STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PROGRAM AUDIT

ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION'S DISCIPLINING OF PHYSICIANS

AUGUST 2006

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OFFICE OF THE AUDITOR GENERAL
WILLIAM G. HOLLAND

To the Legislative Audit Commission, the Speaker and Minority Leader of the House of Representatives, the President and Minority Leader of the Senate, the members of the General Assembly, and the Governor:

This is our report of the program audit of the Department of Financial and Professional Regulation's disciplining of physicians who violate provisions of the Medical Practice Act of 1987.

The audit was conducted pursuant to House Resolution Number 16. This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

The audit report is transmitted in conformance with Section 3-14 of the Illinois State Auditing Act.

WILLIAM G. HOLLAND
Auditor General

Springfield, Illinois
August 2006

REPORT DIGEST

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State of Illinois
Office of the Auditor General

WILLIAM G. HOLLAND
AUDITOR GENERAL

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SYNOPSIS

The Department of Financial and Professional Regulation is responsible for reviewing complaints and issuing disciplines against physicians licensed under the Medical Practice Act of 1987. In Fiscal Years 2004 and 2005 combined, the Department opened 3,687 physician investigations and issued a total of 458 disciplines against physicians. Our audit concluded that improvements were needed in the Department's processes to review complaints and discipline physicians.

- Cases were closed in Complaint Intake without forwarding them to Medical Investigations as required by Administrative Rules.
- Cases were also closed in Investigations without approval from the Medical Disciplinary Board, as required by Administrative Rules.
- Investigators did not have access to prior mandatory reports not sent for further investigation by the Medical Disciplinary Board.
- Half of investigations of cases received in FY04 and FY05 took longer than the 5 month guideline for completing investigations.
- There were problems with timeliness of cases due to backlogs at the Medical Coordinators.
- We questioned the adequacy or consistency of disciplinary actions for six cases where complaints were handled by the Department.
- Although we identified some problems with consistency of disciplines, the Department was unwilling to consider developing formal guidelines to help guide its decisions in disciplinary actions.
- We noted that 41 percent of disciplines were cases based on actions taken by other states' disciplinary agencies and required minimal departmental activity compared to other cases.
- Procedures have not been implemented to involve people making complaints in the disciplinary process as required by the Medical Practice Act of 1987.
- The Division of Professional Regulation has only two Probation Compliance investigators for the entire State for over 100 professions regulated by the Division.
- We found monitoring deficiencies in all of the 25 medical probation cases we selected for testing.
- We identified 41 disciplines of physicians that the Department did not include in its monthly reports in Fiscal Year 2005.
- The Department has not yet implemented several significant requirements of an important new law relating to physician regulation and discipline (Public Act 94-677).
- The Department has a number of problems related to properly documenting the decisions made related to physician disciplines.

REPORT CONCLUSIONS

The Department of Financial and Professional Regulation (Department) is responsible for reviewing complaints and issuing disciplines against physicians licensed under the Medical Practice Act. In Fiscal Years 2004 and 2005 combined, the Department opened 3,687 physician investigations and issued a total of 458 disciplines against physicians.

In May of 1997 the Office of the Auditor General issued a program audit of physicians regulated under the Medical Practice Act which concluded that the Department lacked adequate management controls in its investigatory, disciplinary, and probationary processes. This 2006 audit similarly concludes that improvements are needed in the Department's processes to review complaints and discipline physicians.

INVESTIGATIONS

The Department was not complying with legal requirements in its closure of certain cases and other aspects of investigations could be more effective. Failure to follow up on complaints and complete investigations in a timely manner may result in a physician who has violated the Medical Practice Act not being timely detected and disciplined.

Contrary to the requirements in the Administrative Rules, we identified 54 medical claims that Complaint Intake staff closed in Fiscal Year 2005 without forwarding them to Medical Investigations. Also, when initial claims are received, Intake staff do not log or document each claim.

Cases were also being closed administratively in the Investigations Unit without approval from the Medical Disciplinary Board, as required by Administrative Rules. Our review of data provided for all cases with activity in Fiscal Years 2004 and 2005 showed that 15 percent (665 of 4,357) of cases were closed administratively. The Department could not provide documentation that all administrative closings had been approved by the Board.

Investigators did not have access to prior mandatory reports (such as malpractice settlements submitted by insurance companies or reports filed by hospitals) that were not sent for further investigation by the Medical Disciplinary Board. Also, prior complaints were not documented in investigation files in 16 percent (15 of 94) of the investigative files we reviewed.

Half of the investigations of cases received in Fiscal Years 2004 and 2005 took longer than the 5 month guideline the Department has

established for completing investigations. The Department is also experiencing problems with timeliness of cases due to backlogs at the Medical Coordinators. As of May 2006, the total number of cases at the Medical Coordinator's office was 210.

PROSECUTIONS

In Fiscal Years 2004 and 2005 the Department issued a total of 458 disciplines against physicians. Those disciplines included refusing to renew licenses, suspending or revoking licenses, reprimanding licensees or placing them on probation. We questioned the adequacy or consistency of disciplinary actions for six cases that we reviewed where complaints were handled by the Department. We also noted that at least 41 percent (189 of 458) of the disciplines were cases where the Department's discipline was based on actions taken by other states' disciplinary agencies and, therefore, required minimal departmental activity compared to other cases.

The Department has not implemented procedures to involve people making complaints in the disciplinary process, as recommended in our 1997 audit and as required by the Medical Practice Act of 1987.

The Department has not established timeliness standards for Prosecutions. Cases took an average 258 days after referral to Prosecutions to reach final resolution.

PROBATION

The Department has not dedicated sufficient resources to carry out its Probation Compliance responsibilities. The Division of Professional Regulation has **only two** Probation Compliance investigators for the entire State for over 100 professions regulated by the Division. As of April 2006, these two employees of the Probation Compliance Unit were monitoring a total caseload of approximately 1,100 cases, of which approximately 150 were physician discipline cases.

The Department is not adequately monitoring disciplined physicians. Monitoring deficiencies were noted in **all** of the 25 medical probation cases we selected for testing. In 9 cases, most of which involved physicians who had their licenses suspended or revoked, the Department could not provide a file or any other evidence of Probation Compliance monitoring. In 12 other cases, the files provided lacked evidence to show that some or all of the required monitoring had occurred.

PUBLIC INFORMATION

The Department maintains a website to provide public access to license status and discipline information on physicians. This information,

which has been provided on the Department's web page since 2001, provides information to the public on physician disciplines.

However, the Department's monthly reports, used to report on the disciplinary actions taken by the Department, were not accurate. We identified at least 41 disciplines of physicians that the Department did not include in its monthly reports in Fiscal Year 2005. In addition, there is some conflict about what reportable disciplinary actions include. The law requires publication of all disciplinary actions while Administrative Rules distinguish between disciplinary and non-disciplinary actions, with non-disciplinary action not being published.

The Department has not yet implemented several significant requirements of an important new law relating to physician regulation and discipline (Public Act 94-677). Required revisions included: increasing the number of public members on the Medical Disciplinary Board, adding a new Deputy Medical Coordinator, and requiring new detailed physician profiles which will supply new information to the public about physicians.

The Department has a number of problems related to properly documenting the decisions made related to physician disciplines. These problems exist in both paper files that are maintained by various units and in the agency's computer systems and include missing files and lack of consistent or adequate documentation.

Finally, the Department had not followed its own policies in the Enforcement Manual related to the following issues: it did not require secondary employment requests to be submitted for approval on an annual basis; it did not establish appropriate training programs; and it did not require employees to disclose conflicts of interest.

BACKGROUND

On March 15, 2005, the Illinois House of Representatives adopted House Resolution Number 16. The resolution directed the Auditor General to conduct a program audit of the Department of Financial and Professional Regulation's disciplining of physicians who violate provisions of the Medical Practice Act of 1987. House Resolution Number 16 specifically asked us to determine:

(i) The Department's compliance with State law regarding the disciplining of physicians;

(ii) The Department's procedures for determining the need for, and nature of, any recommended disciplinary actions;

(iii) The Department's process for ensuring that its recommended disciplinary actions are implemented and that any specified corrective steps are instituted; and

(iv) The Department's process for communicating results of disciplinary action to the public.

THE MEDICAL PRACTICE ACT OF 1987

The Medical Practice Act of 1987 (225 ILCS 60/1 *et seq*.) contains provisions that the Department of Financial and Professional Regulation must follow in the regulation and disciplining of physicians. The Act creates the Medical Disciplinary Board, which is responsible for disciplining physicians licensed under the Act, composed of eleven members. Members of the Disciplinary Board are to be five licensed physicians, along with one osteopath and one chiropractor, and four public members not engaged in healthcare. However, since March 2005 the Board had no public members. One public member was serving as of January 2004, but he resigned in March 2005. As a result, the Board is without any of the four currently required non-medical members.

The Act also requires the Director to select a Chief Medical Coordinator and two Deputy Medical Coordinators, all licensed physicians, to be the chief enforcement officers of the Act. At least one Medical Coordinator is to be located in Chicago and at least one in Springfield. They review the completed investigations and make recommendations about disciplinary actions to the Board and the Complaint Committee.

Within the Disciplinary Board, the Act creates the Complaint Committee. Composed of one of the Medical Coordinators, the Chief of Medical Investigations, and at least 3 voting members of the Disciplinary Board, the Committee is to meet twice a month to recommend decisions regarding complaints or refer complaints to the Prosecutions Unit. The Department may take the following disciplinary actions on a license:

- revoke;
- suspend;
- place on probationary status;
- refuse to renew;
- reprimand;
- fine; or
- any other disciplinary action deemed proper.

The Act lists 43 grounds that could result in disciplinary action against licensed physicians including: gross negligence; dishonorable, unethical or unprofessional conduct; substance abuse; fraud; immoral conduct; filing false records or omission to file; and willful overcharging for professional services. With few exceptions, proceedings for disciplinary action must be commenced within five years after receipt of a complaint by the Department. (pages 3-4)

COMPLAINT INTAKE

Complaint Intake staff close some initial claims and do not forward them to the Medical Investigations Unit for review, as required by Administrative Rules. When an initial claim is received, Intake staff review the information in the claim to determine if there is sufficient information to determine: 1) the nature of the alleged violation; 2) if the Department has jurisdiction; and 3) if the alleged action, if proven, would constitute a violation of the professional practice act. If a claim meets these criteria, it is then forwarded to Medical Investigations. However, the Department's Administrative Rules (68 Ill. Adm. Code 1285.215) require that all initial claims be forwarded to the Chief or Medical Investigations for review. We found 54 medical claims in FY05 that were closed in Complaint Intake and not forwarded to Investigations. Also, Complaint Intake does not log each claim it receives. We recommended that the Department log all initial claims, forward them to Medical Investigations and close them according to requirements in Administrative Rules. (pages 6-7)

DFPR Complaint Intake staff close some initial claims and do not forward them to the Medical Investigations Unit for review as required.

INVESTIGATIONS

The Department was not complying with legal requirements in its closure of certain cases and other aspects of investigations could be more effective. Failure to follow up on complaints and complete investigations in a timely manner may result in a physician who has violated the Medical Practice Act not being timely detected and disciplined.

Cases were being closed administratively in the Investigations Unit without approval from the Medical Disciplinary Board, as required by Administrative Rules. This was also reported in the 1997 OAG program audit. If the initial claim does not become a complaint, then the Chief of Medical Investigations is required to recommend closure to the Complaint Committee of the Medical Disciplinary Board. The Complaint Committee is established by the Medical Practice Act to review complaints and make recommendations for disciplinary actions to the Board. No initial claim or

complaint is to be closed without the recommendation of the Complaint Committee and approval of the Board.

Investigators did not have access to prior mandatory reports (such as malpractice settlements submitted by insurance companies or reports filed by hospitals) that were not sent for further investigation by the Medical Disciplinary Board. We recommended that the Department make information related to mandatory reports closed by the Board prior to investigation available to assist in the investigation and prosecution of physicians who demonstrate patterns of behavior.

The Department was experiencing problems with timeliness of cases due to backlogs at the Medical Coordinators. As of May 2006, the total number of cases at the Medical Coordinator's office was 210. A Department official noted that this figure was down substantially from 2003 and that some cases take over a year to be reviewed by the Medical Coordinators. We recommended that the Department take the steps necessary to assist the Medical Coordinators with backlogs and improve case timeliness.

We also discussed three other issues related to investigations of physicians. We recommended that the Department:

- Develop management controls to ensure timely completion of investigations of complaints received by the Department.

- Include requirements in its procedures that prior complaint information be incorporated in files and should assure that information is included.

- Develop controls to ensure that all investigative activities are properly conducted and documented in both the case file and the computer system.
  (pages 15-28)

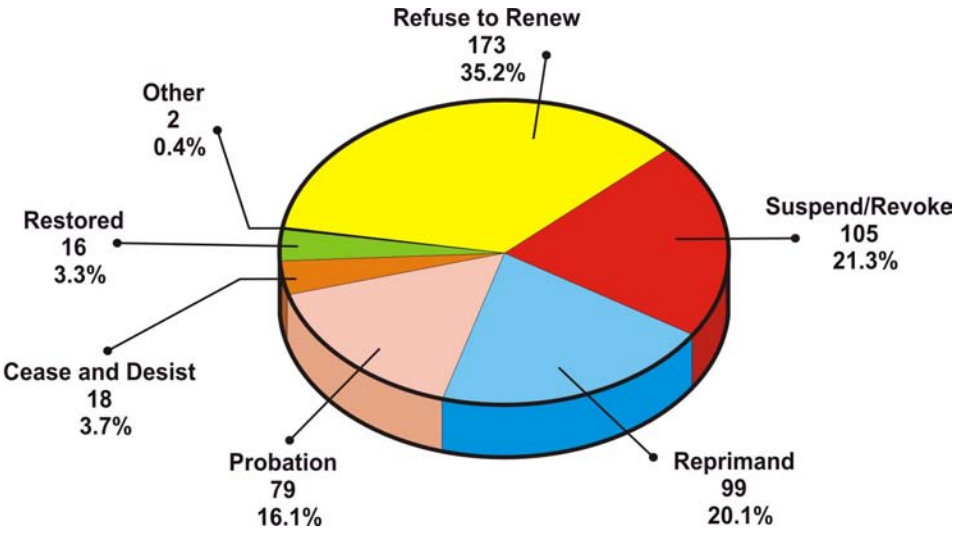
DISCIPLINARY ACTIONS

The need for and nature of disciplinary action is a significant and sensitive area because of the risk to the public if there is a physician practicing who is incompetent or fraudulent. If physicians are given minimal punishment and continue to practice after a serious violation, further dangerous or inappropriate medical practice could occur. Additionally, giving dissimilar disciplines for similar violations of the Medical Practice Act could undermine public, as well as physician, confidence in the Department's process.

In Fiscal Years 2004 and 2005 the Department issued a total of 458 disciplines against physicians. Those disciplines included refusing to renew licenses, suspending or revoking licenses, reprimanding licensees or placing them on probation. Digest Exhibit 1 shows a breakdown for the 492 actions that were levied by the Department in Fiscal Years 2004 and 2005. It includes 18 cases where someone was practicing without a license and was asked to cease and desist. It also includes 16 cases where licenses were restored after being disciplined.

In Fiscal Years 2004 and 2005 DFPR issued a total of 458 disciplines against physicians.

Digest Exhibit 1
DISCIPLINARY ACTIONS FOR FY 2004 & 2005 BY TYPE



Note: Percentages do not add due to rounding.
Source: DFPR data analyzed by OAG.

Adequacy and Consistency of Disciplinary Actions

We questioned the adequacy or consistency of disciplinary actions for six cases that we reviewed where complaints were handled by the Department. We also noted that 41 percent (189 of 458) of the disciplines were cases where the Department's discipline was based on actions taken by other states' disciplinary agencies and, therefore, required minimal departmental activity compared to other cases.

Although our case reviews identified some problems with consistency of disciplines, the Department was unwilling to consider developing formal guidelines to help guide its decisions in disciplinary actions. Our 1997 audit of physician disciplines also noted that disciplines decided by the Board for similar violations were not always consistent and recommended that the Department develop criteria to help guide decisions in disciplinary actions.

DFPR was unwilling to consider developing formal guidelines to help guide its decisions in disciplinary actions.

We recommended that the Department and the Medical Disciplinary Board develop general criteria to help guide their decisions in disciplinary actions. Such criteria would help to ensure that similar violations under similar circumstances receive similar discipline.

Other Discipline Issues

The Department has not implemented procedures to involve people making complaints in the disciplinary process, as recommended in our 1997 audit of physician disciplines and as required by the Medical Practice Act of 1987. Section 60/37 of the Act requires that

> *. . . both the accused person and the complainant shall be accorded ample opportunity to present in person, or by counsel, such statements, testimony, evidence, and argument as may be pertinent to the charges or to any defense thereto.*

According to Department officials, the Department does not represent the complainant. Once a complaint is filed with the Department, it becomes the complainant, not the person who filed the original complaint. We recommended that the Department develop procedures for involving people making complaints in the disciplinary process.

Additionally, related to disciplining of physicians we recommended that the Department:

- Assure that complaints received about out of state physicians are forwarded to the licensing board of the appropriate state.

- Develop and implement management controls to ensure that Prosecution activities are timely and properly documented. (pages 29-44)

PROBATION COMPLIANCE

DFPR has not dedicated sufficient resources to carry out its Probation Compliance responsibilities.

The Department of Financial and Professional Regulation has not dedicated sufficient resources to carry out its Probation Compliance responsibilities. The Division of Professional Regulation has **only two** Probation Compliance investigators for the entire State for over 100 professions regulated by the Division. As of April 2006, these two employees of the Probation Compliance Unit were monitoring a total caseload of approximately 1,100 cases, of which approximately 150 were physician discipline cases.

Monitoring deficiencies were noted in **all** of the 25 medical probation cases we selected for testing. In 20 of 25 cases we tested, the Department either could not provide a Probation Compliance monitoring file or the files lacked evidence to show that some or all of the required monitoring had occurred.

Six of the 9 cases with no probationary files were cases where the physician's license was either suspended or revoked. We found no evidence that Probation staff were performing any follow-up actions to attempt to ascertain that physicians whose licenses had been suspended or revoked were not continuing to practice. Not undertaking efforts to check for practicing physicians who have had their licenses suspended or revoked not only results in noncompliance with departmental policy, but also increases the risk to the general public.

According to the Department's Enforcement Manual effective June 15, 2000, responsibilities of the Probation Compliance investigators include:

- Probation monitoring;
- Verification of suspensions;
- Revocation/cease and desist surveillance;
- Liaison with federal, State and local agencies regarding disciplined licenses; and
- Violation investigations and prosecutorial referrals.

Digest Exhibit 2 shows examples of order conditions requiring probation monitoring. According to Department personnel, most disciplinary actions that require some type of monitoring are the responsibility of the Probation Compliance Unit.

Digest Exhibit 2
EXAMPLES OF ORDER CONDITIONS REQUIRING PROBATION MONITORING

- Alcoholics Anonymous Meetings
- Caduceus Meetings
- Aftercare Program
- Urine Drug Screenings
- Supervised Work
- Psychiatrist/Psychologist Treatment
- Revocation
- Suspension
- Continuing Education
- Random Breathalyzer Tests

Source: OAG analysis of Probation Compliance case files and DFPR Enforcement Manual.

We recommended that the Department devote sufficient resources to ensure that physicians' compliance with terms of disciplinary orders are adequately monitored, including that physicians who have had their licenses suspended or revoked are not practicing. Furthermore, the Department should ensure that probation files contain all required documentation and that staff follow up when required documentation is not submitted. We also recommended that the Department take actions to ensure that initial interviews are conducted within 30 days and adequately documented and that files receive appropriate supervisory review. (pages 45-52)

DISCIPLINES REPORTED TO THE PUBLIC

Although the Department provides information to the public, there is a 1-2 month backlog in reporting disciplines on the Department's website and not all disciplines in the system are reported on the monthly reports to the public. The Department's website allows users to look up physicians and determine if they have been disciplined. The website also includes monthly reports on disciplines taken against various professionals regulated by the Department.

However, the Department's monthly reports, used to report on the disciplinary actions taken by the Department, were not accurate. We identified at least 41 disciplines of physicians that the Department did not include in its monthly reports in Fiscal Year 2005. In addition, there is

some conflict about what reportable disciplinary actions include. The law requires publication of all disciplinary actions while Administrative Rules distinguish between disciplinary and non-disciplinary actions, with non-disciplinary action not being published.

Because of the conflict about which disciplines should be reported to the public, we recommended that the Department make its Administrative Rules (68 Ill. Adm. Code 1285.225) relating to the definition of disciplinary and non-disciplinary actions consistent with requirements of the Medical Practice Act (225 ILCS 60/2 (4)). We also recommended that the Department:

- Ensure that the public is fully informed of disciplinary actions on a timely, accurate, and consistent basis.

- Send required summary reports of final actions taken upon disciplinary files to every licensed health care facility, medical association, and liability insurers as required by the Medical Practice Act of 1987. (pages 53-59)

STATUS OF IMPLEMENTING PUBLIC ACT 94-677

The Department has not yet implemented several significant requirements of an important new law relating to physician regulation and discipline. Several sections of the Medical Practice Act were amended on August 25, 2005 by Public Act 94-677. According to the Act, these requirements are effective immediately. We recommended that the Department continue to work to comply with amendments to the Medical Practice Act made by Public Act 94-677, including promulgating rules to accomplish these requirements.

DFPR should continue to work to comply with amendments to the Medical Practice Act made by Public Act 94-677.

We made specific recommendations about two requirements of Public Act 94-677 that have not yet been implemented. We recommended that the Department:

- Continue to work to make available to the public, through the Internet, and, if requested, in writing, a profile of each physician licensed by the Department as required by Public Act 94-677.

- Work to assure that all members, including public members, are appointed to the Medical Disciplinary Board as required by the Medical Practice Act.
(pages 60-63)

OTHER ISSUES

We also identified other issues which need the Department's attention. We recommended that the Department:

- Document its decisions and activities sufficiently and ensure that the replacement system for the Regulatory Administration and Enforcement System has the capability to help management better control the adequacy of the Enforcement process.

- Monitor employees engaging in secondary employment closely by reviewing and approving requests on an annual basis.

- Establish appropriate training programs for medical investigators as directed in its own policies and procedures.

- Require its employees to disclose potential conflicts of interest as required by its Enforcement Manual.

