, many of the sources of referrals to the IPP have obvious legal or moral obligations to report suspected impairments to the BME. Their decision to report exclusively to the IPP not only

represents a flagrant violation of the law in certain instances, but also ignores their duty to give the BME an opportunity to officially decide whether any threat to patient care exists.

The IPP's statistics obscure the fact that major sources of referrals have independent obligations to report to the BME. A September, 1986, comparison of SCI and IPP breakdowns of referral sources for IPP participants—based on each organization's own count and categorization of the same group of files—is revealing. As demonstrated by the chart below, IPP statistics lump referrals from doctors, other professional colleagues and hospitals into a single category, "Colleagues/Hospitals". This obscures the fact that a substantial number of referrals—73 by the SCI's reckoning—came from hospitals, which have a statutory obligation to report physician disciplinary actions to the BME.

	SCI	IPP	
Hospitals	73	—	
Doctors	65	—	Colleagues/ Hospitals
Other Prof. Colleagues	17		
	<u>155</u>	171	
Family/Friends	47	40	
Self Referral	41	61	
All Other Referrals	130	66	
	<u>373</u>	<u>338</u>	

The confidentiality which the IPP promises thus serves only to exacerbate the failure of these hospitals to live up to their statutory reporting mandate. Current IPP statistics do not even list a category for hospitals.

BME's Waiver of Authority

Both the BME and the IPP belatedly concede that the ambiguous 1982 working relationship memorandum should be revised to reflect the impact of the 1983 reporting laws, particularly with respect to misdirected hospital referrals. The 1982 protocols also require clarification to prevent further misuse of the confidentiality policy by IPP to obscure its obligation to inform the BME of potentially life-threatening problems that come to its attention. Former BME President Luka testified that "the relationship between the [BME] and the [IPP] is a very loose relationship." He revealed that in mid-January, 1987, the Board had asked its executive committee to draft a new and more comprehensive agreement with the IPP. Luka said

that Canavan's program "has had a lot of leeway in making certain judgments. I think some of those judgments should be made by the Board" rather than by the IPP. Luka also testified during his appearance at the SCI:

COMMISSIONER ALONGI: Do you see some area of compromise [regarding mandated reporting of incompetency or impairment by the IPP]?

A. Yes, and I think we are looking into that.

COMMISSIONER ALONGI: What is it you're specifically looking into?

A. We want to try to establish [with the IPP] what we consider are criteria for jeopardy. There [are now] no criteria. They decide whether the doctor is jeopardizing the patients. We don't have established criteria for what that means. We would like to try to establish some criteria, some actual measurement of criteria that would say that if this guy does this, even though he is under [the IPP], we want to know about it, but we haven't established those criteria.

COMMISSIONER ALONGI: Is there going to be in your discussions anything regarding time for reporting?

A. Yes.

COMMISSIONER ALONGI: Because it appears from the examples we have heard so far that [the IPP is] allowed to linger over a large period of time without anything really being done.

A. Yes. Again, it's a matter of what their attitude is on when the public is in jeopardy, and I think it's very important. Time is a factor here, a very important factor.

The BME's Grossman testified about other deficiencies in the BME-IPP relationship as a result of the BME's abdication of authority in the 1982 memo:

... I have worked fairly closely with the [IPP], [and] I think as a Board we are entitled to know the magnitude of the problem, and I don't think we do because of the [IPP's] lack of need to report to us what is going on. I would like to see the IPP report to us all of the physicians that they have in their program in an anonymous fashion. I don't want to know the county he practices in, I don't want to know his name, I don't want to know his

address, I don't want to know his initials, I just want to know that we have 10 obstetricians, 14 anesthesiologists and the ENT guys all in rehab going to AA, going to Narcotics Anonymous, and we are having this many urines generated by this many doctors, that's all I want to know. I don't need more than that, and I want to see where the problem is going and I don't have that now. And I want an interface with the [IPP] so that if [the IPP] say[s] to me "one of our docs had a positive urine but we think it's a lab error, we are going to hang onto him for another three months and keep an eye on him," that's fine to me, but I would like to know that. I feel we have responsibility [as] the Board, and we abdicated a bit too much to the [IPP]. I don't want it all back, but I want to hear what is going on.

Grossman elaborated on his views as to an appropriate relationship between the BME and the IPP:

Q. *You believe that the [BME] should not know the name of every physician in the [IPP]?*

A. I don't think the program can work if we do.

Q. *Would that be because it would discourage referrals?*

A. Dramatically.

Q. *Why do you say dramatically?*

A. Because I don't think physicians or families who are going to take their impaired physician colleague or family member to the [IPP] will have the confidence in our ability to stay out of it if we know the name of the person.

Q. *Is the IPP regarded as an official substitute for the [BME]; that is, is there a feeling in the medical community that if you report something to the IPP, you need not report it to the [BME]?*

A. I suspect there is that feeling, yes.

Q. *Why do you suspect that?*

A. Because I see it happening.

Public Safety Is Not IPP's Top Priority

The IPP has failed, on occasion, to properly balance the need to ensure the public's safety with

its desire to restore the careers of impaired physicians.

The Commission found several instances in which the IPP failed to adequately investigate information concerning questionable activities by potentially impaired physicians. Sometimes when the IPP did make inquiries, it allowed too much time to elapse before tracking down additional information. It also failed to contact people with detailed, firsthand evidential knowledge. It would often wait excessive periods, for example, for "additional documentation" to arrive that would indicate whether threats to patients were actual, potential or nonexistent.

In one case still listed as an "open file," a county medical society reported to the IPP that the office assistant of an allegedly senile specialist in internal medicine, #01 (throughout this report physicians in the IPP will be referred to by numbers), became concerned about her liability for the physician's treatment of patients. Canavan's August 9, 1985, note in the file states, "Main concern was absence of sterile technique and reuse of needles on more than one patient without sterilization." Canavan confirmed that the IPP's inquiries about #01 did not extend beyond a couple of physicians who supposedly had information. The office assistant, a key witness, was not contacted and no inspection or review of #01's practice was conducted. Canavan testified:

The only thing we had was the one allegation from the nurse. At that particular point in time we felt we had inadequate information to move on it, and it's really what I would consider an open file. . . . I did not confront that physician. I made an effort, a diligent effort, to speak to the two physicians [indicated by the county medical society to have precise information] and neither one felt that they had any evidence that this guy was impaired.

Well certainly it would help us in these situations if we had the ability to investigate these more thoroughly and document some of the evidence. I think part of our problem is because of the constraints of time that when we have something like this where the information is marginal, that it doesn't take priority over the more acute problems that we deal with.

Brain Surgery Had To Be Corrected

In another case, #02, a neurosurgeon, was referred to the IPP by a physician concerned about his colleague's excessive drinking. After a meeting with Canavan on June 30, 1983, #02 began attending support group meetings but stopped attending the meetings in September. The IPP received a report on October 1, 1983, that another surgeon had to substitute for #02 to perform an operation because administrators at the hospital were concerned about #02's ability to do the case.

On December 16, 1983, the husband of one of this same physician's patients inquired why brain surgery performed on his wife had to be redone. The husband, whose business brought him into close contact with hospital personnel, reported to the IPP that he had learned that one hospital would not allow #02 to operate because of his alcoholism and inability to attend to his patients. The husband stated that one of his wife's new surgeons at the hospital where #02 does do operations commented to the husband, "I thought there were only six of us that were aware of the problem."

Subsequently the doctor insisted to the IPP's Canavan that he had his drinking under control and refused to resume attending support group meetings. Canavan at one point made a note that certainly would have terrified any of the doctor's prospective brain surgery patients could they have read it: "Intervene, *if any incident*, with vigorous [treatment] plan." [Emphasis added]. Finally, on September 22, 1986, a physician telephoned Canavan to express concern about #02 "for several reasons":

- 1) Not writing discharge Rx for CDS; 2) Drinking heavily at hospital social functions; 3) Takes residents out to dinner [and] drinks heavily [and] does not eat; 4) Seems "hung over" in A.M. in OR [operating room]; 5) Frequent AOB [alcohol on breath] in A.M. in OR; 6) Recently "totalled" his car—this is the 3rd time he has totalled a car; 7) Currently the [Neurosurgery] Division is reviewing one of his cases.

That was the last entry in the IPP files on #02. Canavan testified about this case at the SCI:

He just absolutely refuses to accept the diagnosis, and we don't have, you know, irrefutable proof. We have lots of reason to suspect that he's having problems with al-

cohol. I don't know that the [BME] is in a position to get better evidence. Maybe they are, I don't know. Certainly it would be nice to be able to have some way of investigating the facts and really documenting them so you could do that. Now, whether they have the power and we, similarly, to do that ourselves or whether leaning on the Board would be the appropriate way, I'm not certain.

Chief Surgeon Had the "Shakes"?

In another example, on September 8, 1983, a physician telephoned to report that hospital personnel had complained that the hospital's chief surgeon, #03, had appeared on occasion with alcohol on his breath and had "the shakes." Canavan on September 16, 1983, met with the hospital's administrative and medical executives. Among the issues discussed was the allegation that #03, who was chairman of the Admission Committee, had appeared drunk during crisis admission situations and was "rarely in the emergency room without alcohol on the breath." It was noted that there were no formal complaints; it was alleged the operating room nursing supervisor "may be protecting him." In addition, it was noted that #03 was extremely well liked and was a "founding father" of the hospital.

The IPP did not discuss the case with potentially knowledgeable nurses or with a physician who had testified about #03's alleged drunkenness during a suit against the hospital for alleged discriminatory termination. Some months later, on June 25, 1984, Canavan received an anonymous call from a person purporting to be a physician on the hospital's staff that #03 "is an active alcoholic who needs to be confronted regarding his disease." However, the hospital's president insisted that #03 had not been a problem and that the assistant administrator for nursing had "no evidence of any deterioration" in the doctor's conduct.

A year later the hospital's president called Canavan to report two incidents. On November 15, 1985, when a trauma case appeared in the emergency room while #03 was on call, a physician noted #03's "flushed face/thick tongue/early staggering which improved over two hours;" allegedly #03's partner nonetheless "approved his ability to operate." The hospital president said he asked #03 not to drink when on duty. In the second incident, on November 19, 1985, #03 alleged-

ly appeared in the emergency room with alcohol on his breath. According to a note in his file, Canavan merely advised the hospital president "to continue documentation of incidents."

IPP Probing Inadequate

The obvious conclusion in the above cases is that, lacking the resources and inclination, the IPP failed to pursue inquiries to necessary limits. Had the allegation that a physician had used unsterile syringes been substantiated, the case would have been of paramount importance to public health and safety. In the other cases, thorough inquiries should have been made of all of the health care professionals with whom targeted physicians came into contact. In these instances, the IPP demonstrated how shockingly ill-equipped and disinclined it was to conduct the kind of aggressive probing necessary to protect the public.

As a private organization, the IPP's access to information available to official sources, such as the BME and Federal Drug Enforcement Administration, is limited. It lacks subpoena power and the authority to conduct inspections. Moreover, the IPP has tended to back away from confrontations when physicians hire attorneys.

IPP Criticizes BME

As partial justification of its reluctance to report even difficult cases to the BME, IPP officials sought to characterize the BME as inadequate. Under questioning by Commissioner Zazzali, IPP Director Canavan elaborated on this issue:

COMMISSIONER ZAZZALI: How often do you think to yourself what am I going to do and did I do the right thing if Doctor X slips with a scalpel and loses a patient three months from now, and had he had his license lifted or suspended maybe that death would have been avoided? I know that's a tough question, but does that occur to you?

A. I worry about it. But there is another side of the coin, and that is that I have been involved in cases where we have reported people to the State Board and no action has taken place for two years, and I can give you a very classic example.

I was involved with a doctor . . . alcoholic. He appeared in the hospital on several occasions with alcohol on his breath. I had been called by the chief of staff that they wanted

action taken, so we went up and confronted this doctor, and he absolutely denied his problem. He refused to cooperate, and I said to the chief of staff you have no choice but to report this case to the State Board.

Now, this is now January, 1987, okay. My initial involvement with this physician was in January of '86. . . .

They did report him to the Board but they did not suspend his privileges [at the hospital]. Late in the summer there was another episode where he again came into the intensive care unit under the influence of alcohol. There were some questions about inappropriate management of a case. Somebody came in and took over the case. The patient was all right, and at that point we reconfronted him and got him to go into treatment on the basis that his staff privileges would be taken away if he did not go. He went into treatment, and he has been home from treatment. He is in follow-up this week, and last Friday I got a letter from the Board asking what I know about this case.

Now, this is a year after he was reported to the Board. So, you know, you can say do I have concerns about maybe three months later that this guy is going to slip with a scalpel, and I'm saying sure, but I know that even when we report him, nothing may happen for a year or two, and I don't know why the bureaucracy of the Board moves so slowly.

COMMISSIONER ZAZZALI: Do you think they are understaffed?

A. I can't answer that question, but I find that . . . we have had occasions that we felt were real problems that we referred to the Board and nothing has happened for several months. That's standard operating procedure.

DEPUTY DIRECTOR CLARK: . . . In light of the fact that the Board has [certain] powers, would it be desirable to enlist them in certain cases of documentation?

A. I think that if there was a way for the Board and the [IPP] to work cooperatively together that there certainly could be real advantages. I think if that working together meant that the State Board had immediate access to every bit of information that we had, that that would

defeat the confidentiality that we have in terms of attracting clients to us. There would have to be a way to work together but at the same time get away from the concept that there is an automatic disciplinary involvement in that action.

Certainly, we could use assistance in documenting who is impaired if we could use it in such a way that we didn't . . . jeopardize our appeal to the physicians that we were indeed a therapeutic alternative to disciplinary action. If it became apparent that we were married to the Board in some way, I think we would have problems in terms of reporting.

"Conspiracy of Silence"

IPP officials have aggressively sought to encourage referrals by talking at medical society and hospital staff meetings and by publishing articles in medical journals. The only problem with this public relations campaign is that it has swept a number of impaired physicians into the IPP who should have been referred to the BME pursuant to statutory and moral reporting requirements for hospitals and doctors.

There is an irresponsible tendency on the part of hospitals and health care professionals to allow the IPP to determine whether official complaints should be made to the BME. The BME is often unfairly regarded as a punitive organization to be avoided by those interested primarily in the rehabilitation of an impaired physician rather than as a partner in the appropriate supervision of such a physician's practice. The IPP's Canavan testified about this situation:

Q. If there were stringent reporting laws requiring that hospitals report, that insurance companies report, that colleagues report physicians and other health care professionals, would not those strict reporting requirements, assuming they were enforced and abided by, identify and bring into some kind of oversight the physicians who might otherwise be voluntary self-referrals?

A. In the ideal world that might happen, in the real world it does not, and the reason is that colleagues in states where those laws exist do not report. They just don't do it. They don't want to put the guy's career in jeopardy by reporting. . . .

Q. Do you believe that there is a so-called conspiracy of silence?

A. Absolutely, absolutely, but the conspiracy of silence isn't so much not reporting people to the disciplinary authorities; the conspiracy of silence is people being afraid to report [to] anybody, even to us. People are afraid to report to us, a therapeutic program, because of a fear of the anger or the hostility, . . . the fear of loss of friendship, fear of suit for libel or slander. There are all sorts of phantom doubts there.

COMMISSIONER ZAZZALI: Who are the conspirators? And I don't mean to throw brickbats.

A. Anybody is a conspirator who knows of a problem. The person having a problem is a conspirator, we call them conspirators; the hospital nurses can be conspirators. Nurses are more liable to report doctors than other doctors are. Colleagues are conspirators when they know a guy has a problem and they cover up for [him]. Anybody who knows somebody is in trouble and knows a guy needs help and is unwilling to report it is a conspirator in that sense.

The SCI discovered a conspicuous example of the conspiracy of silence involving physicians, hospital administrators, a PSRO (professional standards review organization), the IPP and even a member of the BME. The case involved a hospital staff cardiologist, #04. The hospital's chief executive officer testified that the hospital's appeal to retain official designation and funding as a cardiac diagnostic and surgical center was being threatened by a PSRO finding that #04 had performed unwarranted diagnostic surgery.

What the hospital CEO did not know at the time, September, 1983, was that two years earlier #04 had been suspended twice from the hospital staff (his appointment had remained provisional) and he had been warned that he faced automatic dismissal. Despite this admonition, #04 had still been retained on staff after he was reprimanded for an incident in 1981, in which he conducted an unauthorized treadmill test on another doctor's patient knowing that the patient had undergone coronary bypass surgery eight days earlier.

The hospital CEO, testifying further about the case at the SCI, said he had never seen a memorandum, dated May 2, 1983, from the hospi-

tal's chief of cardiology complaining about #04's sexual exhibitionism and warning of "serious disciplinary action." After confronting #04—and receiving denials—about his alleged professional misconduct, including the sexual exhibitionism issue, the CEO conducted his own investigation. He requested two registered nurses and a technician to report on #04's activities in writing. Their reports revealed an appalling litany of sexual indignities inflicted on anesthetized patients and sexual exhibitionism distracting other health care personnel involved in crucial tasks.

The written allegations against #04 included his exposing himself in the cardiac catheterization facility, occasions in which he squeezed bloody gauze over anesthetized patient's genitalia prior to propping up the penis and asking others to look at it, interposing an anesthetized patient's penis under a nurse's hand when she was about to apply pressure to a puncture site in the groin, slapping a patient's genitals to induce a cough, and occasions when his wife could not rouse him to respond to calls from the hospital concerning patient care. Several other incidents prompted concern about possible substance abuse by #04.

Under questioning by SCI Counsel Clark, the CEO described how unusual it had been at his particular hospital for such allegations against a physician to be reduced to writing:

Q. *Was this unusual . . . for a nurse to reduce a complaint like this against a doctor to writing?*

A. Absolutely.

Q. *What makes you say that it was unusual?*

A. [The hospital] did not, prior to my arrival there, have incident reporting. Physicians handled their own business, and ancillary people, including nurses, did not make reports relative to any physician's practice. . . . The nurses and the technician that were involved were frightened to put anything in writing. It was generally frowned upon to put a report like this together.

Q. *Frowned upon by the—*

A. By the medical staff.

Q. *Did any members of the medical staff communicate with you concerning their displeasure at this type of documentation?*

A. Not in the case of [04].

Q. *In other cases have they?*

A. Absolutely.

Q. *What was your position in the face of such criticism?*

A. That documentation of that sort had to be made; you have to practice medicine in the 20th Century; and that if there is a wrongdoing by a doctor, it doesn't mean that there has to be punitive action; that there can be corrective action to make sure it doesn't happen again.

The CEO also testified that he contacted a representative of the BME (he could not recall the identity) and "outlined the details of the problem." He was referred to Canavan at the IPP. The CEO testified that he had been contemplating a temporary suspension of #04 but changed his mind. He described why:

A. The [IPP] program that was introduced to us by Dr. Canavan I think set a different moral tone for the rest of us who wanted to take action against [04]. It appeared to all of us at the time that this would be a first step, that if [04] was what we all thought he was and we gave him enough rope after this, he was only going to take it and hang himself anyway, but we would be less than decent human beings if we didn't accept this first available choice. Dr. Canavan led us to believe that he was authorized to step in in these matters.

Q. *Authorized by the [BME]?*

A. Absolutely. . . .

Q. *What did Dr. Canavan represent to you . . . as the obligation of the [IPP] should [04] not show signs of rehabilitation?*

A. I am left with the impression that he represented that there would be an automatic reporting to the [BME] should this have gone awry.

Q. *Did you feel that in dealing with Dr. Canavan and the [IPP] you were dealing with an officially authorized arm of the [BME]?*

A. Yes.

Q. *Is that what Dr. Canavan represented to you?*

- A. Yes.
- Q. *Is that what he represented in the seminar in describing the role of the [IPP]?*
- A. Yes.
- Q. *Was that in so many words or was that an impression that you gathered from some of the substance of his conversation?*
- A. My memory tells me that it was indicated through years of negotiating with the [BME] that they have recognized the New Jersey Medical Society's need to have an intermediary, and he was that intermediary.
- Q. *At this time, was the medical staff urging you to suspend [04] or were you being urged to find some alternative short of suspension?*
- A. Suspension.
- Q. *So, in effect, Dr. Canavan was persuading the medical staff hierarchy at the hospital as well as yourself?*
- A. That's right. The role of introducing the third party, a therapist, into this equation didn't occur to any of us until David Canavan came along. . . .

"Threatened" With BME Referral

The CEO testified that in a confrontation with #04, Canavan persuaded the physician to sign an agreement to enter a rehabilitation program outlined by the IPP. The CEO described how Canavan persuaded #04 to attend weekly therapeutic sessions "for one full year:"

[Dr. Canavan] did tell [04] in a very threatening way, and I think it was probably the main reason [04] signed the agreement, that if he didn't sign the agreement, that he would clearly have no peace with the [BME]. He threw out three reasons. He said the [BME] doesn't excuse murder, doesn't excuse substance abuse, and they don't excuse sexual misconduct. He said, "And Dr. Albano [the late former president of the BME] will take your license, rip it up and, at a minimum, you won't be allowed to go back down there [to get it back] for five years, and then you will have to come in on bended knee to get this license back." That's practically verbatim.

A memorandum of understanding signed by #04 on January 4, 1984, stipulated that failure to continue in treatment with a mutually agreeable therapist "will be grounds for immediate dismissal from the Medical Staff . . . with appropriate reporting to other medical bodies [BME]." The therapist was to submit monthly reports of "continuing participation in treatment" to the IPP and, through the IPP, to the president of the hospital's medical staff.

From then on, however, #04's "rehabilitation" was marked by confusing misinterpretations of the memorandum of understanding, by differences of opinion between #04 and his designated monitors, by wilful violations by him of subsequent peer review requirements imposed to protect patients, by haphazard filing by the physician's therapist of so-called progress reports that failed to even discuss progress, as well as by inappropriate advice at critical times by Canavan to the hospital.

The hospital CEO testified about his increasing concerns with #04's professional performance. For example:

There were times when he signed out for coverage to a physician that didn't agree to cover for him. There were many times he claimed that we didn't contact him, and generally he would tell that to the patients, and many times he would chart things like that as well.

Moreover, recalled the CEO, there were reports that #04 had prescribed unwarranted medication. In another incident other doctors had cancelled a pre-surgery cardiac catheterization that #04 had scheduled because the patient was so close to death an operation could not have been performed.

By 1985 the hospital, which never received any progress reports, no longer was being notified about #04's actual attendance at the therapy sessions, even though the physician was still in active practice at the institution. The attendance reports ceased because #04 believed he had completed his commitment to a year of therapy. No one who knew of the particulars of the case appeared to know what #04's status as a practitioner was, including Canavan. On March 11, 1985, the latter, according to a copy of the letter in Canavan's files, requested the therapist to submit an "evaluation of the need for continued treatment." Although Canavan pointed out that the

treatment had been arranged "to avoid an embarrassing and possibly disastrous public disciplinary procedure," the therapist merely replied that the treatment contract did not call for such an evaluation but that he would provide it if the client agreed to it. That permission was not forthcoming until December, 1985.

On December 17, 1985, the therapist wrote to the CEO that at the time of #04's final visit on that date, "I could not observe the presence of a psychiatric condition that might jeopardize his professional practice." By then, although there were no further reports of sexual incidents within the hospital, there was no specific determination by the therapist that #04's sexual exhibitionism had ceased. The CEO explained in his SCI testimony that he did not press that issue with the BME because:

We were under the assumption that we made the election to use a therapeutic alternative as introduced to us by the [IPP], and we were under the impression that our rights to take any further action with regard to these specific improprieties were now waived.

Despite the therapist's supportive statement on #04's behalf on December 17, 1985, to the hospital, Canavan's files revealed a copy of a letter Canavan wrote to the CEO on that same date suggesting that the CEO take punitive action against #04:

I think at the present time that it is perfectly appropriate for you, in your role as Chief Executive Officer at [the hospital], to call [04] in to see you and tell him that unless there is a report from his psychiatrist about his suitability to continue in practice that you will have to take action to suspend his privileges pending action of the Medical Board and the Board of Trustees.

During his appearance at the SCI, the CEO said he could not find such a letter in the hospital file. In any event, despite not receiving what he considered to be adequate assurances regarding #04's ability to continue an active hospital practice, the CEO did not report the situation to the BME.

Canavan testified at the SCI that he did not consider it to be his responsibility to report to the BME:

I spoke to the psychiatrist and tried to get him to send reports. He continued to refuse and

at that point the [CEO] said, "What do we do?" And I said, "Tell the doctor if we don't get the reports, we're going to take disciplinary action." He didn't give reports, and that was the end of the case. Now, what I'm saying is that shortly after that, I can't tell you exactly how soon, [the CEO] left that hospital and became the [CEO] at [another], so I lost my contact [as to] what was going on there. But it was my understanding as my role as advisor to the hospital in that case I told them precisely what should be done. We can argue I should report it myself. I didn't feel at the time, given the circumstances, that that was my responsibility.

Evidence of Incompetence Hushed Up

Despite #04's obvious threat to patients, the CEO testified that none of the physicians who were indicating his "inappropriate" conduct ever recommended that the BME be notified. Indeed, the CEO did speak to the BME's Edward Luka on several occasions about the case (Luka was on the CEO's hospital staff and was president of the BME at the time of one of the discussions) but said that Luka insisted that the talks be classified as personal and unofficial:

Q. *What did you understand an unofficial call to be?*

A. It means he was giving me personal advice and it was not a matter of public record.

Q. *And that the [BME] would not learn of the discussion that you had concerning [04]?*

A. That's correct.

The CEO testified that he would have welcomed the BME's scrutiny because he knew at the time the PSRO's and the hospital's peer review of the doctor had become "weak-kneed" and that Dr. Luka's "unofficial" suggestion for an "independent review" of the doctor's cases had also failed because no one would agree to conduct it. At one point in his testimony, the CEO said that Dr. Luka "was made aware of everything."

BME's Luka Tells A Different Story

The BME's Luka testified to a somewhat different recollection of the events concerning #04. He contended he had never been involved in any monitoring of #04, that he had heard about allegations of sexual misconduct from another physician

about a doctor "at one of the hospitals I'm associated with," and that "there was an error in judgment in not letting the BME know about this." Luka, who was BME president at the time of his appearance at the SCI, testified in part:

Q. *And you still don't know his name?*

A. I think I know who it is. I mean, I really—no one ever mentioned his name to me. There are only about four people in that particular hospital who do that work. He is a cardiac surgeon. . . . That case certainly should have been reported to the [BME] very early on once he failed to comply originally [with the therapist reporting requested]. I mean, my information, just from hearing about it in the hospital, was that the doctor denied the accusation. . . . Certainly if it causes an abuse to the patient, it has to be stopped. . . . [A]busing the patient sexually, obviously, is [reason for a doctor to lose his license]. To the best of my knowledge, . . . there was a question whether this was really true or not. The hospital wanted him to be evaluated, and that's all I heard about it, and apparently he is still practicing, so I assume that the evaluation went through and nothing was wrong. I did not know the full extent of that story.

Q. *Do you feel it would be appropriate that the [BME] be given an opportunity to review the psychiatrist's reports?*

A. Absolutely.

Q. *And that would be the appropriate organization to make the determination one way or another?*

A. I think there was an error in judgment in not letting the [BME] know about this when there was no original report from the psychiatrist. . . . I think it's been compounded by the failure of this thing to be carried on to its appropriate investigation. . . .