- Require employees, including medical investigators, to prepare timesheets as required by the State Officials and Employees Ethics Act. (pages 65-76)

RECOMMENDATIONS

The audit report contains 24 recommendations, all of which are noted in this digest. The Illinois Department of Financial and Professional Regulation generally agreed with the recommendations. Appendix D to the audit report contains the Department's complete responses.

WILLIAM G. HOLLAND
Auditor General

WGH\EKW
August 2006

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Chapter One

INTRODUCTION AND BACKGROUND

REPORT CONCLUSIONS

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disciplinary actions, with non-disciplinary action not being published. In addition, the Department has no written policies and procedures guiding the public reporting process.

The Department has not yet implemented several significant requirements of an important new law relating to physician regulation and discipline (Public Act 94-677). Required revisions included: increasing the number of public members on the Medical Disciplinary Board, adding a new Deputy Medical Coordinator, and requiring new detailed physician profiles which will supply new information to the public about physicians.

The Department has a number of problems related to properly documenting the decisions made related to physician disciplines. These problems exist in both paper files that are maintained by various units and in the agency's computer systems and include missing files and lack of consistent or adequate documentation.

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BACKGROUND

On March 15, 2005, the Illinois House of Representatives adopted House Resolution Number 16. The resolution directed the Auditor General to conduct a program audit of the Department of Financial and Professional Regulation's disciplining of physicians who violate provisions of the Medical Practice Act of 1987. House Resolution Number 16 specifically asked us to determine:

(i) The Department's compliance with State law regarding the disciplining of physicians;

(ii) The Department's procedures for determining the need for, and nature of, any recommended disciplinary actions;

(iii) The Department's process for ensuring that its recommended disciplinary actions are implemented and that any specified corrective steps are instituted; and

(iv) The Department's process for communicating results of disciplinary action to the public.

A copy of the resolution is attached as Appendix A.

REGULATION UNDER THE MEDICAL PRACTICE ACT

The Medical Practice Act of 1987 (Act) contains provisions that the Department of Financial and Professional Regulation (DFPR) must follow in the regulation and disciplining of physicians (225 ILCS 60/1 *et seq*.). The Act creates the Medical Disciplinary Board (Board), which is responsible for disciplining physicians licensed under the Act, composed of eleven

members. Members of the Disciplinary Board are to be five licensed physicians, along with one osteopath and one chiropractor, and four public members not engaged in healthcare. However, since March 2005 the Board has had no public members. One public member was serving as of January 2004, but he resigned in March 2005. As a result, the Board is without any of the four currently required non-medical members.

The Act also requires the Director to select a Chief Medical Coordinator and two Deputy Medical Coordinators, all licensed physicians, to be the chief enforcement officers of the Act. At least one Medical Coordinator is to be located in Chicago and at least one in Springfield. They review the completed investigations and make recommendations about disciplinary actions to the Board and the Complaint Committee.

Within the Disciplinary Board, the Act creates the Complaint Committee. Composed of one of the Medical Coordinators, the Chief of Medical Investigations, and at least 3 voting members of the Disciplinary Board, the Committee is to meet twice a month to recommend decisions regarding complaints or refer complaints to the Prosecutions Unit. The Department may take the following disciplinary actions on a license:

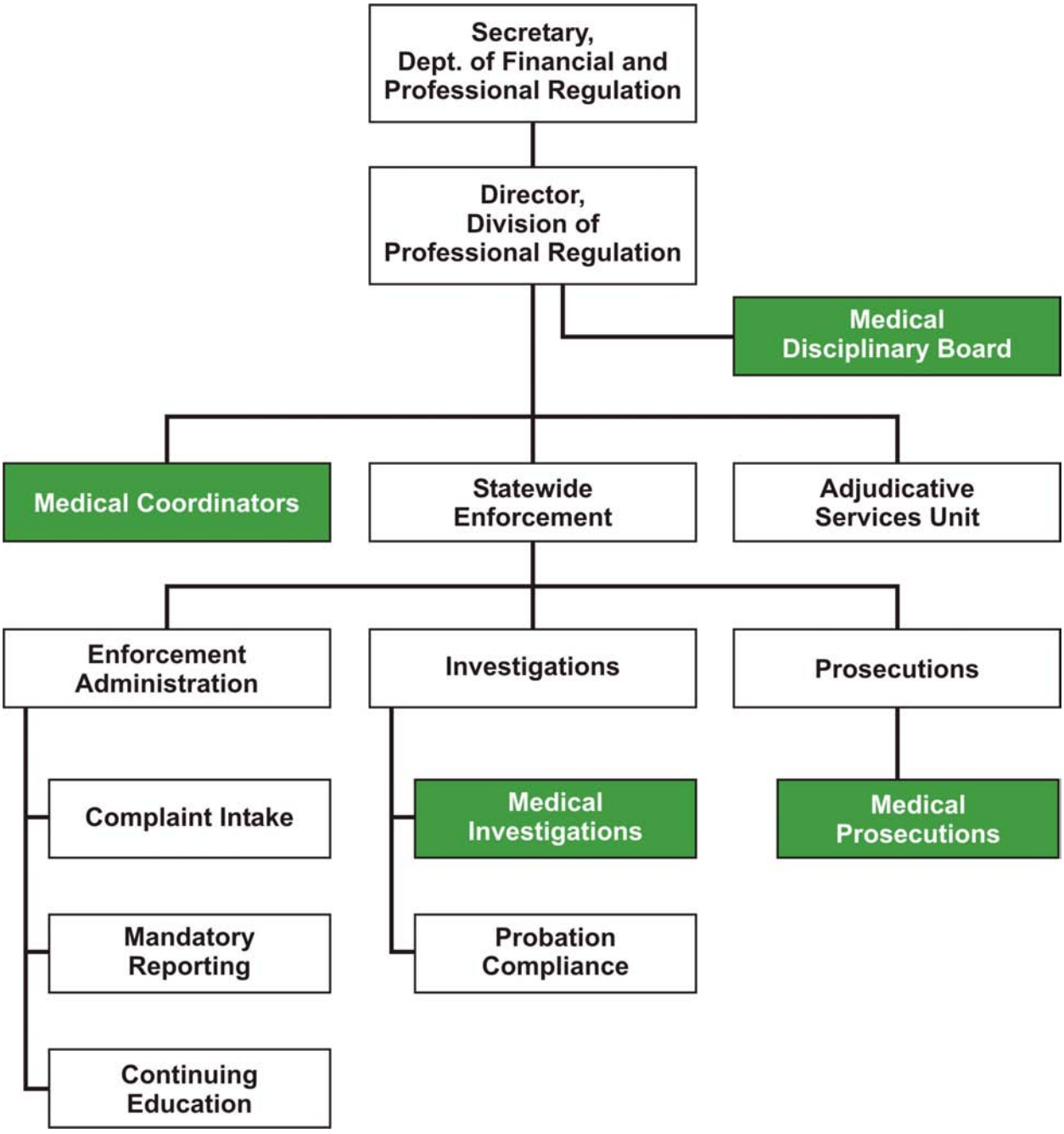
- revoke;
- suspend;
- place on probationary status;
- refuse to renew;
- reprimand;
- fine; or
- any other disciplinary action deemed proper.

The Act lists 43 grounds that could result in disciplinary action against licensed physicians including: gross negligence; dishonorable, unethical or unprofessional conduct; substance abuse; fraud; immoral conduct; filing false records or omission to file; and willful overcharging for professional services. For a complete list of these grounds, see Appendix C. With few exceptions, proceedings for disciplinary action must be commenced within five years after receipt of a complaint by the Department.

THE PROCESS FOR DISCIPLINING PHYSICIANS

The physician disciplinary process at DFPR is handled through a four step process. The units that handle those four steps are Complaint Intake, Investigations, Prosecutions and Probation Compliance. Both Complaint Intake and Probation Compliance are units that handle cases from all professions while Investigations and Prosecutions are both included in Statewide Enforcement and have a specific medical component. Exhibit 1-1 is an organization chart that shows the physician regulation portion of the Department. The four components that make up the process are described below. The units that handle Investigation, Prosecution, and Probation Compliance are discussed in greater detail later in this report.

Exhibit 1-1
ORGANIZATIONAL CHART
PHYSICIAN REGULATION PORTION OF THE
DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION



Note: Green boxes are exclusively for physician regulation. For the green boxes there are 2 Medical Coordinators, 18 medical investigators, and 6 medical prosecutors. These 26 staff are exclusively medical disciplinary and compare to approximately 825 total staff for DFPR.

Source: DFPR data summarized by OAG.

Complaint Intake

Complaint Intake receives complaints for **all** professions regulated by the Department. The Unit consists of a supervisor, 2 full-time, and 1 temporary staff. Complaints are received by telephone, facsimile, mail, in person, and through the Department's web site.

The Department's Administrative Rules require that all initial claims against physicians be documented and forwarded to the Chief of Medical Investigations for review. The Administrative Rules related to complaint processing are located at 68 Illinois Administrative Code 1285.215. The rules define an initial claim as:

> *an allegation made against a physician or physician assistant that results in a preliminary analysis to determine whether the Division should conduct a further investigation;*

A complaint is defined as:

> *the initial claim made against a physician or physician assistant that results in an inquiry or investigation.*

Contrary to the requirements in the Administrative Rules, Complaint Intake staff close some initial claims without forwarding them to the Medical Investigations Unit for review. When the initial claims are received, Intake staff do not log or document each claim and forward them to Medical Investigations as required. Instead, they review the information in the claim to determine if there is sufficient information to determine: (1) the nature of the alleged violation; (2) if the Department has jurisdiction; and (3) if the alleged action, if proven, would constitute a violation of the professional practice act. If a claim meets all of these criteria and is deemed as a valid complaint, staff document and enter the complaint into RAES (Regulatory Administration and Enforcement System) with a complaint number. Physician complaints are then forwarded on to Medical Investigations.

Case Examples
Initial Claims Closed in Complaint Intake

Example 1 – A complaint was made by a friend of an elderly patient that alleged gross negligence and inadequate treatment which resulted in the patient's death. The complaint stated that the patient had no other friends or family, and had documentation of dates and times available if necessary. DFPR staff informed the friend who filed the complaint that the executrix or person holding power of attorney needed to file the complaint.

Example 2 – A physician notified the Department on 2/20/05 of a lawsuit against another physician with evidence of alleged falsifying information on IDOT physical and State disability forms, lacking patient records, and overusing prescribed controlled substances. After review by Department officials, on 5/2/05 staff noted "complaint matters pertains (sic) to patients. Complainant does not have authority to release patient info. Nothing to pursue."

If Complaint Intake staff determine that an initial claim is not a valid complaint, they contact complainants by phone to explain why they cannot proceed with the claim and/or try to get more information. Complaint Intake staff said that they keep some documentation for some of these closed initial claims, but there are no criteria for when these claims are kept and when they are not. For FY05, we found 54 initial claims closed in Complaint

Intake that we identified as medical. Case examples (see inset) show initial claims closed in Complaint Intake. These examples show potentially serious cases closed in Intake. Although some complaints are clearly not violations of the Medical Practice Act, rules do not allow initial claims to be closed at Intake.

Further, all initial claims are to be referred to the Complaint Committee and Disciplinary Board for closure. However, the initial claims against physicians which are closed in Intake are never referred to Medical Investigations or the Board for closure. Administrative Rules require that no initial claim or complaint shall be deemed closed except upon recommendation of the Complaint Committee and approval by the Disciplinary Board.

INITIAL CLAIMS CLOSED AT INTAKE	
RECOMMENDATION NUMBER **1**	***The Department of Financial and Professional Regulation should log all initial claims, forward them to Medical Investigations and close them according to requirements in the Administrative Rules.***
DFPR RESPONSE	The majority of initial claims are forwarded to Medical Investigations and processed according to the requirements in Administrative Rules. In response to this recommendation, the Department will change its procedure relating to initial claims that do not warrant further investigation upon receipt by the Complaint Intake Unit. They too will be processed and forwarded to the Complaint Committee and Medical Disciplinary Board, for review and final approval of closure. The Department, on average, receives 1,600 initial claims annually and has developed and implemented a comprehensive and efficient Complaint Intake Unit which efficiently analyzes and processes each claim. Complaint Intake personnel are highly qualified to make preliminary analyses of claims and routinely treat each as potentially serious. After preliminary analysis of an initial claim is conducted, Complaint Intake personnel render a determination that further investigation is or is not possible and/or required. There are limited but clearly and statutorily defined instances where it is not possible or required that a complaint case be opened on an initial claim. The majority of initial claims received by the Department, however, are opened as an official complaint case for further investigation. Because Complaint Intake personnel are only authorized to open complaint cases, at no time are complaint cases closed by Complaint Intake personnel.
	AUDITOR COMMENT: For FY05, auditors found 54 initial claims that had been closed in Complaint Intake that we identified as medical. Although Complaint Intake does not close "complaint" cases, they have closed "claims." Also, as noted in the report, Complaint Intake does not log all initial claims received which would help ensure that claims are processed efficiently.

For initial claims that become valid complaints, complainants are to be sent an acknowledgement letter and brochure as part of the investigative process. Once the complaint is entered into the RAES system, this letter is automatically generated and then mailed by Complaint Intake staff. Intake staff make a case file and include the complaint documentation in the file. The files containing medical complaints along with reconciliation sheets are then forwarded to Investigations within 2-3 days of the date the complaint was received by the Department.

Mandatory Reports

Mandatory reports are another source of complaints. According to the Act, certain entities are required to report to the Board on professional conduct and any instances where licensed individuals have committed a violation of the Act. Entities required to submit reports are as follows:

- professional liability insurers;
- health care institutions;
- professional associations;
- State's Attorneys; and
- State agencies.

The Board reviews these reports and can close them without further investigation or may refer them to Medical Investigations, where the case is investigated under the normal investigative process. In some cases, the Board may also refer the cases directly to Medical Prosecutions. Mandatory report cases are received in a unit located in Springfield which is made up of two people.

Investigations

When complaints are sent to Investigations, supervisory staff assign investigators to cases based on a number of factors, including whether the investigator has investigated similar complaint types, other complaints against the same physician, complaints from the same complainant, and geographical location of the complainant and the physician. During Fiscal Year 2005, 1,771 cases were opened and 2,121 were closed. Of the cases closed 1,867 (88%) were closed without discipline and 254 (12%) were closed with discipline.

Exhibit 1-2
MEDICAL INVESTIGATIONS OPENED AND CLOSED
FY04 and FY05

	FY04	FY05
Cases Opened	1,916	1,771
Cases Closed without Discipline	1,680	1,867
Cases Closed with Discipline	238	254

Source: DFPR data summarized by OAG.

Exhibit 1-2 shows the number of complaints opened for investigation by the Department in Fiscal Years 2004 and 2005. It also

shows the numbers closed with and without discipline. Cases closed in the Exhibit are not a subset of cases opened because many of the closed cases were actually opened in a previous fiscal year.

The Medical Investigations Unit maintains a very low staff turnover rate. As of February 2006, the Department employed 18 medical investigators. More than half of the medical investigators have been in their positions for over 15 years. The Department has not hired any new investigators in over three years.

Prosecutions

Prosecutions staff is primarily made up of attorneys who pursue a discipline against physicians who have been alleged to have violated the Medical Practice Act. Currently, there are 6 Medical Prosecutions Unit attorneys who represent the Department against physicians where the investigations indicate some possible violation of the Medical Practice Act. They represent the Department in formal hearings against the physicians. However, the majority of disciplines against physicians are obtained through informal conferences. The procedures guiding this informal process have been established in Administrative Rules.

During informal conferences, a Medical Disciplinary Board member and staff attorney usually discuss the allegation and evidence with the physician (and/or his attorney). The staff attorney is there to ask questions and advise the Board member. At the informal conference a violation and discipline can be proposed. If accepted, the full Medical Disciplinary Board and the Secretary approve the proposal.

If a resolution cannot be obtained, if there is a statute of limitations approaching, or if the Board is concerned about a case, a formal complaint is filed. Under this process, hearings are held by an administrative law judge, who makes a recommendation to the Board at the end of the hearing. The Secretary of the Department of Financial and Professional Regulation must approve and sign all disciplinary orders. If he does not agree, he must notify the Board in writing, giving his reasons.

Exhibit 1-3
EXAMPLES OF ORDER CONDITIONS REQUIRING PROBATION MONITORING

- Alcoholics Anonymous Meetings
- Caduceus Meetings
- Aftercare Program
- Urine Drug Screenings
- Supervised Work
- Psychiatrist/Psychologist Treatment
- Revocation
- Suspension
- Continuing Education
- Random Breathalyzer Tests

Source: OAG analysis of Probation Compliance case files and DFPR Enforcement Manual.

Probation Compliance Unit

The Probation Compliance Unit, which has two staff, is responsible for monitoring **all** professions regulated by the Division of Professional Regulation, including physicians whose licenses have been placed on probation. In addition, the Unit is responsible for monitoring physicians whose licenses are suspended or

revoked to ensure that they are not practicing. As of April 2006, the total caseload for the two Probation investigators was approximately 1,100 cases. About 150 of these cases were medical. Exhibit 1-3 shows examples of order conditions requiring Probation monitoring.

EXPENDITURES FOR PHYSICIAN DISCIPLINE

Expenditures for the process of disciplining physicians have been relatively flat for years, even declining. During the same time revenues to the Illinois State Medical Disciplinary Fund have varied because of a three-year renewal cycle for physician licenses. Exhibit 1-4 shows revenues, appropriations, and expenditures from the Medical Disciplinary Fund since 1992. As the Exhibit shows, revenue generated by physicians' fees and fines has been more than sufficient to cover expenditures of the Medical Disciplinary Fund. The Medical Disciplinary Fund had $1.5 million transferred out to the General Revenue Fund in Fiscal Year 2004 to address a fiscal emergency.

Exhibit 1-5 shows graphically the revenues and expenditures for the Medical Disciplinary Fund. The fluctuation in revenue is related in part to the fact that physicians pay their license renewal fee of $300 once every three years. The renewal fee of $300 has not been increased since the Medical Practice Act of 1987 was first passed and effective May 1987. Recent changes in the Act requiring physician profiles and requiring more investigators may require larger appropriations and expenditures.

Exhibit 1-4
REVENUES APPROPRIATIONS AND EXPENDITURES FOR THE ILLINOIS STATE MEDICAL DISCIPLINARY FUND
Fiscal Years 1992 to 2005
(in millions)

	Revenues [1]	Appropriations	Expenditures
FY1992	$1.8	$4.9	$4.6
FY1993	3.9	4.8	4.5
FY1994	9.3	5.1	4.9
FY1995	1.9	5.0	4.6
FY1996	5.5	4.9	4.8
FY1997	9.6	3.4	3.3
FY1998	1.5	3.5	3.4
FY1999	7.5	3.7	3.6
FY2000	7.9	3.7	3.5
FY2001	1.6	3.8	3.5
FY2002	11.5	4.1	3.5
FY2003	4.5	4.2	3.7
FY2004	1.6	3.8	3.1
FY2005	11.6	3.4	3.3
Totals	$79.7	$58.3	$54.3

Note :[1] Revenues are higher in some years because of the three-year license renewal cycle.

Source: OAG audit and Comptroller data summarized by OAG.

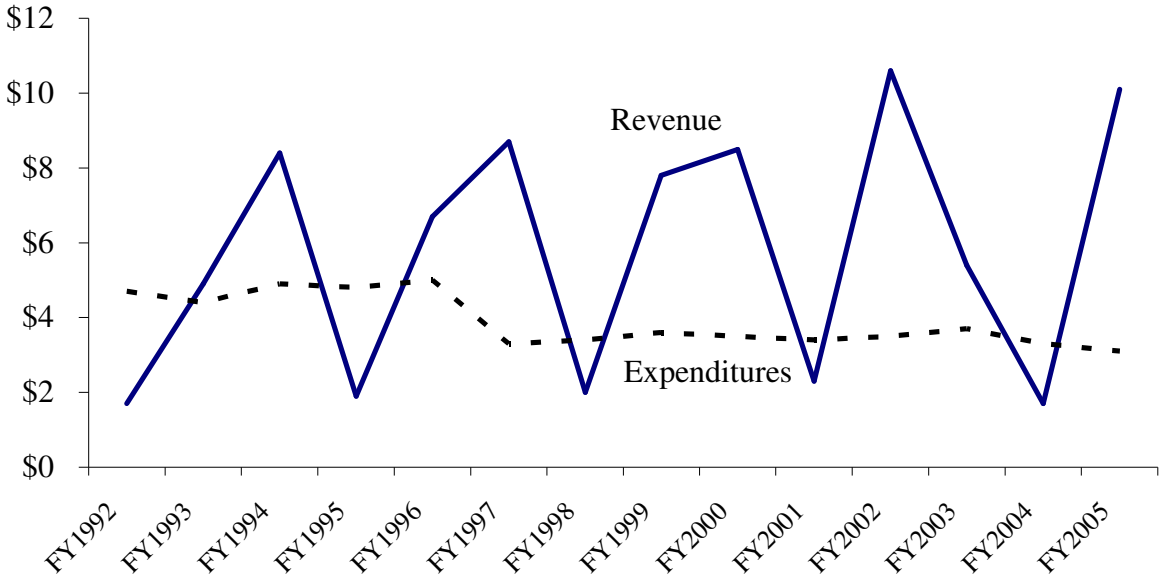
NUMBERS OF PHYSICIANS

The number of physicians has generally been increasing in Illinois since Fiscal Year 2001. However, in a pattern that can be seen in Exhibit 1-6, the number decreases dramatically

Exhibit 1-5

REVENUE AND EXPENDITURES - MEDICAL DISCIPLINARY FUND

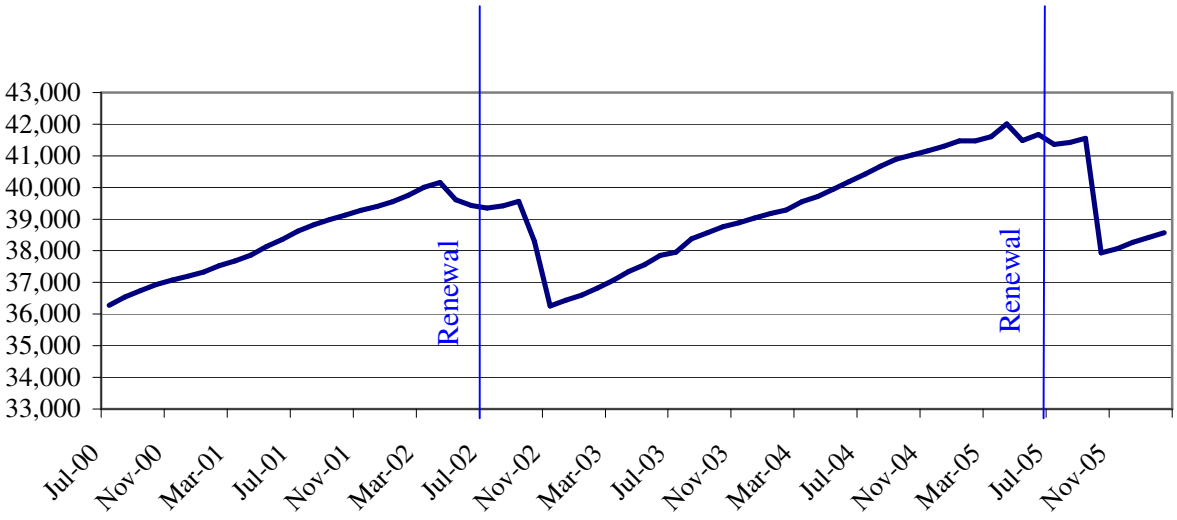
$ in Millions



Source: OAG audit and Comptroller data summarized by OAG.