By early 1986, according to the CEO's testimony, the case of #04 had become so notorious that "he became a household name in the physicians' locker rooms" in two counties, that there was "professional concern that he was still practicing at the hospital," and that he had an "image" that other doctors "did not want to be associated with."

Since so many of #04's colleagues knew about his professional and personality problems and their potential to endanger the health and dignity of patients, it is egregious that to this day the BME, as an official body, has never been made officially aware of the allegations in this case for a thorough investigation.

The case history detailed above was one of dozens of examples available to the SCI of the failure on the part of various components of the medical profession to heed statutory or moral responsibility to report patient-threatening doctors to the BME. However, a review here of one other case should convince any reasonable reader that a drastic reform of the reporting process is essential to sharply reduce, if not eliminate, the horrible risks that impaired or otherwise incompetent physicians confront innocent patients. The following example of a disturbing situation widely known within the medical community—except the BME—concerned an obstetrician-gynecologist, #05.

In June, 1983, a physician who had hired #05 as an associate (and fired him within a year) wrote to the AMA, with copies to the MSNJ and the county medical society:

I now have definitive evidence that [05] is an uncloseted transvestite and a sadomasochist, who has inflicted pain upon my patients in the course of their medical care. I have numerous patients who are willing to sign affidavits to that effect. In addition, I have been in touch with a woman writer who has done a study on his sexual deviancy for a book that she is writing. She has informed me that the individual is a pathological liar and is potentially dangerous to other people. I would like advice as far as what to do next to protect people from him.

The complaining physician also told the IPP that #05 had allegedly refused appropriate medication to patients in labor, thus allowing them to needlessly suffer. Without attempting to substantiate the complainant's information, Canavan wrote to the judicial committee of the county medical society on July 8, 1983:

This case was discussed in detail by the Executive Subcommittee of the [IPP], a Committee which includes two practicing psychiatrists as members. It was the opinion of the Committee members that the issue of

transvestism is not amenable to psychotherapy and that the charges of sadomasochism in these cases needs to be positively substantiated before any action can be taken. If, indeed, these charges are substantiated, then the appropriate forum for the management of this case would be the Judicial Committee of your Society or the [BME].

This matter has yet to be reported to the BME by any of the knowledgeable parties. Thus, there has been no official inquiry by the only agency capable of investigating all aspects of #05's practice and protecting the public should the misconduct be proven.

Official Oversight of Rehabilitation Needed

It seems obvious to the Commission that the BME, with expanded resources including a medical director to expedite priority cases, should be the initial, and only, clearinghouse for all information concerning impaired and incompetent physicians in New Jersey. The system should not tolerate or encourage any hospital, insurance company or health care professional to seek intervention elsewhere—as with the IPP, for example. Even those physicians who are true “self-referrals” (seeking assistance on their own or at the urging of family or friends who do not have an official reporting obligation) should participate in rehabilitation programs under BME oversight but divorced from punitive aspects. The BME should insure that such programs report to the BME those physician-clients who, having initially requested help, fail to abide by its requirements or who, despite completed participation, still pose a threat to their patients.

Only under certain conditions requiring a high rehabilitation priority would Canavan endorse a mandate that physicians report impaired colleagues to the BME:

Q. If there was a reporting requirement that physicians had to report problems that they had encountered with other physicians, would you have to abide by such a requirement being a physician in the State of New Jersey?

A. Sure, absolutely.

Q. What would that do to your program?

A. Torpedo it.

Q. If there was a system worked out where, number one, there was adequate protection against liability for reporting, and number two, there was a system in which the official bodies had an adequate rehabilitation system, would you have less of a problem with [such a] reporting system?

A. I think that if it were clearly promulgated to the health professionals that reporting was not automatic discipline, but opened up the therapeutic option as the first step, that there would be a lot less resistance to people being reported. If you had immunity, if you had it clearly understood and well-publicized that the first approach would be an effort to try and rehabilitate physicians who were identified and keep them in practice, that would open the door.

Canavan elaborated on the tension between the BME's statutory obligation to protect the public and the IPP's goal of restoring wayward physicians and their careers:

Q. Are you afraid, with this view that the Board is too punitive, that during these educational meetings and seminars where you're publicizing the IPP you may be giving people the impression that the last place they would want to go to is the Board?

A. If I do that, I certainly don't do that deliberately, but there have been articles published in journals . . . that categorize . . . the toughest [boards], and New Jersey is always right up at the top. So it's not that I'm out there trying to discredit the Board. I'm trying to recognize reality to begin with, that the New Jersey Board takes its responsibility very seriously and tends to be very tough. . . .

The BME is regarded by many in the medical profession as overly disciplinary, partly because it has no official rehabilitation mechanism of its own. This does not mean, however, that the Board has not proven willing—as Canavan himself conceded—to accommodate reasonable rehabilitation goals for impaired or incompetent physicians consistent with the public safety. Former BME President Luka testified on this issue under questioning by the SCI's Clark:

Q. Now, the [BME] has in the past made determinations that people with chemical dependency who can demonstrate that they

have control of those dependencies should be allowed to continue to practice?

A. If they are either supervised and under conditions. Every case is different and every case may require different forms of supervision.

Q. *Should the [BME] be the agency which makes those determinations?*

A. Yes, and that's not outlined. . . .

Q. *In many cases it goes the other way. The [BME] finds that there is a physician with an impairment and as part of their solution to the problem they refer the physician to the IPP; is that right?*

A. Exactly, yes, but we have them monitored in a certain way. We have certain demands . . . in the rehabilitation process.

Q. *When you say in general the IPP is responsive to the requests of the Board, you're really referring to those situations?*

A. Yes, absolutely. Those that we don't know about, obviously, we can't follow.

The BME of course understands that New Jersey's public policy recognizes alcoholism and drug addiction as diseases. Nonetheless, it must, and does, "discipline" those chemically impaired physicians that come to its attention to protect the public. Compassion toward professionals with illnesses should not extend to the point of lowering barriers that protect public health. The BME's primary concern, and the IPP's as well, must be the protection of the public interest and maintenance of public confidence in the capabilities of physicians. The BME must be satisfied that any program developed in conjunction with the IPP or otherwise will promise both the avoidance of public injury and rehabilitation.

Lawyers Subject to Stricter Discipline

The New Jersey Supreme Court, in its regulation of lawyers, has recognized that the diseases of drug addiction and alcoholism are not necessarily defects in character. Nonetheless, the Court has held that an addicted or alcoholic attorney who misappropriates client funds must be disbarred, not merely suspended, even if he arrested the disease, reorganized his life and made full restitution. The Court recently indicated, in *Matter of Hein*, 104 N.J. 297, 304 (1986), that it might alter

this severe stance if an adequately controlled rehabilitation program were devised to assure that dependency would not again intrude adversely on the attorney's conduct. Indeed, a State Bar Committee on Drug and Alcohol Abuse is presently investigating mechanisms for such a rehabilitation program.

Although the Supreme Court also recently decided that a public reprimand was sufficient in cases involving a single purchase of cocaine where the offending attorneys' conduct had no impact upon their clients, in *Matter of McLaughlin*, 105 N.J. 457, 462 (1987), it nonetheless noted that similar conduct in the future would ordinarily call for license suspension. In the case of an addicted attorney guilty of a single episode of drug distribution, not for gain or profit and unrelated to the practice of law, the Court deemed a one-year suspension appropriate, provided the attorney could prove that he had remained drug and alcohol free during the suspension period. *Matter of Kinnear*, 105 N.J. 391, 396, (1987).

As in the regulation of attorneys, the primary concern of those who regulate physicians should be their ability to foster confidence that a physician will properly serve those members of the public who seek his services as a state-certified licensee.

In the case of impaired physicians, the BME admittedly relies heavily on monitoring by the IPP because that program is "the only game in town," as then BME President Luka testified:

We have no facilities to rehabilitate physicians. As a matter of fact, the state does not even provide adequate retraining for incompetent physicians, and I have met with the president of the medical school here, with the deans of the three medical schools to advocate a policy where they would retrain physicians that we feel need retraining, and under the bureaucratic process so far—it's been two years and so far nothing has happened. Yes, we need a lot of things where I think there are deficiencies in our system, and I think we are working on it. . . . We have maybe 9 or 12 doctors like this a year, and the medical school doesn't feel it's necessary to do it. It costs them money, but that's not the point. They are here to do that. We had a dispute about that. They accepted the concept and they are looking into it, and they have been looking into it for two years.

Senile Doctor Remained Eligible to Practice

In at least one case the lack of coordination between the IPP and the BME resulted in an obviously senile dermatologist, #06, obtaining relicensure by renewal after the IPP had persuaded him to resign due to senility.

A medical malpractice insurance company reported to the IPP on January 31, 1984, that #06 was "potentially impaired." The IPP did not confront him until the following November. When he did agree to tests, they were postponed until after the Christmas holidays. On February 6, 1985, the IPP received a psychologist's report that #06 "should be encouraged to retire immediately." At this point his cooperation ceased and his lawyer requested new tests. On June 28, 1985, the Executive Subcommittee of the IPP agreed to defer a referral to the BME until another series of tests could be conducted. These tests produced similar results, and #06 sent a letter to the BME on August 12 indicating his intention to retire. Without understanding the underlying cause for this decision, the BME staff did not flag his file for special attention. Meanwhile, in the course of the routine computerized mailing of biennial renewal applications prior to BME receiving his letter of retirement, #06 received a renewal form, filled it out and was listed as a current licensee through 1987.

Canavan testified that "the Board knew [the IPP was] involved in this case and [that] it was at our direction that [06] retire." There was no proof in the BME files, however, to indicate that that fact was clearly conveyed to the BME. The BME placed an "inactive" designation next to #06's name on the list of licensed physicians. However, it did not request that he surrender his license or take any steps to insure that he was not continuing to practice.

"An Error in Judgment"

The degree to which the IPP concentrates on rescuing the careers of fallen physicians at the potentially deadly expense of patient safety is particularly demonstrated by the program's mothering reaction to uncooperative clients. Far too many impaired participants who should be reported to the BME for disciplinary action because they cannot or refuse to complete therapy are, instead, often permitted to resume their practices, including surgery and other perilous tasks, while still chemically addicted or otherwise incompetent. The IPP's Canavan not only has withheld

notice to the BME of certain client relapses, but he also delayed reports of actual or prospective failures while giving such clients more time to effect a professional comeback no matter what the risk to patients they continue to treat. Too often, when it does go to the BME, the IPP reports inaccurately and incompletely, in order to serve its own special interest.

One such case involved a staff anesthesiologist, #07, who managed to continue an active career for more than seven years despite hospitalization for drug dependency and depression for two months in 1977 and for a month in 1979, as well as his voluntary surrender of federal and state narcotics registrations in 1982. One of the relatively few cases to reach the BME directly, that agency in June, 1983, referred it to the IPP because of #07's unjustified personal use of drugs. The BME required that the IPP client's psychotherapist submit quarterly reports to it concerning the doctor's therapy results. Although the submission of reports was haphazard and nothing of an updating nature came from Canavan, the BME exercised no active oversight of this case.

When #07 began to fail as an IPP client, Canavan did not report this regression either to the client's hospital or to the BME. #07 often did not keep appointments to give urine specimens. His attendance at therapy meetings was sporadic. From time to time he drank to excess. His quarterly reports were being submitted as much as two months late. Meanwhile, not all health care professionals involved in operations with him were formally alerted to his addiction. Also, no special steps were taken to determine what addictive anesthetics he would be using, to account for them, or to assess whether they could escape detection in the IPP urine tests. During the fall of 1984, #07's behavior worsened. He was unable to account for drugs he ordered, particularly Fentanyl, a powerful narcotic used in anesthesia. He ordered more Fentanyl than any other anesthesiologist at the hospital, including some withdrawn from the hospital pharmacy in the name of a fictitious patient. When this information accumulated in late November, the hospital president demanded a surprise urine test, only to be informed that ordinary urinalysis could not detect the presence of Fentanyl. Nonetheless, a confrontation was arranged for December 6, 1984. Despite the obvious risks to patients, #07 was allowed to work on the morning of the scheduled confrontation, although the chief anesthesiologist was

advised to pay close attention. Fatefully, following one surgical procedure and prior to another, a nurse reported that #07 had taken a syringe of Fentanyl to the men's room. The chief anesthesiologist entered the men's room and, by standing on the toilet adjacent to the stall occupied by #07, observed him injecting himself. He was brought to the confrontation early and admitted his continuing addictive use of Fentanyl.

No one formally notified the BME of #07's relapse. Instead of receiving a suspension, he was granted a medical leave of absence and shepherded that same day by Canavan to a rehabilitation center in Georgia. Under questioning at the SCI, the hospital's president tried to explain the failure to notify the BME:

Q. *Was the leave of absence suggested by Dr. Canavan?*

A. It may have been. I don't recall necessarily. It was the expeditious thing to do at the time and it made sense for getting him out of the institution.

Q. *Were you aware, at that time, of a law requiring that disciplinary proceedings by hospitals be reported to the [BME]?*

A. I am aware of that law. Whether it struck me that morning or not, it surely struck me later. . . .

Q. *And did you submit a report to the [BME]?*

A. No, I did not.

Q. *Why did you not?*

A. Because it was my understanding that the [IPP] was their agent with regard to [07] and would report all of the incidents, including his obvious admission to a drug inpatient facility; therefore, that was fulfilling my obligation of reporting. The other part of the law is that if we take his privileges away at the institution board level, then I would be required to submit a report to the [BME] at that time. . . .

Q. *Did Dr. Canavan indicate that he would report this incident to the [BME]?*

A. I was definitely under the understanding that after [07] was admitted, that that report went to the [BME] as part of his progress, particularly this significant event that he no longer

was a part of the program that we had outlined . . . and I just assumed that [Canavan] was going to report that, sure. . . . Dr. Canavan made me aware by telephone at some later date that he was in big trouble with the [BME] for not having reported [07's] admission. . . .

Q. *Were you aware that [07's] therapist had, after this incident, submitted a favorable report on [07] to the [BME]?*

A. Not until it was read to me a week or so ago by [SCI Special] Agent [Richard] Hutchinson.

Canavan thus failed to live up to the IPP's obligation to report accurately to the BME regarding a transgressing physician being monitored on behalf of the BME. Further, he sought to hide #07's status from the BME.

The BME learned the truth about #07's situation only when Charles Janousek, the agency's executive director, received an anonymous telephone call in February, 1985, that #07 was still using Fentanyl and that this drug was hard to detect in urine screenings. This prompted Janousek to send a letter asking the IPP psychotherapist for his impression regarding the validity of the statements made by the anonymous caller. Canavan quickly responded in a letter to Janousek, dated February 28, 1985, which finally set forth the facts of #07's regressions.

Canavan testified before the SCI about his "error in judgment" in personally ordering a false report to the BME concerning #07's relapse:

I have to take full responsibility [for] this one. That was an error in judgment on my part in that case, and I have to also take responsibility for the psychiatrist making that statement, okay, because I asked him to and I'm admitting that freely here.

Now, in a sense we felt that we had protected the public by getting this guy out of the operating room, putting him on the plane to long term treatment where he ended up staying for about six or seven months. I made an error in deciding not to notify the Board. The error was compounded when the psychiatrist told me, "hey, I've got to send a quarterly report, what do I do?" And I directed him to write a letter simply saying [the doctor] is continuing to cooperate with his treatment, and he did that because I requested, so in that sense I'm responsible for that.

I subsequently notified the Board when it became apparent the Board had called [the psychiatrist] to ask about that letter. . . . [I] was subsequently called before the Board in a disciplinary proceeding of my own, and was censured for this and advised to cease and desist from trying to cover people up, and since that time have studiously avoided anything of that sort.

It is clear to the Commission that the IPP—which the BME continues to allow to monitor impaired physicians on its behalf—all too frequently perceives that its role is to protect wayward doctors from what it regards as overzealous discipline. Too often, when IPP representatives anticipate that the BME will take a strict stance against a client, their communication with the BME is deceptive. Canavan's letter on February 28, 1985, to the BME, while admitting #07's transgressions, was misleading about this client's true situation, saying that his problem "is under complete control and . . . there is no current risk to patient care."

In reality, there was at that time almost no hope that #07 could be rehabilitated. When he returned from Georgia in July of 1985, he regressed immediately. In August, a drug abuse clinic director reported that his attitude was worse "than some of the street addicts." In October, his support group sponsor reported that it would be a mistake to reactivate #07's license because "he's not doing well at all."

Despite these warnings and #07's continued recalcitrance, the IPP supported a restrictive restoration of his license. The BME, however, reacting as though it had recognized yet another IPP deception, revoked #07's license on November 26, 1985, saying it would not consider reapplication until June, 1986, at the earliest and urging him to consider a different type of practice. (On December 29, 1986, the BME restored #07's license on condition that he practice only as a house physician in a halfway program, with no access to drugs).

IPP Often Misled BME

Another example of the BME being misled by the IPP involved an emergency room physician, #08, with a long history of drug and alcohol abuse. His probationary licensure was being monitored by the IPP and the probation was to expire in December, 1984.

In May, 1984, a member of the IPP's Impaired Physicians Committee reported that #08 had relapsed and used drugs while employed full time on emergency room duty. In August, #08's live-in girlfriend confirmed his drug use and confided that he had experienced problems at work and with an impaired memory. After a confrontation on August 23, 1984, when he admitted to Canavan the continued use of Stadol (a drug not then detectable by urine tests) and alcohol, #08 was enrolled as an outpatient at a rehabilitation center. In December, 1984, IPP Assistant Director Reading noted that the rehabilitation center called to report that #08 "was going to become 'too honest' and tell BME about his most recent relapse." Reading's note continued: "When I saw [08] this evening I made sure he wouldn't do that. . ." Another report to the IPP in January, 1985, indicated that #08 "has not been in since 8-31-84."

Since the BME probation had ended, meanwhile, the BME's Executive Director Janousek asked the IPP on January 14, 1985, for a final report. Canavan's reply suggested that his admitted lack of candor in the case of #07 was more than a momentary aberration. He reported to Janousek untruthfully that #08 "remains alcohol and drug free" and that "I am pleased with his recovery and am happy to know that his probationary status is terminated." As Canavan testified at the SCI:

Okay. There's, obviously, some problem there. It's not my style to deceive, and I freely admitted that in the case of [07] where I had the psychiatrist cover up for him. I don't know why this happened. . .

By misdirecting certain wayward colleagues to the IPP instead of the BME, the medical establishment ensured that when the BME developed an independent concern about a physician, it would lack complete information to guide its judgment. An example concerned #09, a family practitioner at a state institution, which agreed in September, 1985, that he could be sent for treatment for alcoholism through the IPP in lieu of suspension. Although #09 entered outpatient treatment, the IPP's Canavan noted in December, 1985, his dissatisfaction with #09's lack of attendance at therapy sessions.

Meanwhile, #09 had come to the attention of the BME after a patient alleged that she became ill while participating in a diet program sold by a diet center to which #09 provided medical advice for

an hourly wage. He was called before a BME committee for failing to respond to six written inquiries from the Board about the patient's complaint. Before #09's scheduled BME appearance in February, 1986, the IPP demonstrated a continuing practice of deception with respect to the BME, according to Canavan's own office notation:

Call from [09]. Appearing at SBME exec com today re incident involving [patient] he saw at diet center and his failure to respond to SBME request for information on case. Advised him to avoid issue of alcoholism. Plead unusual problems/judgmental error/failure to appreciate seriousness. Apologize and assure future compliance with SBME requests.

Canavan essentially told the SCI that he had advised #09 to "answer honestly and candidly the questions you are asked, but I would not volunteer information about the alcoholism." Apparently as a result of such advice, #09 "explained" to the BME committee that marital and money problems had diverted his attention from his responsibilities. He was not asked about alcoholism and he did not volunteer that he had an alcohol problem. The BME, presumably, did not become aware of his impairment.

Without having the benefit of complete information, the BME simply issued him a private letter of admonishment on April 9, 1986, for ignoring its communications (the patient's complaint having been resolved by the diet center with a refund). Ironically, #09 has from December, 1985, through the last entry in his IPP file on September 27, 1986, failed to attend group meetings called for by his IPP rehabilitation program.

The IPP's lack of candor also extended to reports to the BME concerning doctors whose problems had already come to the BME's attention. For example, #10, a resident in internal medicine at a hospital, had entered the IPP after being confronted by the U.S. Drug Enforcement Administration about his use of fictitious prescriptions to feed his drug addiction. On July 17, 1985, the IPP's Assistant Director Reading appeared at the BME and related the IPP's support for #10. Three months later Canavan wrote to #10 complaining that "you have failed to keep a single appointment for your scheduled urine monitoring" and warning that "I shall have no choice but to notify the [BME] that you have ceased to cooperate. . ." In a mail-gram on September 30, 1985, Canavan again ad-

monished #10 even more harshly about his "cessation in all activities of our program."

Canavan's IPP did not convey its problems with #10 to the BME. Indeed, it apparently gave the BME a false picture of a recovered client because BME filed the following consent order on September 30, 1985:

Representatives of the [IPP] in [NJ] support [10]'s contention that he is now well on the road toward rehabilitation and intends to maintain his current program of personal recovery. . . . The Board has given careful consideration to the efforts at rehabilitation demonstrated by [10], and will therefore assess no penalty for his improper conduct while he was functioning in this State under the unwarranted protection of the exemption from licensure [as a resident in a certain hospital setting].

In another case of IPP deception, the BME had allowed #11, a drug-addicted physician, to participate in a residency program under IPP supervision with a restored conditional license. #11 had been convicted of manslaughter after attempting to hide the body of a friend to whom he had administered an overdose of drugs and had served a prison sentence.

Canavan wrote to #11 in February, 1986, saying that his "level of cooperation, on a scale of 1 to 10, strikes me as being about a minus 4," but one week later he misrepresented to the BME that the doctor "continues to cooperate with the IPP, despite the fact that he is currently employed outside the field of medicine." Even in the face of continued noncompliance the IPP persisted in giving false favorable reports to the BME. Eventually, the BME permitted #11 to practice in an institution "under direct supervision of [the] institution director for one year." Again Canavan tried at the SCI to justify the practice of IPP's lying to the BME:

- Q. . . . I wonder whether [the BME] would want a protocol that would say they should have the same picture of the individual that you have.
- A. Well, you know, that would be nice, except I don't know how we could do that within the constraints of the time we have to do this job. We have 338 doctors in the program that I'm supposed to be on top of. I spend a great deal of my time chasing around the state trying to

pick up five or six doctors in a day to be on top of them, and I don't know how I can do this and have the time to go back and give the Board an in-depth understanding of each individual as I have. I don't know if there are enough hours in the day to do this.

The Commission believes that the IPP needs no more resources to tell the BME the truth than it utilizes to tell the BME a partial truth or an outright falsehood.

Coworkers Not Alerted

The SCI uncovered evidence that the IPP failed to alert sufficient people in an impaired physician's working environment so they could adequately monitor and evaluate him. Canavan's SCI testimony on this issue suggested that saving a doctor's career was his sole objective.

Q. Now, when the IPP is monitoring an impaired physician, is it standard practice to notify all of the places where the client works and all of the people with whom he works of the impairment?

A. No, no. . . . [I]f a physician is cooperating in our program and is doing well, we don't notify anybody that he is in the program. . . .

Q. Now, recognizing your limited resources and the fact that urine monitoring and the like is not infallible, doesn't this leave a substantial gap if the people who are in daily contact with the impaired physician are unaware of the impairment and then are unable to know that there is a place that they can go if they see something that is suspicious activity?

A. I would say it's an imperfect system, but by far it's the best we have got. . . . One of the problems you deal with is that, despite the increasing enlightenment that alcohol and drug abuse are treatable illnesses, there is still a lot of ignorance on the part of people who should know about these diseases.

Q. Even in the health care community?

A. Absolutely. There is a lot of bias. . . . So we are concerned when we know that there is ignorance and bias out there about jeopardizing people's ability to get back into the community if people who are not understanding and not sympathetic are going to

make those decisions, but we don't like to stir up things like that.

Public Safety Again Ignored

The Commission believes that it is better to have informed supervisors and coworkers, even if that involves some risk to a physician's career, than it is to have ignorant supervisors and coworkers and tolerate a risk to the lives and health of the public.

This view has been strongly reinforced by the IPP's inept role in the case of #12, a doctor with a record of drug convictions in three states, including New Jersey. For more than five years the IPP promoted this individual's ability to practice despite periodic relapses and continued law-breaking. The IPP's (and IPC's) association with #12 began in 1981 when the doctor, having changed his specialty from anesthesiology to family practice during supervision for drug impairment, was authorized by the BME to serve in a hospital residency program while on probation after a drug conviction.

In January, 1982, as the hospital assured the judge who had placed #12 on probation that all was well, he was involved in a scheme that eventually enabled him to obtain at least 808 drug doses from 22 physicians on the hospital's staff. His relapse was finally discovered by the hospital in March and he was discharged to a rehabilitation program. Subsequently, after a period of family practice at a Connecticut hospital, and then a return to New Jersey as a licensed plumber (he submitted a licensure application form on which he denied his drug convictions), he asked the BME in 1983 to restore his physician's license—with the assistance of the IPP's Canavan. The BME finally granted #12 a conditional license, one condition being that his "drug screening counselor" submit quarterly reports. The BME received good conduct assurances on #12's behalf in July, 1985, from a rehabilitation supervisor who nonetheless cautioned that "wherever he might work as a physician I would hope that his colleagues would be well aware of his difficulties with addiction and supportive of his efforts to remain drug-free."

Nonetheless, by the fall and winter of 1985, #12 had clearly relapsed. He utilized nonexistent federal registration numbers to obtain drugs from the facility where he was employed at the time (he was ultimately convicted and imprisoned) and at one

point consumed so much of a liquid substance while on emergency room duty that he was unable to work. Paradoxically, #12 had applied for a renewal of his federal authority to prescribe controlled substances and the IPP's Canavan went to Washington on November 15, 1985, to testify at a hearing in support of his application. While #12 was back in New Jersey succumbing again to his addiction, Canavan—unaware of his client's latest relapse—was telling the Washington hearing how effective rehabilitation could best protect the public from wayward doctors:

I constantly fight a battle in New Jersey with the State Board that discipline is not as effective as rehabilitation, and that you will protect the public welfare more effectively by rehabilitating impaired doctors than by suspending their license for six months or fining them \$2,500 or making them take an idiot course in South Jersey that they make them take—don't quote that, okay. That the way to get them well is to put them into an effective rehabilitation program.

Imperfect Urine Monitoring

Urinalysis has long been the primary method of testing for drug use, or misuse. Because of the devious schemes addicts will concoct to hide their chemical dependency, urine testing procedures are constantly being refined and expanded to promote the accuracy of test results. The IPP generally relies on an inexpensive urine screen, not unlike a home pregnancy test, and charges clients a \$10 fee to cover costs. (More complicated and reliable tests can cost up to \$300). The urine collection necessary for testing must be closely monitored to prevent faking and switching of specimens that would hide a subject's relapse. To its credit, the IPP has attempted to impose effective controls over its collection system. It relies on cooperating physicians on its IPC to monitor collection and on the professionally respected Eastern Laboratories in New York for sample testing. This facility can be relied upon for near-foolproof processing—such as freezing the urine for two confirmatory analyses of positive results, providing 24-hour notification of positives, auditing of false positives, testing for the newer test-elusive "designer drugs" and testing for a wider variety (about 14 compounds) of mood-altering drugs.

Since IPP's Canavan testified at the SCI that about half of his program's clients are being sub-

jected to testing under this system, one can only assume that some chemically addicted clients who are not so thoroughly assessed—given their status as physicians with protective privileges and easy official access to drugs—are escaping detection, and are resuming active, but life-threatening, practices. One flagrant example of how the IPP failed to screen out a drug abuser concerned #13, a specialist in internal medicine, who managed to continue in active hospital practice for almost two years while he outwitted required periodic urine screening under the inattentive "guidance" of Canavan and his staff. The following chronology suggests how the IPP's drug screening procedures can go dangerously awry.

In December, 1984, after his father reported him, #13 was placed by the IPP on twice-weekly urine screening. In April, 1985, after his father and his wife reported that he was "timing" his drug abuse so it would not be revealed by urine tests, #13 admitted manipulating the testing procedure, "because," according to IPP Assistant Director Reading, "he didn't like it." The IPP merely warned him that if there were more violations, he would be reported to the BME or assigned to inpatient care. Contrary to his family's suggestion that he be continued on twice-weekly urine tests for at least two years, a much less stringent weekly screening was ordered in November, 1985. On June 6, 1986, despite reports that #13 had been "somewhat erratic, hostile with patients and counseling staff" at his hospital and "not seen much" at support group meetings, the IPP placed him on an 18-month program of urine monitoring every two weeks. This schedule next was drastically reduced by Canavan to one test per month for a three-year period, effective in November, 1986. By then, however, reports of poor cooperation in the program had multiplied to such an extent that the IPP was finally forced to adopt a more disciplinary approach to #13. Indeed, Assistant Director Reading caught him in a lie about a drug test specimen. Also IPP learned via hospital nurses that #13 took disposable syringes from medication carts twice in October, 1986. The same incident had occurred six months earlier but the nurses said nothing at that time "because he was a doctor." When Canavan related these and other incidents to #13 during a belated confrontation in November, 1986, the doctor admitted his relapses and agreed to inpatient treatment.

Ironically, up until the point where #13's drug abusing behavior became too obvious to ignore,

the IPP was gradually making it easier for him to circumvent urine monitoring by providing greater intervals between tests. Once again, the IPP focused on a doctor's career rather than on the elimination of risk to patients.

The Commission believes that certain general observations about drug testing should be noted here. Experts agree that faulty laboratory procedures or equipment and sloppy work by ill-trained technicians can easily lead to erroneous results. A reliable procedure requires supervised specimen production, careful labeling of the specimen samples, measures to avoid taint by other specimens, a rigorous "chain of custody" that closely tracks the specimen from the time it is produced through the completion of the analytical process, and retention of a sufficient amount of the specimen for confirmatory tests in the event of a positive reaction. Urine screens should be conducted randomly to ensure that a chronic drug user does not avoid detection by abstaining prior to testing or diluting the urine by overhydration. Ominously, a booming cottage industry of suppliers of bogus urine samples, ranging from powdered material to small, sealed packages that can be carried in a pocket or a purse, stands prepared to assist an intransigent physician to deceive the system. Add to that concern the physician's ready familiarity with laboratory processes and access to high tech devices, and the need for utmost vigilance is apparent.

Any New Jersey urine monitoring program, whether under the auspices of the BME or the IPP, or both, will have to impose the strictest measures possible to insure that specimens are authentic and that test results are reliable. The IPP has instituted a number of safeguards (which have frequently been bypassed) but its program of urine monitoring has never been extensively reviewed by the BME. The BME certainly should not allow the IPP to monitor physicians for drug abuse while also permitting them to continue in practice without first conducting a comprehensive study of methods that will guarantee reliability and without also requiring the IPP's adherence to established standards.

Switching Jurisdictions To Avoid Disclosure

The IPP has not been consistently diligent in notifying other states, other hospitals or other programs when impaired physicians relocated from

one jurisdiction to another. Following are examples of its highly inappropriate lack of attention to this problem.

#14 was identified to Canavan in November, 1984, by his chief medical officer not only as a "heavy user" but also as the "local supplier" of drugs to certain other hospital staffers. In December, Canavan noted that #14 had denied the allegations when confronted by a colleague. In February, 1985, Canavan himself confronted #14 with what evidence he could gather, and #14, admitting only to occasional personal use of cocaine, agreed to submit to random monthly urine testing until July, 1985, "to demonstrate his drug-free status." #14's New Jersey residency was scheduled to conclude in June, however, and he planned to work for the U.S. Public Health Service in another state. Canavan therefore decided to terminate further investigation in light of this doctor's test agreement. Despite the fact that the substance abuse center collecting urine samples for testing told Canavan that #14 had last been seen on May 14, 1985, Canavan noted in June that #14 had complied with his agreement and advised him merely to contact the IPP if he returned to New Jersey. Canavan took no steps to contact his IPP counterparts in the state where #14 went to practice. The Commission believes as a result, that there is a substantial likelihood that #14 has "slipped through the cracks" of effective rehabilitation and licensure controls and constitutes a perilous risk to patients.

Again, officials at five hospitals reported to Canavan in mid-1985 that #15, a physiatrist, had engaged in bizarre behavior associated with a psychiatric malady. It was reported that he had rambling, embarrassing conversations, incidents of weeping, inappropriate laughter and screaming at therapists, and illusions that his car was wired to a bomb after he had been cited for numerous parking infractions. At least one hospital had not renewed his contract (although keeping his clinical privileges intact) without reporting this action to the BME. With the IPP's knowledge, #15 saw a psychologist once every two weeks until January, 1986, when he relocated his practice to another state. Again Canavan did not notify his counterparts in the other state that they might wish to monitor #15's progress. The Commission is concerned that yet another potentially impaired practitioner has slipped through interstate cracks in New Jersey's regulatory system.

Reporting By Other Health Care Professionals

Persons in allied health care professions are often in a position to observe signs of incompetency or impairment. Pharmacists, nurses and a multitude of specialized practitioners who are not physicians should, because of their frequent contacts with physicians, be able to provide early warnings of objectionable behavior.

A regulation, *N.J.A.C. 13:37-1.4*, of the State Board of Nursing, effective in December, 1985, requires nurses to report to the Board all violations of the Nurse Practice Act or of any regulation of the Board. The Board publishes a leaflet, "Guidelines for Reporting Unlawful Activities by Licensed Nurses." Such mandatory reporting fails to extend, however, to the conduct of physicians and other health care professionals who may be recognized by nurses as incompetent or impaired.

The inappropriate writing of prescriptions is, by far, the most common violation charged against physicians, accounting for about half of all actions taken by state licensing boards. These are serious matters, involving not only excessive or unnecessary prescribing of drugs to patients but also unlawful distribution to addicts and abuse by physicians whose drug dependency adversely affects their professional lives. Naturally, pharmacists who are called upon to fill illegal or improper prescriptions are in the best position to alert the proper authorities to the problem. Nonetheless, there is no reporting requirement in New Jersey for pharmacists. In states with triplicate prescription laws, prescription abuses may be investigated with relative ease, but New Jersey does not have such a law either.

Non-Reporting By Health Care Facilities

As previously noted, the Legislature passed a law, *N.J.S.A. 26:2H-12.2a*, effective in 1983, requiring that a health care facility such as a hospital notify the BME of any disciplinary proceeding or action taken by its governing body against a physician resulting in reduction or suspension of privileges or removal or resignation from the medical staff. Compliance with the letter and the spirit of this reporting requirement has been unacceptable. In far too many cases it has been deliberately circumvented.

The Commission uncovered instances in which errant physicians were encouraged to take leaves of absence from hospital staffs so that no official (and therefore reportable) "disciplinary action" would appear on their records. In addition, hospitals have not reported disciplinary actions conveniently affirmed at levels below that of the governing body.

Hospitals are not required to inform patients when they take disciplinary actions against doctors. Even if a patient asks, officials at most hospitals will not say whether a doctor has been put on probation or otherwise disciplined. In addition, a hospital's willingness to protect patients often ends at its doors. A doctor removed from such a hospital may simply go on to another without being followed by a warning alert. The reporting

law was designed to allow the BME to reaffirm a hospital's assessment of a physician's abilities and, if necessary, universally and officially restrict his practice. If the effectiveness of the reporting statute is undermined, as the SCI found, patients can be endangered by physicians deemed incapable by certain health care institutions.

In June, 1986, the AMA Board of Trustees proposed that hospitals report to the AMA whenever they discipline physicians and that the AMA expel members found to be incompetent or untrustworthy. In light of the lack of reporting to the BME in compliance with the statutory mandate, the Commission seriously questions whether the AMA's well-meaning gesture, if implemented, will significantly help to identify incompetent physicians. In addition, an AMA sanction has no legal effect on any doctor's ability to practice.

Capacious Loopholes

In numerous cases the IPP has encouraged or acquiesced in a hospital's effort to design its remedial decisions against a physician so that it can avoid its obligation to report to the BME. Essentially, the IPP has promoted hospital utilization of the reporting law's capacious loopholes. Under questioning by the SCI's Clark, IPP Director Canavan testified candidly about IPP's promotion of

legal—if not morally acceptable—noncompliance by hospitals with the objectives of the reporting statute:

Q. *Do you encourage hospitals to place physicians on leaves of absence rather than disciplining them in order to avoid the statutory requirement that they report to the [BME]?*

A. In the cases where we are called by the physician who has been identified to us . . . who agrees to go into treatment, yes, we would make that representation.

Q. *Doesn't that create a problem in terms of the hospital's obligation?*

A. No, because the obligation of the hospital is very specific. The law says that the hospital must report the final action of the board of trustees to restrict or limit a physician's privileges. If no action is taken, there is no problem.

Now, the other side is you can't let a guy resign to avoid that. You can't say, "Look, let the guy resign but don't take any action," because the Board has taken the position in that very specific instance that the hospital must report that action.

Q. *In making these decisions and judgments, you're looking at the letter of the law; are you not?*

A. Absolutely.

Q. *What about the spirit of the law?*

A. Okay. The spirit of the law, as I interpret it, is to protect patients from doctors whose performance is impaired. If we have taken a doctor who is alleged to be impaired, put him into treatment and take him out of the [practice] environment and he is getting well, we are protecting the public welfare far more efficiently, so I don't think we are violating the spirit of the law, which is to protect the public, and we are certainly not violating the letter of the law.

I have been challenged on this at a meeting of the State Board and made this very specific statement that this is what the letter of the law says and this is what we do, and there are physicians on the Board who agree with the position that I have taken, that that is true,

not everybody, but there are some who do agree.

Q. *What if the spirit of the law is to provide for reporting so that there can be official monitoring of the physician's activities?*

A. If that's the spirit, I don't understand it. . . .

Many physicians who were not reported to the BME by hospitals but were otherwise removed from the "practice environment," as Canavan phrased it, have been permitted to resume their practices without adequate official monitoring from the standpoint of patient safety. For example, the IPP confronted a cardiologist, #16, in mid-1984 about alleged drug abuse. Although #16 entered an inpatient detoxification and rehabilitation program, he was not reported to the BME by the hospital where he worked. Upon return from rehabilitation, he was allowed not only to resume staff work but also to practice at another hospital where he had previously completed a residency, in each case under IPP supervision. However, in June, 1985, a routine urine specimen tested positive for opiates but was assumed by the IPP to be a "false positive" because of #16's "regular/active program participation." In August, however, among other evidence adverse to #16 was a pharmacist's proof that since the middle of July the doctor had written a prescription every two weeks for 25-30 controlled drug pills in his wife's name. By September 6, #16 had re-entered inpatient treatment, again on leaves of absence from the hospitals that did not have to be reported to the BME. As Canavan testified:

In neither case, to my knowledge, was any action taken against his privileges at the hospital. He was allowed to go into treatment. So, again, we're back to the scenario where in the absence of a disciplinary action the letter of the law did not apply, and I would presume that that's why they were not reported by the hospital.

By taking advantage of a loophole in the reporting law, the hospitals and the IPP were able to monitor #16 as they saw fit, free of any regulatory contact. BME involvement may not have prevented #16's relapse but it may have allowed authorities to recognize his regression at an earlier point. The Commission believes that since the BME is composed in part of public members and is primarily responsible for protecting the public, it should play a direct role in any rehabili-

tation program that involves the continuing practice of a problem physician. Only by strengthening the BME in this manner will the imbalance between physician self-interest and the public interest ever be corrected.

Another IPP-promoted loophole in the hospital reporting law is that it excludes residents, even if they are practicing for up to five years under the exemption from licensure for residents working in government or nonprofit hospitals.

This loophole created a problem in the case of #17, a third-year anesthesiology resident with a history of drug abuse. The IPP began to monitor him for a New Jersey hospital on July 1, 1984. During 1985, #17 demonstrated increasing unwillingness to attend support group meetings and to submit to urine screening, especially after he once tested positive. Finally, in October, 1985, a surprise urine test revealed continuing drug use and #17 resigned his residency and entered inpatient rehabilitation. No report was made to the BME. When he returned from inpatient treatment, #17 went into family practice with his father in Pennsylvania. It is conceivable that #17 may one day return to practice in New Jersey without the BME ever knowing that he remains a potential threat to patients.

In a situation involving a licensed obstetrician, #18, hospital administrators in late 1983 received reports that he had passed out, his hands were shaky during deliveries, alcohol had been noticed on his breath, a patient's mother claimed he "murdered my grandchild", and a prospective father had to help him place an oxygen mask on his wife's face during delivery because the doctor's tremors were so severe. Based simply on a two-hour discussion with the subject and a typically cursory inquiry, Canavan reported to the hospital:

It is my professional judgment that [18] is neither alcoholic, addicted to drugs [nor] suffering from a disabling neurologic defect. In short, I do not believe he is an impaired physician. . . .

[18] does indeed have a fine tremor which has been present for at least two or three years. . . . As you know, these tremors are often exaggerated under stressful situations and certainly the recent incident in the delivery room involving the case that ultimately lead to a dead baby at caesarean section is a classic example of a stressful situation.

Despite Canavan's snap judgment that #18 was not an alcoholic, a month later he was admitted for inpatient alcohol rehabilitation. Not only did the hospital fail to take action reportable to the BME, but the IPP failed to notify the BME or the hospital of #18's subsequent relapses. In January, 1984, #18 reported to Canavan that he had "not been completely abstinent." In May, 1984, he reported he had a three-day relapse over the Mothers' Day week-end after receiving a card from the mother of a baby that had died the week before saying that because of him she wasn't getting a card that year. In June, 1985, he reported to Assistant Director Reading that he had not gone to any meetings in months, had had a relapse and wanted to talk to Canavan "about malpractice suits he's settling out of court." Reading noted that "at best he's on shaky ground . . . He's either already, or soon to be, in a major relapse. We need to be on top of him more."

#18 remained a problem doctor. In May, 1986, his wife wrote that he had been drinking and "recently left for [the] hospital in bad shape." Although Canavan noted that #18's wife was in the "best spot to know," there was no further attempt to verify his return to drinking and no report to the BME or to the hospital.

One more case: #19, a specialist in internal medicine, was diagnosed as having "acute paranoid psychosis" after "behaving inappropriately" in a hospital intensive care unit in May, 1984. After leaving the hospital that night, he was found walking naked on a nearby railroad. After #19's superiors discussed his plight with Canavan, the doctor agreed to limit himself to his office practice until the hospital could receive a psychiatrist's report. Meanwhile, no one apparently paid any attention to the safety of his office patients, although there was much solicitude in the medical community about his health and career.

Less than three weeks after the incidents at the hospital and on the railroad, the psychiatrist wrote that after five sessions #19 had recovered and was fit to return to work at the hospital and his practice. He added that #19 "intends to continue his sessions with me for some period of time." However, on the same day he wrote recommending #19's return to practice, the psychiatrist telephoned Canavan to report that he had just seen #19 and "is not too happy with what he sees." Canavan noted that #19 should "hold off on return to work" after the psychiatrist mentioned that he

had stopped taking medication, distorted the context of their last interview, "mixes up his pronouns" and "has a great deal of difficulty in dealing with his anger. . . ." On June 1, 1984, Canavan convinced #19 to agree to defer returning to hospital practice and to again "limit himself to [the] office." Although #19 returned to work in the hospital later that month, he did not remain trouble-free. In December, 1984, Canavan learned that #19 "had another episode of inappropriate behavior" at a second hospital where he had privileges. This second hospital suspended him after he told patients of other physicians that their doctors were "no good." On Canavan's advice, the hospital changed its action from suspension to medical leave of absence. Canavan also suggested that the other hospital place #19 on a medical leave of absence pending release from the psychiatrist. The hospital accepted this recommendation. Canavan later told a hospital medical staff official who expressed concern about reporting to the BME that "in the circumstances here the law is not applicable." Less than a month later Canavan passed on to the hospitals the psychiatrist's letter recommending that, with medication and weekly therapy, #19 "be returned to full status in the hospitals in which he has appointments." The only condition suggested was that #19 not be asked to serve on hospital committees until approved by the psychiatrist.

This is a critical example of a case in which the BME should have had the opportunity to determine whether the patients in the doctor's office practice were adequately protected and whether a second opinion should have been sought from another psychiatrist prior to the doctor's return to hospital practice.

Testimony Confirms Reporting Deficiency

The failure of hospitals and other health care facilities to respond to the intent of the reporting law, that is to protect the public from mistreatment by impaired or incompetent doctors, was fully confirmed by regulatory authorities during testimony at the SCI. Such testimony also criticized the devious methods utilized to circumvent the statute, as documented by the SCI, even when it should have been obvious that lives of patients were at risk. One witness, Edward Tumminello, chief of the investigative arm for all professional boards in the State Division of Consumer Affairs, testified that since the law took effect in 1983 hardly 10 such reports had been submitted. Tumminello

testified that this could not possibly reflect the actual incidence of reportable actions:

Q. *Do you have an opinion as to whether that adequately reflects the amount of disciplinary actions actually occurring in the hospitals?*

A. I definitely have an opinion, that it certainly does not. We have encountered situations where we've gotten involved in an investigation and during the investigation have found that there had been disciplinary action at an institution, a hospital, that was not reported. . . . Some of those situations involved out and out failure to report . . . a staff suspension or disciplinary action . . . Others also occurred where we found that the institution perhaps should have taken some type of action against the physician but did not, for whatever reason, and therefore there was no report made, and also on occasion the reduction in staff privileges or the removal of a physician from the staff was cloaked in a terminology that would take it out of the reporting requirement. In other words, a therapeutic leave of absence, for example, which they didn't feel was necessary to report. And we've seen several of those in situations where the physician involved was impaired or had a substance problem.

Q. *Also the reporting requirement requires the reporting if there was action taken by the board of governors of the hospital; is that correct?*

A. Yes, sir.

Q. *So have you encountered examples where the actual disciplinary action was taken at a level below the board of governors and that was not reported to the Board of Medical Examiners?*

A. I believe so, yes. I believe that happens as well.

COMMISSIONER ALONGI: Are there penalties if they do not report as required by the statute?

A. . . . I believe the only penalties . . . involve things like revocation or suspension. I have not seen a situation where a hospital or an institutional license has been suspended or revoked. It would be virtually impossible to take action like that against the institution. I don't know exactly how the penalties would

be assessed by the Department of Health in these instances. We have reported these situations to them. I have not seen any results of those reports to date. I'm not saying there were no results, but I'm saying I have not personally seen the results of any of these. . . . And, again, the problem there is who is held accountable by the statute, and who actually pays the penalty. If the hospital pays it as a nonprofit organization, it's really passed along to the patients ultimately.

BME Executive Director Janousek also testified that hospitals have provided little information concerning disciplinary actions. He was able to locate only 19 reports dating from July, 1983. Several did not relate to issues of incompetency or impairment. The BME has not kept track of the exact number of such reports and no log of hospital reports is maintained. Reports requiring investigation are submitted to Tumminello's Enforcement Bureau. Under questioning by the SCI's Clark, Janousek described the lack of identification and discipline of noncomplying hospitals:

Q. *Has the [BME] ever reported any hospital or other health care facility to the Department of Health for failure to report in compliance with that statute?*

A. No.

Q. *Are you aware of the Department of Health ever penalizing any hospital or other health care facility for violating that statute?*

A. To the best of my knowledge, no.

Former BME President Luka said circumvention of the hospital reporting law is "totally inappropriate." His testimony in part:

Q. *In your opinion, would it be appropriate for a hospital to place a physician on a leave of absence in lieu of a suspension, for example, as a means of avoiding the reporting requirement?*

A. I think we have tried to avoid that because if . . . there is a planned action against that individual, I think that would be a totally inappropriate way of handling the situation. If it's a disciplinary matter, I think then the physician, if he takes a leave of absence, I think certainly then the Board should be notified of that.

BME member Dr. Floyd J. Donahue said the reporting law should be amended to eliminate its loopholes:

Q. *Should the law be changed to require reports if the [hospital] action is taken at a [level below board of governors]?*

A. Yes.

Q. *Should the hospitals be required to report if a person's privileges are curtailed, in effect, by a medical leave of absence [instead of an actual disciplinary action such as a suspension]?*

A. Yes.

Q. *In effect, what you're saying is that more good could come out of the present hospital reporting requirement if it were fine-tuned and perhaps some loopholes closed?*

A. Yes.

The BME is not particularly concerned with the routine details of a hospital's relationship with its physicians. However, it believes it must by law be directly concerned procedurally when a hospital or other health care facility takes steps to curtail medical privileges on grounds of impairment or a lack of skill or judgment. The BME obviously should be immediately notified so that it can monitor the process and take action of its own, if necessary, to protect the public. Nonetheless, there is little or no official encouragement to comply with the law.

The minimal hospital reporting to the BME that does take place occurs on forms promulgated by the Department of Health. These forms are not distributed to hospitals unless requested, a procedure which has the practical effect of discouraging reporting. Neither the Department of Health nor the BME has conducted educational campaigns or prepared leaflets to remind the hospitals of their obligations or to guide the reporting of improper conduct.

Under the reporting law, failure to report subjects a health care facility to monetary penalties or license revocation, suspension or probation. There is no clear statement in the statute as to the amount of penalties that may be assessed, but the Commissioner of Health may accept an "offer in compromise" in lieu of license suspension in an amount not less than \$250 for a first offense and

\$500 for subsequent offenses. Thus far, no hospital has been penalized for failing to report.

The Commission's inquiry has confirmed several procedural inadequacies in the statute. For instance, hospitals may delay with impunity reporting an aberrant physician to the BME until after the conclusion of hospital disciplinary proceedings. Even if a hospital curtailed a physician's practice there pending the conclusion of its investigation, the physician would be allowed to continue to practice at other hospitals or in his office until final determination. The Commission feels strongly that the only way to guard against this threat to patients is to require hospitals to report all pending disciplinary proceedings to the BME. The Board could then decide whether it should take any emergent action to protect the public.

The deficiency in hospital reporting is all the more discouraging because hospitals are otherwise actively involved with formal quality control mechanisms for detecting and dealing with incompetency. Each hospital typically monitors medical cases, by means of utilization, mortality, morbidity, tissue and other peer review committees. Moreover, the Joint Commission on Accreditation of Hospitals (JCAH), a private accrediting agency, checks physician monitoring functions and medical staff activities as part of its ac-

Revealing Malpractice Information

Numerous studies of malpractice actions filed in various areas of the country have shown that a small percentage of physicians account for a large percentage of medical malpractice claims and payments. It is recognized that many capable physicians are sued more than once because they courageously accept high-risk referrals and emergency cases. In addition, a number of suits are frivolous. In general, therefore, the mere filing of a lawsuit by no means supports a conclusion that a particular physician is incompetent.

However, some physicians who have been successfully sued many times obviously lack medical judgment or skills to properly handle certain patients. The Commission's investigation confirmed that these doctors are seldom, if ever, disciplined. Nor can they be easily identified under the present inadequate system of reporting medical malpractice actions. More adequate reporting is essential

crediting investigations. The Department of Health routinely inspects hospitals and other health care facilities. Although it has the power to review the minutes of committees dealing with staff impairments or incompetency and could, therefore, check on the hospitals' compliance with their reporting requirements, it does not conduct such checks as a matter of routine. Neither does the BME.

With passage of the Health Care Quality Improvement Act of 1986, the federal government has indicated optimistically its intention to provide an additional incentive for reporting by hospitals and HMOs. Under the law by November 14, 1987, hospitals and HMOs (as well as medical societies) must begin to report to their state licensing boards the names and pertinent information concerning investigations or review actions adversely affecting or leading to the surrender of physician clinical privileges. Unfortunately, failure to "substantially" comply merely causes the hospital or HMO to lose the accompanying federal immunity against liability to disgruntled physicians subjected to peer review by the hospital or HMO. This new federal law, however, in no way obviates New Jersey's need for its own stronger reporting and enforcement mechanisms to overcome entrenched resistance to reporting.

since a substantial number of malpractice filings against a single physician is an ominous warning of possible incompetency.

Neither the BME nor the Enforcement Bureau has ever reviewed medical malpractice case filings to determine if there is reason to conduct inquiries into the practices of certain practitioners involved in those cases. Computerized information on pending and closed medical malpractice cases is available at the Administrative Office of the Courts (AOC). In addition, several counties with local filing projects have significant data on malpractice filings.

The SCI requested AOC data concerning 4,877 lawsuits filed from mid-1982 through 1986. Using data base software to analyze this information, the SCI discovered one physician alone was named in 194 lawsuits, and three were named in 13, 11 and 10 lawsuits, respectively. Six practitioners

were named in eight suits each, eight in seven suits, 14 in six suits and so on up to 548 named in two suits each. These figures are conservative because some resolved cases had been removed from the files, the cases were listed by first-named defendant only, some medical malpractice cases had been mistakenly classified, and recent filings in counties with local filing projects were not included in the figures.

The Commission determined that the complaints against at least the 32 practitioners involved in six or more lawsuits each were serious enough to have been probed for medical incompetency by the BME. The SCI found that five of these physicians were known to the IPP and 13 had come to the attention of the BME for a variety of reasons generally unrelated to the question of competency (i.e., advertising and fee disputes). Only two of the 13 were recently disciplined by the BME for problems relating to the quality of the medical care they provided. The practice of one of these two doctors would have been reviewed three years earlier and the other one year earlier if the BME had had a policy to investigate licensees named in multiple lawsuits. One obstetrician, named in six lawsuits, came to the attention of the BME only because he was arrested by the State Police for firearms offenses. The BME did not assess his practice or review his malpractice history once it learned that the offense for which he was arrested did not relate to his medical license. As for the physician named in 194 suits, the BME did not learn of the case until informed by the SCI.

The two major insurers of physicians for medical malpractice in New Jersey reported to the SCI that from time to time they have developed substantial evidence of incompetence. Usually this has resulted in denials of insurance coverage for or surcharges against the offending physicians. The SCI has determined that while this information, which is highlighted in the examples below, is an important indicator of incompetency, none of it, as well as many other situations encountered by the SCI, has been brought to the attention of the BME.

Surgical Records Altered

Dr. A, an orthopedic surgeon, was not allowed to renew his malpractice insurance because of a discreditable claims history. In one case involving A's failure to recognize a broken wrist, the peer

reviewers confirmed "obvious evidence . . . of altered records." In certain other cases deemed indefensible, the peer reviewers noted that the doctor "has had considerable difficulty at area hospitals [that] he didn't want revealed." In a case in which an expert witness for the defendant confirmed a "below standard repair of fracture," the reviewers stated, "we are facing very explosive information being used at trial which shows this insured to have his privileges suspended on numerous occasions at three area hospitals and his operating privileges subject to supervision and clearance, etc., and loss of emergency room privileges."