Exhibit 1-6

ACTIVE PHYSICIAN LICENSES - JULY 2000 TO FEBRUARY 2006



Source: DFPR data summarized by OAG.

after the physician license renewal period. The number of physicians then begins a steady increase. A Department official said that the decrease is due to the fact that physicians have 90 days until their licenses lapse and during that period a number of physicians do not renew their licenses because they no longer practice in the State. The Exhibit shows with vertical lines when the two renewals were during the time period that is covered by the chart.

AUDIT SCOPE AND METHODOLOGY

This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

Fieldwork for this audit was conducted between January and April 2006. We interviewed representatives of the Illinois Department of Financial and Professional Regulation with responsibilities related to disciplining physicians. We reviewed documents at DFPR including Intake initial claims, mandatory reports, Investigations files, Prosecution files, and Probation Compliance files. We tested samples and reviewed case files related to the audit's objectives. A more complete description of our testing and analyses is in Appendix B of this report.

In conducting the audit, we reviewed applicable State statutes and rules. In particular, provisions of the Medical Practice Act and related Administrative Rules were reviewed in detail and our testing considered whether the Department was in compliance with statutes and rules as specified by the resolution. Any instances of non-compliance we identified are noted in this report. We also obtained and reviewed departmental policies and procedures that relate to physician discipline that were available.

We reviewed risk and internal controls at DFPR related to the audit's objectives. The audit objectives are contained in House Resolution Number 16 (see Appendix A). This audit identified some weaknesses in those controls, which are included as findings in this report.

We reviewed the previous financial audits and compliance attestation engagements released by the Office of the Auditor General for the Department of Financial and Professional Regulation and its predecessor agency, the Department of Professional Regulation. This included reviewing findings for the most recent compliance attestation engagement for Fiscal Year 2005. As directed by House Resolution Number 16, we also reviewed findings from the 1997 OAG program audit of Physicians Regulated under the Medical Practice Act and checked the status of the 16 recommendations included in that audit.

To the extent necessary we reviewed the reliability of computer processed data used in our audit report. That included reviewing findings included in the compliance attestation engagements and audits that were done by the Auditor General. Weaknesses related to computer data and computer systems are noted in this report.

REPORT ORGANIZATION

The remainder of this report is organized into the following chapters:

- Chapter Two – Investigating Complaints
- Chapter Three – Implementing Disciplinary Actions
- Chapter Four – Probation Monitoring
- Chapter Five – Communicating Results to the Public
- Chapter Six – Other Issues

Chapter Two

INVESTIGATING COMPLAINTS

CHAPTER CONCLUSIONS

The Department of Financial and Professional Regulation was not complying with legal requirements in its closure of certain cases and other aspects of investigations could be more effective. Failure to follow up on complaints and complete investigations in a timely manner may result in a physician who has violated the Medical Practice Act not being timely detected and disciplined.

Cases were being closed administratively in the Investigations Unit without approval from the Medical Disciplinary Board, as required by Administrative Rules. Our review of data provided for all cases with activity in Fiscal Years 2004 and 2005 showed that 15 percent (665 of 4,357) of cases were closed administratively. The Department could not provide documentation that all administrative closings had been approved by the Board.

Investigators did not have access to prior mandatory reports (such as malpractice settlements submitted by insurance companies or reports filed by hospitals) that were not sent for further investigation by the Medical Disciplinary Board. Also, prior complaints were not documented in Investigation files in 16 percent (15 of 94) of the investigative files we reviewed.

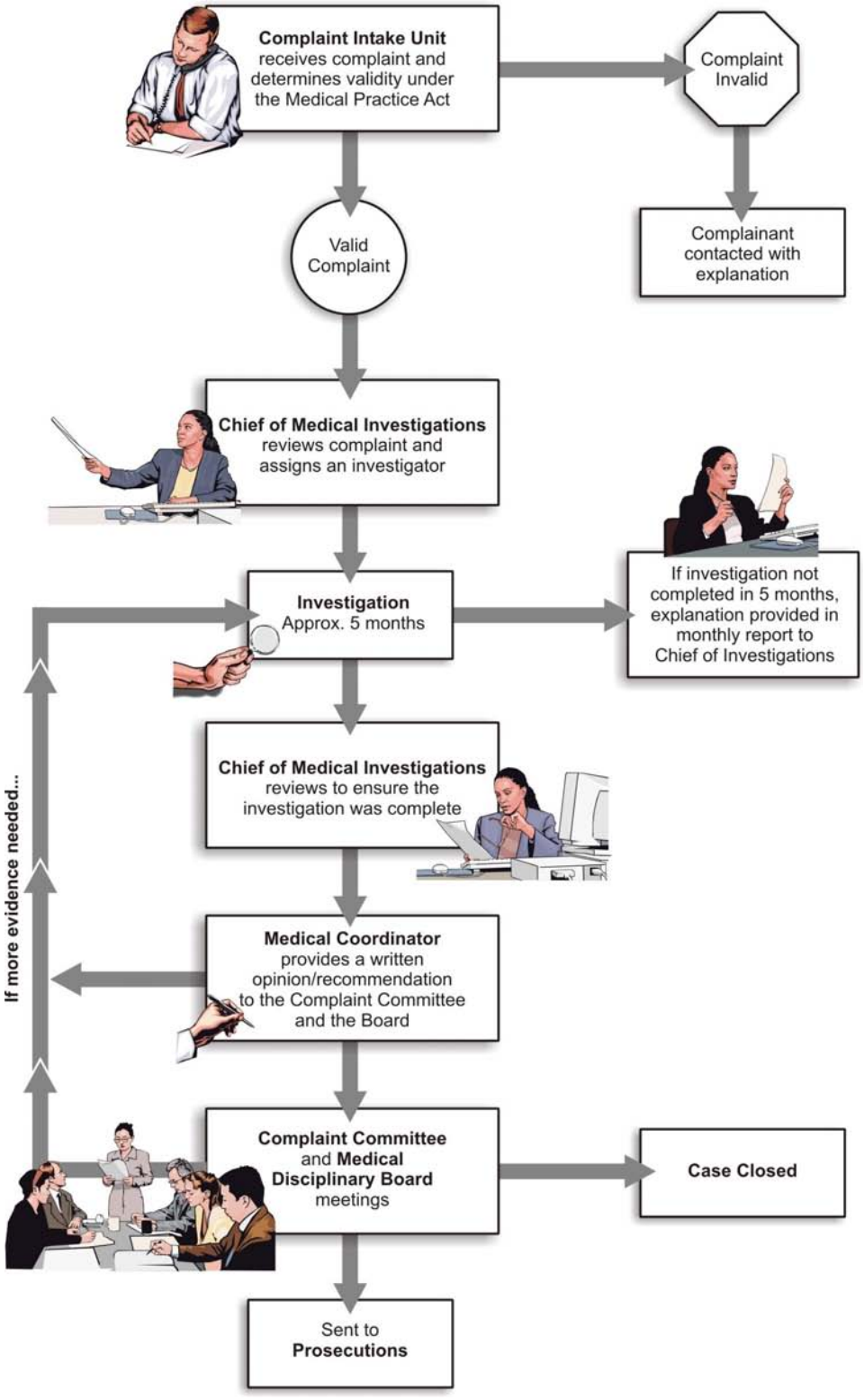
Half of the investigations of cases received in Fiscal Years 2004 and 2005 took longer than the 5 month guideline the Department has established for completing investigations. The Department is also experiencing problems with timeliness of cases due to backlogs at the Medical Coordinators. As of May 2006, the total number of cases at the Medical Coordinator's office was 210.

BACKGROUND

When complaints are considered possible violations of the Medical Practice Act by the Complaint Intake Unit, they are referred to Medical Investigations. Supervisory staff in Investigations assign cases to investigators based on a number of factors, including whether the investigator has investigated similar complaint types, other complaints against the same physician, or other complaints from the same complainant, and the geographical location of the complainant or the physician. As of February 2006, the Department employed 18 medical investigators. Exhibit 2-1 on the following page shows the flow of cases in Investigations.

For our fieldwork testing, we selected a total of 130 cases for review – 67 for Investigations and 63 for Prosecutions. However, we traced all cases in our sample throughout the discipline process. If an Investigation sample case was referred to Prosecutions, we reviewed

Exhibit 2-1
FLOWCHART OF THE INVESTIGATIONS PROCESS



Source: DFPR information summarized by OAG.

the prosecution file as well. Similarly, we reviewed the Investigation files available for all cases selected in our prosecution sample. We also reviewed the probation compliance files for any cases in our sample that resulted in discipline requiring monitoring. As a result we examined 94 investigative files and 80 prosecution files.

CASE CLOSURE WITHOUT PRIOR APPROVAL

Cases were being closed administratively in the Investigations Unit without approval from the Medical Disciplinary Board, as required by Administrative Rules. This was also reported in the 1997 OAG program audit. The Department's Administrative Rules (68 Ill. Adm. Code 1285.215) require that initial claims be forwarded to the Chief of Medical Investigations for review. If the initial claim does not become a complaint, then the Chief is required to recommend closure to the Complaint Committee of the Medical Disciplinary Board. The Complaint Committee is established by the Medical Practice Act to review complaints and make recommendations for disciplinary actions to the Board. No initial claim or complaint is to be closed without the recommendation of the Complaint Committee and the approval of the Board.

Our review of data provided for all cases with activity in Fiscal Years 2004 and 2005 showed that 15 percent (665 of 4,357) of cases closed had the last activity in the Department's RAES system as "Close: Administrative." Department officials stated that administrative closings include cases where the investigator determines after talking with the complainant that no violation of the Act has occurred; the situation has been resolved; or the complainant does not cooperate with the investigator.

A DFPR official stated that the Board is given a list of administrative closings that it approves at every meeting. However, we reviewed copies of Board and Complaint Committee minutes for Calendar Year 2004 and half of Calendar Year 2005 and found that the list of administrative cases to be closed was neither mentioned nor included in any of the minutes from those years. Additionally, we requested these lists of administratively closed cases for Calendar Year 2004 and Calendar Year 2005 on two occasions but the Department did not provide the documentation until the exit conference. We reviewed the information, but still found 2 of 15 cases from our sample where closing was not documented in the minutes. The Department should assure that **all** cases closed are approved by the Board as required.

ADMINISTRATIVE CLOSURE OF CASES	
RECOMMENDATION NUMBER **2**	***The Department of Financial and Professional Regulation and the Medical Disciplinary Board should comply with the Administrative Code provisions requiring that closure of all initial claims and complaints be approved by the Board. This approval should be documented.***
DFPR RESPONSE [Response continued on the following page.]	The Department complies with the Administrative Code provision requiring that closure of all complaints be approved by the Medical Disciplinary Board. However, the complaints are reviewed in the

[Continued Response]	closed session of the Medical Disciplinary Board meeting and the discussion of these complaints is, therefore, not included in the Medical Disciplinary Board's general minutes for the audit years FY04 and FY05. The case closures from closed sessions of FY04 and FY05 are documented separately. This documentation provides the dates that the Chairman of the Board reviewed and approved each case for closure along with his or her initials. As stated in the Department's Response to Recommendation 1, initial claims that do not warrant further investigation will also be approved for final closure by the Complaint Committee and Medical Disciplinary Board.
	AUDITOR COMMENT: Over the course of audit fieldwork, auditors requested documentation of Board approval for closure on two occasions: first, on February 16, 2006; and later on March 7, 2006. It was not until the exit conference, on June 29, 2006, that the Department made documentation available for this finding. When auditors reviewed the information related to sample cases, auditors still found 2 of 15 cases where closing was not documented in the Board documentation provided.

INVESTIGATION TIMELINESS

The Department does not have a specific timeliness standard and our analysis showed that half of medical investigations are not completed within the general guidance of five months. The Department's Enforcement Manual says that most investigations are completed within five months; however, 50 percent (548 of 1,090) of cases investigated and sent to the Medical Coordinator during Fiscal Years 2004 and 2005 took longer than five months to complete the investigation. In addition, we found investigators do not always document and explain cases that are over five months old on monthly reports as required by the Department's Enforcement Manual.

The Department's policies and procedures have no specific guidance on how long investigations should take. The only guidance that is included in the Enforcement Manual is a general guideline that states:

> *Department experience has shown most investigations can be completed within five months of assignment to an investigator. There may be extenuating circumstances which may prevent this goal from being achieved...*

Investigations Unit chiefs are required to prepare monthly reports listing the number of pending investigations, with cases over five months listed separately with an explanation of each case and projected completion time. When we did our work for the 1997 Program Audit of physician regulation, the Department did have a timeliness standard that required employees to complete

their investigations within 90 days of assignment. Failure to follow up on complaints and complete investigations in a timely manner may result in a physician who has violated the Medical Practice Act not being detected and disciplined.

Evaluating Timeliness

To evaluate timeliness, we requested complete case data for all cases with activity during Fiscal Years 2004 and 2005. The Department provided data on all cases with activity, including benchmark dates (complaint receipt, case closure, referral to Medical Coordinator, referral to Prosecutions), current status (such as closed, probation monitoring, investigation proceeding), and the last recorded activity on the case. We examined the time between complaint receipt and the date the case was sent to the Medical Coordinator for review. Excluding mandatory reports, there were 1,090 cases investigated and sent to the Medical Coordinator. Of those, 548 (50 percent) took longer than 5 months from the date the complaint was received.

Exhibit 2-2 shows the time ranges for those 1,090 cases. The Exhibit also breaks out categories where the investigations took longer than 5 months. Mandatory report cases were excluded because the Medical Disciplinary Board has 180 days after receipt to determine whether or not to investigate.

The Office of the Auditor General conducted a similar audit of physician discipline by the Department of Professional Regulation that was released May 1997. In that audit, we recommended that the Department develop management controls to ensure timely investigations because the investigations were taking too long to complete. The Enforcement Manual, updated in June 2000, reflected the Department's response. The Manual requires supervisors to review complaints from the Complaint Intake Unit "as quickly as circumstances permit" and states that they should review investigator-prepared reports "as soon as possible." The Manual notes that no time limits are set because all investigations are different and states that "Supervisors and Chiefs . . . ultimately are responsible for completing investigations as quickly as possible."

Exhibit 2-2
TIME TO COMPLETE INVESTIGATIONS CASES RECEIVED IN FY04-FY05

Number of days	Cases	Completed
153 or less	542	50% in five months or less
154-180	189	
181-210	175	
211-240	90	
241-270	42	50% (548) took
271-300	15	longer than
301-330	18	5 months
331-365	7	
366-1096	12	
TOTAL	1,090	

Source: OAG analysis of DFPR data.

Monthly Reporting of Pending Cases

Investigative staff do not always document and explain cases that are over five months old on monthly reports as required by the Department's Enforcement Manual. The Manual requires the Chief of Medical Investigations to submit a monthly report listing to the Chief of Enforcement which shows the number of investigations pending. Investigations longer than five months are to be listed separately with an explanation of each case and projected time of completion. Medical Investigations has implemented these monthly reports. Officials stated that investigators prepare their own reports for submission. The monthly reporting form also requires a summary for any case over six months old and a description of all miscellaneous cases over 30 days old.

We obtained the monthly reports for Calendar Years 2004 and most of 2005 and examined the reports to determine if explanations were included for cases in our sample where the investigation took longer than 5 months. There were 10 cases in our sample which required a total of 22 monthly reports because they were over 5 months. Our analysis showed that 12 of the required reports for cases in our sample were lacking an appropriate explanation. Problems included no explanation at all and no estimate on time to complete.

Further, when examining the reports for those cases, we discovered one investigator failed to properly report in two of the months examined. This investigator did not properly submit the reports and there is no evidence that these errors were caught in supervisory review in the following instances:

- Failed to attach the listing of active cases for the report for March 2004.
- Failed to attach an explanation of any of the 8 cases listed on the report for August 2004 as being over 5 months old.

Generally, there was no evidence that the reports submitted were ever reviewed or used by management as a tracking tool. There were no signatures, initials, or other indications of review by management personnel. While the monthly report has the potential to be an effective tool in tracking the timeliness of investigations, without proper management review to ensure proper submission, accuracy, and follow up to assure issues are addressed, the tool loses its effectiveness.

TIMELY INVESTIGATIONS	
RECOMMENDATION NUMBER **3**	***The Department of Financial and Professional Regulation should develop management controls to ensure timely completion of investigations of complaints received by the Department. These controls should be in the form of written policies which include specific timeliness requirements. Any reports required should be reviewed by management personnel to ensure accuracy.***
DFPR RESPONSE	The Department is in the process of reviewing what timeliness requirements should be implemented to improve the quality of its enforcement of the Medical Practice Act as amended. The Department's Medical Investigations Unit reviews, investigates and processes 1,600 complaint cases per year. Because the nature of cases and the amount of investigation necessary to develop those cases vary significantly, the Department wants to make sure that timeliness requirements actually improve the quality of the cases it brings against physicians. The investigation of a medical case is oftentimes extremely complex. While written policies regarding timeliness requirements are and shall continue to be as specific as possible, the Department must give careful consideration to each individual case as well as to due process requirements. Since the review may not determine that timeliness policy changes will improve the quality of medical investigations, the Department has implemented new tracking systems to signal potential timeliness issues. For example, the Department is developing an automated alert system within its upgraded computer system which will generate tracking reports to assist management personnel in addressing timeliness requirements. The Department notes that, at no time during or since the audit period, has it been unable to prosecute a case due to timeliness issues. Cases pursued against physicians with serious complaints are typically open for 5 months or longer, as would befit complex medical investigations. The Medical Investigations Unit has been an effective force in conducting sound investigations of potentially serious violations of the regulations set forth in the Medical Practice Act and its Administrative Rules.
	AUDITOR COMMENT: While the auditors agree that the Department must give careful consideration to each individual case, we do not agree that taking excessive time to complete a medical investigation is conducive to due process. As noted in the audit, 50 percent of the investigations took longer than the 5 months suggested by the Department's own policies, with one case taking 1,096 days.

INVESTIGATION ADEQUACY

Investigation files that we reviewed did not always contain sufficient documentation of activities performed and recorded in the RAES (Regulatory Administration and Enforcement System) case tracking system. Overall, we found that 70 percent of files we reviewed (66 of 94) did not contain sufficient documentation. Items that were missing included prior complaints, opinions rendered by the Medical Coordinator as to whether the conduct violated the Medical Practice Act, and documentation of the date the complaint was received by the Department. We judged the file to contain sufficient documentation if:

1) All investigative reports prepared were in the file;

2) Prior complaint histories and medical records which had been obtained were in the file; and

3) Information in the hard copy file was consistent with the information on the case chronology from the RAES system.

Prior Complaint Documentation

Investigators did not always fully document prior complaints in the file. Investigations and Complaint Intake Unit staff told us prior complaints should be documented in the investigative file. They said the RAES system is checked for prior complaints and prior disciplines under the physician's license number. If prior complaints or disciplines are found, the investigator is to print the screen showing the list of prior complaints or disciplines. Further, copies of the case chronologies are to be printed to include in the file. Although we could not find this requirement in the Enforcement Manual, we did examine whether investigative files contained these documents, since both Investigations Unit and Complaint Intake Unit staff indicated the procedure should be followed.

In our review of 94 investigative files, we found 15 cases (16 percent) where the prior complaints and disciplines were not documented in the file. Thirteen of the 15 cases were missing the screen prints of prior disciplines, even though sometimes the file showed that a check was done and a prior complaint was found. Three cases were missing chronologies where screen prints showed prior complaints existed (one case involving multiple physicians was missing both screen prints and chronologies for some physicians).

In addition, investigators did not have access to information regarding prior mandatory reports that were not sent for further investigation by the Medical Disciplinary Board. Mandatory reports indicate that some action has been taken against a physician or that a lawsuit against the physician has been adjudicated. Further discussion is included later in this chapter.

PRIOR COMPLAINT INFORMATION	
RECOMMENDATION NUMBER **4**	***The Department of Financial and Professional Regulation should include requirements in its procedures that prior complaint information be incorporated in files and should assure that information is included.***
DFPR RESPONSE	Medical investigators and prosecutors have access to all prior complaint and case information. In most cases, once the information has been reviewed, copies of relevant cases are incorporated into the working case file maintained by each investigator. However, during Fiscal Years 04 and 05, investigators were unable to use much of that information in the development of current cases due to statute of limitations constraints that have since been lifted. Working files do contain prior complaint information for each case such as the Respondent and Complainant history. Reports for the chronologies and historical information is always checked in the computer system, printed, and forwarded to the investigator for inclusion in the working file. This allows the investigator to determine if any previous complaint information is related to or helpful in investigating the current case. If a chronology is not present in a working file, it was either not required by guidelines or it was not applicable to conducting a thorough investigation. Working files are highly detailed and will contain the appropriate information that the medical investigator requires to conduct a complete investigation. Unfortunately, when the Auditor General requested the investigative file, they were not given the working files and instead reviewed the historical file which did not contain the prior complaint information. This was the Department's error.
	AUDITOR COMMENT: We requested the most complete files for each case and were told the files provided contained the most complete record of each case. The Department's response that "historical files" were provided instead of "working files" illustrates the weakness in the Department's ability to retrieve complete case information when requested, as discussed in Chapter Six and Recommendation 20. For two cases tested, auditors specifically requested prior complaint information from the Department after our review. For those cases, no additional documentation was provided by the Department.

Unable to verify information between file and RAES

As part of our review, we compared the information in the case files to the information found on the case chronology. The case chronology is a summary of the information on the RAES system which includes complaint receipt date, date of the incident, dates assigned to various Department personnel and activities performed, and the final outcome of the case, if closed. Of the total 130 cases examined for both Investigations and Prosecutions, we found that we could not verify all the information on the chronology in 73 cases (56 percent). Among the problems that we identified were:

- In 31 cases (42 percent), we could not verify the complaint receipt date from the information in the file. In most instances, it was because the Complaint Intake form or complaint letter was not date-stamped so we could not verify the date it was actually received.