Abortions Mishandled

Dr. B's malpractice insurance was not renewed after he exhibited an appalling history of botched abortions and other medical mishaps. In one case the insurance company claim reviewers noted allegations that B, an obstetrician, entered the delivery room in an impaired state, smoking a cigar and with a lei around his neck. When a fistula developed from a laceration that occurred during delivery, he attempted to repair it within two months when recommended procedure called for a wait of three to six months. A spontaneous abortion of a subsequent pregnancy resulted from this incident.

In a second case, B perforated a patient's uterus during an abortion. In a third case, a suction abortion was attempted two weeks later than recommended and, when the patient was sent home, she aborted the next day in front of her children. In a fourth case, B perforated the small bowel, causing peritonitis. A fifth case involved an incomplete abortion requiring a second abortion, followed by two similar cases. In one of these cases, the peer noted that "it wouldn't appear that the patient received very much consideration." In an eighth abortion case, where an examination should have been conducted in response to life-threatening complications, B merely ordered a prescription without conducting an examination. In a ninth case B had his nurse handle complaints from and give advice to a patient who exhibited continuing signs of pregnancy after an abortion attempt. (Eventually the unwanted child was born).

Cuts Wrong Hip

Insurance company peer reviewers found that a nurse prevented Dr. C, an orthopedic surgeon,

from proceeding beyond the incision when she realized that he was operating on the wrong hip to repair a fracture. In a second case they discovered that he had failed to notice a fractured hip in x-rays and instead diagnosed contusions and bursitis. In a third case, where a patient complained of burns to her stomach during surgery, and C claimed that the patient had spilled hot coffee on herself, reviewers felt that the doctor had "fudged" hospital records. In a fourth case, a month after C repaired a leg fracture, doctors at another hospital confirmed the presence of maggots in the cast and corrected the condition. In a fifth case an antibiotic dosage prescribed by C was deemed inadequate. Lastly, C admitted in a sixth case that his surgery on the foot of a patient with degenerative arthritis had probably not been required.

The Doctor in the Closet

An insurance company employee reported that, while he was investigating a case involving a patient's death on the operating table, he was informed that during the operation Dr. D, an anesthesiologist, left the patient's side to have sexual intercourse with a nurse in a closet. D later admitted the occurrence to the insurance company investigator.

Doctor Caused Patient Addiction

A malpractice insurer cancelled the policy of Dr. E for overprescribing drugs to the point that his patient became addicted. Although E had no other adverse claim experience, the insurance company had a policy that whenever a claim revealed gross, inexcusable error the coverage must be terminated.

Operated Because He "Needed Money"

After insurance company peer reviewers found that Dr. F had too many indefensible surgical cases, his malpractice insurance was cancelled. In one case, after surgery that "never should have been done" led to numerous operations to remove portions of the patient's intestines and to a colostomy, F admitted he performed the surgery "because he needed money at the time." In a second case in which an expectant mother died, F's treatment was found indefensible because he prescribed an improper dosage of one medication, failed to repeat a drug which he should have, failed to give a third necessary drug and

departed the hospital without leaving adequate orders. A third case involved a voluntary sterilization in which a second operation had to be performed because F had removed only one fallopian tube. A fourth case, in which F needlessly used forceps, left a newborn with an intra-cranial hemorrhage, a seizure disorder, cardiac problems and an eye shift. In a fifth case the investigator concluded that the doctor lied and fabricated records to make it appear that he had performed an abortion in a hospital rather than in his office.

Inadequate Malpractice Reporting

Not a single one of these cases, and no other important information from malpractice lawsuits, has ever been reported to the BME. Neither has the BME assertively requested such information to investigate and determine whether malpractice-prone physicians should be barred from practice or have limitations imposed on their practices. These regulatory aberrations reflect, in part, a weak, so-called mandatory system of reporting of malpractice insurance awards of more than \$25,000.

This substantially ineffective system, which the BME has only partially implemented, has imposed serious administrative burdens on the insurance companies without providing commensurate public protection against incompetent physicians.

Although many companies are authorized by the New Jersey Department of Insurance to write medical malpractice insurance, only four companies write a significant number (sixty or more) of these policies.

The New Jersey Medical Inter-Insurance Exchange (Exchange) of Lawrenceville, New Jersey, is a professional liability insurer owned by its policyholder-physicians. It was formed in 1976 by the Medical Society of New Jersey and has approximately 7,250 policyholders (Exchange members), who need not be members of the MSNJ. About 500 policyholders are members of the Osteopathic Association, and approximately 300 are not members of either organization. In addition, several hundred MSNJ members are insured by the one other major carrier, Princeton Insurance Company (PIC).

The Health Care Insurance Exchange (HCIE), a hospital-owned company, covers ninety percent of the State's hospitals. HCIE owns 100 percent of the stock of the PIC, created in 1982 as a for-

profit corporation to provide coverage for approximately 5,220 physicians, as well as other health care practitioners. HCIE can but does not write policies for individual physicians. Many physicians are insured under policies written for hospitals which cover their employees.

It should be remembered that medical malpractice claims are by themselves an unrefined indicator of physician incompetency. Peter Sweetland, president of New Jersey State Medical Underwriters, Inc., which manages the day-to-day operations of the Exchange, testified at the SCI about the judgments which he said lead to a reasonable estimate that 10 percent of medical injuries involved in insurance claims are preventable:

Of all those cases presented to us, roughly 30 percent of them wind up with a payment [to the complainant]. Of [that] 30 percent, a fair portion are paid, even though we would rather not pay them, either because the jury disagreed with our view or we wound up being presented with circumstances that made the case indefensible, although the medicine was defensible. So, I could cut that 30 percent in half in that process. Of the remainder, a certain portion of them would be those which even the best physician would tell you shouldn't have happened, but are they really preventable or are they a risk of the care? . . . [O]f those that cause question on the part of the patient, maybe I would pick 10 percent as preventable, really preventable. That's a big amount when you look at the fact that that's a third of those that are paid, so this is why we devote the effort we do to loss prevention.

In implementing their loss review programs the Exchange and PIC gather a great deal of information on individual physicians. Both maintain claims and litigation histories on their policyholders. The Exchange operates a "high risk evaluation program" which determines whether it should continue coverage, impose a premium surcharge, mandate an office practice evaluation by its loss prevention staff, require practice restrictions, or mandate completion of a correspondence course. The system is designed to take into account the fact that practice in certain high risk specialties tends to generate more claims. Greater significance is attached to a claim if it is determined to be indefensible or otherwise

problematic after a peer review by volunteer members in the same specialty. PIC operates a less comprehensive system based simply on the number of claims in which more than \$10,000 have been paid within a five-year period.

The Exchange reported that from 1982 through 1986 it turned down 39 physicians applying for medical malpractice insurance based on their claims records. During the same period the Exchange dropped coverage for up to 31 other physicians on account of their claims histories and surcharged about 160. In addition about 21 physicians withdrew from Exchange membership voluntarily rather than face surcharges for histories involving five or more paid claims. During the same period PIC rejected approximately 50 applicants and refused to renew another 50 for reasons other than non-payment of premiums. There is no routine follow-up to determine how many of the physicians who lose insurance get insured by another company or practice without coverage.

Witnesses representing both the BME and the major medical malpractice insurers concede that the companies do not report to the BME information concerning physicians who have been rejected or dropped from coverage. Neither do they report physicians who have been surcharged or required to take remedial courses. The Exchange's Sweetland testified that the system constrains reporting of useful information while requiring reporting of voluminous but only superficially illuminating malpractice award data:

If we have an objective of preventing the loss and we come upon those instances where as much as we attempt to convince a practitioner to work towards preventing loss, and we see that he is unwilling or unable to cooperate and has a past history that shows a subpar medical performance, we shouldn't be the policeman of medicine in that case. We should be shielded but obliged to report what we know to the Board. . . .

COMMISSIONER ALONGI: What about the people that you cancelled, are they reported to the Board?

A. They are not. The reasons for our cancellation [of insurance], as I have indicated, are that [those physicians] present a higher than expected hazard. It might not always be the medical care issue, although it is usually, but that's our judgment, and we were distinct

from a medical review authority at this point, and we are really concerned about the legal issues. . . . We do conform to the reporting requirements that the Legislature set out. We really think that they ought to be redone, that's the way we think it ought to happen. . . . We have no objection to being required to [notify the BME if we do not renew an insurance policy], but we don't [do so] at this point.

Sweetland also revealed that hospitals where insured physicians have privileges are not notified when a physician's coverage is terminated except when proof of insurance is requested. Thus, if a doctor's malpractice history at hospital A results in termination of coverage, hospital B, where he also has privileges, may not be informed so that it might consider whether this would impact on his privileges there. In addition, if a doctor whose insurance has been terminated loses his privileges at a hospital that requires insurance coverage, this may not be construed as a "disciplinary action" requiring the hospital to report to the BME. The doctor thus could continue a potentially incompetent practice in another hospital or in his office.

PIC's executive vice president, Donald E. Smith, testified under questioning by the SCI's Clark that the lack of reporting extends to even the most severe cases:

Q. If PIC becomes aware of a particularly acute case of damaging mistakes or questionable risks, and the like, would it still adhere to that policy of only reporting to a hospital if that hospital had indicated that it wished to receive that information and the insured physician wished that that information be reported?

A. Yes, we would still not give it, unless the physician gave us permission.

Q. Has any of that information, that is, the damaging mistakes, the questionable risks, the claims paid, the coverage denied, been reported by PIC to the BME?

A. The only thing we report is what they require, and that's a claims payment over \$25,000. That's all we report to them.

Q. Do you feel that if adequate laws [providing protection for reporting] could be con-

structed that this information should be provided to the BME?

A. Yes.

Q. Is that opinion derived from your feeling that there are some physicians, whatever the number, who do present significant risks to patients?

A. Yes.

Parties to a medical malpractice case may agree that they will not comment as a condition of settlement. In addition, the defendants may agree to pay substantial sums of money without admitting liability. Thus, in such situations, the settlement of a case may provide no conclusive information on the question of competency of a physician defendant. Since doctors who settle out of court can bargain to have case records sealed, the worst can continue in practice—or malpractice—without anyone knowing about their serious professional breaches.

The \$24,999 Nonreportable Settlement

Medical malpractice insurers may also be bound by settlements limiting the information which they may voluntarily supply to the BME or hospitals. In addition, some settlements are purposely reduced to \$24,999 so that the doctor will cooperate in return for not being reported to the BME. As Sweetland testified:

There are numerous settlements in which we reach agreement not to disclose the specifics of the settlement, particularly the amount. Routinely, also, in a settlement, as with any settlement, there is an indication that liability is not admitted in that settlement. Beyond that, to my knowledge, there are no settlements in which we have agreed to withhold information from the [BME] that the [BME] is expected to receive. Now, recognize that because the reporting requirement of the [BME] is at a set dollar amount [awards of higher than \$25,000], there are often negotiation pressures before the settlement to arrive at a number just below the threshold, and as you review our cases, you will certainly find some in which the payment amount is \$24,999. . . . The impounding of court documents is requested periodically of the judge and granted. It's not to my knowledge done that often. But fundamentally the objective of

an effective settlement is to continue to shield the doctor from unnecessary publication of the award, other than that which is required in the normal [BME] review, and in effect to expedite the process.

The parties to malpractice litigation may not cooperate in exposing the transgressions which led to the suit and to a settlement. Moreover, plaintiffs' attorneys in malpractice actions have tended to be more concerned about winning a particular case than in helping to assure that demonstrably incompetent defendants are prevented from harming other patients.

The sealing of court records and settlement agreements that pledge litigants to silence deprive the BME of knowledge about the possibly serious cases of physician incompetency. Further, the present system of malpractice litigation tends to make an aggrieved patient or a survivor a willing partner in yet another "conspiracy of silence" designed to maximize malpractice awards at the expense of reducing further malpractice. The Commission also believes that many patients remain at risk because malpractice insurers cannot or will not report to the BME those physicians that they have identified as uninsurable. If hospitals or colleagues continue to refuse to abide by legal or moral obligations to alert the BME about the conduct of certain physicians, the insurance companies could provide an important alternative safety net for protecting an unsuspecting public. This potential role was conceded by PIC's Smith in testimony before SCI Chairman Henry S. Patterson, II:

Backlog of Unreviewed Reports

The insurance companies appear to be obeying the 1983 law requiring them to report any claim settlement, judgment or arbitration award for over \$25,000 involving a physician or surgeon to the BME, *N.J.S.A. 17:30D-17*. Although about a thousand reports have been submitted, hardly half of them have received even a superficial review by the BME. Indeed, the BME's general reaction to this potentially valuable source of regulatory data has been casual and hesitant. For example, it established a Medical Malpractice Report Review Committee but delayed for two years after the law was enacted the adoption of a policy for organizing and reviewing the report infor-

MR. SMITH: . . . I'd like to point out that I don't think it's an insurance company's obligation to police the medical profession. We feel it's up to the profession itself and/or the [BME]. . . .

CHAIRMAN PATTERSON: The problem is—I'm sure you know the medical profession much better than I do—it tends to be protective of its own.

A. Yes.

CHAIRMAN PATTERSON: And, if that's so, then somebody has to do it. If they are not going to do it, somebody has to do it, and I don't suggest that it be the insurance companies, but if the doctors won't do it and the insurance companies don't think it's their responsibility, who is going to do it?

A. I can't answer that. And I agree completely. Perhaps, as you say, there's some type of immunity that will help, but still there is an old boys' network out there . . . I don't know how you're going to resolve it.

CHAIRMAN PATTERSON: I think it probably has to be a joint effort of a lot of people. I don't think that the insurance companies can say "no, it's not our responsibility". I think that they have to say, "We are not in the best position to do the job, but we certainly have a vested interest in making sure that somebody does it and to the extent that we can help do it, we will do it."

A. I certainly agree with that.

mation and obtaining supplemental data. That was in July, 1985. Yet, during the two years since that formalized policy for reviewing the reports has been in effect, the BME has done little more than list the physician-defendants in alphabetical order. What reviews have occurred have been cursory, incomplete and obviously unproductive.

None of the sorting called for by the review policy—classification by specialty, classification by certification status, determination of whether two or more dispositions occurred within two years for given physicians, and separation of cases involving more than \$100,000, unexpected

death, unexpected major incapacity, abandonment of a patient and settlements based on demonstrated incompetency—has ever been accomplished.

The BME has yet to determine how many of the physicians mentioned in the reports have come to its attention from other sources. The insurance reports have not been checked against the BME's master list of monthly disciplinary actions, the BME complaint files, malpractice action filings, hospital disciplinary reports or other sources of information that could provide insight into whether a particular physician is a probable threat to patients. The members of the Medical Malpractice Report Review Committee have not examined any of the underlying facts of any reported case. Neither has even one case been referred to the Enforcement Bureau for a preliminary evaluation by its investigators.

One reason cited for the lack of action on the malpractice reports is that they don't provide sufficient data upon which investigative priorities can be based. However, the reporting statute requires that the notification form "shall contain such information as may be required" by the BME. The SCI has yet to discover any communication with the Department of Insurance by the BME concerning the reporting form that it now blames for its failure to utilize them effectively.

The data provided by the reports is minimal—including the identification of the physician, the amount of the award, a brief description of the nature and grounds of the award, and whether an appeal is pending. The Commission found such limited information totally inadequate for judging whether to initiate an incompetency inquiry. Nonetheless, even prior to July 17, 1985, when the BME adopted the review policy it has not been able to implement, the Review Committee divided the reports on hand among themselves and attempted to set aside reports that appeared to require further action. As explained by the committee's chairman, Dr. Floyd J. Donahue, at the SCI:

... We concluded that about 75 percent of the cases ... needed no further action, that there was no cause for action based on the minimal detail that we had. In about 25 percent of the cases we felt that additional information was needed before we could evaluate the case any further, and that information was not available to us. ... I personally have contacted the presidents of both [major] in-

surance companies requesting that additional information be given to the Board, and they are reluctant to do that until such time as a mandate comes from the Board or through some authority in order to protect the privacy of their insureds. So, in fact, the Committee and the [BME] is really lame or ineffective in carrying out the mandate of the Legislature through lack of information.

Despite the fact that its Review Committee determined that at least 25 percent of the cases merited further inquiry, the BME failed to aggressively promote such a move. When concerns were raised by insurers about their potential liability for submitting information beyond what the forms required, they should have been reminded bluntly of the law's promise that they "shall be immune from liability for furnishing information to the [BME] in fulfillment of the requirements of" the law, which includes "such information as may be required by the BME."

The BME also could have sought a declaratory judgment to allow the courts to determine how much information the insurers could give it. If the judiciary proved ineffective in resolving the issue, the BME could have asked the Legislature to clarify its intent by legislative amendments. Instead, the BME merely named a committee that could not, or would not, do what it was supposed to do.

Committee Chairman Donahue did discuss with the Exchange's Sweetland the possibility of obtaining expert witness reports in certain cases. Sweetland was receptive but felt this would not be effective. Instead, he offered to submit an enlarged narrative of what a reported case involved to help the Board decide which cases to investigate further. Typically, this offer prompted no affirmative action by the BME.

BME Executive Director Janousek contended that the BME lacked the resources to investigate the malpractice reports from the insurers:

- Q. *How many reports have been submitted so far since the law went into effect?*
- A. Since July of '83, approximately 800 to 1,000 have been reported.
- Q. *And what has the Board done with them?*
- A. At the present time [January, 1987], very little. ...

Q. Has the [Review Committee] reviewed any of these reports yet?

A. When the reports were initially received, I undertook the task in the office of having someone photocopy everything I got five times; I sent it out to the Committee members; and they reviewed it and at a point in time brought it back to the Board and came up with this policy. They, basically, said that without some type of computerization, it would be unwieldy the way it was being handled, and it's really taken that long to sit down and create something workable.

Q. Your requests for additional resources in the past, have they had this particular requirement of analyzing these reports in mind?

A. That's been one of the major aspects of the request for upgrading. Unfortunately, at the present time this Board is one of 22 professional boards going anywhere from shorthand court reporters, to barbers, to dentists, to physicians, and I really think that powers-to-be look at us as just one of 22 boards, not any more important or any less important than the others, and I think that that's why funding or whatever impetus to upgrade the Medical Board has not been done.

Looking In The Wrong Place Too Late

Although the law set \$25,000 as the cut-off figure for the mandatory reporting of malpractice insurance awards, the BME set \$100,000 as the smallest reported award that it would scrutinize under its malpractice report review policy. While this rule reduced the amount of paperwork confronting the BME review committee, which remained sorely backlogged nonetheless, more significantly the higher dollar figure reflected the belief that large awards would most likely reveal the most serious cases of potential incompetency and thus make the review process more productive. However, the Commission found that the dollar minimums for either law-required reporting or the BME malpractice reviews were not particularly useful as barometers of physician incompetence. In fact, witnesses at the SCI were unanimous in concluding that numerous malpractice awards, even for small dollar amounts, were a more accurate indication of physician incompetency than a single large award. There were also other deficiencies in the malpractice reporting situation that reduced the effectiveness of the reports as a means by which the BME could pinpoint a potentially impaired or otherwise incompetent physician whose practice required monitoring in order to protect patients. One such additional fault was the previously noted inadequacy of the data provided on the report forms for BME review purposes. Another major deficiency that was not the fault of either the reporting law or the BME's effort to utilize it was the prolonged passage of time between the incidents that prompted the lawsuits,

and the actual award decisions, a time lapse that reflected the delay between a medical mishap and the filing of a claim and between the processing of a claim and the resolution of a suit by settlement or judgment. The Commission reviewed these various malpractice reporting issues with a number of witnesses who were most involved with them. One such witness was the BME president at the time, Dr. Luka:

I felt that the statutes presented on reporting malpractice situations were ineffective, the way the statutes are written [is] meaningless. The case may be adjudicated five years down the line and here is a guy practicing all that period of time without anybody realizing what he is doing, and I think it's more important . . . to inform the Board immediately if there is a malpractice action filed where there is a death involved, and also if there are a repeated number of malpractice cases against one individual, even though they are not adjudicated. There may be some individual out there who has five or six or seven cases of malpractice against him, they may be minor malpractice cases, but obviously something is wrong. He may not be wrong, but there is enough there for the Board to look into that.

Dr. Grossman, then BME's secretary, testified that under the present malpractice reporting system, the data available for BME review purposes has also been meaningless:

I don't think the \$25,000 threshold means a thing. . . . If I had my druthers, I would love to know what suits are filed as they are filed and I would love to have the ability to know if it's the second, third or fourth suit for the doctor, and I would love to have access to the expert's written report from both sides as a way of scanning the cases, and I would also love to know who the insurance company decides they are not going to insure any more.

The Inter-Insurance Exchange's Sweetland not only testified about flaws in the reporting requirements but also suggested a viable alternative:

Q. *Would there be some cases involving conduct that could be characterized as incompetent that would involve amounts less than \$25,000?*

A. Certainly.

Q. *I think you indicated that you would be more interested in the frequency of claims than the amount of any given claim?*

A. I would suggest [frequency] as a more important factor, again based on the way we underwrite in insurance. Certainly, severity has a part to play, but, you know, consistent negligence is to me the strong indication of a problem.

Q. *Basically, what you are saying is that the Exchange's own evaluations of the claims take into account the number and types of claims. When I say types, I mean the underlying circumstances involving the claims to determine those physicians that are considered to be problematic for the Exchange, and you are saying that a similar system could be utilized to determine those physicians that are problematic from the [BME's] perspective?*

A. Correct. And based on the way you phrased it, I confirm that it isn't going to be an identical list.

Q. *Can you succinctly describe a reporting system that the Exchange believes should be substituted for the present system?*

A. My succinct description would be that we be required to report all individuals whom we cancel and all individuals who exceed the screening level of our high risk evaluation program, giving the same amount of detail on paid losses as we are now working out and some agreed upon amount of information on the open ones that still protects some of our concerns and satisfies the Board that they have enough information to work with.

Utilizing its own computer expertise—a technological capability that the BME desperately needs—the Commission dissected 427 of the reports submitted to the BME between August 11, 1983, and March 12, 1985. These reports identified 459 doctors, and the malpractice allegations involved deaths, deformities, brain damage, diminishment of life, disabilities, amputations and paralysis. One physician had a history of seven awards, of which three stemmed from a "wrong operation." Another doctor was penalized by five awards, four involving a "wrong operation," and in two of the five awards the physician with seven awards was also a defendant. These cases, which were not reviewed by the BME, illustrate the insufficiency of the insurance award reporting system as an early warning mechanism to alert the BME to physician incompetency. By the time these cases were settled and reported to the BME, both physicians had lost their licenses as a result of independent reports of their transgressions—performing unnecessary surgery—from a peer review organization. In the meantime, the Commission wonders, how many patients these two doctors treated—or mistreated—before their licenses were revoked.

Whatever the deficiencies of the malpractice award reporting system, it is appalling that four years after the Legislature created the system the information it does provide remains largely ignored. The insurance reports, despite the inadequacies of form and timing, reveal examples of potential incompetency that have gone undetected by the BME and should be probed. Even untimely information could be effectively utilized by the BME as a tool to identify incompetent practitioners.

Self-Insured Not Reporting

Nothing prevents a doctor from practicing without insurance, except where it is required as a condition for obtaining hospital privileges. Doctors who are sued so many times that they cannot get coverage may, and often do, simply practice without insurance protection. Collectively, they constitute a particularly ominous threat to the public health and welfare because so little is known about who and where they are.

The reporting law requires that uninsured and self-insured physicians notify the BME of any medical malpractice settlement, judgment or arbitration award for over \$25,000. However, even though it is known that many physicians—perhaps hundreds—are at least self-insured, not one has ever submitted notice of a malpractice award to the BME.

Neither the BME nor any other agency maintains statistics on the number of uninsured or self-insured practitioners, chiefly, and regrettably, because no one has seen fit even to attempt to establish a data base that might identify them. Further, although many physicians practice under the auspices of health care facilities or research organizations that provide and pay for insurance coverage, no one knows the precise identity of these practitioners. The BME's inability to keep track of these

physicians, as well as its failure to identify them, is officially conceded. The BME's Executive Director Janousek testified that he didn't know that self-insured physicians were required to report malpractice actions to the BME:

Q. *Has anyone tried to determine how many physicians actively practicing in New Jersey are self-insured?*

A. No.

Q. *The statute imposes a requirement that self-insured physicians also report their medical malpractice actions; is that correct?*

A. I'm not aware of that. If it's true, I've never gotten one from a self-insured physician.

Hospitals and other health care facilities, in addition to being required to report disciplinary actions against physicians, also must report to the BME any medical malpractice liability insurance claim settlements, judgments or arbitration awards of more than \$25,000 to which they are parties. A form promulgated by the Department of Health must be completed by hospitals and forwarded to the BME. The BME has received such reports but has largely ignored them.

Federal Reporting Requirement

The Federal Health Care Quality Improvement Act of 1986 reflects Congress' conclusion that paid malpractice claims may signal incompetency. The law provides that by November 14, 1987, medical malpractice insurers must report all payments on lawsuits or claims to the Secretary of Health and Human Services or his designee and to the appropriate licensing board in the state where the action arose. Not only is no payment threshold amount applicable, but the reporting also is required for actions against licensed health care practitioners other than physicians. Insurers that fail to comply are subject to maximum penalties of \$10,000 for each payment not reported.

Congress also ordered the Secretary to study and report, not later than November 14, 1988, on whether a threshold payment amount should be

established and whether claims should be reported without waiting for a payment following a settlement or judgment. The Commission has already concluded that the need for timely reporting and the desire to have a complete claims history, regardless of amount, require a review of all pending claims and court actions. The federal law will, for the time being, preempt the \$25,000 threshold applicable in New Jersey's current reporting law. New Jersey should urge federal officials to permanently eliminate any threshold and to mandate reporting of unpaid claims. The Enforcement Bureau should also receive additional resources to correlate insurer and court data and to enable the BME and other boards to effectively assess the information and investigate cases in which incompetence is indicated.

BME Is Critically Backlogged

The BME is assigned to the Division of Consumer Affairs within the Department of Law & Public Safety. A single Enforcement Bureau handles its investigations and those of most of the 21 other professional boards in the Division. Deputy attorneys general provide legal advice to the BME and prosecute disciplinary proceedings before it.

Aside from the BME's deficiencies as portrayed in this report, the agency has been generally recognized as one of the most effective medical boards in the country and the most capable professional board in New Jersey in terms of dealing with wayward licensees. Typical of the praise accorded the BME is the testimony of Enforcement Chief Tumminello:

The Medical Board is a very active board. Of the 22 licensing boards it is the most active board. It meets the most frequently. The Board members appear to devote the most time to their duties. . . . They don't take a summer vacation, as some boards do. They meet monthly 12 months a year. They also have executive committees which meet I would say a minimum of twice a month and sometimes three times a month to handle disciplinary matters. There's also a credentials committee which meets at least once a month to review credentialing matters. They are very busy. They have the most comprehensive, detailed minutes of any board that I've had the opportunity to review minutes for.

In many respects, also, the BME is proactive rather than reactive. It has, for example, published a quarterly information bulletin informing licensees of its regulations, dealt with problems associated with foreign-trained physicians, examined continuing medical education proposals and sponsored a registration system to ensure greater regulatory control over unlicensed medical graduates in residency programs.

Lack of Resources

Despite its overall positive stature, the BME lacks sufficient resources and procedures to adequately contend with its existing volume of complaints, let alone the additional workload that would result from properly responsible reporting of incompetency and impairments.

The BME, for example, does not review available studies to determine whether high mortality rates at certain hospitals indicate incompetency by individual physicians. It has not studied autopsy reports to determine whether deaths in hospital emergency rooms could have been prevented if patients had received proper trauma care. Neither has the Board commissioned the Department of Health or any other organization to assess the practices of certain physicians to determine if the care provided meets required standards.

Statistics obtained from professional groups and BME activity summaries indicate that from 1982 through 1986 the agency suspended or revoked at least 186 medical licenses, ranging from 33 to 42 such punitive actions per year. In 1985 New Jersey's BME ranked ninth among all states in the number of disciplinary actions against physicians—eight actions per 1,000. In 1979 the BME reviewed 70 investigative reports for violations by doctors, a review activity that just one year later more than doubled to 153. The number of such investigative reports reviewed peaked at 228 in 1982 and since then has averaged 175 per year. From 1983 through 1986 a total of 1,165 physicians appeared before the BME, ranging from 250 to 325 per year.

The 17 part-time members of the BME regulate twelve categories of health care professionals, including physicians and surgeons. The other categories are chiropractors, podiatrists, midwives, nurse midwives, laboratory directors, specialty laboratory directors, hearing aid dispensers, acupuncturists, athletic trainers and orthoptists. In all categories governed by the BME, about 30,000 licensees actively practice in New Jersey. At the outset of this Commission's report it was noted that there are 28,766 physicians with current New Jersey licenses. However, not all of these doctors practice in this state. The BME cannot determine precisely how many of its licensees are actively practicing in New Jersey.

The BME's members are appointed by the Governor. Except for the *ex officio* member and three public members, the Governor must, by law, "give due consideration to . . . recommendations submitted by the appropriate professional organizations" in making his appointments, although he is not bound by such recommendations. The *ex officio* member must be the head of a department "closely related to the profession . . . regulated."

The Governor has designated the Chancellor of Higher Education as the BME's *ex officio* member.

Board members serve three-year terms. In addition to the three public members and the chancellor, BME's membership includes nine medical doctors, one osteopath, one chiropractor, one podiatrist and one laboratory director.

Prior to any appointment to the BME, a limited background check is conducted that does not include a review of records to determine if the individual has a criminal history or a flawed license status. The BME's Dr. Luka, who was its president for four years until mid-1987, testified that the Governor's office had asked him about three potential appointees, none of whom were appointed. Executive Director Janousek, describing the problems that could result from an inadequate background check of BME appointees, recalled how a member was appointed to one professional board who had been fined \$130,000 for aiding and abetting an unlicensed activity.

There is no formal indoctrination or training of Board members. New members are supplied with a BME policy manual and copies of relevant statutes and regulations. They are briefed by the executive director and deputy attorneys general assigned to the Board.

Inadequate Compensation

BME members receive \$25 for each meeting under five hours and \$50 for each over five hours. The statute allows members to receive an amount determined by the attorney general, with the approval of the state treasurer, not to exceed \$100 per day or \$2,500 annually, in addition to expenses for mileage and tolls. Regular monthly meetings normally run for 10 hours and sometimes up to 14 hours. Executive and credentials committee meetings usually last approximately eight hours. Thus, an actively participating Board member attending a regular meeting and three Committee meetings in a given month will have worked at least 34 hours, not counting preparation time, for \$200, carfare and four lunches. Assuming his travel and preparation time brought the total to 50 hours, he would be compensated at little more than the minimum hourly wage rate as a prestigious professional exercising significant responsibility for preserving the public health and welfare. Such compensation for the time expended and the professional expertise required is obviously unreasonable.

Part Time Operation Unwieldy

After noting the diligence of certain Board members, despite the meager compensation, Executive Director Janousek, frankly admitted the functional shortcomings of such a large group of part time regulators:

Q. *Are there some members of the Board who only attend the 12 regular meetings [held annually]?*

A. That's correct.

Q. *About how many?*

A. . . . I'd say at least two or three just attend the one full Board meeting a month, though they may be on an ad hoc committee for a special project. . . .

Q. *Assuming that all . . . members of the Board, if all vacancies were filled, were putting in their best efforts on the job, would that be enough, given the volume of work that the Board of Medical Examiners has?*

A. No.

Q. *And what would be desirable as a change in the system to allow all the work of the Board to be accomplished?*

A. Personally I think the Board should be a smaller Board. I think it's too unwieldy. . . . I also think, though it may be very idealistic, that there should be a full time Board, which when I say idealistic, I don't know what kind of recompense or salary these people would get. But it's a full time daily job and these people are part time members trying to wrestle with a lot of problems, whether they be disciplinary problems, ethical problems.

I also think that it's conceivable that the Board has too many different types of licensing categories to wrestle with. Its name is the Medical Board but it has a lot of other categories . . . that it has to deal with, and I think possibly the State . . . should consider an allied health board to take away some of the lesser categories and let the Board be the Medical Board.

CHAIRMAN PATTERSON: Is it difficult to get people to serve on the Board?

A. I'm not in that process, but I think the prestige probably doesn't make it hard to get a Board

member; but when they see the volume of the work, it's whatever type of individual that person is to decide how much they want to put into it. And I don't think they are informed as to what they are getting into and do they want to make a commitment, and do they know that they are going to have to serve on committees, not just go to one Board meeting a month. I think they have to get—whoever makes the appointment has to get some type of commitment out of that Board member that he's going to serve the Board as the total Board wants him to serve. . . .

CHAIRMAN PATTERSON: If a person is appointed to the Board and accepts the appointment and then finds out . . . that the work is harder, more hours than he expected, does that person tend to resign quickly or does that person tend to go through the motions?

A. They tend to go through the motions.

No-Show Public Member

It has been customary in most states, including New Jersey, to include so-called "public members" on various appointive boards to insure that the performance of such boards reflects a wider community-oriented and a reduced self-interest influence than might otherwise be the case. This practice supposedly has been particularly effective on the 22 professional boards that regulate scores of thousands of licensed professionals in this state. How effective such public members on the professional boards are depends, of course, on how active a minority role they play with respect to their associates who represent a more narrowly defined and specialized self-interest that, unwitting or not, may not always be equated with the public interest. For several years the BME membership has been required by law to include three public representatives, but vacancies have persisted from time to time. Their's has been a critical responsibility considering the potential pressures on them by the members who constitute the BME's majority and who generally can be expected to unite on decisions important to the medical profession. Thus, if a public member fails to respect even the minimal obligations of his office, the abdication leaves a huge public constituency exceedingly vulnerable to an imbalance of judgments by the Board.

One such public member was appointed to the BME in March, 1986, and resigned in July, 1987.

During that period, he attended part of only one scheduled meeting of the agency. BME officials sought to have him replaced as long ago as early January, 1987.

It should be emphasized here that the service of the BME's veteran public member, Ruth S. Ballou, has been distinguished by steady attendance and close, intelligent and public-minded attention to the official affairs, problems, discussions and decisions of the Board. Indeed, Dr. Grossman, then the BME secretary, singled out Ballou's performance when he testified at the SCI on the subject of public members:

I think [public members] play an important role on the Board. I think the Board has been drifting a little bit for the last year for lack of public member input, not a lot, just a little. We have one public member [Ballou] who has been on the Board for some time who is the editor of our newsletter that goes out to our licensees, who has been very effective reminding the Board of their responsibilities to consumers. . . . They should watchdog us. We had a public member who resigned I guess a year or two ago who I thought was a very effective watchdog who often called the physicians to task for being protective of physicians. I would like to see us have a strong group of public members. I would like to see four strong public members on the Board.

The Commission believes that all appointments to the professional boards are important. However, public members serve a key function of ensuring that the members who belong to the profession being regulated do not lose sight of their obligations to the general public out of misguided loyalty to colleagues. The Commission believes that an existing statutory procedure, allowing the Governor to remove public members after a hearing for neglect of duty, should be implemented as soon as such a situation appears. Moreover, as is the case with several other professional boards, the law governing non-public members of the BME should be amended to allow removal by the Governor, after hearing, for "misconduct, incompetency, neglect of duty or any other sufficient cause."

Full Time Medical Director Needed

The most important staff improvement at the BME would be the addition of a full time, salaried

medical director. Such a specialized officer could aggressively communicate the BME's sense of priorities to the Enforcement Bureau and the Division of Law, assist in coordinating the work of these three entities, direct the screening of malpractice and other data to determine matters warranting further inquiry, and negotiate effective protective medical practice restrictions as an alternative to lengthy disciplinary proceedings. None of these important functions is effectively coordinated at the BME at the present time.

During the many years (1959-1984) when the late Dr. Edwin Albano was president of the BME, the State reaped the benefits of having a medical director at the agency—without cost. When not performing his duties as the State Medical Examiner, at the time, Dr. Albano could be truthfully described as also working full time at the BME. Dr. Donahue of the BME described how effective a full time medical director would be at the BME:

Q. *What tasks would a medical director perform?*

A. Well, if I could just go into the history of the Board a little bit. For 18 years Dr. Albano was president of the Board, and it was his full time job which he did for no financial remuneration. He did it for the love of the Board. All the members of the Board are practicing physicians or have other requirements for their livelihood. It would be very good if the Board had a full time professional director who would answer to the Board, who could coordinate all activities of the Board, not only reports of incidents of violation but policy matters and even a creative thinker for the Board who would add to the Board as Dr. Albano did. [Right now] a significant void [is] present.

Q. *This medical director would, to some extent, determine priorities for the Board's activities?*

A. No, I don't think so, except by his position he may influence priorities.

Q. *I'm thinking specifically in terms of the Board's relationship with the Enforcement Bureau and the Division of Law, that is, the medical director indicating which investigations should take priority, that sort of thing.*

A. Yes, absolutely.

Q. *Being able to give some indication to the people doing the investigations or preparing the legal cases as to the extent of preparation necessary and that sort of activity?*

A. Yes, that would be his prime activity, I would think.

Q. *Would you see . . . the appointment of a full time medical director . . . to be as important as devoting additional resources to the acquisition of more investigators and more deputy attorneys general to handle the Board's work?*

A. More important.

Q. *Could you briefly summarize why?*

A. Probably a great deal of work is done by the investigating team that doesn't have to be done. I have seen many reports in which there has been extensive investigation which could have been done by a momentary decision by a [medical] director in terms of its importance, and you can take it from there. I think that, as you have mentioned, the decisions that could be made to efficiently develop the workload of the various subordinates to the Board could be carried out very well by a professional director.

A full time medical director would be able to conduct or supervise more complete analyses of the practices of allegedly incompetent or impaired physicians. Former BME Secretary Grossman testified that this would allow the BME to focus on an entire practice rather than one or two incidents that may not accurately reflect a physician's patient care abilities or attitudes:

I would love to just take it a step further. [The BME] will have [a] complaint based on . . . the care of two patients and we ask for records and we talk to the doctor and we talk about the care of those two patients and we look at the records on those two patients. Then we try [to] make a judgment about his competency based on those two patients. I think that's terrible. There are records of 500 patients sitting in his office. I would like somebody to go into his office and . . . look at every tenth chart. You want to talk about resources; I am scared to death to suggest that in public, because what they are going to do is say, "Good, you do that." We don't have the

people. Then you could make a judgment as to whether or not a doctor is competent, maybe.

Grossman described additional tasks a medical director could undertake:

Q. *What would be this medical director's duties?*

A. Well, this issue [of priority setting] we have already described, number one. Number two, he certainly would have the ability to look at complaints as they came in and evaluate them medically. . . . I think that he could certainly be involved in policymaking decisions. . . . What do you do with doctors who don't want to treat patients with AIDS, et cetera, et cetera. There is so much mileage you get out of Board members and I don't think that the Board members can supply all of the medical expertise that is needed. . . .

Q. *Someone who could give guidance as to the effective utilization of scarce resources?*

A. That would be a big part of his job.

Q. *Would he also participate in settlement negotiations, that is, negotiations leading up to consent judgments?*

A. I would think so, with the Board having the final say.

Q. *You mentioned that in some cases reeducation would be the appropriate course to achieving some kind of change in the way a practice [is] conducted. I take it that the medical director would provide this information to the physicians being scrutinized?*

A. Yes. . . . I really see him as again also having the ability to surround himself with a group of consultants that he could call upon on short notice to look at some matters.

Fees Pay Most of BME's Costs

The BME has annual expenditures of about \$1,827,000. Its expenses include a proportionate share of the cost of services by the Enforcement Bureau, the Division of Law and administrative support from elsewhere in the bureaucracy.

The BME staff—consisting of 15 full time employees, a full time hourly employee and six part time workers—devotes at least 60 percent of its efforts to licensing and the remainder to dis-

ciplinary matters. With the exception of the executive director and two assistant executive directors, all BME staffers are clerical. The revenues to pay for the BME's operations come primarily from examination and license fees. A sum of about \$150,000 is derived from penalties and costs assessed against disciplined health care professionals regulated by the BME. By statute the BME may retain license fees to defray "expenses of securing evidence against and prosecuting persons violating the provisions of the laws with the enforcement of which they are charged. . . ."

The initial physician license fee was \$150 and the biennial fee was \$80 until August, 1987, when increases to \$225 and \$160, respectively, were approved by the BME. These increases will provide funds for additional Enforcement Bureau personnel to review medical malpractice cases and other evidence of potential incompetency, as well as for follow-up support.

Until the SCI began its investigation, increased appropriation requests to enable the BME to keep pace with its increasing workload had not been submitted. Such fiscal timidity, in the face of an obvious need for more resources, perhaps reflected a concern within the profession that any increased funding for BME's benefit would automatically mean increased licensing fees.

That such a concern was not illusory was demonstrated when the Department of Law and Public Safety, obviously alarmed about BME's failure to conduct more than a superficial review of the hundreds of accumulated malpractice reports submitted by insurance companies, requested and received an additional \$439,000 for fiscal year 1988 to fund a malpractice section in the Enforcement Bureau. As noted, the concomitant increases in the physician license renewal fees will be the funding source for the new section, as well as additional necessary resources.

Regulatory Procedures Outdated

Many of the BME's most critical and burdensome office processes are handled manually—a shocking anomaly in this high-tech electronic age considering the sophistication of the profession the agency regulates. Files are not cross-indexed or not indexed at all. Data is not maintained so that it can be easily retrieved to effectively evaluate compliance with statutes and regulations the BME must enforce. For example,

no summary information is available to indicate the existence, much less the frequency, of hospital reports of disciplinary proceedings against physicians. All important license fee payments are not even collected in some instances, as BME's Luka testified:

We have found that there are physicians who run into a problem, a disciplinary problem of some type, that supposedly have an active license in the State of New Jersey and have not paid their biennial registration for five, six, seven years.

Q. Do you know how many?

A. No. We just don't have that computer ability to find it out, and I think that's silly. We have tried to address that issue, and [Executive Director] Janousek is well aware of it, and . . . it's in the process of being computerized to check on it.

Janousek reported hopefully that for the 1987 biennial renewal period the BME will for the first time institute an Order of Ineligibility system that will bar from practice those physicians who fail to renew their licenses within a required period. This procedure was proposed after it was belatedly discovered that physicians in two recent disciplinary cases were practicing (one in a hospital setting) without having renewed their licenses.

A single clerk recently worked part-time on the task of inserting data from the insurance reports of malpractice awards into a personal computer. The SCI had suggested using data base software to organize the insurance report information. Concededly following up certain SCI mid-probe recommendations, the BME staff has completed much of the data entry work. However, further action has yet to be taken on the reports.

Concerning the BME's erratic tracking of complaints, Janousek testified:

Q. Does the Board maintain a log of all complaints?

A. It maintains a log of complaints, though it may not be a full and complete log.

Q. What might be absent?

A. I started that log some years ago only because the Division of Consumer Affairs required that in a monthly and then yearly com-

pilation of information that I indicate the number of complaints that I received and the disposition number. . . . And I enter complaints that come across my desk, but I'll tell you, when I get a report from a hospital or something to do with advertising, something to do with a criminal conviction . . . , for some reason I don't put it in the book. I don't know why. I consider the routine complaints the ones that they are interested in, and I can't give you a better explanation.

Obviously, to have a full and complete record you should put everything that comes across my desk that has any question of violation of some rule, regulation or statute, but it's not being done. I do it myself, and I have a lot of things that keep me busy.

Q. To assist you, you have recently obtained a personal computer?

A. Yes. I have asked for and am in the process of completing information that the computer center wants to obtain [for justification of] two additional PCs. . . . It's my hope that I can personally use [one], learn how to use it and enter complaints and be able to track them when somebody calls up and says what's the status of the complaint rather than relying on my memory, which is my computer right now, and not a bad one, but not infallible.

BME Struggling to Modernize

Considering the BME's national reputation as one of the best state regulators, it is difficult to imagine the plight of its sister agencies in other jurisdictions on the basis of the SCI's probing into the Board's licensure procedures. It may well be true that, beginning with the biennial renewal period in the fall of 1987, a number of reforms will mark a procedural update that will at long last modernize the BME. Consider the disturbing lack of information about the licensees which the SCI encountered:

The minimal information routinely collected by the BME on its physician licensees is contained in the initial license applications, biennial renewal applications and forms for changes in "office address or . . . employment." Until the 1987 biennial renewal period, renewal applications had space only for a single address, which was not specified to be an office address. Also, there was no place to identify a practice or an employer, so the BME

often wound up having a residential "address of record" and no information about the scope of a given physician's professional practice. There was space to indicate a single "main specialty" but no space to indicate secondary specialties. Although the applicant had to indicate whether he maintained a practice in New Jersey, he did not have to specify its location. There was space for listing two licenses held in other states but no place to indicate the type of license, whether the person was practicing in another state or precisely where such practice occurred. Hospital affiliations were also absent, as were group practice names, employers, residency programs, military reserve affiliations, other licenses held in New Jersey, driver license suspensions, criminal arrests not yet resulting in indictment, medical malpractice insurance carriers, history and status of malpractice coverage, specialty certifications held and license denials or disciplinary actions in other states. This lack of information left the BME with not even a rudimentary foundation on which to begin inquiries concerning alleged shortcomings on the part of suspect physicians.

Executive Director Janousek reported that for the 1987 biennial renewal, which is scheduled to begin in the fall, more information is being sought from licensees. The renewal form now asks for all states where the physician holds a license. It also asks for all hospitals where privileges are held by the physician, as well as all office addresses in New Jersey. The question seeking information about any administrative offenses has been expanded to specify the types of agencies and private organizations that regulate or grant practice privileges to physicians (state licensing agency, Department of Health CDS Registry, Drug Enforcement Administration, hospital, Medicaid, Medicare). The question relating to convictions or indictments for crimes has been expanded to include arrests and to specify various types of dispositions for a criminal offense. Although minor traffic offenses need not be listed, offenses such as driving while impaired or intoxicated must be disclosed. The new form also provides that the entry of an expungement or sealing order in any judicial or administrative proceeding or an order authorizing pre-trial diversion does not relieve the applicant of his duty to disclose. Moreover, the new form specifies that a failure to answer questions or to answer them truthfully may result in denial of renewal or a suspension or revocation of licensure.

Nonetheless, there are continuing deficiencies in the system. The new license renewal form still does not ask for the names of a physician's practices or employers. There is space to indicate a single "main specialty" but still no indication of secondary specialties or what the applicant does. There again is space for listing two licenses held in other states but still no place to indicate the type of license, whether the person is practicing in another state or precisely where such practice occurs. Also absent from the new form are current participation in residency programs, military reserve medical affiliations, other licenses held in New Jersey, driver license suspensions, medical malpractice insurance carriers, history and status of malpractice coverage and specialty certifications held. Thus, the renewal form still lacks much useful information. In addition, it does not yet contain an applicant's certification that information supplied is true and an acknowledgment that he is aware that if any of the statements made are wilfully false he is subject to punishment.

The initial license application form has yet to be revised. It therefore will not provide considerable data vital to the BME's regulatory obligations. It does not request the applicant's office addresses, practice names or employers, specialties, other state practice locations and hospital affiliations, all residency programs attended, military reserve affiliations, other licenses held in New Jersey, driver license suspensions, medical malpractice insurance carriers, history and status of malpractice coverage, specialty certifications held and license denials or disciplinary actions in other states. At present, incongruously, the renewal application seeks more information from the applicant in these important categories than the initial license application.

Janousek testified at the SCI that the BME only recently started including an AMA questionnaire with its initial license applications. If (by chance) the questionnaire is returned, it is placed in the physician's file.

The BME's physician files are confusing and difficult to utilize effectively. The shelves of open files represent ongoing investigations of physicians and matters awaiting action by the BME. There are also shelves of closed or "#2 files" on physicians whose cases are no longer being investigated. While the files are arranged in alphabetical order on the shelves, no indexing has been available for several years. The closed files

are merely placed in a separate area of the shelves and only in alphabetical order. This scattering of files without adequate indexing and cross-indexing has resulted in an incomplete history for individual applicants for licensure or for other purposes. The BME's staff might not know, for example, that a closed file exists for a physician presently under investigation. Thus, the Enforcement Bureau would lack information to assist its investigation and the BME would not have a complete history upon which to base decisions. A master index referencing all files pertaining to a given physician is essential to reduce confusion.

Some improvement may be forthcoming when the BME participates in a Centralized Licensing Information System (CLIS), which will be maintained by the Division of Consumer Affairs in a computerized data base. Originally scheduled to go on line in fiscal 1985, the system will not become fully implemented until fiscal 1988. Despite its critical need for procedural modernization, the BME, with its large volume of data, will be one of the last agencies to participate, according to present plans.

A most important additional use for CLIS would be to notify hospitals and other important parties of the details of any action taken against a physician's license. Presently, the BME relies upon hospitals to observe notices of disciplinary actions contained in its monthly newsletter and to obtain copies of orders on their own initiative. The SCI has observed examples where hospitals either did not see notices pertaining to their staff members or did not obtain copies of orders so that important practice restrictions could be implemented. This was especially the case for hospitals other than those where the actual conduct which resulted in the disciplinary action took place. Based on the increased practice and affiliation information which will accumulate in the BME's files, it should supply copies of disciplinary orders to all interested parties as immediately as possible in addition to publishing a general notice in its monthly newsletter.

Among other uses, the CLIS should allow the BME to rapidly supply information concerning licensees to members of the public making telephone inquiries. Presently, callers to the BME telephone number may obtain such information only after a time-consuming manual search of files by BME staffers.

Unused Statute Should Be Repealed

Pursuant to what the Commission regards as a useless statute, *N.J.S.A. 45:9-17*, licensees must file certified copies of their licenses with the clerks of the counties in which they reside (or if they live out-of-state, in the county where they practice). County clerks must annually report their lists or registries of licensees to the BME "to be approved by the board." Executive Director Janousek testified that the statute has not been followed by county clerks, with the exception of "one or two that have done it within the last seven or eight years." No statistics are kept based on what little information is received and the information is not cross-checked against BME files. The Commission believes that no useful purpose is served by this admittedly ineffective reporting requirement imposed on county clerks. The statute would especially be outdated if the BME were to collect all the data that the SCI believes it should collect routinely at the time of initial licensure and license renewal, as previously noted.

Criminal History Checks Not Done

Neither the BME nor its investigative arm, the Enforcement Bureau, conducts routine criminal history record checks of applicants for physician licensure or relicensure. Even when they are interested in the criminal history of a particular physician under investigation, they are only authorized to receive so-called "Code E" information, which is New Jersey convictions alone. Arrest data ("Code C" information) is unavailable unless the Enforcement Bureau is working with a law enforcement agency on a current criminal investigation. Also, neither the BME nor the Enforcement Bureau has access to criminal history information maintained by the Federal Bureau of Investigation.

The value of criminal history checks is illustrated by the case of a Maryland physician who applied for a New Jersey license in 1985. He indicated that a disciplinary action had been taken against a previous license but failed to disclose that he had been charged with a crime. The BME determined that the disciplinary action—revocation of license in 1980 for incompetence concerning the treatment of 16 patients—occurred in Maryland. Fortunately, the BME received from Maryland regulators a newspaper clipping that revealed the doctor's arrest and indictment allegedly for sexual assault while

examining a pregnant patient. The BME found out that the patient withdrew the charges before trial; however, its further inquiries revealed that the doctor had omitted from an application for privileges at a hospital any indication of his forced resignation from a residency program. The BME also discovered that he had used a favorable reference in an unauthorized way. Had criminal record checks been a routine procedure, the BME would not have had to find out indirectly about the doctor's deception.

Increased Authority Necessary

The public should better realize that many legal remedies exist that the BME can utilize to protect patients from physicians who are identified as impaired or incompetent. In appropriate cases these provisions allow the BME to exclude offenders from the profession or impose substantial monetary sanctions. Indiscriminate or bad faith prescribing or dispensing of controlled substances is grounds for license revocation, suspension or refusal, or to deny admission to an examination. Other grounds include gross negligence, malpractice or incompetence, repeated acts of negligence, malpractice or incompetence, professional misconduct, adjudicated insanity, habitual use of intoxicants or drugs, illegally or fraudulently obtaining a diploma, license or certificate, employing unlicensed persons, conviction for violation of a

Enforcement Bureau

The Enforcement Bureau conducts investigations and inspections for all 22 professional boards in the Division of Consumer Affairs. It also can initiate investigations on its own under the supervision of the attorney general and the director of the Division. Of its four staff sections—administration, inspection, investigation and drug diversion—the last two are those with which the BME has the most direct contacts. The investigation section has two supervisors and 14 field investigators, including three registered nurses. In the drug diversion section, there are two supervisors and 10 field investigators. Most of this section's cases are referred by a Drug Diversion Committee chaired by the chief of the Enforcement Bureau. The committee consists of representatives of the Enforcement Bureau, Medicaid Fraud Section in the Division of Criminal Justice,

federal or state narcotic law, conviction for or practice of criminal abortion, conviction of a crime of moral turpitude or a crime relating adversely to the practice of medicine, etc. Indeed "professional misconduct" has been held to include drinking during work hours and having alcohol on the breath even though no determination was made that it adversely affected performance. The BME also may require a physician to take affirmative corrective actions in order to retain his license, and it may condition licensure on securing medical or other professional treatment.

Despite these powers, it is not clear to what degree the BME may supervise or restrict the practices of physicians whose questionable actions do not amount to gross negligence, malpractice or incompetence. Neither is it clear that such physicians may be required to practice only under supervision or a proctorship or to participate in retraining as a condition of practice. The Commission believes that it is necessary to amend the uniform licensing law to provide for specific remedial measures that a licensing board may take in the event that the licensee fails to practice in a manner deemed by the board to be in the best interests of the public. Such an amendment would emphasize the remedial role of the professional boards rather than the disciplinary role. It would also clarify the authority of the boards to deal in more rehabilitative ways with problems that might not require severe sanctions.

State Police, Department of Health Drug Control Program and the Federal Drug Enforcement Administration.

Investigations Backlog

Overall the Enforcement Bureau monitors all criminal investigations conducted by other agencies and reports findings and results to the respective professional boards. It also conducts investigations of an administrative nature.

It was no surprise to the Commission, considering the range of the Bureau's enforcement obligations and the variety of "clients" it is required to serve, that the Bureau's case work is seriously backlogged.

As of October 1, 1987, the Bureau listed 555 pending investigations on behalf of all 22 boards.

Almost half, 259, were BME cases, of which 97 had been open for four months to one year and 104 for more than a year.

A major development so far as the BME is concerned was the Legislature's approval, effective in Fiscal Year 1988, of funding for a medical malpractice section. This section's 10 investigators would investigate the hundreds of medical malpractice case settlements, arbitration awards and judgments reported to the BME by insurance carriers pursuant to the 1983 reporting law. The Commission of course endorses this and other expanded efforts to adequately investigate complex incompetency cases.