- In 19 cases (26 percent), there was no evidence on the chronology that the case went to the Complaint Committee before being closed. Department officials stated that it is up to the individual investigator or prosecutor to decide what is to be entered into the RAES system.

- In 12 cases (16 percent, sister state disciplines), the receipt date on the chronology was at least 2 months after information in the file indicated that the Department was aware of the discipline in the other state. Department officials noted that during this time they would have been doing preliminary analysis before opening a case.

Previous OAG compliance audits and our 1997 audit of physician disciplines also noted problems with the documentation in files.

DOCUMENT INVESTIGATION ACTIVITIES	
RECOMMENDATION NUMBER **5**	***The Department of Financial and Professional Regulation should develop controls to ensure that all investigative activities are properly conducted and documented in both the case file and the computer system.***
DFPR RESPONSE	The opening and investigating of medical complaints requires appropriate documentation and tracking. As part of the new computer system being implemented, all citizen complaints received via e-mail, sister state disciplines and mandatory reports will be automatically logged and linked to the licensed physician's intradepartmental computer file. When cases are opened based on phone conversations or other non-computerized means, the Department will develop controls to ensure these cases are also logged into the system immediately upon receipt.

1997 AUDIT RECOMMENDATIONS CONCERNING INVESTIGATIONS

Eleven of the recommendations concerning investigations found in the OAG program audit of physician disciplines in May 1997 have not been fully implemented, including not closing cases without approval from the Medical Disciplinary Board and making mandatory report information available to assist investigators. The Department has implemented a prior recommendation relating to criteria for when medical records are necessary.

Criteria for Medical Records

Our 1997 audit found that the Department of Professional Regulation (now a division within the Department of Financial and Professional Regulation) had not developed criteria to assist investigators in determining when to obtain medical records. As a result, medical records were not always obtained in cases where the records could have been used to help determine whether a physician's actions warranted discipline.

A policy was included in the Enforcement Manual effective June 15, 2000 that states "in order to investigate a complaint of gross negligence or other patient care issues, patient medical records are normally obtained…"

In the 94 investigations we examined for this audit, we noted only 1 instance where the medical records were not obtained when records could have helped the Department decide whether the physicians' actions were proper.

Mandatory Report Information

The 1997 program audit also recommended that mandatory report information be available to investigators. Mandatory reports come from insurance companies, hospitals, agencies, boards, and others who take adverse actions against physicians; they are required by the Medical Practice Act to report such actions to the Department. The majority of mandatory reports are reports from insurance companies when malpractice lawsuits are adjudicated or settled.

As discussed in Chapter 1, mandatory reports are received in Springfield by a separate unit. Each mandatory report is given a case number and entered into the RAES system. The Medical Disciplinary Board reviews these reports and must determine whether to investigate the physician's actions between 61 and 180 days after receiving the report. If the Board decides the physician's actions warrant an investigation, the mandatory report information is forwarded to Medical Investigations.

As part of the investigation, the investigator checks the RAES system for any prior complaints received and any disciplines issued for those prior complaints. Mandatory reports that were sent to Investigations by the Board can be reviewed by Investigations. However, for mandatory reports not sent to Medical Investigations, an investigator checking for prior complaints does not have access. Many mandatory reports (41 percent in 2004 and 2005) are not sent to Medical Investigations. Access to mandatory reports that are not referred for

investigation is strictly limited – even the Acting Chief of Medical Investigations cannot access these cases. So the Department may have information that a physician has previously engaged in conduct the same as or similar to conduct currently under investigation and that information is not available to the investigator. The 1997 audit recommended that the investigators be given access to these reports, as they may be relevant to a subsequent complaint the investigator has received.

The Department accepted the recommendation and stated in a response to the Legislative Audit Commission that it had made prior mandatory reports available to Medical Investigations staff. However, our testing revealed that investigators still cannot access this information. When we selected our sample of cases for Investigations, the Acting Chief of Medical Investigations told us she could not access mandatory reports that were not sent to Investigations. If given access to prior mandatory reports, an investigator might be able to determine that a physician has engaged in a pattern of behavior that is inconsistent with requirements of the Medical Practice Act.

MANDATORY REPORT INFORMATION FOR INVESTIGATORS	
RECOMMENDATION NUMBER **6**	***The Department of Financial and Professional Regulation and the Medical Disciplinary Board should make information related to mandatory reports closed by the Board prior to investigation available to assist in the investigation and prosecution of physicians who demonstrate patterns of behavior.***
DFPR RESPONSE	On August 25, 2005, the Governor signed the Medical Malpractice Reform Bill (PA 94-677) which expanded the statute of limitations to include older Mandatory Reports for review and inclusion in investigative cases to show a pattern of practice. At the time of the audit period, which covered FY04 and FY05 and ended on June 30, 2005, information contained in prior Mandatory Reports would not have been admissible and therefore, were not made available to investigators. When PA 94-677 became effective, the Department began the process of making prior Mandatory Reports available to investigators for inclusion in medical investigations cases.
	AUDITOR COMMENT: Until this response, the Department had not indicated that it had been prohibited by law from using prior mandatory reports to determine whether a physician demonstrated a pattern of practice or other behavior which demonstrates incapacity or incompetence to practice under the Act. In fact, the Department concurred with a similar recommendation in our 1997 program audit. Further, even before Public Act 94-677, the Medical Practice Act provided that "[a]ny information reported or disclosed shall be kept for the confidential use of the Disciplinary Board, the Medical Coordinators, and Disciplinary Board's attorneys, the medical investigative staff, and authorized clerical staff. . . (emphasis added)" (225 ILCS 60/23 (B)). However, as reported in this audit, such mandatory reports were not always made available to investigators.

BACKLOGS AT THE MEDICAL COORDINATOR

The Department was experiencing problems with timeliness of cases due to backlogs at the Medical Coordinators. As of May 2006, the total number of cases at the Medical Coordinator's office was 210. A Department official noted that this figure was down substantially from 2003 and that some cases take over a year to be reviewed by the Medical Coordinators.

Medical Coordinator Case Example

In a case received on 10/19/04, a physician alleged he received substandard care after becoming ill on a flight to Chicago. The case was referred to the Medical Coordinator on 3/9/05. As of 2/8/06, the case was still with the Medical Coordinator and the last activity recorded on RAES was the referral to the Coordinator.

During the audit period, the Medical Practice Act of 1987 required the Department to select a Medical Coordinator and a Deputy Medical Coordinator, one in Cook County and one in Springfield, to be the chief enforcement officers of the Act. The Medical Coordinators review cases and make recommendations to the Medical Disciplinary Board on whether cases should be prosecuted or closed. The Act requires that Medical Coordinators be licensed physicians. The Act also allows the Board to use advisors to assist the Medical Coordinators with their work. Public Act 94-677, effective 8/25/05, requires at least two Deputy Medical Coordinators. As of May 2006 the second Deputy Medical Coordinator had not been hired.

In our 1997 Program Audit there were also problems with timeliness of cases awaiting review by the Medical Coordinator. In that audit we recommended that the Department take the steps necessary to assist the Medical Coordinators with backlogs. That finding was repeated in OAG compliance audits of the Department for 1999 and for 2001, but in the 2003 audit it was noted that the Department employed additional part-time contractual Medical Coordinators to reduce backlogs to an acceptable level.

We examined data from the Department to evaluate the time it took for the Medical Coordinators to review cases. In the data that we received for FY04 and FY05 there were 886 cases that had been sent to the Board. Exhibit 2-3 summarizes how long cases took at the Medical Coordinator by ranges of days and average days.

Exhibit 2-3
TIME AT THE MEDICAL COORDINATOR
Cases with Activity in FY04-FY05

# of days	Cases
0-90	571
91-180	147
181-365	124
Over 365	44
Total cases	886
Average Days	100

Source: OAG analysis of DFPR data.

MEDICAL COORDINATOR	
RECOMMENDATION NUMBER 7	***The Department of Financial and Professional Regulation should take the steps necessary to assist the Medical Coordinators with backlogs and improve case timeliness.***
DFPR RESPONSE	As of July 1, 2006, there is no backlog at the Medical Coordinators level. For a portion of the audit period, there was only one Part-Time Medical Coordinator on staff. Since that time, the Department has hired an additional Full-Time Medical Coordinator and the number of cases at the Medical Coordinators level has been significantly reduced from nearly 600 to less than 200, which the Department does not consider to be a backlog. The Medical Malpractice Act (PA 94-677), as amended on August 25, 2005, authorizes the Department to hire an additional Deputy Medical Coordinator to assist in case preparations which will further streamline the disposition of disciplinary cases. It is important to note that the Medical Coordinator's primary role is to ensure that when cases are sent to the Board for review, the cases are as complete as possible. In light of that, the Medical Coordinator may require additional investigation or medical records before presenting cases to the Board, thus extending the time a case is in the Medical Coordinator's control.

Chapter Three

IMPLEMENTING DISCIPLINARY ACTIONS

CHAPTER CONCLUSIONS

In Fiscal Years 2004 and 2005 the Department of Financial and Professional Regulation issued a total of 458 disciplines against physicians. Those disciplines included refusing to renew licenses, suspending or revoking licenses, reprimanding licensees or placing them on probation. We questioned the adequacy or consistency of disciplinary actions for six cases that we reviewed where complaints were handled by the Department. We also noted that at least 41 percent (189 of 458) of the disciplines were cases where the Department's discipline was based on actions taken by other states' disciplinary agencies and, therefore, required minimal departmental activity compared to other cases.

The Department has not implemented procedures to involve people making complaints in the disciplinary process, as recommended in the our 1997 audit of physician disciplines and as required by the Medical Practice Act of 1987.

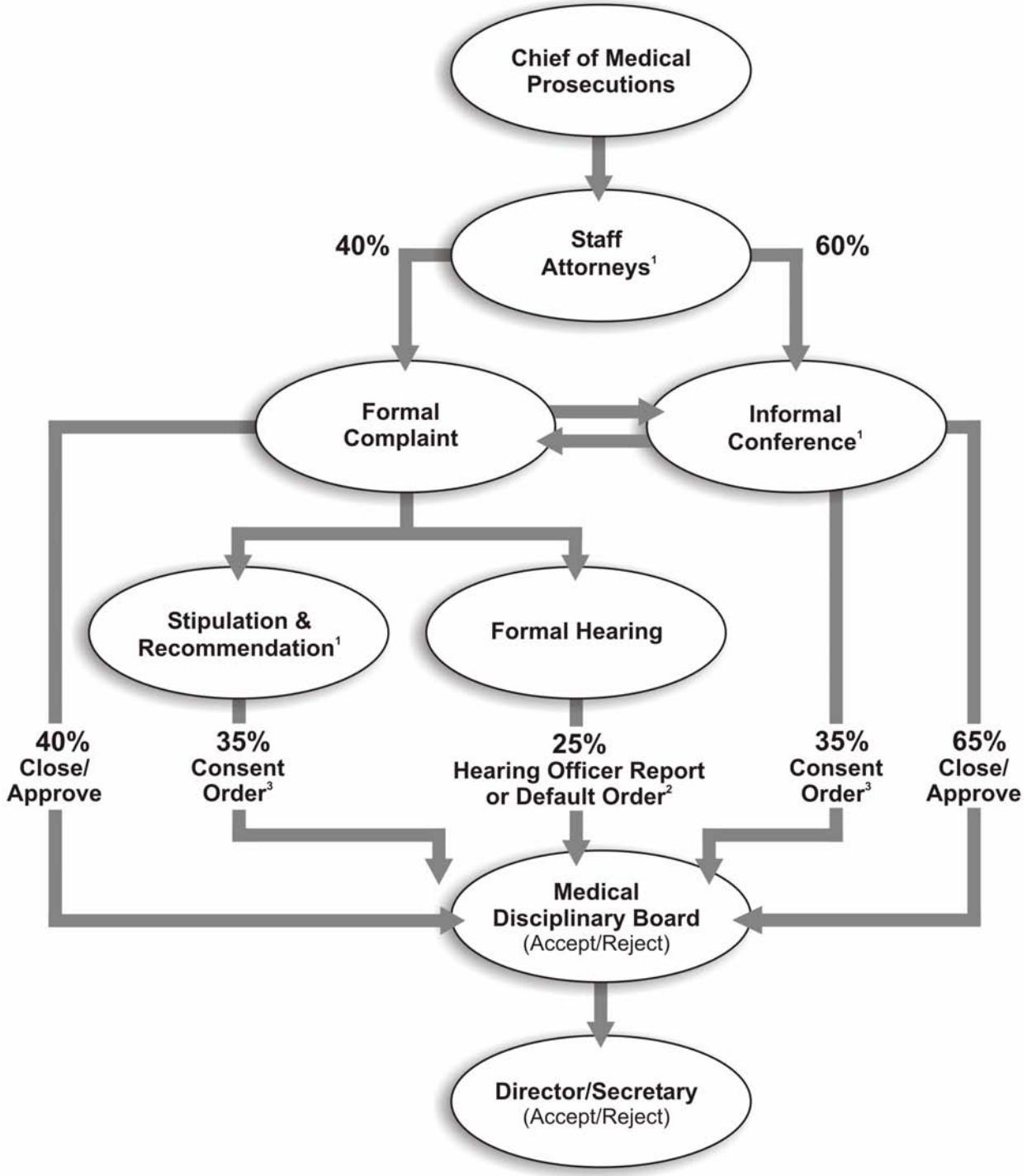
The Department had not established timeliness standards for Prosecutions and experienced timeliness problems with cases taking an average of 258 days after referral to Prosecutions to reach final resolution.

BACKGROUND

The need for and nature of disciplinary action is a significant and sensitive area because of the risk to the public if there is a physician practicing who is incompetent or fraudulent. If physicians are given minimal punishment and continue to practice after a serious violation, further dangerous or inappropriate medical practice could occur. Additionally, giving dissimilar disciplines for similar violations of the Medical Practice Act could undermine public, as well as physician, confidence in the Department's process.

Cases for physicians who receive discipline under the Medical Practice Act proceed either through what is known as the formal process, which is established under the Act, or through an informal process which is established under the Administrative Rules. Under the formal process, a formal complaint is filed. That makes the complaint public, and a hearing is scheduled before an administrative law judge. If a hearing is held, the administrative law judge makes recommendations to the Medical Disciplinary Board. The Board then reviews the hearing record and the judge's recommendations and makes its own recommendations to the Secretary of the Department, who makes the final decision. Exhibit 3-1 shows a flowchart of the disciplinary process.

Exhibit 3-1
FLOWCHART OF THE DISCIPLINARY PROCESS

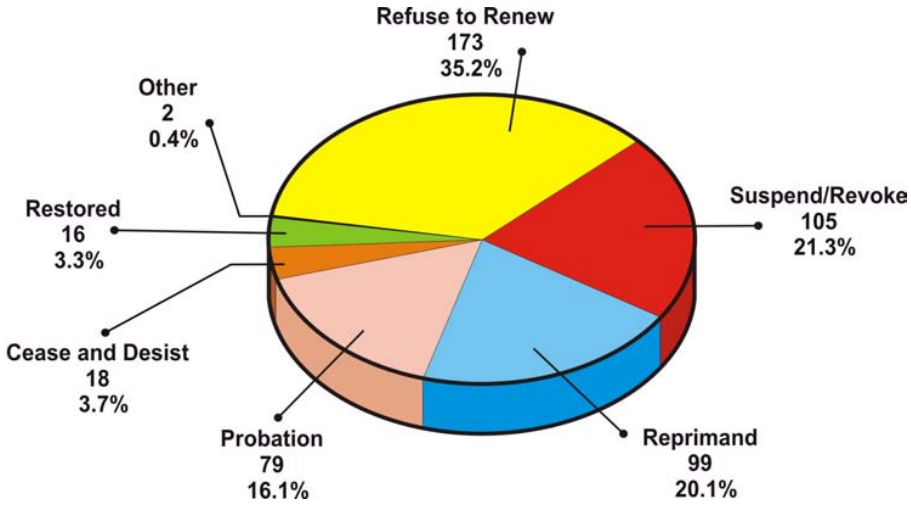


Notes: [1] Case can be closed at this stage for various reasons, including inadequate evidence. Case still requires Medical Disciplinary Board approval.
[2] Default orders happen when the physician does not show up for the hearing.
[3] Approximately 95 percent of orders are resolved with a consent order.

Source: DFPR information summarized by OAG. Percentages are estimates provided by DFPR.

Most complaints that are referred to Prosecutions are resolved using the informal process pursuant to the Administrative Code Section 1285.220. Even if a formal complaint is filed, the attorneys may try to resolve the case through an informal conference. If a discipline is recommended by the Medical Disciplinary Board member and accepted by the respondent physician, a stipulation and recommendation or consent order outlining the recommended discipline will be entered into. The informal conference allows the Disciplinary Board member and prosecuting attorney to ask the physician questions about the alleged violation of the Act and to go over the evidence from each party, after which the Board member can make a recommendation for settlement. Present at informal conferences are the Department's prosecution attorney, the physician's attorney and/or the physician, and a member of the Board. If the recommended discipline is accepted, a consent order is drafted to be signed by all the parties present. Later the agreement is approved by the Board and eventually by the Director. The prosecuting attorney is there as an advisor to the Medical Disciplinary Board member, who may conduct the conference.

Exhibit 3-2
DISCIPLINARY ACTIONS FOR FY 2004 & 2005 BY TYPE



Note: Percentages do not add due to rounding.
Source: DFPR data analyzed by OAG.

DISCIPLINARY ACTIONS

In Fiscal Years 2004 and 2005 the Department issued a total of 458 disciplines against physicians. Those disciplines included refusing to renew licenses, suspending or revoking licenses, reprimanding licensees or placing them on probation. Exhibit 3-2 shows visually the 492 actions that were levied by the Department in Fiscal Years 2004 and 2005. The exhibit includes 18 cases where someone was practicing without a license and was asked to cease and desist. It also includes 16 cases where licenses were restored after being disciplined. Exhibit 3-3 contains definitions of disciplines.

In the 130 cases we tested at the Department, 83 (64 percent) were referred to Prosecutions for possible disciplinary action. The Department took disciplinary actions in 37 tested cases in Fiscal Years 2004 and 2005. Disciplinary actions include license revocations, suspensions for various periods, probation for various periods and with various conditions, reprimands, and fines. Some physicians in our sample and in all disciplines received more than one discipline at the same time.

Exhibit 3-3
DEPARTMENT DEFINITIONS OF DISCIPLINARY ACTIONS

DISCIPLINES

Cease & Desist – This is only for those not licensed under the Medical Practice Act to cease and desist the unlicensed practice of medicine.

Denial – When an applicant for licensure is denied a license by the Medical Licensing Board.

Fine - Fines are not to exceed $10,000 for each violation of this Act. Fines may be imposed in conjunction with other forms of disciplinary action, but shall not be the exclusive disposition of any disciplinary action arising out of conduct resulting in death or injury to a patient (225 ILCS 60/22(A)).

Probation – Professionals whose licenses are placed on probation are allowed to continue practicing subject to certain terms and conditions.

Refuse to Renew – Licensee is put on notice that the Department will refuse to renew the license because of a violation of the Medical Practice Act. The Refuse to Renew order can be used whether license is current or inactive. Refuse to Renew orders are placed on sister state disciplines where the license is non-renewed or inactive.

Reprimand – A reprimand is an official record that the license has been disciplined but typically does not affect the status of the license or the licensee's ability to practice.

Restore – When a license is restored to active status after being revoked or suspended.

Revocation – Professionals cannot practice with a revoked license. A petition must be filed with the Department Director to have a revocation lifted.

Surrender – Licensee voluntarily surrenders license in lieu of discipline, per the Medical Disciplinary Board's discretion under the Rules for the Administration of the Medical Practice Act.

Suspension – Professionals whose licenses have been suspended cannot practice during the period of suspension.

Summary Suspension – The Director may immediately suspend a medical license, after consultation with the Medical Coordinator, under two conditions: 1) upon receipt of a written communication from the Director of the Departments of Mental Health and Developmental Disabilities, Public Aid or Public Health that continued practice of the licensed person constitutes an immediate danger to the public (225 ILCS 60/25); and 2) if a licensee violates the terms of a Consent Order, Stipulation and Recommendation for Settlement or Agreement of Care, Counseling and Treatment (225 ILCS 60/22(A)). In either case, a hearing must be commenced within 15 days.

Termination, Censure – Not used by the Department.

NON-DISCIPLINES

Administrative Warning/Letter of Concern - prepared by the Medical Coordinator to advise the physician of Department's concerns.

Admonishment – Not used by the Department.

Other – Could be non-disciplinary orders where a fine was issued or continuing medical education was required but no discipline was recommended.

Source: DFPR information summarized by OAG.

Exhibit 3-4 shows the violation type for all cases where disciplinary actions were taken as categorized by OAG. The most common violation type was sister state violations, where a physician who is licensed in Illinois also has a license in another state, and that state has taken disciplinary action against the physician. The next most frequent type involved medical issues.

Exhibit 3-4
VIOLATIONS RECEIVING DISCIPLINARY ACTIONS
Fiscal Years 2004 and 2005

Violation Type	Actions
Sister State Discipline	189
Medical Issue	46
Medical Education Violation	43
Nonpayment of Student Loans, Taxes, or Child Support	34
Drugs Prescribing/ Personal Use	30
Medical Records Issue	26
Probation Violation	18
Unlicensed Practice	18
Conviction	17
Restored License	16
Inappropriate Contact	10
Billing	10
Had not renewed	7
Advertising	6
No Response to Mandatory Report	3
Other	19
Total	492

Source: OAG analysis of all disciplines for Fiscal Years 2004 and 2005.

Among cases in our sample that were referred to the Prosecutions Unit but did not receive any discipline in Fiscal Year 2004 or Fiscal Year 2005, the Department did take some non-disciplinary actions in 10 cases. Eight non-disciplinary orders were issued as well as two administrative warning letters. The non-disciplinary orders usually were issued to require payment of a fine; in one case the physician was required to attend continuing education. An administrative warning letter is a warning that the Department is closing the case but maintains the right to further review the incident if a similar complaint is filed against the physician in the future.

Sister State Disciplines

The Department and the Medical Disciplinary Board have developed procedures governing sister state disciplines. A physician who is practicing in another state may choose to keep an active Illinois license or may choose not to renew the license, letting it become inactive.

If the physician's Illinois license is active, the case is sent to Investigations to obtain the disciplinary order from the other state. However, according to the Department, the investigation work required is minimal. If the Illinois license is inactive, then the case is referred directly to Prosecutions, which seeks a refuse to renew order. Such an order would prohibit renewing the Illinois license until proof of compliance with the other state's order has been provided to the Department.

ADEQUACY AND CONSISTENCY OF DISCIPLINARY ACTIONS

We questioned the adequacy or consistency of disciplinary actions for six cases that we reviewed where complaints were handled by the Department. We also noted that many of the actions taken were cases where minimal departmental activity was required compared to other cases. Of the 37 cases in our sample where disciplinary action was taken, 19 were sister state cases which involved minimal Department investigation or prosecution work compared to other cases. Examples of cases where we questioned the disciplinary actions are shown in exhibits on this page.

Case Example #1 - Questionable

A physician was suspended for six months for engaging in an inappropriate relationship with a patient. The six months of suspension were served one month at a time with three month intervals in between where he was not suspended. The Department counted this as six suspensions.

We questioned the consistency of discipline related to one sample case involving the use of the term MD after his name. This person had earned a medical degree from an accredited university but did not apply for a physician's license in Illinois. However, on literature for an academic conference, he put the "MD" after his name. The Department fined him $1000, stating that his use of "MD" could confuse patients as to his licensure in Illinois. This case took two years from receipt until closure. In another case involving questionable use of title, no discipline was issued.

Case Examples #2, #3, and #4 - Inconsistent

A case was closed before investigation in Complaint Intake that alleged two podiatrists advertising as "Dr." without the "DPM" after their names denoting they were podiatrists, not physicians and surgeons.

Fine to a chiropractor for not listing "DC" after his name when using "Doctor" in front of it. The public may think that the chiropractor had a medical license.

Discipline to an individual with a medical degree but no Illinois license for using "MD" after his name.

In the fifth example case (#5) we questioned why no action was taken. The formal complaint against the physician had multiple counts of violations of the Act, including unprofessional conduct, improper billing, and a personality disorder. The Medical Coordinator's opinion says the "evidence supports allegations of unprofessional conduct in the practice of medicine likely to deceive or defraud the public." However, the case was eventually closed in Prosecutions. When we inquired why this case was closed with no action taken despite the multitude of complaints, the Department provided a closing memo which indicated that the Board took the physician's word over the word of one other physician, as well as other people.

We also identified a case where an error was made on which physician to discipline. The only information in the file we reviewed was for a different physician who had the same last name as the selected case. The Department told us that this physician was disciplined in error and corrected the mistake.

Case Example #6 - Error
The wrong physician was disciplined after a sister state discipline was received from California. The physician involved had the same last name, but different first name, as the physician in the case we reviewed. The DFPR refuse to renew order for the wrong physician was issued March 2005. After we brought this issue to the Department's attention, the order was vacated in November 2005. Although both physicians had been licensed in Illinois, neither license was active when the error occurred.

Guidelines for Consistent Discipline

Although our case reviews identified some problems with consistency of disciplines, the Department was unwilling to consider developing formal guidelines to help guide its decisions in disciplinary actions. Our 1997 audit of physician disciplines also noted that disciplines decided by the Board for similar violations were not always consistent and recommended that the Department develop criteria to help guide decisions in disciplinary actions.

When we inquired about the status of this prior recommendation, Department officials stated that this recommendation had not been implemented. They stated that the Board's legal counsel had frowned upon the Board drafting any such written guidelines.

Even though no written guidelines exist, the Board has used informal guidelines in some situations to determine appropriate punishments. During our testing of 130 medical enforcement cases, we noted differing fines and punishments given to physicians who failed to supply the Department with proof of their continuing medical education hours. The Chief of Medical Prosecutions stated that the amount of the fine and the discipline imposed depended upon the amount of formal education hours each physician was missing. Formal guidelines for other types of disciplines would help ensure that Board disciplines are consistent and equitable.

CRITERIA FOR DISCIPLINARY DECISIONS	
RECOMMENDATION NUMBER **8**	***The Department of Financial and Professional Regulation and the Medical Disciplinary Board should develop general criteria to help guide their decisions in disciplinary actions. Such criteria would help to ensure that similar violations under similar circumstances receive similar discipline.***
DFPR RESPONSE [Response continued on the following page.]	One of the most important functions of the Medical Disciplinary Board is to determine an appropriate discipline for those found to be in violation of the Medical Practice Act. The Board is, by statute, composed of a range of medical and non-medical members who are required by the Medical Practice Act to carefully consider each case on its own merits and provide advice to the Director with regard to disciplinary matters.

[Continued Response]	Neither the Medical Disciplinary Board nor the Department has the authority to institute "sentencing guidelines." Should the General Assembly amend the Medical Practice Act providing for such authority, the Department would look forward to developing "sentencing guidelines." Rather, the Department and the Medical Disciplinary Board make their decisions in disciplinary actions on a case by case basis. Their decisions are based on multiple factors including, most importantly, the evidence available to prove the allegations against a Respondent Physician. Each complaint received or instituted by the Department is unique and the investigative file and evidence obtained is different for each file. The Department and the Medical Disciplinary Board strive for consistency of disciplinary actions based on soundly investigated cases.
	AUDITOR COMMENT: The Department is responsible for taking action against physicians who violate the Act. It is imperative that the Department be able to demonstrate that its actions are not arbitrary or capricious. General guidelines followed by appropriate documentation supporting its decision in each case would help establish the validity of the actions taken by the Department. While the auditors do not recommend "sentencing guidelines," we do recommend that the Department either follow general guidelines applying similar discipline to similar violations under similar circumstances or document its rationale for applying disparate disciplines. In the absence of such guidelines and documentation, the general public may view the Department as treating some physicians who violate the Act more favorably than others. Further, development of such guidelines is within actions necessary and proper to administer the Act, is consistent with the breadth and scope of other policies developed by the Department, and may not require specific legislation to implement. As noted by the Department in its response to Recommendation 10, it has the "power and duty to formulate rules and regulations necessary for the enforcement of any Act administered by the Department." Therefore, we continue to recommend, as we first did in the 1997 program audit, that the Department implement general guidelines for physician disciplines.

Out of State Complaints

There were five complaints in our sample where little work was done and the Department had not referred cases to investigations because the physicians were out of state and did not hold Illinois licenses. In each case, the complainant was told to contact that state's medical licensing board. There is no evidence that the Department forwarded the complaint to the appropriate state's licensing board. As part of protecting the health and welfare of Illinois citizens, the

Department should forward complaints it receives from Illinois residents regarding care they received in other states.

OUT OF STATE COMPLAINTS	
RECOMMENDATION NUMBER **9**	***The Department of Financial and Professional Regulation should assure that complaints received about out of state physicians are forwarded to the licensing board of the appropriate state.***
DFPR RESPONSE	By statute, the Department has jurisdiction only over physicians licensed in Illinois and for the licensed physicians' actions that occur within Illinois. The Department has no statutory authority to institute cases for events involving physicians licensed, or actions that occurred, in other states. Records indicated that only five (5) of the total number of complaints received were about out of state physicians. In lieu of implementing this recommendation, the Department has provided all staff of the Intake Unit with a list of Medical Boards throughout the United States so that citizens can be directed to appropriate State's Complaint Intake Unit.

INVOLVING THE COMPLAINANT IN THE DISCIPLINARY PROCESS

The Department has not implemented procedures to involve people making complaints in the disciplinary process, as recommended in the 1997 audit of physician disciplines and as required by the Medical Practice Act of 1987. Section 60/37 of the Act requires that:

> *. . . both the accused person and the complainant shall be accorded ample opportunity to present in person, or by counsel, such statements, testimony, evidence, and argument as may be pertinent to the charges or to any defense thereto.*

According to Department officials, the Department does not represent the complainant. Once a complaint is filed with the Department, it becomes the complainant, not the person who filed the original complaint.

We asked how the Department currently involves the complainant (person making the original complaint) in the disciplinary process. The Medical Prosecutions Chief stated "the complainant is involved only as a witness if the case goes to formal hearing. The testimony serves as evidence to prove a case. The Department contacts them if they are required to testify at a formal hearing." Further, the Department's response states that the nature of Department investigations is confidential and investigative documents are confidential by statute; therefore, that information cannot be disclosed unless a formal complaint is filed.

The Department should consider involving the person making the complaint against a physician in the disciplinary process. If the Department believes that complainant involvement is not appropriate, they should work to have this changed in the statute. Some possibilities include using signed witness statements during informal conferences and notifying individuals making complaints of the date and time of pertinent hearings and Medical Disciplinary Board meetings so they can attend.

INVOLVE COMPLAINANTS IN DISCIPLINE PROCESS	
RECOMMENDATION NUMBER **10**	***The Department of Financial and Professional Regulation should develop procedures for involving people making complaints in the disciplinary process.***
DFPR RESPONSE [Response continued on the following page.]	To the extent allowed by statute in the Illinois Medical Practice Act, pursuant to 225 ILCS 60/37, the Department does involve complainants in the disciplinary process. In order to protect the privacy of the complaining party and the due process of the physician under investigation, the Department is limited in the extent to which it can share information. Under the Illinois Medical Practice Act, "at the time and place fixed in the notice, the Disciplinary Board provided for in this Act shall proceed to hear the charges and both the accused person and the complainant

[DFPR Continued Response]	shall be accorded ample opportunity to present in person, or by counsel, such statements, testimony, evidence and argument as may be pertinent to the charges or to any defense thereto." See Section 225 ILCS 60/37. The "notice" referenced to in this section of the Act is attached to every formal complaint filed by the Department in the form of a Notice of Preliminary Hearing. Once a Notice of Preliminary Hearing and Formal Complaint are filed, the Department's allegations against the Respondent Physician become public[1] and litigation begins. Once a case is scheduled for a Formal Hearing before the Medical Disciplinary Board and Administrative Law Judge, the Department issues subpoenas to all witnesses it will call. If a case is received by way of a Mandatory Report, the Department will subpoena its expert witness and the patient involved. In the majority of cases received by way of Mandatory Reports, the patients are no longer living or they do not wish to cooperate with the Department's case. If a case is received by way of Citizen Complaint, the Department will subpoena the complainant to testify. [1] Patients' identities are never identified and are referenced to in a Formal Complaint by initial only. Under the Illinois Medical Practice Act, 225 ILCS 60/36, "all information gathered by the Department during its investigation including information subpoenaed under Section 23 or 38 of this Act and the investigative file shall be kept for the confidential use of the Secretary, Disciplinary Board, the Medical Coordinators, persons employed by contract to advise the Medical Coordinator or the Department, the Disciplinary Board's attorneys, the medical investigative staff, and authorized clerical staff, as provided in this Act and shall be afforded the same status as is provided information concerning medical studies in Part 21 of Article VIII of the Code of Civil Procedure, except that the Department may disclose information and documents to a federal, State, or local law enforcement agency pursuant to a subpoena in an ongoing criminal investigation." As such, the Department is prohibited from sharing any information related to the investigation of a complaint received by it to anyone except those listed in Section 60/36. The list does not include complainants. The practice of the regulated professional, trades, and occupations in Illinois is hereby declared to affect the public health, safety and welfare of the People of the State of Illinois and in the public interest is subject to regulation and control by the Department of Financial and Professional Regulation. See the Civil Administrative Code of Illinois, 20 ILCS 2105-10. The Department represents the "People of the State of Illinois." The Department does not represent individual complainants. For this reason, the Department cannot involve complainants in settlement negotiations.
[Response continued on the following page.]	The Department has the power and duty to formulate rules and regulations necessary for the enforcement of any Act administered by the Department. See the Civil Administrative Code of Illinois, 20 ILCS

[DFPR Continued Response]	21/05-15(a)(7). Under this authority granted by the Civil Administrative Code, the Department implemented Rule 1285.220 of the Rules for the Administration of the Medical Practice Act which states: a) An informal conference is the procedure established by the Division to resolve complaints, licensing issues, or conflicts prior to initiating any action requiring a formal hearing. Informal conferences are for the purposes of compliance review, fact finding, and discussion of the issues. b) Notice of an informal conference shall be sent to the respondent not less than 10 days before the conference is scheduled. The notice shall include a brief statement of the alleged violations. c) Informal conferences shall be conducted by a Division attorney and shall include a member of the Disciplinary Board or his or her designee. d) The respondent may bring an attorney or other representative to the informal conference. e) The respondent shall have an opportunity at the informal conference to make an oral statement and to present any documents that might be relevant to the matter. f) Results of Informal Conference. The informal conference shall result in one or more of the following recommendations being made to the Board: 1) The case be closed. 2) The case be investigated further. 3) A consent order be entered. 4) The matter be referred for a formal hearing. The informal conference process is analogous to a settlement conference. The informal conference process could not allow for the complainant to be involved because it would be in violation of Section 60/36 which prohibits the Department from sharing information obtained through the Department's investigation. The process of litigation inherently involves settlement negotiations and the Department engages in settlement negotiations in the process of litigation. Settlement negotiations are not mandated by the Illinois
[Response continued on the following page.]	

[DFPR Continued Response]	Medical Practice Act. Settlement negotiations should not be mandated or regulated by statute because there may be times where the Department does not want to engage in settlement negotiations. For example, if the allegations against a Respondent Physician are so egregious and the Department's evidence is overwhelming and/or substantial, the Department will not want to enter into settlement negotiations. For the reasons stated above, the Department does sufficiently involve the complainant in the disciplinary process to the extent that it is allowed under the law. Should the General Assembly amend the Medical Practice Act to further involve complainants in the disciplinary process, the Department would look forward to implementing this procedure.
	AUDITOR COMMENT: Contrary to the Department's assertion, the Department does <u>not</u> have a process to involve people making complaints in the disciplinary process. The Department also notes limitations to the complainant being involved in the process unless the Department subpoenas them as a witness. Involving the complainant by subpoena, at the Department's discretion, does not accord the complainant the "ample opportunity" required by statute. Regardless of the elements that make involving the complainant in the disciplinary process difficult to implement, the Medical Practice Act of 1987 still requires: ***. . . at the time and place fixed in the notice, the Disciplinary Board provided for in this Act shall proceed to hear the charges and both the accused person and the complainant shall be accorded ample opportunity to present in person, or by counsel, such statements, testimony, evidence and argument as may be pertinent to the charges or to any defense thereto. (225 ILCS 60/37)*** ***In summary, the General Assembly has already directed the Department to involve the complainant in the disciplinary process and the Department should amend its current practices to do so.***

TIMELINESS IN PROSECUTION

The Department had not established timeliness standards for Prosecutions and experienced timeliness problems with cases taking an average of 258 days after referral to Prosecutions to reach final resolution. Our 1997 audit of physician disciplines recommended that the Department establish management controls to ensure that prosecutions were conducted timely. The Department's Enforcement Manual did not contain any timeliness standards.

Exhibit 3-5
TIME IN PROSECUTIONS

# of cases	83
Range # of days	1 – 1,223
Average # of days	258

Source: OAG analysis of sample data.

To examine the activities of the Prosecutions Unit, we selected a sample of 63 cases that had been referred to Prosecutions and were also closed as of September 20, 2005, the date the original data file was provided to us. In addition, 20 cases in our investigation sample were referred to Prosecutions after the investigation was complete. We also examined the Prosecution activities for those 20 cases, for a total of 83 Prosecution cases examined.

Case Example 7 - Untimely

Doctor moved out of state and was allegedly not providing records to former patients when requested for further treatments they needed. Assigned to an attorney 5/22/03, informal conference notice sent 8/27/03. Then no activity until another attorney assigned 4/6/04. Case closed without action 7/30/04.

As shown in Exhibit 3-5, for the 83 closed Prosecution cases we sampled, the days in Prosecutions ranged from 1 to 1,223 days. Of the 43 cases that resulted in an order by the Department, the shortest time in Prosecutions was 42 days from the date referred to Prosecutions through the date of the signed order; the longest time for these 43 cases was 1,192 days.

In addition, we noted 28 of our 83 Prosecutions sample cases (34 percent) where no activity was documented on the case chronologies for a period of 90 days. Other examples of periods with no activity included:

- One case had no activity documented on the case chronology for 373 days;
- Six cases had multiple instances of 90 days with no activity; and
- Three cases had three periods of inactivity ranging from 90 day to 350 days.

Case Example 8 - Untimely

Mandatory report of death of 48 year old male due to alleged failure to monitor blood loss during surgery. Case assigned to attorney 3/6/03. Next activity recorded in RAES is 2/19/04. Only 1 more activity recorded until case closed without action on 11/3/04.

For one case there were 5 separate instances of 90 day periods without activity. That case took a total of 1,169 days from the referral to Prosecutions until an order was signed by the Director.

Recent OAG financial and compliance audits have also noted problems with untimely Prosecution activities, including the time to assign cases to a prosecutor and filing of required notices.

TIMELY PROSECUTION ACTIVITIES	
RECOMMENDATION NUMBER **11**	***The Department of Financial and Professional Regulation should develop and implement management controls to ensure that Prosecution activities are timely and properly documented.***
DFPR RESPONSE *[Auditor Comment on following page]*	The medical case tracking system will be upgraded to the same case tracking system used by the other professions regulated by the Department. As an additional safety measure under the upgraded system, the Department will be developing an automatic alert for the Chief of Medical Prosecutions that a specific action needs to be taken. However, because the life of a case in prosecution and litigation is typically dominated by factors out of the control of the prosecution attorney, the Medical Practice Act and its governing Rules are intentionally silent relating to specific timeframes for documentation. Just some of the factors that exclude the feasibility of specific timeframes for documentation include the schedules of the Medical Disciplinary Board Members, the schedules of the Respondent Physicians and/or their attorneys and the Administrative Law Judges' court docket. Except for the specific statute of limitations dates, neither the Illinois Medical Practice Act nor the Rules for the Administration of the Medical Practice Act specify a particular timeframe for the completion of prosecution activities or documentation of prosecution activities. The Department has implemented management controls to ensure that Prosecution activities are timely and properly documented. Medical Prosecutions staff have not missed any statutes of limitations nor failed to file necessary documents in a timely manner. Most importantly, the Medical Prosecutions staff has not placed the People of the State of Illinois in jeopardy for failing to timely and properly prosecute a Respondent Physician. In spite of the schedule constraints enumerated above, the Department has efficiently managed its medical prosecutions caseload. The auditors have even found in their sample of cases that a case in prosecutions took an average of 258 days, which is less than one year. Even more telling is that the State of Illinois Department of Financial and Professional Regulation has risen from 46 to 18 in ranking for the nation in number of disciplinary actions taken against Physicians as determined by the independent watch-dog group *Public Citizen*. Also, according the Federation of State Medical Boards of the United States, the total number of actions taken against Physicians in 2000 was 110 and in 2005 the total number of actions taken against Physicians rose to 281 disciplines.

	AUDITOR COMMENT: Auditors recognize that there are elements related to the timeliness of prosecutions which are outside of the Department's control. However, having management controls to encourage timeliness and to ensure proper documentation is essential. Case examples show that there were cases with long periods with no documented activity. The Department asserts that the Medical Prosecutions staff has not placed the People of the State of Illinois in jeopardy for failing to timely and properly prosecute a Respondent Physician. However, long periods of time with no documented activity and no documented reason for that inactivity do create the risk that people of the State of Illinois could be in jeopardy from an incompetent physician who continues to practice. ***The Department alludes to recent improvement in its ranking among state medical boards since 2002. Some of this improvement appears to come from the Department's new policy, implemented in 2004, of using Refuse to Renew orders as disciplines. This type of order is placed on sister state disciplines where the individual's Illinois license is non-renewed or inactive. As a result, these are not disciplines on active licenses. Rankings the Department cites are based on serious actions per 1,000 active physicians. The Department issued 45 refuse to renew orders in FY04 and 128 in FY05 for a total of 173 or 35 percent of disciplines for the two years as is shown in Exhibit 3-2 in the report. Because we do not know what data other states report, we do not know whether only Illinois includes Refuse to Renew orders on non-active licenses in its discipline statistics or if it is a common practice among the states.***

Chapter Four

PROBATION MONITORING

CHAPTER CONCLUSIONS

The Department of Financial and Professional Regulation has not dedicated sufficient resources to carry out its Probation Compliance responsibilities. The Division of Professional Regulation has **only two** Probation Compliance investigators for the entire State for over 100 professions regulated by the Division. As of April 2006, these two employees of the Probation Compliance Unit were monitoring a total caseload of approximately 1,100 cases, of which approximately 150 were physician discipline cases.

The Department is not adequately monitoring disciplined physicians. Monitoring deficiencies were noted in **all** of the 25 medical probation cases we selected for testing. In 9 cases, most of which involved physicians who had their licenses suspended or revoked, the Department could not provide a file or any other evidence of Probation Compliance monitoring. In 12 other cases, the files provided lacked evidence to show that some or all of the required monitoring had occurred.

Lack of monitoring to verify that physicians are complying with the terms of disciplinary orders can undermine the effectiveness of the Department's regulatory efforts as well as compromise the public's safety and well being. Deficiencies we identified fell into the following categories which are not mutually exclusive; as a result, some cases had more than one of the following deficiencies:

- In 9 cases, the Department could not provide a file or any evidence of Probation Compliance monitoring. Most of these cases involved physicians who had their licenses suspended or revoked.

Among the 16 cases where files were provided:

- In 12 cases, files lacked evidence to show that some or all of the required monitoring had occurred.
- In 9 cases, there was no evidence that an initial interview was conducted within 30 days as required by the Department's Enforcement Manual.
- In 9 cases, files did not contain evidence of supervisory review.

BACKGROUND

Probation Compliance investigators are responsible for ensuring that disciplines ordered by the Department are carried out and monitored. Monitoring and verifying that physicians are

complying with the terms of disciplinary orders is essential to promote the effectiveness of the Department's regulatory efforts as well as to protect the public's safety and well being.

Responsibility for monitoring all professions rests with the Probation Compliance Unit; medical cases are only a part of its caseload. While the Department licenses over 1 million individuals in over 100 professions, currently there are only two investigators to monitor all of the Division of Professional Regulation Probation cases. As of April 2006, one Probation investigator's caseload was approximately 700 cases and the other investigator's caseload was 400. Approximately 150 of these cases are medical.

In the OAG program audit released in 1997, we recommended that the Department develop controls to ensure that Probation cases were properly monitored and establish procedures for operation of the Probation Compliance Unit. We also recommended that the Department ensure that physicians whose licenses have been suspended or revoked were not continuing to practice. In June 2000, the Department updated its Enforcement Manual, which contains specific guidelines on these issues for Probation investigators. While directives were established, as discussed in the following sections, problems identified in the 1997 audit regarding probation monitoring remain.