Diminished Undercover Role

Present law unnecessarily restricts the Enforcement Bureau's ability to conduct safe and successful undercover investigations. Since they are not criminal law enforcement officers, Bureau investigators may not electronically intercept or record their conversations with others who are not aware of the interception, except with advance approval of the Attorney General or a county prosecutor after demonstrating a suspicion that evidence of criminal conduct would be derived. However, the Bureau often investigates serious matters not amounting to criminal offenses. Bureau Chief Edward Tumminello testified at the SCI that electronic surveillance of an undercover investigator's activities is

particularly important in situations where there may be transactions involving drugs and especially where we're investigating an individual who is alleged to have sexually assaulted patients, particularly female patients [and] we are required to send a female investigator into a physician's office, for example, and that individual may be alone . . . with the physician. We have no way of monitoring what is occurring in that situation.

Since at present the unlicensed practice of medicine is not a criminal offense in New Jersey, Bureau investigators lack electronic surveillance protection even when they are operating undercover to expose a person who is violating this most basic regulatory safeguard. In other areas where a licensed practitioner is unfit to practice medicine but not likely to be charged with any criminal offense, the Bureau is similarly hampered. The present limitation on electronic support for undercover operations increases the

danger to Bureau investigators and unnecessarily extends the period during which practitioners may perform harmful procedures on unsuspecting patients.

The Commission believes, therefore, that the New Jersey Wiretapping and Electronic Surveillance Control Act should be amended to allow interceptions, consented to by Enforcement Bureau investigators or other individuals, of conversations between themselves and others where there is a reasonable basis to believe that such conversations will provide evidence of violations of statutes and regulations governing the conduct of health care professionals. The amendments should provide for attorney general approval of all such interceptions.

Coordination and Priority Setting

Witnesses testifying at the SCI generally agreed that the BME and the Enforcement Bureau have an excellent working relationship. The Enforcement Bureau chief attends regular BME meetings and receives copies of minutes of those and of BME committee meetings. There was some concern, however, that routine investigative processes unduly delay decision-making in cases where the threat to patient safety demands a swifter, better-coordinated process. The BME's Grossman described this problem in his SCI testimony:

[One case involved] a doctor who was an obstetrician whose privileges were summarily suspended from [a] hospital about two years ago because he practiced poorly, and I am being kind. [The BME was] notified by the hospital. . . . Within a couple of months . . . a brief abstract was sent to me for screening. My response was, "get the Executive Committee to look at this, I think this is a significant matter." The Executive Committee looked at it and said "we would like to see hospital charts of four patients mentioned in this particular case." We then, instead of writing a letter to the hospital saying "send us the four charts," we went to the [Enforcement Bureau]. [They] ultimately went to the hospital and got the charts. They then came back to us. The time was 10 months. Now, that case is now two years old and that doctor has been practicing in another hospital for two years. He got his privilege at the other hospital prior to his suspension from the first hospital. I just think that's terrible.

I have a case . . . I was asked to look at, and the consumer complaint was she went to the hospital hemorrhaging in a miscarriage situation and her obstetrician wasn't available. When she said to the hospital "get me any obstetrician," they were unable to come up with one. It turned out her hemorrhaging stopped and she was not injured, fortuitously, and she left the hospital six hours later and went to another hospital, never having been seen by an obstetrician. In my response back to the Executive Committee as a screening Board member, I said, "let's write to the hospital and ask them . . . why is it that you don't have an obstetrician available for an emergency situation?" What has their medical director done about this complaint and what is their routine and procedure? I sent that report back to the Board. The Board handed it to the [Enforcement Bureau]. . . . The investigative report came back to my desk 14 months later, 14 months. That consumer thinks we are the biggest bunch of idiots in the world. If there is a bad situation down there at that hospital—I don't know if there is or there isn't—we let it go on for 14 months. I think that's terrible.

Grossman further testified that insufficient resources and lack of coordination are responsible for the investigative delays:

Q. *What are some of the reasons that it takes so long, in your opinion?*

A. . . . Resources. I am sure from conversations with the [Enforcement Bureau chief] that they are understaffed. And secondly, it's my opinion that they pursue the investigative effort in some cases beyond a reasonable . . . amount of effort. . . . And I don't think that the investigative people have the medical skills to know that, and I don't fault them for that.

Q. *So you would say [that there is] investigative overkill?*

A. Lack of ability of investigators to know the severity of the problem.

Q. *Now, to avoid that situation from occurring, I take it it would require some degree of coordination with either the Board members who are physicians or with some staff person for the Board who would have medical expertise?*

A. Yes.

Q. *Is that sort of coordination happening?*

A. No.

Q. *Why is it not?*

A. At the end . . . [of the monthly BME meeting] agenda . . . we have the closed agenda. And during the closed meeting . . . the Board is asked, "do you want us to pursue this." . . . Well, to be honest with you, it is usually 6 o'clock at night and later when those questions are asked. I have been there since 8:30 in the morning, I don't have any paper in front of me and I don't remember the details of the case. I am real unhappy about being asked those kinds of questions in that kind of a setting.

Q. *Basically, you are saying that it would be preferable to have day-to-day coordination between the [BME] staff and the Enforcement Bureau?*

A. And the deputy attorneys general.

Q. *In the Division of Law?*

A. Yes.

Q. *And the purpose of that coordination would be so that the Board could take more expeditious action?*

A. Yes.

Revise, Expand Deputy AG Role

Assisting the BME in handling its legal affairs—whether in connection with investigative referrals to the Enforcement Bureau, its own disciplinary proceedings or complaint processing or the conduct of its cases before administrative law judges—the BME is represented by three full time deputy attorneys general and one part time deputy. Because official policy requires that a deputy other than the one who prosecuted a case advise the BME on the legal issues affecting its disposition, the alternating of advisor and prosecutor roles has been criticized as an obstacle to impartiality. Dr. Luka, the BME president at the time, described his discomfort with the system:

Q. *An attorney general's policy requires that a deputy attorney general other than the one*

who prosecuted a particular case before the Board provide the Board with legal advice on issues affecting that matter's disposition. Is this system workable?

- A. It's workable, it's worked. I'm not very happy with it. I think I find it uncomfortable to sit with a deputy attorney general next to me advising me on a case that I may be adjudicating or presiding over and then 20 minutes later the same [deputy] attorney general is presenting a case to me, a different case granted. It's uncomfortable at times.

We are in the process of recommending some recommendations in that respect too, and I have had several conferences with Deputy Attorney General [Douglas] Harper

[Chief of the Professional Boards Section in the Division of Law] concerning this matter. He is now in the process of putting some of this on paper, presenting it to the attorney general for his review, for some possible changes.

- Q. *Are you talking about a far-reaching reform such as having a separate counsel for the Board?*

A. Yes, I am.

- Q. *As opposed to just a modification of DAG assignments?*

A. Well, I'm looking for a change; . . . I think . . . a legal advisor to the Board should not prosecute cases.

Insufficient Probation Monitoring

A number of physicians are practicing in New Jersey with license restrictions imposed by the BME, either as conditions for licensure or as a result of disciplinary proceedings. The restrictions include mandatory supervision by other physicians, limits on the place of practice, curtailment of procedures that may be performed, limited narcotic prescribing, submission of therapist reports and mandatory attendance at support group meetings or courses.

The BME does not maintain statistics on the number of licensees practicing under restrictions. It could not produce a report on who or where such physicians are.

When a licensee is placed on probation, there is little, if any, monitoring of compliance. A BME staff member maintains an index card file, which is reviewed each month to determine whether a required report or an installment payment on a penalty is due. Overdue submissions to the BME office are reported to the executive director, who then sends a letter to the licensee requesting compliance. Executive Director Janousek testified at the SCI about the lack of monitoring:

Probation to a physician in this State is really a hollow term. People ask me what it means and it means, I guess, that if you commit an offense during probation, the Board will be more severe on you the second time around. But the Board does not have the mechanism

in place, nor does it have the personnel to go out on a daily basis to the people on probation just to talk with them as you would with somebody on probation from the court system.

Enforcement Chief Tumminello testified that his office was also limited:

. . . We don't [monitor probation] routinely—only if there's some complaint or information received that indicates there has been or is a violation.

The BME's Dr. Luka condemned the probation monitoring system:

Probation has been really meaningless for this Board, totally meaningless; we have no way of monitoring it. . . . I very strongly believe that these people should be on probation, that something should be followed, that we should have someone go out there and look into their office periodically to see what they are doing, find out what they are doing in the hospitals, and we just don't have the facilities for that. When we place someone on probation administratively, all it means is if that individual should do something abnormal again he would probably get smacked twice as hard for a very small transgression of the Medical Practice Act, but we really don't have a probationary follow-up.

The BME's Grossman testified that the word probation itself "is meaningless, because there is no probation. There is no system whereby [the BME] brings [the doctor] into the office and says, 'How are you doing?'" Asked by Commissioner Zazzali whether probation at the BME was nothing more than a written or oral reprimand, Grossman replied, "That's correct."

Usually if the BME determines that an impaired physician has been rehabilitated and must be

monitored to make sure that he has no relapse, it allows the IPP to supervise the case and to report progress or transgressions to the Board. Thus, a private organization, itself understaffed and underequipped to handle sophisticated monitoring, is often called upon to relieve the BME of a major responsibility. Since the IPP owes primary allegiance to members of the profession, including impaired physicians, its objectives often conflict with the BME's primary responsibility of protecting the public.

Quality Assurance, Peer Review and Utilization Review

New Jersey and, indeed, the nation have placed considerable reliance on health care review systems (variously called quality assurance, peer review or utilization review) under the control of health care professionals to detect and deal with physician incompetency or other shortcomings. At least five major review systems function in New Jersey in an effort to restrain the cost of medical care and to monitor its quality.

First, the State Department of Health certifies utilization review organizations (UROs) to review the care provided to all hospitalized patients in New Jersey. Second, the Joint Commission on the Accreditation of Hospitals (JCAH), as part of its accreditation program in which all New Jersey hospitals participate, monitors hospital compliance with its quality assurance (QA) program. Third, the Federal Department of Health and Human Services (HHS), through the Health Care Financing Administration (HCFA), supervises a system of Utilization and Quality Control Peer Review Organizations (PROs) to assess the performance of physicians authorized to provide care for patients enrolled in the federally-funded Medicare system for the elderly. Fourth, the New Jersey Division of Medical Assistance and Health Services (the State agency that administers the federally and state-funded Medicaid program of health care for the indigent) contracts with a PRO and uses its own employees to determine whether Medicaid providers fail to meet "acceptable and customary standards of medical practice." Fifth, the Alternative Health Systems (AHS) program within DOH monitors quality assessment programs mandated for HMOs by federal and state law.

The Commission has determined that peer review in whatever form has failed to live up to its full potential as a mechanism for exposing and reducing incompetency in New Jersey. This failure results primarily from the lack of coordination between the various peer review systems and lack of reporting to and oversight by the BME.

Congress recently sought to encourage "effective professional peer review" with enactment of the Health Care Quality Improvement Act in November, 1986. Under this law hospitals, HMOs and professional societies that follow formal peer review processes meeting federal standards to take action against a physician's clinical privileges or society membership, as well as their peer review committees, staffs, truthful witnesses, contractors and other participants, are not liable for the review actions. No liability under state law will exist for such actions commenced on or after October 14, 1989. However, a state legislature may opt to exempt such peer review from liability earlier or it may by legislation reject altogether the immunity from liability under state law. If the protected parties are sued and have met federal standards in the review activities, the court must order the suing physician to pay their costs and attorney's fees, provided such parties "substantially prevail" in the lawsuit and the physician's claim or conduct of the litigation was "frivolous, unreasonable, without foundation or in bad faith."

Certified Utilization Review Organizations

On behalf of the Department of Health, UROs determine whether hospital inpatients or same-day surgery outpatients have been properly

classified under the State's prospective reimbursement system. This system allows hospitals to be paid fixed amounts for each patient based on the diagnosis related groups (DRGs) into which the patients fall. The reviewers scrutinize discharges of all hospital patients as well as concurrent medical necessity and appropriateness of admissions and continued stays of patients. Assessments of the quality of patient care provided are made during the course of the reviews.

Faith K. Goldschmidt, director of the health department's Reimbursement Systems Development, Evaluation and Research, and the overall supervisor of the state's utilization review program, testified about the lack of coordination among her department, the BME, the Medical Society and the UROs. What should be a "standardized smooth flowing process," she said, "is not occurring now." In addition, utilization review has not fully established standards of medical care upon which the competency of physicians may be judged. Goldschmidt testified that this process was begun as early as 1976 but was not implemented.

A staff of just five state health department employees supervises the entire utilization review program. Because of the team's lack of resources, many potentially useful studies have not been conducted. Indeed, because of the emphasis on "money type" problems quality issues are largely overlooked. Bernice Ferguson, head of the clinical team that administers the department's utilization review program, testified:

[The] main focus is rate setting . . . the real focus in our unit is reimbursement, capital, all the money type problems; that really gets the attention.

Q. You are saying there are very little resources available for quality of care?

A. To really correct some of the limitations that we have, yes.

DOH's Goldschmidt testified that a departmental reorganization of resources and priorities would enhance the quality assurance function, even if overall resources were not increased:

Instead of having the quality issues segregated within the . . . programs and done by people who have other responsibilities, it might be more efficient to pull out a group

within the Department, or, if you want to get very ambitious, for the state as a whole, to do nothing but monitor, direct, coordinate quality of care issues. . . . The quality issue is going to be increasing, and it's not going to be [just] the physicians; it's going to be nurses and everyone else. Looking to the future that might be something that would be very good for New Jersey in terms of making sure that the citizens' health and safety are taken care of.

The state program allows UROs to delegate the concurrent review function to the hospitals. Fifty-one out of 89 hospitals have availed themselves of this option. Another six hospitals are partially delegated; that is, either the initial registered nurse reviews or the follow-up physician reviews are delegated. In light of the obvious potential for a uniformity of interest between the reviewers and the reviewed in the delegated setting, the Commission was not surprised to hear the health department's Ferguson testify that "there have been some concerns as to the vigorousness of the hospitals providing their own reviews."

When utilization review, primarily concurrent, of a particular physician discloses an inferior level of care, the problem is most often dealt with privately within the confines of the medical community. As described by Ferguson:

The question is, what happens to the information? . . . Presently what the utilization review physicians do is to bring it to the attention of the practitioner and the hospital administrator for them to correct it. Beyond that, we have no—they have no authority from the Department to go any further than that. . . . If they feel that that physician needs a co-manager, in other words, they are still not comfortable with the way he is practicing, they will require another specialist in his field to be a co-manager of this patient until such time that they are satisfied. But that information does not go any farther than that.

The SCI investigation revealed that the UROs and the BME do not consult regarding standard physicians prior to the time that a particular case reaches an impasse involving what the UROs call "continued aberrant behavior." In addition, the BME claims it has received no referrals from the UROs on questions about the quality of patient care. This lack of contact with the BME has occurred despite the existence of a state law allow-

ing hospital utilization review committees to disclose information to "representatives of . . . government agencies in the performance of their duties, under the provisions of Federal and State law." Although the law protects members of such committees from liability for their recommendations or findings or for furnishing such information to the government agencies, peer review officials indicated that one hinderance to effective communication with the BME is a fear of lawsuits brought by reviewed physicians. Therefore, the Commission supports portions of a pending bill, S-403, that would expand immunity from civil suit to individuals employed by or assisting certified UROs and further urges that the original law be amended to provide similar protection for individuals who may not be members of the designated peer review committees but who assist the committees in their functions, serve as witnesses or provide information to the committees. Moreover, the law should be amended to provide for the award of reasonable attorneys fees expended on behalf of members, assisting parties, witnesses or persons providing information who substantially prevail in lawsuits that may be filed against them and which are found to be frivolous, unreasonable, without foundation or brought in bad faith. Sections of S-403 that provide for confidentiality of information secured by the UROs should be amended to clarify that disclosure to the BME must be made upon its request and may be provided to the BME on the initiative of the URO. Such disclosure is essential to the early identification of incompetent and impaired physicians. Since investigations on behalf of the BME are conducted in confidence, there is little cause for concern that innocent reputations might suffer.

A major gap in the utilization review system is the fact that it is limited to hospitals. The health department's Goldschmidt testified about this deficiency:

What concerns me is some of the referrals and the things that we have gotten in [from] outside of the Department in terms of the quality of care in other facilities like nursing homes, specialized rehabilitation facilities . . . , psychiatric facilities, home health care. The UROs certified by us . . . have no authority to do anything about that and that's, I think, something that will have to be taken into consideration . . . None of them have that concurrent, in-the-facility, hands-on, daily

kind of monitoring process, and I think that's really important.

JCAH-Certified Quality Assurance Programs

The Joint Commission on Accreditation of Hospitals (JCAH) is a private non-profit organization composed of representatives of the American Medical Association, the American Hospital Association, the American College of Physicians, the American College of Surgeons and the American Dental Association. The JCAH's purpose is to evaluate and assure the quality of patient care provided by hospitals, ambulatory health care programs, psychiatric and substance abuse programs, long term care facilities and hospice programs. Hospitals which meet JCAH standards are accredited for three-year periods. All hospitals in New Jersey are JCAH-accredited.

In order to comply with the quality assurance program of the JCAH (implemented in April, 1984), a hospital must maintain certain standing medical staff committees. The committees are set up to perform studies in these areas: 1) blood usage, 2) surgical review, 3) medical review (including appropriateness of care and sufficiency of records), 4) pharmaceutical and therapeutic review (including adverse reaction to medication), 5) antibiotic review, 6) morbidity and mortality review (including deaths, complications, early discharges, retrospective case mix review, etc.), and 7) generic screening program (including unplanned transfers, readmissions, etc.).

The Commission had neither the time nor the resources to fully assess the merits of the JCAH accrediting program. However, from what it has learned about the failure of hospitals to respond to moral or legal obligations to report serious disciplinary matters to the BME, the Commission would not be surprised to discover that certain hospitals may be much less deserving of accreditation than the JCAH realizes. As with other programs, hospitals are handling their quality assurance problems internally at every level of resolution, again with far more concern for salvaging medical careers than for either health care quality or safety. The SCI focused on this issue with respect to the JCAH's program.

Although the broad authority granted to representatives of the BME and the Department of Health appears to allow them access to the minutes and other records of hospital quality assurance committees, routine inspection of such

materials has never occurred. Thus, state regulators have not utilized an unusually important means of identifying physicians who may pose a danger to patients. An example of a potentially lax hospital investigation discovered by the SCI points out the need for the BME and the Department of Health to take a more active role in monitoring hospital quality assurance.

On September 22, 1986, an anesthesiologist reported to the Impaired Physicians Program (IPP) of the Medical Society of New Jersey that #20, another anesthesiologist at the same hospital, and a possible drug abuser, was responsible for as many as five unnecessary patient deaths. The only information possessed by the BME concerning #20 was that when he applied for a license in late 1985 he failed to mention two schools that he had attended in the foreign country where he obtained his medical training. After satisfying itself that "there was absolutely no reason for #20 to misrepresent his education on his application, other than ignorance," the BME declared him eligible for licensure "with an admonishment."

The SCI learned that what the BME did not know at the time was that #20 also falsified another portion of the application for licensure. In response to the question, "Have you ever been charged with, arrested for, or convicted of, a crime of any degree in this or any other State of the United States or foreign country?" #20 checked "no." However, he had been arrested in 1983 (and subsequently acquitted) for theft from a department store in Pennsylvania. Moreover, #20 was continuing to drive with a suspended New York driver's license and no New Jersey license.

Despite uncovering severe allegations concerning his medical practice, supported by several sources, the IPP never made any information or sources known to the BME. On the question of competency, the IPP deferred to the hospital administration, which also never reported any information to the BME.

In light of what the SCI has learned about the reluctance of hospitals to report serious lapses in the quality of care provided by certain physicians, the Commission urges that express statutory authority be given to representatives of the Department of Health and the BME to inspect all records of all health care facilities relating to the JCAH's quality assurance requirements, including the minutes of quality assurance committee meet-

ings. Both agencies have sufficient confidentiality protections to safeguard the reputations of physicians who practice properly. Since their primary mission also is to insure the quality of patient care, the BME and the Department of Health (which could refer appropriate cases to the BME) are better equipped than the hospitals to put aside concerns about collegiality among peers and the potential for institutional embarrassment in order to vigorously protect patients.

Medicare's Peer Review Organization

Since October, 1984, the Peer Review Organization of New Jersey, Inc. (PRO of NJ), a physician-sponsored PRO and a nonprofit corporation, has under contract with the federal government conducted peer reviews for hospitalized Medicare patients throughout New Jersey. It is assisted by two subcontractors, Axiom of Springfield and Passaic Valley PSRO of Wayne. (The three organizations are also certified by the State Department of Health). Based on their findings a physician may be temporarily or permanently barred from treatment of Medicare patients. Until recently a PRO had the authority to deny payments only to hospitals that violated its standards. However, under a new policy, effective September 26, 1986, physicians who perform unnecessary surgery, order patients hospitalized for inappropriate reasons or keep them in the hospital too long stand to lose their fees for those services. Previous Medicare discipline of physicians based on PRO findings had been restricted to instances involving fraud.

PROs conduct reviews of billing information supplied after the discharge of patients by two fiscal intermediaries, Blue Cross of New Jersey and Prudential. After a computer-assisted selection process, hospitals are requested to make available for PRO screening additional information pertaining to the care provided to a substantial portion of all discharged Medicare patients. Based on physician-developed criteria, the PRO determines whether a particular patient needed to be admitted to the hospital, whether the stay exceeded acceptable limits and whether services provided met appropriate standards of medical care. If anything occurred that typically should not happen, the matter is referred to a PRO physician for further review.

A predenial notice may be sent to the treating physician notifying him that payment may be de-

nied and giving him time to respond if he contests the denial. In addition, quality of care questions may be raised concerning unexpected events in the care of particular patients, such as abnormal laboratory values or unanticipated returns to the operating room. If the treating physician's response to questions is not acceptable, the PRO may engage a specialist in the same field to continue the review. The issues may be discussed by committees that deal with quality within the PRO or the hospital. In an effort to correct unacceptable practices, the PRO may intensify its monitoring of the physician and mandate educational efforts. Finally, if the PRO determines that attempts to improve performance have proven futile or that a "gross and flagrant" danger to patients exists, sanction proceedings begin. PRO recommendations for sanctions are sent to the Inspector General (IG) of HHS, who has 120 days to approve or to disapprove of them. They are automatically approved if no action is taken by the IG. The federal government then takes out an advertisement in a local newspaper announcing that sanctions are in effect. Finally, the BME is notified.

Although the PRO program operates in facilities that handle Medicare patients, its effects are felt by far more than the approximately 30 million people enrolled in the Medicare program nationwide, because the same facilities and their staffs also treat a multitude of patients whose care is paid for by the patients themselves or by other payers. Thus, a successful PRO program would impact favorably on far more patients than just the elderly.

Since its authority and resources were strengthened in May, 1985, the PRO in New Jersey has generated an increasing number of cases against New Jersey doctors and hospitals. It also appears, according to its own estimates, to be making notable progress in reducing hospital mortality rates.

It seems sensible to conclude that the BME would have an acute interest in making sure that the physicians contributing to excessive and preventable deaths are not jeopardizing their non-hospitalized patients nor their non-Medicare patients. Nonetheless, contacts between the New Jersey PROs and the BME are almost nonexistent. PRO of NJ's executive vice president, Martin P. Margolies, could only recall one instance in which a representative of the BME inquired about a physician. Only two physicians have been referred

to the BME for discipline after a federal sanctioning proceeding, and these two referrals were attributed to a predecessor federal review system. One additional referral is currently under Board review.

The federal regulations appear to allow for, and to some extent even mandate, more frequent exchanges of information between the PROs and state licensing bodies than presently occurs. In general terms the federal regulations provide that PRO information must be held in confidence except where "necessary . . . to assist appropriate state agencies having responsibility for licensing or certification of providers or practitioners." 42 CFR Sec. 476.103(b)(5).

PRO of NJ has not made permitted disclosures because it does not want to be viewed as a part of the physician disciplinary system and because it has not identified physicians that in the opinion of its governing board constitute a sufficient threat to patients to warrant referral to the BME. PRO of NJ's Margolies explained the reasoning behind the minimal contacts with the BME:

- Q. *Would you see some benefit in terms of your responsibility for insuring the quality of patient care to that kind of an exchange of information, that is a fairly free-wheeling exchange of information between PRO of NJ and the [BME]?*
- A. My own opinion is it may be detrimental to the whole review process. One of the reasons why we are able to get the cooperation and frankness from physicians is they view [our purpose] . . . as being to educate and not to be punitive in nature. . . . I think if the physicians who participated felt that every time we looked at a particular problem, regardless of how serious it was or wasn't, we were going to be sending this on to the [BME], I think they would see this as a more punitive process and we would be less apt to get physician participation in the process and make or take corrective action where we need to.
- Q. *So what would your response be if there was an assumption that the [BME] would not do anything until it followed its own processes of inquiry and determination?*
- A. I personally might not have a problem, but I can't speak for the board of trustees because I don't make that policy.

Contrary to the concerns expressed by Margolies and others about the disciplinary focus of the BME, the Commission has found that inquiries on behalf of the BME are conducted with recognition that a physician cannot be said to be incompetent until all the proofs are in and have been reviewed by the Board. Moreover, the BME has demonstrated its willingness to salvage the careers of problem doctors so long as their patients can be protected through practice restrictions. There is no serious basis for believing that the BME or its representatives cannot be trusted to deal fairly with information concerning potential problems in a physician's practice.

The BME's then President Luka testified that the existing system of peer review could be improved:

The program as it's operated at the present time it's not a true peer review organization, it's a cookbook type of review problem. It does help us, it has helped in attracting attention to physicians who are incompetent. However, it is not a true peer review program because the people that are doing the reviewing are only reviewing charts, they are reviewing on a cookbook type of basis. In my own humble opinion, I think that in many cases they are adding to the morbidity [relative incidence of disease] of patients of the State of New Jersey in the actions that are taken. There is a very important place for a peer review in the whole medical system. I don't think the way the system operates now is an adequate way to do it.

Q. A proper peer review system would operate how?

A. If it's going to be an ongoing review, if you have a dermatologist reviewing a dermatologist's charts and say this guy is doing something stupid or he is not doing the job well, or a pathologist reviewing the pathologist's charts, or an internist reviewing an internist's charts. That's not happening in our system.

Q. Is such peer review happening at all in New Jersey?

A. No, it's not. It exists only within a limited area in hospitals that have the tissue committee reporting, a department which reviews cases

of admissions; it's done in that way, but it's done on the basis of a hospital requirement.

Margolies of PRO of NJ contended that the term "cookbook" peer review can no longer be applied to peer reviews conducted for the federal Medicare program because physician peers, including committees of specialists, are brought in as the reviews progress through the system. He also defended other aspects of his operation:

Q. What is your response to the criticism that PROs are placing economics above quality in their reviews?

A. We believe that the physicians who participate in our organization participate because they are concerned about the quality of medical care on a short term and long term basis. Their feeling is that if physicians don't stay involved the quality will deteriorate. They recognize that the federal government and other peers are concerned that the care be rendered in the most effective and efficient manner, but their concern is that quality doesn't suffer. And consequently everything that we are geared towards doing is geared toward quality.