PROBATION CASE MONITORING

Monitoring deficiencies were noted in all of the 25 medical probation cases we selected for testing. In 21 of 25 cases we tested, the Department either could not provide a Probation Compliance monitoring file or the files lacked evidence to show that some or all of the required monitoring had occurred.

According to the Department's Enforcement Manual effective June 15, 2000, responsibilities of the Probation Compliance investigators include:

- Probation monitoring;
- Verification of suspensions;
- Revocation/cease and desist surveillance;
- Liaison with federal, State and local agencies regarding disciplined licenses; and
- Violation investigations and prosecutorial referrals.

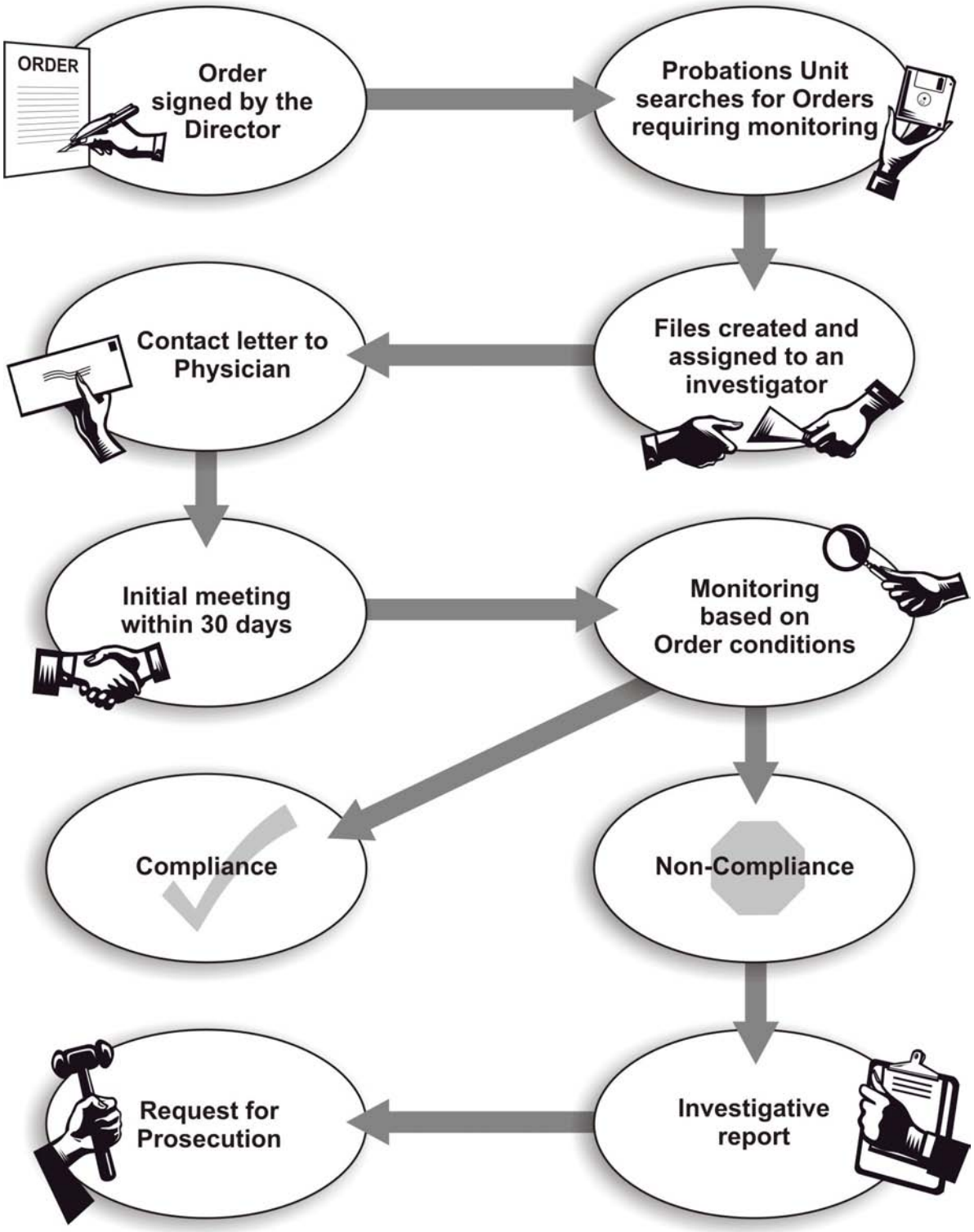
Exhibit 4-1
EXAMPLES OF ORDER CONDITIONS REQUIRING PROBATION MONITORING

- Alcoholics Anonymous Meetings
- Caduceus Meetings
- Aftercare Program
- Urine Drug Screenings
- Supervised Work
- Psychiatrist/Psychologist Treatment
- Revocation
- Suspension
- Continuing Education
- Random Breathalyzer Tests

Source: OAG analysis of Probation Compliance case files and DFPR Enforcement Manual.

Exhibit 4-1 shows examples of order conditions requiring probation monitoring. Exhibit 4-2 shows the process used by the Probation Compliance Unit from a disciplinary order being signed through the point where the

Exhibit 4-2
FLOWCHART OF THE
PROBATION COMPLIANCE UNIT PROCESS



Source: IFDPR procedures summarized by OAG

physician complies or fails to comply with the requirements of the order. According to Department personnel, most disciplinary actions that require some type of monitoring are the responsibility of the Probation Compliance Unit.

In 9 of the 25 (36%) cases sampled, the Department could not provide a file or evidence that any Probation Compliance monitoring occurred. In these 9 cases:

- Three physicians had indefinite suspensions:
  - one physician pled guilty to federal fraud charges regarding the practice of medicine,
  - one physician had a felony conviction, and
  - one physician came to the Department from the Drug Enforcement Agency for misuse of controlled substances.
- Two physicians had license revocations:
  - one physician allegedly abandoned patients and failed to provide records, and
  - one physician had a sister state discipline relating to a mental impairment.
- One physician had a probation and fine for prescribing drugs for non-therapeutic purposes.
- Two individuals were ordered to cease and desist the unlicensed practice of medicine:
  - one for providing chiropractic and acupuncture services, and
  - one for performing laser hair removal and botox injections.
- One physician's license was suspended for failure to pay State income taxes.

Six of the 9 cases with no probationary files were cases where the physician's license was either suspended or revoked. Department staff noted that a file is not maintained on suspension/revocation cases unless a follow-up investigation was warranted on a given case. However, they also noted that the Probation Compliance investigator will send a letter requesting the license back and ideally check once a year to ensure the physician is not practicing. Furthermore, the Department's Enforcement Manual states that:

> *It is the guideline of the Department of Professional Regulation periodically to review suspensions and/or revocations issued to license holders under the provisions of the Medical Practice Act. The Department will confirm, using the best available information, those physicians whose license(s) have been suspended or revoked are not continuing to practice. The Department will undertake this effort for one year from the date of discipline.*

We found no evidence that Probation staff were performing any follow-up actions to attempt to ascertain that physicians whose licenses had been suspended or revoked were not continuing to practice. Not undertaking efforts to check for practicing physicians who have had their licenses suspended or revoked not only results in noncompliance with Departmental policy, but also increases the risk to the general public.

Probation Case Example 1

A physician was disciplined for: dishonorable, unethical or unprofessional conduct of character likely to deceive, defraud or harm the public; prescribing, selling or administering drugs to patients without examining them; and promoting the sale of drugs to exploit patients for financial gain.

The physician's license was suspended for one year and his controlled substance license suspended for a minimum of five years. The suspension was to be followed by probation, continuing medical education, and quarterly reports.

No Probation activity was documented until 7 months **after** the order was signed, or more than halfway through the one-year suspension of the license. In addition, the investigator did not follow up when the continuing medical education requirements were not met and a quarterly report was not submitted. A Violation of Probation was only done **after** the physician pled guilty to 2 counts of mail fraud and was sentenced to 5 months confinement and a $70,200 fine.

Of the 16 cases sampled where a file was provided, 75 percent (12 of 16) of case files lacked evidence to show that some or all of the required monitoring had occurred. Inadequate monitoring included instances where follow up was not conducted when required documentation was not submitted to the Department. Documentation missing from files included:

- Quarterly reports of the respondent's condition as required by the order from a psychiatrist, a primary care physician or a practice monitor,
- Drug screen results, and
- Proof of completion of past due and additional continuing medical education hours or that such hours were pre-approved by the Medical Coordinator.

Probation Case Example 2

The Department issued an order on a sister state case on July 15, 2003. The Illinois order placed the physician on Probation and required reports required by the sister state to also be submitted to Illinois. The other state's order was not in the file and the Department was unable to provide it. No activity was documented in the file that any reports were received.

The case was closed before the Department received notification that the other state's order had been satisfied. The Department closed the case on January 5, 2004. On February 2, 2004, the Department received notice that the other state's probation had been satisfied.

The Department did not always follow up when order conditions were not met. For example:

- One order, dated November 20, 2003, required the physician to maintain a practice monitor to review patients and charts and to submit a quarterly report to the Department on his findings. The only follow up to ensure a practice monitor was maintained was in August 2005 after the Department

received a report that the physician was not in compliance with the Aftercare Agreement. As of May 2006, the physician had still not obtained a practice monitor as ordered on November 20, 2003.

- Four files lacked documentation to show completion of continuing medical education (CME) hours or that the Probation Compliance investigator followed up to ensure they were completed. Two cases originated from a Department CME audit during the August 1, 1999 through July 31, 2002 licensing cycle. One case was noted in case example one above. This physician was ordered on June 26, 2002 to complete an additional 50 hours of CME in the area of Prescribing Controlled Substances and Pain Management Control. The last physician was ordered on June 15, 2004 to complete 20 hours CME pre-approved by the Medical Coordinator within one year of the order date. The Department subsequently reported it has placed pre-approval in the file; however, the physician has not submitted documentation to show the hours have been completed in the allotted time.

- One file had no documentation of activity in the file after July 15, 2005; no quarterly reports, no indication that file has been closed or reports were no longer required. According to the Department, the case was reassigned in July 2005 and appears to be in non-compliance.

Exhibit 4-3
EXAMPLES OF DOCUMENTATION MISSING FROM CASE FILES

- Required Quarterly Reports
- Case Activity Reports
- Completion of Continuing Medical Education Hours
- Other Correspondence
- Sister State Disciplinary Order

Source: OAG analysis of DFPR Probation Case Files.

Our review of Probation case files also found that documentation was either not collected or was missing from case files. Exhibit 4-3 shows examples of documentation that were missing from case files that we reviewed. According to the Chief of the Probation Compliance Unit, the system allows them to enter follow up dates for the next date a report is due; however, there is no policy in place or practice to print or check reports of follow up dates on a regular basis.

Without careful and thorough monitoring of physicians disciplined, the Department cannot ensure that physicians who have had their license revoked, suspended, are on probation, or have a substance abuse/mental illness problem are not jeopardizing the public's safety by continuing to treat patients.

PROBATION MONITORING AND DOCUMENTATION	
RECOMMENDATION NUMBER **12**	***The Department of Financial and Professional Regulation should devote sufficient resources to ensure that physicians' compliance with terms of disciplinary orders are adequately monitored, including that physicians who have had their licenses suspended or revoked are not practicing. Furthermore, the Department should ensure that probation files contain all required documentation and that staff follow up when required documentation is not submitted.***
DFPR RESPONSE	The Probation Unit monitors all of the professions regulated by the Department. Due to increased enforcement activity in all of the professions that the Department regulates the Department has contracted with a Third Party Administrator to facilitate the scheduling, collection and testing of urine samples for drug and alcohol testing. This program is fully funded by the probationers that are being tested. Once this program is fully functional, employees in the Probation Unit will have more time to dedicate to scheduling, monitoring and overseeing other probationary responsibilities.

Other Probation Issues

In 56 percent (9 of 16) of cases with a file, there was no evidence that an initial interview was conducted within 30 days. According to the Department's Enforcement Manual, the Probation Compliance investigator should conduct a physician interview within 30 days of case assignment and document the results in a formal written investigative report. One physician we sampled was placed on probation from July 15, 2003 through September 16, 2003, yet the probation intake interview wasn't conducted until October 21, 2003, over a month after the probation had ended.

Finally, 9 of the 16 case files provided by the Department did not contain sufficient evidence of supervisory review. This is partly due to the fact that one of the two investigators is the Unit Chief and currently there is no policy for reviewing the chief's work. Considering the large caseloads and low staffing the Probation Compliance Unit faces, it is difficult to ensure that every activity is sufficiently reviewed.

INITIAL INTERVIEWS AND SUPERVISORY REVIEW	
RECOMMENDATION NUMBER **13**	***The Department of Financial and Professional Regulation should take actions to ensure that initial interviews are conducted within 30 days and adequately documented and that files receive appropriate supervisory review.***
DFPR RESPONSE	The Department will take appropriate steps to update our policies and procedures.

Chapter Five

COMMUNICATING RESULTS TO THE PUBLIC

CHAPTER CONCLUSIONS

The Department of Financial and Professional Regulation maintains a website to provide public access to license status and discipline information on physicians. This information, which has been provided on the Department's web page since 2001, provides information to the public on physician disciplines.

However, the Department's monthly reports, used to report on the disciplinary actions taken by the Department, were not accurate. We identified at least 41 disciplines of physicians that the Department did not include in its monthly reports in Fiscal Year 2005. In addition, there is some conflict about what reportable disciplinary actions include. The law requires publication of all disciplinary actions while Administrative Rules distinguish between disciplinary and non-disciplinary actions, with non-disciplinary action not being published.

The Department has not yet implemented several significant requirements of a new law relating to physician regulation and discipline. Several sections of the Medical Practice Act were amended on August 25, 2005 by Public Act 94-677. This Public Act made important revisions including: changing the membership of the Medical Disciplinary Board and increasing the number of public members; adding a new Deputy Medical Coordinator; increasing the number of medical investigators to assist with processing cases, and requiring new detailed physician profiles which will supply additional information to the public about physicians. We recommend that the Department continue its efforts to implement these new requirements.

DISCIPLINES REPORTED TO THE PUBLIC

Although the Department provides information to the public, there is a one to two month backlog in reporting disciplines on the Department's website and not all disciplines in the system are reported on the monthly reports to the public. The Department's website allows users to look up physicians and determine if they have been disciplined. The website also includes monthly reports on disciplines taken against various professionals regulated by the Department. Exhibit 5-1 shows the disciplines and non-disciplines as contained on an internal departmental report of Orders Signed by the Director. Exhibit 3-3 earlier in the report shows definitions for these same disciplines.

Physician Information

The Department of Financial and Professional Regulation maintains a website to allow the public to look up license status and discipline information on physicians. Currently, search results will provide the following physician information:

- license number,
- license status (active, inactive, non-renewed, deceased, suspended, etc.),
- location,
- issue date,
- expiration date,
- whether physician has ever been disciplined, and
- if disciplined, discipline start and end dates and a description of the reason for the discipline.

This information, which has been provided on the Department's web page since 2001, provides information to the public on physician disciplines. Providing the information is consistent with the Division of Professional Regulation's mission to serve, safeguard, and promote the public welfare. The Medical Practice Act had not required the Department to place physician discipline information on the web. However, changes to the Act discussed later in this chapter will require new information to be included on the Department's web page.

Exhibit 5-1
DEPARTMENT DISCIPLINES

Disciplines:

Cease & Desist
Denial
Fines[1]
Probation
Refuse to Renew
Reprimand
Revocation
Surrender
Suspension
Summary Suspension
Termination, Censure

Non-Disciplines:

Administrative Warning Letters
Admonishment
Continuing Medical Education
Fines[1]

Note [1] According to the Medical Practice Act, a fine shall not be the exclusive disposition of any disciplinary action arising out of conduct resulting in death or injury to a patient.

Source: OAG summary of DFPR information.

Disciplinary Actions

The Department does not report all disciplinary and non-disciplinary actions to the public via monthly reports. According to the Medical Practice Act of 1987, "The Department may revoke, suspend, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license or visiting professor permit of any person issued under this Act to practice medicine…" (225 ILCS 60/22).

However, there is some conflict about what reportable disciplinary actions include. The Civil Administrative Code of Illinois (20 ILCS 2105/2105-205) requires publication of disciplinary actions. It states that the Department shall publish, at least monthly, final

disciplinary actions taken by the Department against a licensee or applicant pursuant to the Medical Practice Act of 1987. The Medical Practice Act says that "Disciplinary Action" means revocation, suspension, probation, supervision, practice modification, reprimand, required education, fines or any other action taken by the Department against a person holding a license. However, the related Administrative Rules (68 Ill. Adm. Code 1285.225) distinguish between disciplinary and non-disciplinary actions, and non-disciplinary actions are not published in Department Reports. At least two actions, fines and education, are considered non-disciplinary by the Department in some circumstances, but are specifically noted as disciplinary actions in the Medical Practice Act (225 ILCS 60/2 (4)).

Correspondence from the Department shows the only non-disciplinary actions not reported are administrative warning letter/letter of concern or a fine/CME where no discipline was recommended. However, according to the Department's internal Report of Orders Signed by the Director, disciplines include fine, probation, refuse to renew, reprimand, revocation, suspension and summary suspension. Other actions are considered non-disciplinary orders between the Department and the physician. According to the Department, non-disciplinary orders are not reportable to the National Practitioner's Data Bank and as shown in Exhibit 5-2, they are not reported to the public on the monthly reports. In addition, cease and desist orders are listed as non-disciplinary on the Department's internal reports; however, they **are** included in monthly reports, both printed and on the web.

ADMINISTRATIVE RULES	
RECOMMENDATION NUMBER **14**	***The Department of Financial and Professional Regulation should make its Administrative Rules (68 Ill. Adm. Code 1285.225) relating to the definition of disciplinary and non-disciplinary actions consistent with requirements of the Medical Practice Act (225 ILCS 60/2 (4)).***
DFPR RESPONSE	Though the Medical Practice Act and its Administrative Rules differ on reportable disciplinary actions and non-disciplinary actions, the Department has been consistent in reporting its monthly disciplinary actions per the Administrative Rules. The Department would look forward to working with the General Assembly to develop the Administrative Rules relating to the definition of disciplinary and non-disciplinary actions so they are consistent with the requirements of the Medical Practice Act.

Policies and Procedures

According to the Department, there are no written policies and procedures guiding the public reporting process. Once the Director signs an order, one individual at the Department enters all Department orders, not just medical, into the RAES (Regulatory Administration and Enforcement System) computer system. Currently, no review is done once the information is entered. Once the orders are entered, another individual uses this information and prepares a monthly report of all persons disciplined.

Exhibit 5-2
DISCIPLINES NOT REPORTED TO THE PUBLIC ON MONTHLY REPORTS
Fiscal Year 2005

Month	Reported to Public	Orders in System	Disciplines NOT reported to the public	NON-Disciplines[1] not reported to the public
July	7	11	1– Fine	3 – Other
August	23	33	1 – Fine 1 – Denial	6 – Other 2 – Surrender
September	14	20	1 – Fine 1 – Probation	4 – Other
October	16	21	1 – Fine	4 – Other
November	26	36	3 – Fine 1 – Suspension	5 – Other 1 – Surrender
December	7	12	1 – Fine	4 – Other
January	30	49	11 – Fine	8 – Other
February	12	21	5 – Refuse to Renew	4 – Other
March	54	73	5 – Fine	14 – Other
April	12	24	3 – Fine	9 – Other
May	34	39	3 – Fine 1 – Refuse to Renew	1 – Other
June	19	23	1 – Fine 1 – Probation & Fine	2 – Other
TOTALS	254	362	41 NOT reported	67 NON disciplines

Note: [1] The Department includes items in non-disciplines that statutes consider discipline.

Source: OAG analysis of DFPR website and reports provided by the Department.

The Department's website includes monthly disciplinary reports which list disciplinary actions for all professions for that month. As of early May 2006, the Department had reported disciplines through March 2006. There is a backlog because one individual at the Department prepares the monthly disciplinary reports for all disciplinary orders, not just medical. Considering an average of 21 medical cases per month were reported in Fiscal Year 2005, the backlog for medical could be approximately 40 cases.

The Department does not report all disciplinary and non-disciplinary actions to the public via monthly reports. Exhibit 5-2 shows that in Fiscal Year 2005, 362 disciplinary orders were signed by the Director and 254 were reported to the public on the monthly reports. The actions not reported are also listed in the Exhibit and include: 1 denial, 1 probation, 1 probation and fine, 1 suspension, 3 surrenders, 6 refuse to renews, 31 fines, and 64 others. Disciplines not reported were errors and should have been reported to the public. Non-disciplines not reported are due to definitional conflicts between the Medical Practice Act and Administrative Rules.

In addition, the Department's reporting is inconsistent. Non-disciplines such as "surrender" and "other" are not reported to the public via monthly reports; however, "cease and desists," which are listed as a non-discipline on the Department's internal reports, are reported to the public. Violations of the Act worthy of a reprimand, which is a discipline not affecting the license in any way, are reported to the public; however, violations of the Act worthy of a fine are **not** reported to the public. In many cases where a "refuse to renew" discipline was imposed, it was reported to the public. However, as shown in the exhibit, six of them were not reported.

REPORTING TO THE PUBLIC	
RECOMMENDATION NUMBER **15**	***The Department of Financial and Professional Regulation should ensure that the public is fully informed of Department disciplinary actions on a timely, accurate, and consistent basis.***
DFPR RESPONSE	The Department issues monthly disciplinary reports with brief descriptions of actions taken by the Medical Unit and all other professions licensed by the Division of Professional Regulation. In addition to providing the report on-line, it is sent directly to persons who request to be added to the monthly subscription at no cost. Finally, due to improvements in the records unit, electronic copies of the public case file can be provided to anyone seeking additional information about a case. As reflected in the Auditor General's notes, the Department was successful in getting the Civil Administrative Code, 20 ILCS 2105-205, amended to reflect the current practice. The Department is continuing to push for changes to the Medical Practice Act to reflect this requirement. Additionally, the Department is pursuing additional levels of review to ensure that public reporting procedures are accurate.

Summary Report Requirement

The Department, through the Medical Disciplinary Board, did not send bi-monthly discipline reports to specified health care organizations as required by the Medical Practice Act of 1987. This was also noted as a finding in the OAG compliance attestation engagement for Fiscal Year 2005. The Act states:

> *The Disciplinary Board shall prepare, on a timely basis, but in no event less than one every other month, a summary report of final actions taken upon disciplinary files maintained by the Disciplinary Board. The summary reports shall be sent by the Disciplinary Board to every health care facility licensed by the Illinois Department of Public Health, every professional association and society of persons licensed under this Act functioning on a statewide basis in this State, the American Medical Association, the American Osteopathic Association, the American Chiropractic Association, all insurers providing professional liability insurance to persons licensed under this Act in the State of Illinois, the Federation of State Medical Licensing Boards, and the Illinois Pharmacists Association (225 ILCS 60/23 (F)).*

The Department currently makes a monthly disciplinary report available online for anyone to download. The publication is made available upon request and payment of fees; however, the Department does not send the report to every licensed health care facility, medical association and insurer as required by the law.

The Department was successful in getting the Civil Administrative Code (20 ILCS 2105/2105-205) amended to reflect the current practice. Department personnel provided documentation to show they have made efforts to get changes made to the Medical Practice Act but as of May 2006, the above requirement was still in effect.

SUMMARY REPORTS	
RECOMMENDATION NUMBER **16**	***The Department of Financial and Professional Regulation should send required summary reports of final actions taken upon disciplinary files to every licensed health care facility, medical association, and liability insurer as required by the Medical Practice Act of 1987.***
DFPR RESPONSE [Response continued on the following page.]	The Department provides a monthly disciplinary report of final actions taken upon disciplinary files which is available either upon request or online at the Department's website. Current law mandates that the report be sent to every licensed health care facility, medical association and insurer as required by law. However, the current law was written and adopted decades before the availability of current technological advances the Department utilizes such as the World Wide Web and/or email. Therefore, the Department acknowledges that we are out of "technical compliance" with this provision of the law; however, we are in compliance with the *intent* of the law, which is to make disciplinary information available to the public and health care employers.

[Continued Response]	The Department, in conjunction with the Illinois Medical Society, has sought and will continue to seek an amendment to legislation (SB 2608) that will abolish the requirement that summary reports be mailed to every licensed health care facility, medical association and insurer. The new law will instead require the Department to post the summary reports on its website for immediate viewing. The Department, while awaiting the outcome of the new legislation, will continue to post the monthly disciplinary reports on its website and will also send the link via email directing its intended receivers to the monthly report. With the passing of the new legislation, the Department will administer the newly enacted requirements for posting the monthly disciplinary report.

STATUS OF IMPLEMENTING PUBLIC ACT 94-677

The Department has not yet implemented several significant requirements of an important new law relating to physician regulation and discipline. Several sections of the Medical Practice Act were amended on August 25, 2005 by Public Act 94-677. According to the Act, these requirements are effective immediately. Provisions that have not been implemented include:

- **Membership of the Medical Disciplinary Board -** the Medical Disciplinary Board membership is increased from 9 to 11 members. The number of public members required increased from two to four members. The current Board consists of seven members. Since the Board was already missing the two public members required under the old provisions, now it is missing four public members. The Department is awaiting the Governor's appointment of these positions.

- **Deputy Medical Coordinator –** the Secretary of the Department is now required to select not less than two Deputy Medical Coordinators, instead of one required under the old provisions. As of May 2006, a second Deputy Medical Coordinator had not been hired.

- **Number of Investigators –** the Act now requires one full-time investigator to be employed for every 2,500 physicians licensed in the State. The law previously required one investigator for every 5,000 physicians. The Department has 18 full-time investigators. The Department nearly meets this requirement based on 45,583 active licenses in June 2005. One additional investigator would be needed to meet the new standard. An investigator position was posted in September 2005 but no additional investigators have been hired.

OTHER CHANGES TO THE MEDICAL PRACTICE ACT:

1. Refuse to Renew is added as a disciplinary action.
2. Statute of Limitations is raised from three to five years from the date the complaint is received.
3. The time limit to begin action against a physician has been extended to 10 years from the date of the incident or violation of the Act.
4. A pattern or practice of behavior which demonstrates incapacity or incompetence to practice under this Act, now has its own time limit.
5. Maximum fine for each violation is $10,000 instead of $5,000.
6. The Secretary of DFPR approves orders instead of the Director of DPR.
7. Mandatory reports received are now required to identify the patient's date of birth and the hospital or facility where the questioned care took place.
8. The subjects of the mandatory reports are now required to submit pertinent medical records with their responses.
9. The Department may request the medical records for mandatory reports from the plaintiff's attorney, who must provide them even without the patient's consent.

Source: OAG analysis of Public Act 94-677.

- **Physician Profile -** a new section is created requiring a physician profile called the Patients' Right to Know Law. It requires the Department to make a profile on each physician available to the public on an Internet website. Physician profiles are discussed in more detail in the next section.

In addition, the Public Act required that: "The Department shall promulgate such rules as it deems necessary to accomplish the requirements of this Section" (225 ILCS 60/24.1(e)). As of May 2006, no rules have been drafted. An official told us that preliminary meetings have been held with the Illinois Medical Society to discuss rules and regulations of P.A. 94-677; however, no formal rules had been drafted and proposed by the Department.

IMPLEMENTING PUBLIC ACT 94-677	
RECOMMENDATION NUMBER 17	***The Department of Financial and Professional Regulation should continue to work to comply with amendments to the Medical Practice Act made by Public Act 94-677, including promulgating rules to accomplish these requirements.***
DFPR RESPONSE	The Medical Malpractice Reform Bill (PA 94-677) was signed by the Governor on August 25, 2005. The Department has taken significant and appropriate steps to comply with all provisions of the new legislation. The Department worked with the Administration and key sponsors of the bill to ensure that it included provisions sought by the Department, including a lengthening of the statute of limitations and additional authority to expand its investigative authority. As a result, the Department has acted quickly to begin implementing the amendments to the Medical Practice Act and will continue to do so.

Physician Profiles

The Department has not made available to the public a profile of each physician containing specified information required by Public Act 94-677. Public Act 94-677 created a new section (225 ILCS 60/24.1) of the Medical Practice Act requiring a more complete physician profile. It requires the Department to make a profile on each physician available to the public on an Internet website. The profile should contain very detailed information for each licensed physician, including:

- Physician's full name,
- Criminal convictions within the last 5 years,
- Department final disciplinary actions within the last 5 years,
- Final disciplinary actions by licensing boards in other states in the last 5 years,
- Description of loss or involuntary restriction of hospital privileges or resignation from privileges from a case related to competence or character, within the last 5 years,

- All medical malpractice judgments, arbitration awards, and settlements in which payment was made to a complaining party within the last 5 years. Judgments on appeal are to be so marked, and disclaimers about claims being settled but not necessarily reflecting on the competence or conduct of the physician are to be included as well,
- Names of medical schools attended and the dates of attendance and graduation,
- Graduate medical education,
- Specialty board certification, including the toll-free number of the American Board of Medical Specialties for verification,
- Number of years in practice and locations,
- Names of hospitals where the physician has privileges,
- Location of the physician's primary practice,
- Identification of any available translating services at the primary practice location, and
- Whether the physician participates in Medicaid.

The Disciplinary Board is to collect the information and to provide the completed profile to the physician before it is released to the public. The physician is provided 60 days to correct any factual inaccuracies. While the Public Act was effective August 2005, the Department has not made available to the public a profile of each licensed physician. Department officials reported to us that they are in the process of developing software to gather the information and display it on the website.

PHYSICIAN PROFILE	
RECOMMENDATION NUMBER **18**	***The Department of Financial and Professional Regulation should continue to work to make available to the public, through the Internet, and, if requested, in writing, a profile of each physician licensed by the Department as required by Public Act 94-677.***
DFPR RESPONSE [Response continued on the following page.]	The Department maintains an internet website through which the public can learn the licensure status of a physician licensed in Illinois. In fact, the data is deemed so accurate it can be used, by law, to prove a licensee's status for purposes of employment. The website also allows the general public to view press releases, alerts, disciplinary actions and licensing requirements. The Department has been responsive in taking advantage of new technologies as required so that the citizens of Illinois have information they need as quickly as possible through such vehicles as the Department's website. The Medical Malpractice Act (PA 94-677) was signed by the Governor on August 25, 2005, requiring the posting of physicians' profiles on the Department's website. The Department has found that stock software available on the market would not provide the capacity and flexibility needed to post profiles as required by law, and has begun to develop the program required to fulfill the statute's requirements. With this

[Continued Response]	new technology and information, the Department will be an exceptional resource for the citizens of Illinois as well as the larger public.

Public Board Members

None of the four public members of the Medical Disciplinary Board have been appointed. The Medical Practice Act creates the Medical Disciplinary Board, composed of eleven members, which is responsible for disciplining physicians licensed under the Act. Members of the Disciplinary Board are to be five licensed physicians, along with one osteopath and one chiropractor, and four public members not engaged in healthcare. However, since March 2005 the Board has had no public members. One public member was serving as of January 2004, but he resigned in March 2005, leaving the Board without any of the four required non-medical members. Public Act 94-677 amended the Medical Practice Act effective August 25, 2005 by increasing the number of voting public members from two to four. The Department is awaiting the Governor's appointment of these positions.

MEDICAL DISCIPLINARY BOARD MEMBERS	
RECOMMENDATION NUMBER **19**	***The Department of Financial and Professional Regulation should work to assure that all members, including public members, are appointed to the Medical Disciplinary Board as required by the Medical Practice Act.***
DFPR RESPONSE	The Department will work to assure that any vacant position on the Medical Disciplinary Board, including those for public members, is filled as allowed by the determinants of the selection and appointment process. Any state advisory board member is typically selected for his or her contributions and professional expertise in a chosen field as well as other achievements. The process of nomination, selection and appointment for any state advisory board is rigorous. Though many are considered, only a few can be selected for their outstanding qualifications to serve.

Chapter Six

OTHER ISSUES

CHAPTER CONCLUSIONS

The Department of Financial and Professional Regulation has a number of problems related to properly documenting the decisions made related to physician disciplines. These problems exist in both paper files that are maintained by various units and in the agency's computer systems and include missing files and lack of consistent or adequate documentation.

The Department has not followed its own policies in the Enforcement Manual related to the following issues:

- It did not require secondary employment requests to be submitted for approval on an annual basis;
- It did not establish appropriate training programs; and
- It did not require employees to disclose conflicts of interest.

We recommend that the Department monitor employees engaging in secondary employment by reviewing approved requests on an annual basis; establish appropriate training programs for medical investigators and attorneys; and require its employees to disclose potential conflicts of interest. All of these actions are required by the Department's own policies embodied in its Enforcement Manual.

ADEQUATE DOCUMENTATION IN FILES

The Department of Financial and Professional Regulation has a number of problems related to properly documenting the decisions made related to physician disciplines. These problems exist in both paper files that are maintained by various units and in the agency's computer systems and include missing files and lack of consistent or adequate documentation. Previous OAG audits have noted similar problems for at least 13 years. The State Records Act (5 ILCS 160/1.5, 160/8) requires that records are to be created, maintained, and administered to document decision and activities of the State or State Government.

Missing Files

In our sample of 130 total cases in Investigations and Prosecutions, the Department could not provide case files related to 7 cases and for 2 additional cases most of the information was missing. Exhibit 6-1 summarizes the missing files.

Exhibit 6-1
SUMMARY OF MISSING INVESTIGATION AND PROSECUTION FILES

Case	Investigations files	Prosecution files
#1	No file provided	
#2	No file provided	
#3	*Most information was lacking*	
#4	*Most information was lacking*	
#5	No file for mandatory report case	No file provided
#6		No file provided
#7		No file provided
#8		Prosecution file missing for a mandatory report case referred to Prosecutions
#9		Prosecution file was not provided for a Student Assistance Commission case
8 Total Missing Files		***2 Files with most information missing***

Source: OAG analysis of Investigations and Prosecutions files requested for testing.

There were also six cases in our Probations sample of 25 cases where the physician's license was suspended or revoked and no Probations file existed. The Enforcement Manual requires that in such cases, a file be created so that the Probations Unit may monitor the providers every six months to ensure that they are no longer practicing. The Probations Chief stated that the Unit only sends out a letter requesting return of the physician's credentials, so no file is created. The results of our sample testing of Probation documentation is discussed further in Chapter 4.

Case Documentation in RAES

Besides the missing files, we identified other issues that may affect the ability to adequately document the agency's decisions. There are no procedures or policies on what activities must be entered into the Regulatory Administration and Enforcement System (RAES), and information in the system is not always consistent with information in the paper case files.

Previous OAG audits have identified problems with Professional Regulation's documenting case activity in computer systems. Exhibit 6-2 summarizes those findings and the Department's response. In the 1997 Program Audit we recommended that the replacement computer system have the capability to better control quality and timeliness of the Enforcement

process. Similarly, OAG compliance audits found that adequate documentation was not maintained in the Enforcement systems. A version of this finding has appeared in every one of Professional Regulation's biennial or annual audits since 1991 through to the most recent audit for Fiscal Year 2005.

Exhibit 6-2
OAG FINDINGS ON COMPUTER DOCUMENTATION

OAG Audit	Finding	Agency Response
Compliance FY05	Documentation on RAES not adequate.	Concur, will instruct employees to keep RAES updated.
Compliance FY04	Documentation on RAES not adequate.	Will keep updated.
Compliance FY03	Documentation on RAES not adequate.	RAES is a monitoring tool and not the official record.
Compliance FY01	Documentation on RAES not adequate.	Concur, Department is drafting requirements for replacement system.
Compliance FY99	Documentation on RAES not adequate.	Concur
Compliance FY97	Documentation on RAES not adequate	Concur, will enforce procedures more rigidly.
Program Released 97	System being developed should help management control Enforcement process.	Concur
Compliance FY95	Inadequate documentation of case activity in Electronic Case Tracking System (ECTS).	Concur, issued memoranda to staff to enter activities correct and timely.
Compliance FY93	Untimely Enforcement activity and inadequate documentation in ECTS.	Concur, will incorporate use of ECTS.
Compliance FY91	Difficulty implementing ECTS has caused problems with updated policy manual.	Concur, policy revisions to be made.

Source: Material and immaterial OAG compliance and management audit findings.

In the cases we examined, different individuals recorded different activities and did not always record the same activities in the same way. For example, most investigators recorded the receipt of correspondence, while prosecutors did not. Even when the receipt was documented, the degree of the entries varied – some merely entered the activity, and others described the contents of the correspondence in a brief summary. Consequently, the documentation for each case in the system was not consistent.

While we were able to verify most information from the paper case file to the RAES system, we noted that we could not verify the complaint receipt date in 31 cases. Although officials stated that correspondence received in Complaint Intake and Investigations was date-stamped, we found we could not determine when 14 complaint forms or letters were received

because they were not date-stamped. Further, in 7 cases, we noted that information in the file suggested that Professional Regulation had information that formed the basis for the complaint at least one month prior to the complaint receipt date listed in RAES.

We also had problems verifying many Prosecution activities because Prosecution files are not required to contain much information to support the RAES entries and because no standard exists for what should be documented. As previously discussed, there are no standards for which activities must be documented. Some chronologies contained few activities to verify, even though the cases spent months in Prosecutions before being resolved.

According to officials, Prosecutions is not required to maintain documents to show how decisions were made for closed cases that can be found elsewhere, in other various units of the Department. These documents include notices, formal complaints, investigative records, conference memos, and Medical Coordinator opinions. In addition, most correspondence need not be date-stamped or documented if it will not become part of the official case record. Therefore, RAES entries could not always be verified using Prosecution files.

Other Documentation Issues

We found that other activities were not adequately documented in case files, including medical records and the decisions to close cases. Investigative files did not contain the Medical Coordinator's opinions, even when the opinion resulted in case closure.

After an investigation is completed, the case is sent to the Medical Coordinator for review. In 18 of 47 Investigations cases sent to the Medical Coordinator, the Coordinator recommended closure of the case and the case was subsequently closed without referral to Prosecutions. However, none of the files contained the Coordinator's opinion to show the reason the case was closed after the investigation and not referred to Prosecutions for disciplinary action. Officials stated that all opinions are kept in a separate file by the Medical Coordinator rather than in individual case files. Consequently, the reason for closing the case is not documented anywhere in those case files but may be documented in files maintained in other departmental units.

Medical records obtained by investigators were not always provided for the files we requested. If medical records are voluminous, the records are put into a separate file, called a document file, to be kept with the investigative file. However, when we originally requested the investigative files, document files containing the medical records were not provided for 16 cases. While document files were eventually located in various locations after we specifically requested them, this represents a potential weakness in Professional Regulation's ability to retrieve complete case information when requested.

Central Files

Physician Regulation does not have central files to document decisions in physician discipline cases. To determine all the activity on a particular case we found that case documentation was spread among multiple files that needed to be examined. Each Enforcement Unit has a separate file – Investigations, Prosecutions, and Probations. In addition, if a formal complaint is filed, there is the Administrative Services Unit file which contains legal documents filed in the case; the Medical Coordinator's file containing the opinion on the case; and the Board file where closure memos are kept if the case did not result in discipline. Exhibit 6-3 shows various locations where files are maintained related to physician disciplines.

Exhibit 6-3
VARIOUS PHYSICIAN REGULATION FILE LOCATIONS

RAES
Complaint Intake
Administrative Services Unit (Public File)
Investigations
Prosecutions
Medical Coordinator
Medical Disciplinary Board
Official (Record Services in Springfield)
Student Loans
Child Support
Enforcement Administration (MR, CME, and some sister states)

Source: DFPR information summarized by OAG.

Previous audits have also found problems in documentation of case activities. The Fiscal Year 2004 and 2005 audits reported that Enforcement activities were not performed timely or not sufficiently documented.

State law (5 ILCS 160/1.5, 160/8) requires that State agencies adequately document decisions. Decisions concerning physician discipline, since they could potentially affect the health and welfare of the public, are important decisions. Having separate and distinct files for Investigations, Prosecutions, and Medical Coordinator opinions makes it difficult to adequately trace the agency's decisions regarding physician disciplines. When a case is closed on the recommendation of the Medical Coordinator, it is difficult to understand the reasons if the recommendation is not contained as part of the case file.

The Department is in the process of converting from its current enforcement system RAES, to another, called the Illinois Licensing and Enforcement System (ILES). According to Department officials, ILES will be able to better document activities because it will be able to capture computer-created documents. Currently the RAES system records case activities and brief summaries of those activities entered by the persons working on the cases. ILES will be able to capture investigative reports and other word-processing documents as part of the case record, rather than just record the case activities. The conversion is currently about two years behind schedule, and Medical Enforcement is one of the last units to undergo the conversion.

DOCUMENTATION	
RECOMMENDATION NUMBER 20	***The Department of Financial and Professional Regulation should sufficiently document its decisions and activities. The Department should also ensure that the replacement system for the Regulatory Administration and Enforcement System has the capability to help management better control the adequacy of the Enforcement process.***
DFPR RESPONSE	The Department is in the process of upgrading its computer system from RAES (Regulatory and Enforcement System) to ILES (Illinois Licensing and Enforcement System). Because ILES software expands RAES' capacity to monitor adequacy and performance of enforcement processes, the Department will be able to develop even better management controls. The program contains a database, word processing and case document retaining system which allows the Department to automatically document and track files and cases for all of its professions. Because of the sensitive nature of the medical documents and cases, the Department's IT unit will continue to develop the ILES program for implementation and transference of the professions under the Medical Practice Act in stages. Already being developed for future implementation are check lists for investigators and prosecutors, automated alert systems for management, and other tracking aids. It is expected that the ILES system will be fully implemented by the end of 2006.

STAFFING ISSUES

The Department employs 18 medical investigators and 6 medical prosecutors, as shown in Exhibit 6-4. Medical investigators are based out of Springfield or Chicago and attorneys are all based in Chicago. As shown in Exhibit 6-4, the Medical Investigations Unit maintains a very low turnover rate. More than half of the medical investigators have been in their positions for over 15 years. The Department has not hired a medical investigator in over 3 years. All employees, with the exception of the Chief of Medical Prosecutions, Medical Coordinator, and Administrative Assistant II are union employees covered under the American Federation of State, County and Municipal Employees (AFSCME) agreement.

Exhibit 6-4
MEDICAL INVESTIGATORS AND PROSECUTORS EXPERIENCE AND CASELOADS
as of January 2006

Medical Investigations	Years in position	Caseloads 6/30/2005	Caseloads 6/30/2004
Chief of Medical Investigations	7	102	193
Lead Investigator	11	34	52
Lead Investigator	13	43	31
Investigator 1	22	34	35
Investigator 2	21	39	39
Investigator 3	20	28	31
Investigator 4	19	31	34
Investigator 5	18	27	28
Investigator 6	18	34	39
Investigator 7	18	45	34
Investigator 8	17	25	45
Investigator 9	17	29	52
Investigator 10	17	25	34
Investigator 11	15	21	18
Investigator 12	11	*Military Leave*	
Investigator 13	8	33	27
Investigator 14	4	23	26
Investigator 15	3	11	22
Medical Prosecutions			
Chief of Medical Prosecutions	1	161	123
Tech Advisor 1	12	127	85
Tech Advisor 2	6	102	92
Tech Advisor 3 [1]	4	n/a	73
Tech Advisor 4	5	73	95
Tech Advisor 5	2	97	n/a
Tech Advisor 6	1	94	74

Note: [1] Resigned 4/30/05, new attorney hired in September 2005.
Source: Summary of documentation provided by DFPR.

Medical investigators in Springfield are based in the Springfield Office. Medical investigators based in Chicago work from home but do come into the office on occasion. Each investigator is responsible for working in the office on their "duty days." The investigators on duty are available to answer questions and phone calls, and handle walk-ins. This is usually three to five days per investigator per month. This work arrangement could result in a delay in getting cases assigned to investigators timely.

Timesheets

A finding in the OAG FY2005 Financial Audit and Compliance Examination found that the Department was not maintaining timesheets for its employees in compliance with the State Officials and Employees Ethics Act (5 ILCS 430/5-5(c)). Medical investigators do not submit timesheets, which makes it difficult for supervisors to account for investigators' time when they are not in the office. Supervisors note that it is difficult to track investigators' time; however, they use cell phones, leave requests and turnover of investigative reports to review.

Secondary Employment

The Department does not require secondary employment requests to be submitted for approval on an annual basis as outlined in the Enforcement Manual. In addition, the personnel files revealed inconsistent use of the forms. As discussed earlier, investigators work from home and do not submit timesheets. Therefore, loose controls in this area leads to potential for secondary employment activities to interfere with Department employees performance and time working as a State employee.