We also believe that if you give the appropriate quality, treat the patient appropriately, give him the services that are needed, in the long run you end up saving money. If you bring a patient in and short-change him and sent him out before he has completed the course of therapy that he needs, we know that he will probably end up either dead or readmitted to a hospital again, costing the system more money. . . . We think if you treat them appropriately and give them what they need, you are also serving an economic function.

HMO Quality Assessment

As part of the trend toward expanding peer reviews beyond hospitals, the Alternative Health Systems (AHS) program within the health department monitors quality assessment programs mandated for HMOs by federal and state law. In order to obtain a certificate of authority to operate in New Jersey, an HMO must demonstrate that it has a quality assessment mechanism supervised by a physician. The system must comply with broad guidelines in order to be able to identify potential problems, examine them and ensure

that something is done to correct problems that actually exist. AHS staff members review the effectiveness of the quality assessment mechanism at annual visits to the HMO.

AHS also utilizes several external quality assessment programs for HMOs. These include audits of monthly, quarterly and annual utilization reports, complaint reports, malpractice suit review, disenrollment surveys, periodic site visits, resolution of HMO consumer complaints and HMO patient satisfaction surveys.

Medicaid's Review Programs

PRO of NJ contracts with the state Medicaid agency to perform quality and utilization reviews of the care provided by hospitals to indigent patients whose care is paid half by the federal government and half by the state government. The federal government pays 75 percent of the cost of the Medicaid review contract.

PRO of NJ's peer review of Medicaid is similar to its Medicare review. None of the review function is delegated to the reviewed hospitals themselves, as is the case with the DOH-certified utilization review organizations reviewing the care provided to non-Medicaid and non-Medicare patients. On the other hand, unlike the URO program, the more costly concurrent review is not conducted as a matter of routine for all hospital admissions. Instead, the review of patient care subsidized by the federal government under the Medicaid and Medicare programs consists of retrospective review of a large sample of the paid claims submitted to PRO of NJ by fiscal intermediaries. If quality of care problems surface, PRO of NJ may do special studies or concurrent review for a particular physician. It also has the authority to require prior approvals before reimbursement will be allowed in certain cases.

Since the beginning of Medicaid program peer review, Medicaid agency officials could recall receiving only two referrals from PRO of NJ or its predecessor PSROs of quality of care matters involving physician treatment of Medicaid patients (although there have been referrals of a handful of sanctions under the Medicare program). They attributed this to the fact that the original contract emphasized cost issues over quality issues and indicated that negotiations are pending for a new contract that would give more emphasis to quality of care concerns.

This is not to say that during the original contract period there were no quality issues raised. PRO of NJ requested corrective action plans in 28 cases. Intensified review of three physicians was implemented and precertification of admissions for three others was initiated. The Commission believes that the BME should have been given the opportunity to review these cases to determine whether, in conjunction with other information in its possession, it should take steps to protect the public.

If PRO of NJ determined that a physician was continuing to fail to conform his practice to appropriate standards as determined by a committee of his peers, including, if necessary, physicians in the same specialty, it would refer the physician to the Division of Medical Assistance and Health Services (Medicaid agency) for sanctioning proceedings. In the quality of care area a state sanction would involve exclusion from the list of authorized providers or the imposition of practice restrictions in the treatment of Medicaid patients in order to retain provider status.

If Medicaid received a referral from PRO of NJ, it would be screened by Robert Popkin, the Medicaid agency's assistant director in charge of the Office of Program Integrity Administration. Popkin, a lawyer, would have medical review analysts, some with a background in nursing, review the facts of the case prior to screening. In the event that Popkin were to determine that additional medical expertise was necessary, he would have the case reviewed by Dr. Yaovares Thatsneyakul, the office's resident medical consultant.

In addition, Popkin could invoke a rarely used procedure for obtaining review assistance from the state Medical Society. This procedure includes a so-called In-house Peer Review Committee (IPRC) that ultimately determines whether a referral is appropriate.

Since early 1983 the IPRC has sent only one of 12 cases to the Medical Society. None of the 11 actionable cases was reported to the BME. This is another example of the failure to bring potential problems to the attention of the BME so that it might determine for itself whether patients are protected. Further, the BME was deprived of an opportunity to identify additional problems concerning these Medicaid providers and to review their general practice behavior.

The Medicaid program's quality assurance system is unique in several ways. It provides for direct review by government employees or consultants of quality of care. In addition to the contracted reviews of hospital cases performed by PRO of NJ, a Surveillance and Utilization Review Subsystem conducts computer scans of Medicaid billing data for outpatients as well as inpatients, and a number of exception criteria address quality issues. Quality is also assessed by resident teams of physicians, nurses and social workers assigned to the Medicaid district offices and psychiatrists in the central office who preauthorize specified courses of treatment and levels of care. In addition, the fiscal intermediary for physician billings (Prudential) has a unit with professional staff that assesses quality of care, among other duties. Moreover, a Provider Unit reviews information from recipient complaints and other non-computer sources concerning quality of care. A quality assurance program exists in the Medicaid agency-sponsored Personal Physician Plan in which a Medicaid patient volunteers to allow a single physician to manage his care at a prepaid capitation rate. Finally, the Federal Government also recently mandated that Medicaid agencies that contract with HMOs treating Medicaid patients conduct annual reviews of the quality of care provided by the HMOs.

All of this information may be screened by Popkin to determine if quality concerns warrant consideration by the BME. Under written guidelines most recently revised in October, 1986, if a particular case involves a "violation relating to fitness for licensure or involving improper professional practice," Popkin may refer it to a Legal Action Committee (LAC). Composed of key ad-

ministrative and medical personnel of the Medicaid agency, the LAC invites "as needed" a deputy attorney general (DAG) representing the professional boards to consider whether cases should be referred to the BME because of indicated violations of board statutes and regulations.

From January, 1985, through August, 1987, only four cases involving alleged misconduct in the treatment of patients were referred by the Medicaid agency to the BME, directly or through the LAC. Popkin indicated that a significant reason for such a small number of referrals to the BME is that the BME's jurisdiction in incompetency issues appears limited to 1) violations of specific Board statutes or regulations, 2) *gross negligence, malpractice or incompetence*, 3) *repeated acts of negligence, malpractice or incompetence*, or 4) determinations that the professional "is incapable, for medical or any other good cause, of discharging the functions of a licensee in a manner consistent with the public's health, safety and welfare." Although this is an overly confining interpretation of the Boards' jurisdiction, the Commission agrees that the relevant statutes need to be amended to enlarge the grounds for Board action and to enhance the BME's remedial authority.

The Commission also believes that an effective peer review mechanism should be available to the BME itself to assess the practices of borderline physicians who the Board has some reason to believe pose undue risks to patients, even if incompetence has not yet been proven. BME review teams, protected by statute and adequately funded, should operate under the supervision of the proposed medical director.

Exchange Of Information Among States

Certain incompetent physicians have a propensity for interstate travel in order to renew their practices without governmental limitations. Information on disciplinary actions from New Jersey and other states is maintained by the Federation of State Medical Boards (Federation), the National Clearinghouse on Licensure, Enforcement and Regulation (CLEAR) and the American Medical Association (AMA). This combined effort

sounds much more formidable and effective than it actually is.

The Federation maintains a Computerized Disciplinary Data Bank on physicians. It began to provide direct links to the data base for medical boards in mid-1986 in an attempt to better curtail physician "border skippers." New Jersey's BME is not yet sufficiently "computerized" to be able to take advantage of this service.

CLEAR, formed in 1980, is a cooperating organization of the Council of State Governments. It maintains a computerized National Disciplinary Information System (NDIS) containing data on final disciplinary actions submitted on a multitude of health care and nonhealth care professionals by participating enforcement agencies. This system submits quarterly reports to subscribing state licensing agencies. New Jersey does not participate.

The AMA Physician Masterfile attempts to maintain current and historical data on all medical doctors, regardless of membership in the AMA. Doctors of osteopathy are included if they have completed allopathic residencies, are members of the AMA, have requested to be included in the file or have been the subject of a disciplinary action by a licensing board. Also included are graduates of foreign medical schools who are in the United States and meet education standards for primary recognition as physicians. Students in United States medical schools also are included.

A major source of data for the Masterfile is the Record of Physicians' Professional Activities (PPA). This is a mail questionnaire survey which has been sent every four years since 1969 to all physicians residing in the United States as well as those residing temporarily overseas. The latest PPA census was completed in January, 1983, with a response rate of approximately 90 percent.

Concerned that physicians who have been subject to licensure action in one jurisdiction may relocate and practice in another jurisdiction in which they hold a license, the AMA instituted a notification procedure in October, 1984. Based on the monthly Federation summaries of licensure actions in each state and a review of each subject's AMA file, the AMA identifies concerned licensing jurisdictions and advises them that licensure actions have been taken elsewhere. The AMA does not describe the action reported by the Federation or offer any opinion regarding the action. State boards advised of actions may consult Federation reports and seek further information from the jurisdictions reporting the actions.

The BME itself publishes monthly reports summarizing its disciplinary actions. These reports are forwarded to at least 60 entities, including the AMA and the Federation, which maintain the information on computers.

Despite these laudable efforts by individual and influential professional organizations, probably the only truly effective method of establishing a state-by-state network of notices on errant doctors is by federal legislative action. This statutory move was initiated last year.

The federal Health Care Quality Improvement Act of 1986 requires all state physician regulatory boards to report all disciplinary actions and license restrictions, probations or surrenders directly to the Secretary of Health and Human Services or his designee beginning not later than November 14, 1987. Even though the law provides no effective sanction for noncompliance, it promises to create a "superclearinghouse" of information available from licensing boards, as well as from hospitals, HMOs, medical societies and insurance companies. The Commission therefore recommends that the BME fully comply with the new law as it is implemented. In addition, in order to receive federal Medicaid funding, state Medicaid agencies must now report to the federal clearinghouse adverse actions against health care practitioners, including physicians, taken by their respective licensing authorities. Medicare and Medicaid Patient and Program Protection Act of 1987. Professional board cooperation will be necessary for New Jersey's Medicaid agency to properly perform this task.

In October, 1986, the Inspector General for the Veterans Administration (VA) issued a final audit report which found that 93 doctors on the VA payroll had been disciplined by state medical regulatory boards. The licenses of 24 had been suspended or revoked. The 93 represented two-tenths of one percent of the 47,000 full or part time physicians employed by the VA. The VA had been unaware of many of the disciplinary actions because it lacked internal controls to identify physicians with license problems. It had not independently verified the status of physicians' licenses with state medical boards or independent agencies.

The audit had matched the names of VA physicians with records kept by the AMA, the Federation of State Medical Boards and the California Board of Medical Quality Assurance. In many cases the physicians held licenses to practice medicine in more than one state and disciplinary actions did not apply to all their licenses. Drug-related problems, either personal drug abuse or violations in prescribing, were responsible for 60

percent of the actions. The VA reported that it is now requiring a check of the status of all licenses, malpractice insurance claims, drug privileges and

clinical privileges for its physicians. It also plans to establish a review of all VA physicians' licenses every two years.

Continuing Medical Education

Continuing medical education (CME) programs are available in New Jersey but CME is not mandated as a requirement for continued licensure. Despite the rapidity with which improvements in treatment procedures are occurring in the medical world, a physician in New Jersey, once licensed, is officially considered eternally competent and without any need of retesting. Only in certain medical specialty fields is there a requirement for continuing education. Licensed physicians may take additional training in preparation for examinations given by specialty "boards" to enable them to become "board-certified" in a particular specialty. Thereafter, continuing education is a requirement for retaining certification and some boards even require retesting to remain certified. Although a licensed physician may practice in any specialty as a general proposition, board certification denotes advanced skill in a particular field. It is generally required for academic positions and may be required for appointments by certain hospitals or governmental institutions and agencies.

The Academy of Medicine, the 75-year-old "teaching arm" of the Medical Society of New Jersey, offers continuing medical education for physicians. It is affiliated with 28 physician specialty societies. In a recent year it provided approximately 1,300 programs.

The BME's Long Range Planning Committee is studying several facets of mandatory continuing medical education, including whether competency testing should occur as a condition of license renewal. Laws in California and Oregon authorize boards to compel a physician to take a clinical competency examination if there is reasonable cause to believe that his skill level is inadequate. California allows a physician two chances to pass an oral examination conducted by a panel of two physicians. Oregon generally utilizes written tests because they offer a firmer legal basis for subsequently denying a license or imposing discipline.

Reeducation as a disciplinary option is rarely employed by the BME even though it would offer a means of reducing incompetency short of

lengthy and intensely adversarial disciplinary proceedings. However, such an option is not fully available to the BME because of inadequate remedial educational resources. This problem was more specifically described by the BME's Dr. Grossman:

Our sources of reeducation are very difficult to acquire and I think, I am not looking to assign guilt, but I think one of the jobs that is not being done in this state is that when we do discover a doctor whose skills may be borderline and it's tough to decide where the borderline is and it's tough to decide which side of the border he is on, so you really don't want to suspend or revoke [a license] because it's probably not indicated but you want to reeducate, maybe reprimand, whatever, you are hard pressed to find some place to put that doc to get him reeducated. I think at the State University [of Medicine and Dentistry], we have a right to expect them to be able to help us on that.

Q. *Has there been any communication between the Board and the University on the subject of reeducation?*

A. Yes. The Board has approached the President of the University and asked him to discuss with his departments whether or not they would be in a position to accept doctors for reeducation. I don't think we received a response.

Q. *You are just aware that it was discussed at Board meetings?*

A. I am aware that the idea came up that, "Gee, wouldn't it be nice if the University were able to take some of our docs who need reeducating and putting them into a mini-residency or whatever the educators thought was appropriate."

In September, 1985, the State Department of Insurance Task Force on Medical Malpractice recommended that doctors take 150 hours of con-

tinuing medical education every three years as a condition for continuing practice. A Joint BME/Higher Education Committee report joined in this recommendation. Rather than propose that a lesser number of hours of continuing education be taken during the current two-year relicensure cycle, the Joint Committee called for triennial licensure renewal.

BME Executive Director Janousek warned that the administration of a reeducation program would constitute yet another burden on his already overburdened staff. He also testified that at a minimum any proposal should be coordinated within the present biennial license renewal period. He indicated that, something on the order of 100 hours every two years would prove more manageable administratively. The SCI does not endorse adding a year to the renewal period. In a three-year period the practice information on licensees available in the BME files would become significantly outdated. Regardless of regulations requiring that changes be reported as they occur, the effective time for updating of BME file information is upon formal notification of a license renewal.

Certain researchers have claimed that continuing medical education has not produced any significant improvement in patient care. Nonetheless, 27 states and territories mandate continuing medical education as a condition of license re-

newal. Obviously, a properly structured program, utilizing the highest standards of the respected Accreditation Council for Continuing Medical Education and high caliber materials for self-study, would help improve physician practice skills. The Commission favors at least an experiment with mandatory continuing medical education.

The Commission cautions, however, against proposing a superficial continuing education mandate merely to divert attention from more immediately effective reforms for identifying and dealing with incompetent physicians. An ill-conceived CME program would constitute little more than a public relations ploy that would inconvenience able physicians without correcting incompetency. It should be remembered, also, that quality educational programs will require that the BME be given additional oversight and administrative resources.

Lastly, the Commission urges that any mandatory continuing medical education program include specialized instruction designed to help reduce the problems of physician incompetency and impairment. For example, the BME's Dr. Grossman testified at the SCI that he would "include medical ethics and risk management requirements" in any mandatory educational program.

Licensing Standards

Present Standards Summarized

A Joint Committee on Educational and Licensure Standards for Physicians (Joint Committee), composed of members of the BME and the State Board of Higher Education, published a report in March, 1987, which recommended the first major revisions in New Jersey's medical licensing standards since 1921. (Chancellor of Higher Education T. Edward Hollander is an *ex officio* member of the BME).

Presently, to become a licensed physician in New Jersey a person must meet the following requirements:

- Be at least 21 years old, of good moral character and a citizen of the United States (or have declared his intention to become a citizen).
- Complete high school or the equivalent.

- Complete two years of college, including courses in chemistry, physics and biology.

- Complete medical education of "not less than 4 full school years, including four satisfactory courses of lecture of at least 8 months each, consecutively or in 4 different calendar years . . . which courses shall have included a thorough and satisfactory course of instruction in medicine and surgery." (An alternative medical education requirement allows licensure after receiving "the degree of Bachelor of Medicine upon completion of a course of study acceptable to the Board and of not less than 30 months duration in not less than 3 different calendar years in a medical college approved by the Board, and . . . a full year of intern training in a medical college hospital or a hospital affiliated or associated with such medical college.").

- Complete one year of residency or other post-graduate work in a school or hospital acceptable to the BME. (Foreign medical students graduating after July 1, 1985, must complete 3 years of such training).

- Pass an examination approved by the BME.

The Foreign Medical School Dilemma

Although rapidly closing the gap with its University of Medicine and Dentistry, New Jersey was late in providing medical education programs for its citizens. The Joint Committee reported that in 1986 the vast majority of New Jersey's new resident physicians were trained out of state and more than half of these graduated from foreign medical schools, either as citizens studying abroad or as aliens desiring to practice in the United States. Indeed, New Jersey ranks first in the country in the percentage of foreign medical graduates (FMGs) in its graduate medical education programs. A 1986 breakdown: 49 percent of participants in graduate medical education were U.S. medical graduates, 33 percent were citizen FMGs and 18 percent were alien FMGs.

While there are qualified foreign medical schools, BME and Higher Education officials have stressed that most foreign schools, especially the newer ones, are inferior to United States schools. They have expressed particular concern about inadequate clinical training, admission requirements, faculty, curriculum, facilities and equipment in foreign schools.

United States and Canadian allopathic (M.D.) medical schools are accredited by the Liaison Committee on Medical Education (LCME), representative of the Council on Medical Education of the American Medical Association and the Association of American Medical Colleges. Osteopathic (D.O.) medical schools are accredited by the Bureau of Professional Education of the American Osteopathic Association. However, the LCME and the Bureau do not accredit schools outside of the United States or Canada. In fact, there is no centralized accrediting agency for foreign medical schools. In most states, including New Jersey, a listing in the World Health Organization's *World Directory of Medical Schools* is considered a minimum criterion for a foreign medical school's acceptability. Although entry in that directory verifies that a foreign medical school is operating legally, it affirms nothing about the quality of the school's educational program.

New Jersey's BME (unlike the boards of at least eight other states) does not maintain a list of foreign medical schools whose graduates are eligible for licensure. A June, 1986, report by the Inspector General for the U.S. Department of Health and Human Services found that during the previous four years at least eight states (not including New Jersey) had enacted requirements that all applicants for licensure be graduates of schools that meet or are "substantially equivalent" to the standards set by the LCME. Some other states (not including New Jersey) have made similar changes that specified the licensing body's authority to approve or disapprove foreign schools.

All 54 licensing jurisdictions that constitute the Federation of State Medical Boards agreed in 1984 to empower the Federation to collect information concerning foreign medical schools. The Federation established a Commission on Foreign Medical Education which, in turn, developed a comprehensive questionnaire to be sent to such schools. The Commission was to review the information, conduct follow-up visits as necessary, and then relay its findings to the Federation's member boards. The Commission never completed its work because the schools contacted failed to cooperate in completing the questionnaires. (The Federation members also never threatened that unless the schools cooperated their graduates would not be licensed). Thus, the idea of using the Federation as an accrediting body fizzled.

If FMGs are to be appropriately licensed in New Jersey, a system for meaningful evaluation of foreign medical schools must be devised. BME Executive Director Janousek testified at the SCI about the need for a national standard:

Q. Is it the case that there should be background checks conducted on foreign schools which would focus on the curricula, the equipment, the instruction level and the like that would conceivably allow the BME to exclude certain graduates of certain schools from licensure?

A. Yes. I went in 1985 at the request of the GAO, Government Accounting Office, to give a presentation about our state's handling of foreign medical grads. They had a seminar for one day and they invited somebody from Jersey, Florida, Illinois and New York to talk about their involvement with foreign medical schools, foreign medical graduates. And one

of the things that came out of this is that there is a need for some type of central organization to do some type of review of foreign medical schools. . .

The development of training relationships, called clinical clerkships, between certain foreign medical schools and New Jersey hospitals has resulted in limited evaluation of the quality of some foreign medical schools. Under training arrangements, a third-year or fourth-year medical student may receive academic credit at a foreign school for clinical work performed at participating hospitals. BME regulations adopted in 1983 forbade this practice unless the foreign school met certain standards and obtained state approval. Thus far, only six schools have asked for reviews—three located in the Caribbean, two in Mexico and one in the Philippines. The BME requested reviews by on-site teams from the Department of Higher Education's Foreign Medical School Review Panel. Three schools were denied approval and three (one each in the Caribbean, Mexico and Philippines) were approved. Of the three approved facilities, the school in Mexico has not yet established a program with a teaching hospital in New Jersey. There are now about 130 students from St. George's University in Grenada and Far Eastern University in Manila completing clerkships in four hospitals in New Jersey.

New Jersey has developed explicit standards for approval of clinical clerkship programs. The director of the program must be acceptable to the BME, each student must have completed training equivalent to the fifth or sixth semester of a U.S. medical school and students must pass a written medical science exam before they begin clinical training.

The BME's Janousek assessed the incongruity of a system which carefully scrutinizes the qualifications of schools to provide clinical clerks but not their qualifications to supply licensed physicians:

That was one of the concerns that was raised when the Board received the report on Ross University and denied the school [permission to provide clinical clerks]. The concern was we're denying the school the ability to have its students complete third and fourth year clerkships in New Jersey hospitals. Aren't we ultimately making a comment about the whole educational process and should we not deny their graduates licensure? And the Board said no. The Board said we went down

there for one reason. The one reason was to determine if the clerkship process was okay, and it wasn't. That's all we were interested in. I have a different opinion. I mean, if they can't come back for clerkship, that means their first two years are terrible.

The Joint BME/Higher Education Committee report suggested several shortcuts for significantly reducing the numbers of FMGs eligible for licensure without requiring New Jersey to single-handedly shoulder the difficult task of assessing the educational quality of each foreign medical school. One was that applicants for licensure be required to possess a four-year baccalaureate degree or its equivalent, including "the development of appropriate communication skills in English." Another recommendation would require four years of medical education. A third recommendation would abolish foreign medical schools' clinical clerkships in New Jersey hospitals.

The combined impact of these proposals would be the elimination of the more problematic graduates of questionable foreign schools from consideration for licensure. Perhaps recognizing that such policies might exclude worthy applicants, the Joint Committee has further recommended that interested professional groups, such as the Federation and the U.S. Department of Health and Human Services, "establish as soon as possible a process for assessing, reviewing and/or accrediting medical education programs in foreign medical schools as a guide to assist the BME in determining eligibility for licensure of foreign medical graduates."

Examination Review—and Questions

The licensing examinations most frequently utilized by graduates of U.S. and Canadian medical schools to obtain licensure are three-part tests prepared by the National Board of Medical Examiners and the National Board of Osteopathic Examiners (National Boards). Both are independent, nonprofit testing organizations. All U.S. medical licensing authorities, except Louisiana, Texas and the Virgin Islands, will grant a license without further examination to those who have successfully obtained National Board certification.

Graduates of foreign medical schools are not eligible to take the National Boards. In order to obtain New Jersey licensure, foreign medical graduates, whether citizens or aliens, must pass

the Federation Licensing Examination (FLEX), administered by the BME every June and December. Although the FLEX is considered an officially certified licensing examination, most graduates of U.S. medical schools use the National Board examinations as their pathway to licensure. In June, 1985, the states, via the Federation, instituted a new, two-component FLEX test designed to evaluate a candidate's ability to practice independently, as well as to understand diseases and modes of therapy encountered in a supervised setting. The overall performance on the new test was about the same as in the previous year. However, 75 percent of the repeaters taking the test failed, compared with 65 percent in 1984. Fifty percent of all FMGs taking it failed, compared with 43 percent in 1984. (The Federation of State Medical Boards has reported that less than 10 percent of students from Caribbean and Latin American medical schools pass all tests and complete all requirements to become doctors).

In New Jersey there is no limit to the number of times an applicant can fail the FLEX or the National Boards without being prohibited from taking them again or without being required first to take extra training. The Joint BME/Higher Education Committee recommended that, to be eligible for initial licensure in New Jersey, an applicant should have passed the National Boards or FLEX within three attempts or be allowed additional attempts only upon the completion of appropriate remedial education.

New Jersey also does not require that an alien foreign medical school applicant pass an oral examination in addition to the written test. This would assist in weeding out those who present an undue risk to patients because of a language barrier.

There has been dramatic growth in the number of FMGs applying for the medical tests of the Educational Commission for Foreign Medical Graduates (ECFMG), not only an essential first step leading to eventual licensure for an FMG but a pre-licensure requirement for participation in the National Residency Matching Program. Since mid-1984 the ECFMG examination has been upgraded to the point where FMGs now are subject to the same examination standards required of graduates of this country's medical schools for residency positions that provide them with graduate medical education. (ECFMG certification is also required of all alien FMGs seeking a U.S.

visa). The pass rates for both citizen and alien FMGs taking the examinations are significantly below the pass rates of students and graduates of U.S. medical schools taking the National Boards.

The Joint Committee recommended, in the absence of remedial education, that FMGs be allowed only three attempts to pass the ECFMG tests and that a clinical skills assessment be included in the certification process. The Joint Committee noted that, in response to concerns that many FMGs entering residency programs and applying for licensure are deficient in clinical skills, the ECFMG is presently developing a test to warrant that its certified FMGs have sufficient clinical skills to begin training in the first postgraduate year.

Residencies and Fellowships

Residencies (specialty training) and fellowships (subspecialty training)—often called graduate medical education or post graduate year training—range from three to eight years, depending on the specialty. In effect, they are rigorous apprenticeships generally regarded as necessary to prepare medical school graduates for independent practice in one or more of 24 specialties and 42 subspecialties.

According to the Joint Committee report, only four states do not require a minimum of one year of graduate medical education in an accredited residency program to be eligible for licensure. Because of concerns about the quality of FMGs, at least 23 states now require FMGs to have two or more years of residency training and 17 of these, including New Jersey, mandate three years of such training. Five states also require U.S. graduates to have two or more years of graduate training.

Residency training programs seldom pass on to licensing boards any information concerning the personal or professional performance of residents. Neither do program directors share with the BME the annual evaluations required by the Accreditation Council for Graduate Medical Education, a collaborative effort of the AMA and various specialty societies, or by the American Osteopathic Association, even when a resident's performance is unsatisfactory.

Worse yet, there are indications that some hospitals, when dissatisfied with a resident's per-

formance during the first year, will nonetheless acknowledge the satisfactory completion of one year of training but then not allow the individual to continue in the program. BME Executive Director Janousek testified that residents are rarely dismissed for poor performance even if they should be.

Since most residents may obtain a New Jersey license after completing one year, certain individuals deemed too inadequate by supervisors to continue beyond the first residency year, but certified as having completed that year, may obtain licensure. This problem has been reduced since the BME required that FMGs completing their education after July 1, 1985, must also have completed three years of post graduate training in order to obtain a license. Recognizing that a serious gap remains in the State's ability to protect patients from physicians with deficient residency backgrounds who nevertheless obtained licenses, the Joint Committee recommended that to be eligible for licensure in New Jersey all foreign and domestic medical school graduates must successfully complete at least three years of approved graduate medical education.

Because of statutory inadequacies, a resident may work in government or nonprofit hospitals for as long as five years without the check-up requirement of a permit or registration. In recognition of the fact that entry into residency programs is a gateway to medical licensure, about half of all states require that residents obtain a residency training permit or training license. This enables a regulatory board, if it has sufficient staff resources, to monitor background checks on residents and to track their progress in residency programs.

Relying on its present statutory authority, the BME drafted stricter regulations governing residents. The proposed regulations would require medical graduates to obtain permits from the BME before practicing medicine as residents. The permits would be issued for practice in particular institutions, and hospitals would have to report terminations of residencies to the BME. If approved, this regulation would require hospital scrutiny of educational credentials and background certifications presented by all Graduate Medical Education candidates prior to their entry into training. The Commission believes that the BME's jurisdiction over residents should be specified by statute. There is some question as to the

Board's powers in this area, and at least one resident is challenging its authority in the courts.

The SCI is also concerned that no additional resources have been sought to assist in the BME's proposed additional responsibility over residents. Executive Director Janousek testified:

Q. *No one proposed additional resources to handle these responsibilities?*

A. I have at every meeting that the Board has talked about this indicated that with the present staffing the idea of residency permits, while laudatory, could not be implemented successfully.

Q. *And the response has been?*

A. That they—the Board is made up of individuals who do not work within the State system. They do not understand the trouble it takes to get personnel, etc. They believe that it's the real world. It's a little different.

Without provision for staff and other resources to handle the increased workload occasioned by the new registration requirement, the Commission believes its implementation will suffer from the same neglect that precluded follow-up on the malpractice award reports submitted by insurance companies.

Scandals involving the selling of phoney medical credentials have erupted in New York and other nearby states. One involved the selling of bogus medical degrees from the Universidad CETEC of Santo Domingo through a "degree broker." When this incident arose in New York approximately two years ago, the BME staff, assisted by the Enforcement Bureau, received a list of 165 phoney degrees from the investigating postal inspectors. BME Executive Director Janousek testified:

Three of those individuals were practicing in residency training programs in the State of New Jersey, and they were removed from those training programs, two voluntarily and one after a hearing.

A law, *N.J.S.A. 18A:3-15.1 et seq.*, effective in 1986 provides for a \$1,000 civil penalty if a person: 1) with intent to deceive buys, sells, makes, alters, gives, issues, obtains or attempts to obtain a diploma or other document which purports to confer an academic degree; 2) uses a transcript or other document evidencing a degree in a pro-

profession, which has been fraudulently issued, obtained, forged or altered; 3) with intent to deceive falsely represents himself as having received a degree or credential; or 4) uses M.D. or D.O. after his name without obtaining the requisite degree.

Since the violations indicated above may easily lead to an unqualified individual being responsible for patient care, (and perhaps even receiving a license) the Commission believes that a mere \$1,000 penalty trivializes the offense. Such conduct should at least be treated as a crime of the third degree when it involves the health care professions.

Recent press disclosures have highlighted the need for reforms to prevent medical residents from working such long hours and under such grueling conditions that they harm patients because of mistakes due to exhaustion. Although beyond the scope of the present investigation, these reports point to at least one possible root cause of physician impairments—that is, that chronic exhaustion and stress associated with traditional residency programs bring on depression, domestic strife and resort to alcohol and drugs by too many of those on the threshold of the profession.

California and New York are studying proposals to limit the amount of consecutive hours worked by residents and to delineate the standards for their supervision by experienced physicians. Recognizing that such reform proposals could have profound effects on the cost of health care and the methods by which physicians are trained, the Commission recommends that the BME and the departments of Health and Higher Education study such reforms and determine whether and how they might be implemented in New Jersey.

Unlicensed Practice of Medicine

The Commission has not discovered a significant number of unlicensed persons actually practicing as physicians. Nonetheless, the pool of unlicensed physicians in New Jersey and the rest of the country is known to be growing as ever-increasing numbers of graduates of certain offshore medical schools return to find that they are unable to pass examinations required for entry into the all-important residency programs. It is not known how many of the individuals in this group are practicing medicine without licensure. The Federation to which the BME belongs estimates that nationally between 20,000 and 30,000 individ-

uals who have completed schooling have been unsuccessful in their attempts to obtain physician licensure. These numbers are certain to grow, considering that 61.4 percent of citizen FMGs and 76 percent of alien FMGs have been most recently unable to find residency positions in the United States.

In June, 1986, U.S. Representative Claude Pepper, Chairman of the Subcommittee on Health and Longterm Care, estimated that approximately 10,000 unlicensed persons practice medicine in the United States. The President of the Federation, Dr. William E. Jacott, put the figure at 6 percent of practicing physicians or 28,000. These people are part of a medical underground that relies on inept or understaffed licensing bodies and an unwary professional community for continued existence.

Certain instances of unlicensed practice have been egregious and extremely difficult to resolve. The unlicensed practice of medicine includes infringements on the practice of medicine by persons with licenses in other health care professions, defrocked doctors who have resumed their practices and the classic "quack" promoting dubious cures.

The SCI has determined that certain unscrupulous unlicensed individuals will continue to find New Jersey to be an essentially riskless place to practice until the unlicensed practice of medicine becomes a criminal offense.

The case of Dr. G is illustrative. His New Jersey medical license was revoked on January 12, 1978, after close to 100 patients contracted hepatitis from dirty hypodermic needles he used to administer a drug which he claimed was a cure for cancer and other ailments. In addition to license revocation, this doctor was assessed \$20,200 in penalties for violations of the Medical Practice Act. One of the counts proven was that he had practiced medicine without a license in violation of a BME order suspending his license pending a full hearing. In 1982 he was discovered providing injections in a hotel room in Burlington County. A Superior Court consent order issued in March, 1983, enjoined him from again practicing medicine without a license, an additional penalty of \$10,000 was assessed and he was required to pay interest on the previous penalties that had remained unpaid until February, 1983. Nonetheless, he eventually resumed providing injections in Pine Hill, but in November, 1984, he treated an

undercover investigator from the Enforcement Bureau and, in June, 1985, an order was entered in Superior Court finding him in contempt, assessing an additional \$15,000 in penalties and placing him on 3 years probation.

The Commission believes that this unsavory saga illustrates the unnecessary complexity involved in the present system for dealing with egregious cases of unauthorized practice. Had a criminal offense existed for the unauthorized practice of medicine, Dr. G would have been a "three-time loser" by late 1984 and would probably be in jail.

A 1978 law, *N.J.S.A. 45:1-25*, intended to create more uniform enforcement among professions and occupations, increased civil penalties from \$200 to not more than \$2,500 for the first offense

and \$5,000 for subsequent offenses of unlicensed practice. The BME may also issue "cease and desist" orders to violators, and the BME, the Director of Consumer Affairs or the Attorney General may seek to enjoin violations in a summary proceeding in Superior Court. Although the increased civil penalties represent a substantial improvement, the Commission believes that criminal sanctions should be available for serious cases.

Those who practice medicine without a license may be prosecuted under *N.J.S.A. 2C:21-17(1)*, which prohibits impersonating another or assuming a false identity to benefit oneself or another or to injure or defraud another. This statute only covers a limited type of conduct, however, and even if applicable to a given medical situation amounts to no more than a disorderly persons offense.

Conclusions and Recommendations

The Commission concludes that the following recommendations offer reasonable and comprehensive improvements over the present system for coping with physician incompetency and impairment. These proposals would safeguard the public from the transgressions of a relatively few practitioners without overburdening the vast majority of physicians, who serve the public well.

The Commission firmly believes that in-

competency and impairment among other health care professionals pose as great a threat to public health and safety as such conditions among physicians. These recommendations are therefore phrased, where possible, so as to apply to problems encountered among all categories of health care professionals. To encourage uniformity and oversight the Division of Consumer Affairs would be given greater responsibilities.

Improve Identification of Problem Professionals

Health Care Professionals and Associations

Health care professionals (physicians and allied health professionals—psychologists, pharmacists, nurses, dentists, etc.) and their associations or societies should be required by a new law to report incompetency or impairment of any regulated health care professional to the Division of Consumer Affairs and to the professional board which regulates the health care individual. Since "incompetency" and "impairment" are not easily defined, the reporting requirement should be phrased as follows:

Every health care professional and professional association or society shall report,

in writing and in a timely manner, any and all information which reasonably indicates that another health care professional, 1) engaged in any conduct, used any substance or suffered any condition which may have jeopardized or improperly risked the health, safety or welfare of a patient, or 2) violated any statute or regulation governing the health care professional. The reports shall be made to the the Division of Consumer Affairs and to the board which regulates the professional practice of the health care professional in question in accordance with regulations and

guidelines promulgated by the Director of the Division of Consumer Affairs.

For purposes of this and other provisions, "health care professional" should be defined to include a physician, surgeon, medical resident, clinical intern, podiatrist, chiropractor, dentist, midwife, nurse midwife, director of a diagnostic testing center, hearing aid dispenser, acupuncturist, ophthalmic dispenser, ophthalmic technician, nurse, optometrist, orthoptist, pharmacist, physical therapist, psychologist, radiologic technician or marriage counselor.

Since pharmacies and drug distribution companies are in a unique position to observe improper practices by health care professionals who are authorized to order and dispense drugs, they should have a statutory obligation to report to the relevant professional board every instance in which they refuse to fill a prescription or order by a health care professional.

Programs for impaired professionals, such as the Medical Society's IPP, should be required by the regulations to identify all professionals in their programs to the appropriate licensing board. As is the case with the BME, each board should be required to maintain the confidentiality of such information unless it takes official action following its own inquiries.

For the reporting obligation to be effective, the same sanctions available to the professional boards for other violations should be available for failure to report transgressing professionals in accordance with the above reporting requirements. Therefore, the Commission recommends that *N.J.S.A. 45:1-21* (which describes the grounds upon which a license may be refused, suspended or revoked) be amended to add the following:

(j) [The applicant or licensee] has knowingly failed to report, in writing and in a timely manner, to the board which licenses or registers a health care professional, and to the Division of Consumer Affairs, any and all information which reasonably indicates that the health care professional 1) engaged in any conduct, used any substance or suffered any condition which may have jeopardized or improperly risked the health, safety or welfare of a patient, or 2) violated any statute or regulation governing the health care professional.

To eliminate any reasonable concerns that reporting pursuant to the above obligations, or to

fulfill a civic or moral responsibility, may subject the reporting individual to jeopardy, the civil immunity and confidentiality provided for persons reporting physicians to the BME (contained in *N.J.S.A. 45:9-19.1, 19.2 and 19.3*) should be located within the uniform statutory provisions applicable to all professions and occupations (*N.J.S.A. 45:1-1 et seq.*), and expanded to include providing information to the Division of Consumer Affairs or the Attorney General, as well as the appropriate board. The expanded version should substitute the phraseology "any information which reasonably indicates that a health care professional 1) engaged in any conduct, used any substance or suffered any condition which may have jeopardized or improperly risked the health, safety or welfare of a patient, or 2) violated any statute or regulation governing the health care professional" for the current phraseology, "any information concerning any act which the person has reasonable cause to believe involves misconduct that may be subject to disciplinary action."

To ensure that those who report do not have to be overly concerned about harassing lawsuits that could prove costly, even if they eventually prove unsuccessful, a statute should be enacted authorizing the Attorney General to intervene in any civil action filed against any person providing information or services to a professional or occupational board and to defend such person in the action or provide for the defense at State expense.

Alcohol and Drug Abuse Programs

Federal law should be amended to eliminate the prohibition against federally-funded alcohol and drug abuse programs revealing the names and other information about participants without a court order. Indeed, in the case of participants who are health care professionals, when public health and safety are involved and the information is to be reported to a state licensing agency whose investigations are confidential under state law, such disclosures should be mandated.

Malpractice Actions

The Commission is convinced that delaying reporting of malpractice actions until settlement or judgment is totally ineffective as a means of recognizing incompetency or impairment in sufficient time to adequately protect the public. Furthermore, monetary thresholds, such as the present \$25,000 figure for reporting of insurance

awards, ignore the fact that many small claims might be more indicative of incompetency than a single mistake which happened to result in a large settlement. Therefore, so long as the substitute system described below is implemented, the Commission recommends that the present rules governing reporting by medical malpractice insurers, uninsured physicians and health care facilities involved in malpractice actions be repealed. This present scheme will, in any event, soon be superseded by the more comprehensive reporting requirements of the federal Health Care Quality Improvement Act of 1986.

With the additional resources soon to be available in its new Malpractice Section, the Enforcement Bureau should routinely obtain copies of all malpractice actions filed with the Clerk of the Superior Court (and county clerks in those counties where the actions are not also filed with the Superior Court Clerk) involving health care professionals or facilities. The Enforcement Bureau should enter pertinent information from these actions into a computer data base and, based on criteria developed in cooperation with the BME and its proposed medical director, screen the information to identify those practitioners whose cases should be reviewed in depth.

Meanwhile, a statute should be enacted declaring that, in malpractice actions against members of licensed professions or occupations, settlements prohibiting complaints or the providing of information to regulatory boards concerning the underlying facts or circumstances of the action are against public policy, void and unenforceable.

An effective substitute system for obtaining useful information from insurers should be created as follows. A statute should be enacted mandating that all medical malpractice insurers report in writing to the appropriate professional board, within 10 days of the occurrence, any termination of a health care professional's coverage, denial of coverage or surcharge assessed on account of the professional's practice methods or malpractice claim history. The statute should also mandate that within 90 days of the effective date of the act, all medical malpractice insurers shall retrieve from existing records and report to the appropriate boards, for a five-year period immediately preceding the effective date of the act, all terminations of health care professionals' coverages, denials of coverages or surcharges beyond the rates normally assessed those in the

same specialties on account of the professionals' practice methods or malpractice claim histories.

The reporting forms should be promulgated by the Director of the Division of Consumer Affairs, and the Department of Insurance should be authorized to penalize failures to report in the same manner and to the same degree as other violations of insurance statutes or regulations. The statute should also provide that the reports shall not be deemed conclusive evidence in any disciplinary proceeding. In addition, the statute should state that any insurer shall be immune from liability for furnishing information to a professional board in fulfillment of the requirements of the new law. The professional boards should be required to keep the reports by insurers confidential and be permitted to release them only if disciplinary action is taken. The Attorney General should promulgate regulations deeming such records not to be public records pursuant to Executive Order #9 of September 30, 1963.

Hospitals

The Commission firmly believes that the present law requiring hospitals and other health care facilities to report disciplinary actions against physicians has been a failure. Loopholes in the present law should be eliminated and it should also be made expressly applicable to health maintenance organizations. Limiting reports to "disciplinary proceedings or actions taken" is too confining. Relevant boards should also be notified as soon as a health care facility initiates action at any administrative level to eliminate or restrict privileges, instead of waiting until the board of governors acts. The law should also apply to all regulated health care professionals, medical residents and clinical clerks working in a hospital setting.

The proposed statute should read:

Whenever a health care professional [as defined above] enjoying employment, staff privileges, a contractual relationship or other affiliation with a health care facility licensed pursuant to section 12 of P.L. 1971, c. 136 (C. 26:2H-12), or with a health maintenance organization, temporarily or permanently ceases the affiliation, through resignation, termination, leave of absence or any other means, or becomes the subject of a complaint, inquiry or disciplinary proceeding, on account of any information which reasonably

indicates that the health care professional 1) engaged in any conduct, used any substance or suffered any condition which may have jeopardized or improperly risked the health, safety or welfare of a patient, or 2) violated any statute or regulation governing the health care professional, the health care facility or health maintenance organization shall report, in writing and within 10 days of its occurrence, the curtailment of affiliation, the receipt of the complaint or the initiation of the inquiry or disciplinary proceeding to the Division of Consumer Affairs and to the board which regulates the professional practice of the health care professional in accordance with regulations and guidelines promulgated by the Director of the Division of Consumer Affairs.

Within 120 days of the effective date of this act, all health care facilities and health maintenance organizations shall retrieve from all existing personnel and other records, for a five-year period immediately preceding the effective date of this act, curtailments of affiliations, complaints, inquiries and disciplinary proceedings concerning health care professionals, as specified in this act, and shall report them, in writing, to the the Division of Consumer Affairs and to the boards which regulate the professional practices of the health care professionals in accordance with regulations and guidelines promulgated by the Director of the Division of Consumer Affairs.

Health care facilities and health maintenance organizations shall provide such other information relating to the curtailment of affiliations, complaints, inquiries or disciplinary proceedings as may be requested by the Division of Consumer Affairs, Attorney General or appropriate board.

A health care facility or health maintenance organization and any of its licensed administrators that fail to provide the reports called for by this act or fail to comply with requests pursuant to this act shall each be subject to a penalty of not more than \$500 for each day of a failure to report or to comply as determined by the Commissioner of Health pursuant to section 13 of P.L. 1971, c. 136 (C. 26:2H-13).

Complaint & Quality Assurance Records

A statute should be enacted mandating that, in accordance with regulations promulgated by the Commissioner of Health, every health care facility and health maintenance organization shall maintain certain records for a period of seven years. These records should include all complaints, regardless of source or type, against a health care professional affiliated in any way with the facility or organization. The records should also include committee and meeting minutes, quality of care assessments and reviews and any other documents relating to the complaints.

The statute should provide that all such records and minutes be made available for inspection by the Department of Health and the Division of Consumer Affairs. The statute should also provide that, in accordance with regulations promulgated by the Commissioner of Health, every health care facility and health maintenance organization shall maintain all records of mortality, morbidity, complication, infection and readmission data and studies generated by, or on behalf of, the health care facility or health maintenance organization for a period of seven years. The statute should further provide that the records shall be made available for inspection by the Department of Health and the Division of Consumer Affairs.

Peer and Utilization Review Organizations

Federal and state regulations and, if necessary, statutes should be clarified to encourage cooperative exchanges of information among PROs, UROs and the boards regulating health care professionals during any phase of the PRO, URO or board reviews, investigations or proceedings. To insure confidentiality the regulations should specify that as a condition for the sharing of information a professional board must have appropriate confidentiality safeguards in place.

To encourage effective URO activity, certain portions of pending bill S-403 should be passed. These would expand immunity from civil suit to individuals employed by or assisting certified UROs. In addition, the law should be amended to provide similar protection for individuals who may not be members of designated peer review committees but who assist the committees in their functions, serve as witnesses or provide information to committees. Moreover, the law should be amended to provide for the award of reasonable attorney's fees expended on behalf of mem-

bers, assisting parties, witnesses or persons providing information who substantially prevail in lawsuits that may be filed against them and which are found to be frivolous, unreasonable, without foundation or brought in bad faith.

Sections of S-403 that provide for confidentiality of information secured by the UROs should be amended to clarify that disclosure to the BME must be made upon its request and may be provided to the BME at the initiative of a URO.

Increase Board Authority, Resources and Support

Medical Director and Peer Review Teams

A position should be created for a salaried, full time medical director for the BME. The medical director would help to coordinate and set priorities in BME and Enforcement Bureau inquiries. He would also arrange for and supervise peer review consultants providing assistance to the BME in difficult cases. In addition, he would participate in negotiations concerning practice restrictions, probation terms and reeducation requirements to be imposed on practitioners pursuant to settlement agreements.

Statutory authority and funding should be provided for professional board "peer review teams" to evaluate borderline health care professionals. The teams would be called in when a board received information about incidents that could not by themselves be considered conclusive proof of incompetence but that raise questions about a health care professional's practice methods and judgment.

Since 1979, Maryland has had peer review committees comprised of volunteer doctors who examine a colleague's practice at a licensing board's request. The committees can recommend additional education or other corrective action. Maryland also contracts with the state medical society to conduct some of its licensing investigations. In New Jersey the proposed medical director of the BME would coordinate such reviews for the BME.

Upgrade Executive Director Post

Concomitant with the creation of the position of Medical Director, the Commission urges that the BME's Executive Director post be upgraded and expanded to better cope with the increased administrative responsibilities that will result from the implementation of this report's reform programs. The new Medical Director should be free

to fully utilize his professional expertise as prescribed above without being diverted by the BME's continuing and increasing burdens of office and staff supervision. The Executive Director should be granted sufficient authority and resources to thoroughly—and expeditiously—modernize the BME's office systems and procedures in a manner that will promote the professional productivity of the new Medical Director. The present Executive Director, Janousek, has—considering the inadequacies of the BME's resources and structure—certainly handled his responsibilities well and deserves commendation for a job well done under the worst of circumstances. The Commission believes his post should be strengthened to the point that he will be able to function as the administrative partner of the new Medical Director.

Residents

Residents seeking to practice in New Jersey health care facilities should first be required by statute to register with the BME. Although residents are students in a supervised setting, they are also doctors practicing medicine. Accordingly, the BME should have the clear authority to keep track of their conduct and, if necessary, to discipline them.

Background and Practice Information

In applications for initial licensure, as well as renewal, health care professionals should be required to report all practice addresses, including those in other states; group practice names; employers; residences; health care facility affiliations; malpractice insurance carriers and history of insurance coverage, including any terminations of coverage, surcharges or denials of coverage due to claims history; specialty certifications; primary

and secondary specialties; other licenses held in this and other states for any profession or occupation; military reserve affiliations related to the profession; driver licenses and numbers held in this and other states and any suspensions or revocations; criminal convictions, indictments or arrests; and license denials or disciplinary actions pending or completed in other states.

A certification of the accuracy of the information supplied on the initial and renewal license application forms should be signed by the professional.

When a professional applies for an initial license or for a license renewal, all clearinghouse data bases should be routinely checked to determine if derogatory information appears.

All applicants for health care professional licenses should be fingerprinted and their criminal histories checked at the time of initial application. Until approximately three years ago the State Board of Dentistry supplied all applicants for dental licenses with fingerprint cards to take to local police departments or the State Police for fingerprinting. The completed cards were submitted by the Board of Dentistry to the State Police for comparison to state and federal criminal records. The process was discontinued when the State Police began to charge \$10 per applicant for the service.

Under a law signed by Governor Thomas H. Kean on October 8, 1986, all applicants for full time jobs with public schools in New Jersey will have to submit to criminal background checks to determine if they pose a threat to children. Each applicant must provide his name, address, fingerprints and record of any child molestation convictions to the Department of Education, which turns the information over to the State Police as the agency responsible for conducting the background checks in order to comply with federal law. The checks are paid for by the applicants. The law includes applicants for teacher, teaching aide, *physician, nurse*, custodian, maintenance worker, bus driver, cafeteria worker, secretary or any position involving "regular contact with pupils." The Commission believes that if physicians and nurses can be fingerprinted and checked because they may come into contact with students, all health care professionals should undergo a similar process. This is so because the most helpless and vulnerable people in our society are the sick and injured, regardless of age.

Resources

The August, 1987, increases in the BME's initial and renewal license fees should be monitored to determine if the sums are sufficient to cover the cost of additional staff resources (BME medical director and staff consultants to conduct peer reviews where volunteers are not available, data processing analysts, etc.), Division of Law (deputy attorneys general to pursue contested cases) and Enforcement Bureau (personnel to more adequately monitor probations and practice restrictions and to investigate suspected lack of skill or judgment involving professions other than physicians). In addition, computerization and improved checking of practice and background information will cost more. The BME and other boards or, in the absence of board action the attorney general, must determine what fees will be necessary to properly implement the recommendations in this report that are adaptable to their situations.

The computerization of all professional board operations should be completed as soon as possible. This will assist the boards in analyzing the information supplied by the courts, health care facilities, insurers, PROs, health care professionals and other sources, as well as background and practice information concerning licensees.

Monitoring of Probation and Practice Restrictions

The boards should establish stringent monitoring of professionals with conditional or probationary licenses. Such monitoring should be implemented by a unit within the Enforcement Bureau pursuant to standards determined in cooperation with the boards. The Practice Monitoring Section should be authorized to inspect and report deviations from standards on the part of the IPP or any other impaired professional program involved in supervising the practice or rehabilitation of a professional allowed by a board to continue in practice conditioned on participation in the program.

Reeducation, Testing and Supervision

Boards should be given express statutory authority to require reeducation, training or testing as a condition of continued licensure in the event that a licensed professional is deemed to practice in a manner which jeopardizes the health,

safety or welfare of his patients or customers. In addition, express statutory authority should be

provided for proctorships or supervised practice as conditions for licensure.

Increase Department of Health Activities

The State Department of Health should establish credentials validating procedures to be followed by health care facilities and health maintenance organizations before hiring, contracting with or granting privileges to their staff, including medical residents and clinical interns, and other affiliated health care professionals. The Department should then conduct spot checks to determine that the facilities and organizations are following these procedures.

To further encourage hospitals to conduct background checks of their physicians and other licensed health care practitioners, the federal Health Care Quality Improvement Act states that "it is the duty of each hospital to request" from the Secretary of Health and Human Services or his designee the information reported by licensing boards, hospitals, HMOs, medical societies and insurance companies 1) at the time a physician or licensed health care practitioner applies for hospital privileges and 2) once every 2 years for each physician or practitioner already granted privileges. There is, however, no effective sanction for noncompliance.

Improve Enforcement

It should be a crime of the third degree to practice medicine or any other health care profession without a license. Expungement should be denied for this crime, as well as for all crimes arising out of or involving the practice of a health care profession.

It should be a crime of the fourth degree to retaliate against a "whistle blower" who in good faith reports a suspected impaired or incompetent professional to the relevant professional board, the Division of Consumer Affairs or the office of the Attorney General.

It should be a crime of the fourth degree for any person to destroy, alter or falsify medical records in order to deceive any person as to information

In November, 1986, the JCAH, a private accreditation organization which certifies all hospitals in New Jersey, began proceedings to establish regulations that would for the first time require hospitals to check the background of physicians before giving them staff privileges. To enhance the role of institutions in weeding out incompetent practitioners, the New Jersey Legislature should mandate that all health care facilities and HMOs—not just hospitals as is the case in the new federal law—conduct the background checks required by the Health Care Quality Improvement Act and proposed by the JCAH. Federation and AMA data should be included in the checks. The State law should expressly excuse the health care facilities and HMOs, as well as their medical and administrative officials, from liability under State law for relying on the information, so long as they have no knowledge that the information provided in response to their background requests is false.

Communication and joint activities between the health care professional boards and the Department of Health should be increased.

concerning a patient, including but not limited to, diagnoses, tests, medications, treatment and medical history.

Physicians whose federal or state privileges to purchase, dispense or prescribe controlled substances have been revoked or suspended should not be allowed to administer or have access to controlled substances in a hospital unless they are approved by a professional board to practice while participating in rehabilitation under the supervision of a program approved by the professional board.

Pretrial intervention programs should be required to report to professional boards whenever a licensee enters PTI for an offense involving alcohol or other substance abuse.

The New Jersey Electronic Surveillance Act should be amended to allow interceptions, consented to by Enforcement Bureau investigators or other individuals, of conversations between themselves and others where there is a reasonable basis to believe that such conversations will

provide evidence of violations of statutes and regulations governing the conduct of health care professionals. The amendments should provide for attorney general approval of all such interceptions.

Doctors Can Help

The Commission concludes this factually documented critique on the governance of impaired and incompetent physicians with a personal expression of dismay that such a medical care dilemma can be attributed to so few doctors. The Commission therefore desires to reinforce its initial acknowledgement that the vast majority of New Jersey's licensed practitioners are serving a noble calling with the utmost of professional skill and honor. Indeed, the Commission looks to this

preponderance of capable and talented physicians in New Jersey to help lead the way in advancing the above regulatory and statutory corrections so necessary to safeguard public health and safety.

(The SCI's investigative team for this report consisted of Deputy Director [and Counsel] Robert J. Clark and Special Agent Richard S. Hutchinson).