Exhibit 6-5
INCONSISTENCIES IN SECONDARY EMPLOYMENT REQUIRED REPORTS AND FOLLOW UP

Employee	Last SER[1] in File	Did the Department Follow Up When Report Was Not Submitted?
#1	1/31/00	No – 2 other reports in file. 9/92 NO outside employment. 1/88 outside employment.
#2	1/2/03	No follow up
#3	10/16/92	No follow up
#4	1/31/00	No follow up
#5	1/17/03	No – 4 other reports in file. 12/92 and 6/00 NO outside employment. 10/93 and 9/01 outside employment.
#6	5/4/00	No – 2 other reports in file. 6/85 NO outside employment. 10/92 outside employment.
#7	12/19/02	No – 1 other report in file. 3/02 (9 months earlier) NO outside employment.
#8	1/18/00	No – 1 other report in file. 11/94 NO outside employment.
#9	1/25/00	No follow up
#10	1/18/00	No –3 other reports in file. 5/89 and 7/91 NO outside employment. 3/92 reported outside employment.

Note: [1] SER - Secondary Employment Report.

Source: OAG analysis of DFPR personnel files. In these personnel files sampled (10 of 25), medical investigators or attorneys had submitted a secondary employment requests at some point.

Upon written approval, medical investigators and attorneys are allowed to engage in secondary employment not to exceed 20 hours per week. A Secondary Employment Report must be submitted by employees prior to engaging in the work. According to the Manual, these forms should also be submitted on an **annual** basis. The forms are then approved by the immediate supervisor, division head, deputy director and director.

In 10 of 25 personnel files sampled, medical investigators and attorneys had submitted secondary employment requests at some point. Another 4 files showed no evidence of secondary employment forms. The remaining 11 employees reported that they do not hold secondary employment. In all 10 instances, the employees did not file the required annual disclosure form, and the Department did not timely follow up with the employees when the forms were not submitted as shown in Exhibit 6-5.

When employees have outside jobs, there is no follow up to ensure they are acting within the limitations and restrictions set by the Department for engaging in secondary employment. Seven employees have gone six years without any follow up.

SECONDARY EMPLOYMENT	
RECOMMENDATION NUMBER **21**	***The Department of Financial and Professional Regulation should closely monitor employees engaging in secondary employment by reviewing and approving requests on an annual basis.***
DFPR RESPONSE	The Department has developed an agency-wide policy for secondary employment. The agency-wide policy supersedes that of the Enforcement Manual, which is currently under review, and applies to all Department employees, not just those in Enforcement. The Department will revise its Enforcement Manual to correctly reflect the Department's agency-wide policy on secondary employment.
	AUDITOR COMMENT: No Departmental policies on secondary employment other than those included in the Enforcement Manual were provided to the auditors during the course of the audit.

Training

The Department has not established appropriate training programs as directed in its own Enforcement Manual. According to the Manual, "investigator training programs will be offered no less than two times per calendar year." Currently there is no training calendar for investigators. There are no formal training requirements for the types of training investigators must get. According to Department officials, investigators may request training in certain areas if they feel they are lacking in a particular area.

The Department provided auditors with a list of training performed for FY04 and FY05. One document provided just had two dates with "Training" beside them. When asked to specify

what kind of training they were, officials were unable to track it back or find any additional information. Investigators received firearms training and attended occasional staff meetings. There was also a "Work Rules Training," which addressed basic rules about work hours, dress, and some ethics; this training was for all DFPR employees, not just the investigators.

The 1997 program audit recommended the Department develop a training policy to insure the investigators are given systematic and continuing training in areas related to their professional duties. The Department has not been following guidelines in its Enforcement Manual to provide training programs to ensure investigators are continually increasing their skills and ability to conduct medical investigations for the Department.

TRAINING	
RECOMMENDATION NUMBER **22**	***The Department of Financial and Professional Regulation should establish appropriate training programs for medical investigators as directed in its own policies and procedures.***
DFPR RESPONSE	The Department has developed a series of training opportunities for its investigative staff and will continue to work with local, state and federal authorities to expand opportunities for its investigators to improve their skills. Plans are being developed to offer Department investigators recurring training opportunities including seminars by the Secretary of State on Identity Theft, training specifically related to the new ILES system, sexual harassment training, policy and personnel rules review, Sheriff's Association Law Enforcement Training Board and DEA training seminars. Controlled Substance Inspectors received armed weapons training which included two scheduled qualifications for the year. With the passage of the Ethics Reform bill employees were mandated to complete ethics training and successfully pass a computer based ethics test. The Department, through its Training Coordinator, will continue to develop and arrange for training for the medical investigators.

Conflict of Interest Policy

The Department of Financial and Professional Regulation is not enforcing its own policy requiring conflicts of interest be disclosed by employees. The policy requires that staff members, Board members, or contractual employees recuse themselves from cases where they have a conflict and disclose that in a written statement which will be maintained as part of the permanent file for the case. In our prior audit of physician regulation released in 1997, we recommended that the Department develop policies that require employees to report conflicts of interest.

In June 2000 the Department of Professional Regulation issued a policy and the finding was not repeated. However, when we asked Enforcement staff about the policy, they were unaware such a requirement existed and could provide us with no such disclosures for FY04 or FY05. Our review of Complaint Committee minutes showed that members of the Committee do recuse themselves from cases, but Medical Disciplinary Board minutes we reviewed did not contain any such evidence. In our review of files, we found no evidence of written disclosures of conflicts of interest in any of the files we reviewed from the Bureau of Statewide Enforcement.

The Enforcement Manual that contains the policy on conflicts of interest has not been revised by the new administration and, as noted above, is not used to guide Enforcement activities.

CONFLICTS OF INTEREST	
RECOMMENDATION NUMBER **23**	***The Department of Financial and Professional Regulation should require its employees to disclose potential conflicts of interest as required by its Enforcement Manual.***
DFPR RESPONSE	The Department has a stringent agency wide policy with regards to conflicts of interest which applies to all employees as well as Board members. Though this policy differs slightly from the policy as written in the Enforcement Manual, it will supersede that of the Enforcement Manual. The Department will revise its Enforcement Manual to correctly reflect the Department's policy on conflict(s) of interest. The Department is developing future agency wide trainings to address current and any new policies and procedures related to conflict(s) of interest. In addition to the Department's written policy, each employee and Board member is required to report any potential conflict(s) of interest on his or her Statement of Economic Interest. This form is completed, returned and filed with the Illinois Secretary of State's Office. In addition, under the Governor's Ethics Reform Legislation, each employee is required to complete and successfully pass a computer based ethics training course. Within the ethics training course, conflict(s) of interest are addressed again with directives to report any such conflict(s) of interest to the state agency's Ethics Officer.
	AUDITOR COMMENT: No Departmental policies on conflict of interest other than those included in the Enforcement Manual were provided to the auditors during the course of the audit.

TIMESHEETS

Medical investigators do not prepare timesheets as required by the State Officials and Employees Ethics Act. As is noted earlier, Chicago medical investigators work from their homes and are not required to be in the office except for 3 to 5 assigned "duty days" each month. Investigators do not submit timesheets, so it is difficult for supervisors to account for time when the investigators are not in the office. This issue has been reported as a finding related to all Department employees in the OAG Compliance Attestation Examination of the Department for Fiscal Years ending in 2004 and 2005. Timesheets for employees are required by the State Officials and Employees Ethics Act. The Department asserted that employees' time was tracked using a "negative" timekeeping system whereby the employee is assumed to be working unless noted otherwise.

When employees do not work in an office, timesheets could be particularly important for management to assure employee productivity. Supervisors in Medical Investigations said they track the investigators using cell phones and leave request sheets. In addition, the supervisors can also get some sense of the amount of work performed through the investigative reports submitted by the investigators for review. According to caseload reports provided by the Department, investigators had caseloads of 11 to 45 in Fiscal Year 2005.

TIMESHEETS	
RECOMMENDATION NUMBER **24**	***The Department of Financial and Professional Regulation should require employees, including medical investigators, to prepare timesheets as required by the State Officials and Employees Ethics Act. Timesheets should also help management to more closely monitor medical investigators' time.***
DFPR RESPONSE	In January of this year, the Department implemented an additional timekeeping system for approximately 200 of its Merit Compensation Employees. This electronic system requires employees to input the time they spend on state business to the nearest quarter hour, and contains controls to ensure that submission of the timesheet each week results in the employees, in effect, certifying their timesheet. This Department policy was communicated via e-mails and training sessions. The Department plans to begin negotiations with the union to expand this timekeeping system to all union employees, including investigators and attorneys, later this year. Once this is completed, a formal, written policy will be introduced. We will then revise the Enforcement Manual to reflect these changes.

APPENDICES

APPENDIX A
House Resolution Number 16

STATE OF ILLINOIS
NINETY-FOURTH GENERAL ASSEMBLY
HOUSE OF REPRESENTATIVES

House Resolution No. 16

Offered by Representative Mary E. Flowers

WHEREAS, *The Department of Financial and Professional Regulation has established as its mission to serve, safeguard, and promote the public welfare by ensuring that licensure qualifications and standards for professional practice are properly evaluated, accurately applied, and vigorously enforced; and*

WHEREAS, *Among the professions regulated by the Department are physicians licensed under the Medical Practice Act of 1987; and*

WHEREAS, *A 1997 program audit of "Physicians Regulated Under the Medical Practice Act" conducted by the Office of the Auditor General found that the Department of Professional Regulation lacked adequate management controls in its investigatory, disciplinary, and probationary processes; The audit contained 16 recommendations for improving the Department's performance; and*

WHEREAS, *The public needs assurance that the Department is effectively regulating and disciplining physicians who do not comply with the provisions of the Medical Practice Act of 1987 and that the public is appropriately and timely informed of these regulatory and disciplinary actions; therefore, be it*

RESOLVED, BY THE HOUSE OF REPRESENTATIVES OF THE NINETY-FOURTH GENERAL ASSEMBLY OF THE STATE OF ILLINOIS, *that we urge the Auditor General to conduct a program audit of the Department of Financial and Professional Regulation's disciplining of physicians who violate provisions of the Medical Practice Act of 1987; and be it further*

RESOLVED, *That the audit shall include, but shall not be limited to, the following determinations: (i) the Department's compliance with State law regarding the disciplining of physicians; (ii) the Department's procedures for determining the need for, and nature of, any recommended disciplinary actions; (iii) the Department's process for ensuring that its*

recommended disciplinary actions are implemented and that any specified corrective steps are instituted; and (iv) the Department's process for communicating results of disciplinary action to the public; and be it further

***RESOLVED**, That we urge the Department of Financial and Professional Regulation, other State agencies and employees, and any other entity or person that may have information relevant to this audit to cooperate fully and promptly with the Auditor General's Office in the conduct of this audit; and be it further*

***RESOLVED**, That we urge the Auditor General to commence this audit as soon as possible and report the results upon completion in accordance with the provisions of Section 3-14 of the Illinois State Auditing Act.*

Adopted by the House of Representatives on March 15, 2005.

Michael J. Madigan

Michael J. Madigan, Speaker of the House

Mark Mahoney

Mark Mahoney, Clerk of the House

APPENDIX B
Audit Sampling and Methodology

APPENDIX B
AUDIT SAMPLING
AND METHODOLOGY

This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

Fieldwork for this audit was conducted between January and April 2006. We interviewed representatives of the Department of Financial and Professional Regulation (DFPR) with responsibilities related to disciplining physicians. We reviewed documents at DFPR including initial complaints, mandatory reports, Investigation files, Prosecution files, and Probation Compliance files. We tested samples and reviewed case files related to the audit's objectives.

We reviewed the previous financial audits and compliance attestation engagements released by the Office of the Auditor General for the Department of Financial and Professional Regulation and its predecessor agency, the Department of Professional Regulation. This included reviewing findings for the most recent compliance attestation engagement for Fiscal Year 2005. As directed by House Resolution Number 16, we also reviewed findings from the 1997 OAG program audit of Physicians Regulated under the Medical Practice Act and checked the status of the 16 recommendations in that audit.

We reviewed risk and internal controls at DFPR related to the audit objectives. The audit objectives are contained in House Resolution Number 16 (see Appendix A). This audit identified some weaknesses in these controls, which are included as findings in this report.

To the extent necessary, we reviewed the reliability of computer processed data used in our audit report. That included reviewing findings included in the compliance attestation engagements and audits done by the Auditor General. Weaknesses related to computer data and computer systems are noted in this report.

In conducting the audit, we reviewed applicable State statutes and rules and tested compliance with those laws as directed by the resolution. Any instances of non-compliance we identified are noted in this report.

TESTING AND ANALYTICAL PROCEDURE

To examine case files, we selected samples of Investigations, Prosecutions, and Probation files. Investigations and Prosecutions files were randomly selected; Probation files were initially identified from cases in the Investigations and Prosecutions samples that required monitoring by the Department and other cases were randomly selected to reach the desired sample size. The Department provided data on all cases with activity in fiscal years 2004 and 2005, which provided the universe from which our samples were drawn.

The Investigations sample was taken from cases that were opened in fiscal years 2004 and 2005. For Investigations, we used a 90 percent confidence level with a 10 percent error rate to arrive at a sample size of 67 cases. A random number generator was used to select the cases for review. For the Prosecutions sample, we used the 90 percent confidence interval and 10 percent error rate to draw a sample of 63 cases from cases sent to Prosecutions and closed in fiscal years 2004 and 2005. A random number generator was then used to select the cases for review.

Cases selected for these two samples were reviewed throughout the entire process, regardless of which sample they were selected for. We reviewed the Prosecutions files for all cases in the Investigations sample that were referred to Prosecutions. Similarly, we reviewed Investigations files for all cases selected in the Prosecutions samples. Cases were reviewed to determine the following:

- What documentation of Department activities existed in the case files;
- Whether the investigation appeared adequate to determine if the physician had violated the Medical Practice Act;
- Timeliness of both the investigation and the prosecution of the case;
- Whether the information in the case file matched information entered into the Department's computerized case tracking system; and
- Compliance with applicable laws and regulations, including the Medical Practice Act.

Cases from the Investigations and Prosecutions samples resulting in discipline that required monitoring were included in our Probation sample. We also used the random number generator to select additional cases to reach a sample size of 25 cases. These cases were also tested to determine what documentation of activities existed in the case file, the extent of the monitoring by the Probation Unit, and whether the information in the case file matched the Department's computerized tracking system. Results from samples used in this audit have not been projected to the universe. As is noted above, two of our samples were statistical samples with a 90 percent confidence interval and 10 percent error rate. Results from these samples could be projected to the universe by other users. However care is required to assure that results are used appropriately.

We also examined all rejected initial complaints from fiscal year 2005 which we could identify as medical cases relating to physicians. We examined these complaints to determine why they were rejected, what contact the Department had with the complainants, and whether the complaints were properly handled by the Department.

APPENDIX C
Medical Practice Act
Grounds for Disciplinary Action

APPENDIX C
MEDICAL PRACTICE ACT
GROUNDS FOR DISCIPLINARY ACTIONS

Following is the portion of the Medical Practice Act of 1987 as amended through Public Act 94-677, effective August 25, 2005. The section describes disciplinary actions can be taken and the grounds for disciplinary actions.

225 ILCS 60/22 DISCIPLINARY ACTIONS

Section 22. Disciplinary action.

(A) The Department may revoke, suspend, place on probationary status, refuse to renew, or take any other disciplinary action as the Department may deem proper with regard to the license or visiting professor permit of any person issued under this Act to practice medicine, or to treat human ailments without the use of drugs and without operative surgery upon any of the following grounds:

(1) Performance of an elective abortion in any place, locale, facility, or institution other than:

(a) a facility licensed pursuant to the Ambulatory Surgical Treatment Center Act;

(b) an institution licensed under the Hospital Licensing Act; or

(c) an ambulatory surgical treatment center or hospitalization or care facility maintained by the State or any agency thereof, where such department or agency has authority under law to establish and enforce standards for the ambulatory surgical treatment centers, hospitalization, or care facilities under its management and control; or

(d) ambulatory surgical treatment centers, hospitalization or care facilities maintained by the Federal Government; or

(e) ambulatory surgical treatment centers, hospitalization or care facilities maintained by any university or college established under the laws of this State and supported principally by public funds raised by taxation.

(2) Performance of an abortion procedure in a wilful and wanton manner on a woman who was not pregnant at the time the abortion procedure was performed.

(3) The conviction of a felony in this or any other jurisdiction, except as otherwise provided in subsection B of this Section, whether or not related to practice under this Act, or the entry of a guilty or nolo contendere plea to a felony charge.

(4) Gross negligence in practice under this Act.

(5) Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public.

(6) Obtaining any fee by fraud, deceit, or misrepresentation.

(7) Habitual or excessive use or abuse of drugs defined in law as controlled substances, of alcohol, or of any other substances which results in the inability to practice with reasonable judgment, skill or safety.

(8) Practicing under a false or, except as provided by law, an assumed name.

(9) Fraud or misrepresentation in applying for, or procuring, a license under this Act or in connection with applying for renewal of a license under this Act.

(10) Making a false or misleading statement regarding their skill or the efficacy or value of the medicine, treatment, or remedy prescribed by them at their direction in the treatment of any disease or other condition of the body or mind.

(11) Allowing another person or organization to use their license, procured under this Act, to practice.

(12) Disciplinary action of another state or jurisdiction against a license or other authorization to practice as a medical doctor, doctor of osteopathy, doctor of osteopathic medicine or doctor of chiropractic, a certified copy of the record of the action taken by the other state or jurisdiction being prima facie evidence thereof.

(13) Violation of any provision of this Act or of the Medical Practice Act prior to the repeal of that Act, or violation of the rules, or a final administrative action of the Secretary, after consideration of the recommendation of the Disciplinary Board.

(14) Dividing with anyone other than physicians with whom the licensee practices in a partnership, Professional Association, limited liability company, or Medical or Professional Corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered. Nothing contained in this subsection prohibits persons holding valid and current licenses under this Act from practicing medicine in partnership under a partnership agreement, including a limited liability partnership, in a limited liability company under the Limited Liability Company Act, in a corporation authorized by the Medical Corporation Act, as an association authorized by the Professional Association Act, or in a corporation under the Professional Corporation Act or from pooling, sharing, dividing or apportioning the fees and monies received by them or by the partnership, corporation or association in accordance with the partnership agreement or the policies of the Board of Directors of the corporation or association. Nothing contained in this subsection prohibits 2 or more corporations authorized by the Medical Corporation Act, from forming a partnership or joint venture of such corporations, and providing medical, surgical and scientific research and knowledge by employees of these corporations if such employees are licensed under this Act, or from pooling, sharing, dividing, or apportioning the fees and monies received by the partnership or joint venture in accordance with the

partnership or joint venture agreement. Nothing contained in this subsection shall abrogate the right of 2 or more persons, holding valid and current licenses under this Act, to each receive adequate compensation for concurrently rendering professional services to a patient and divide a fee; provided, the patient has full knowledge of the division, and, provided, that the division is made in proportion to the services performed and responsibility assumed by each.

(15) A finding by the Medical Disciplinary Board that the registrant after having his or her license placed on probationary status or subjected to conditions or restrictions violated the terms of the probation or failed to comply with such terms or conditions.

(16) Abandonment of a patient.

(17) Prescribing, selling, administering, distributing, giving or self-administering any drug classified as a controlled substance (designated product) or narcotic for other than medically accepted therapeutic purposes.

(18) Promotion of the sale of drugs, devices, appliances or goods provided for a patient in such manner as to exploit the patient for financial gain of the physician.

(19) Offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine, or the treating, operating or prescribing for any human condition by a method, means or procedure which the licensee refuses to divulge upon demand of the Department.

(20) Immoral conduct in the commission of any act including, but not limited to, commission of an act of sexual misconduct related to the licensee's practice.

(21) Wilfully making or filing false records or reports in his or her practice as a physician, including, but not limited to, false records to support claims against the medical assistance program of the Department of Public Aid under the Illinois Public Aid Code.

(22) Wilful omission to file or record, or wilfully impeding the filing or recording, or inducing another person to omit to file or record, medical reports as required by law, or wilfully failing to report an instance of suspected abuse or neglect as required by law.

(23) Being named as a perpetrator in an indicated report by the Department of Children and Family Services under the Abused and Neglected Child Reporting Act, and upon proof by clear and convincing evidence that the licensee has caused a child to be an abused child or neglected child as defined in the Abused and Neglected Child Reporting Act.

(24) Solicitation of professional patronage by any corporation, agents or persons, or profiting from those representing themselves to be agents of the licensee.

(25) Gross and wilful and continued overcharging for professional services, including filing false statements for collection of fees for which services are not rendered, including, but not limited to, filing such false statements for collection of monies for services not rendered

from the medical assistance program of the Department of Public Aid under the Illinois Public Aid Code.

(26) A pattern of practice or other behavior which demonstrates incapacity or incompetence to practice under this Act.

(27) Mental illness or disability which results in the inability to practice under this Act with reasonable judgment, skill or safety.

(28) Physical illness, including, but not limited to, deterioration through the aging process, or loss of motor skill which results in a physician's inability to practice under this Act with reasonable judgment, skill or safety.

(29) Cheating on or attempt to subvert the licensing examinations administered under this Act.

(30) Wilfully or negligently violating the confidentiality between physician and patient except as required by law.

(31) The use of any false, fraudulent, or deceptive statement in any document connected with practice under this Act.

(32) Aiding and abetting an individual not licensed under this Act in the practice of a profession licensed under this Act.

(33) Violating state or federal laws or regulations relating to controlled substances, drugs, or ephedra, as defined in the Ephedra Prohibition Act.

(34) Failure to report to the Department any adverse final action taken against them by another licensing jurisdiction (any other state or any territory of the United States or any foreign state or country), by any peer review body, by any health care institution, by any professional society or association related to practice under this Act, by any governmental agency, by any law enforcement agency, or by any court for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this Section.

(35) Failure to report to the Department surrender of a license or authorization to practice as a medical doctor, a doctor of osteopathy, a doctor of osteopathic medicine, or doctor of chiropractic in another state or jurisdiction, or surrender of membership on any medical staff or in any medical or professional association or society, while under disciplinary investigation by any of those authorities or bodies, for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this Section.

(36) Failure to report to the Department any adverse judgment, settlement, or award arising from a liability claim related to acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this Section.

(37) Failure to transfer copies of medical records as required by law.

(38) Failure to furnish the Department, its investigators or representatives, relevant information, legally requested by the Department after consultation with the Chief Medical Coordinator or the Deputy Medical Coordinator.

(39) Violating the Health Care Worker Self-Referral Act.

(40) Willful failure to provide notice when notice is required under the Parental Notice of Abortion Act of 1995.

(41) Failure to establish and maintain records of patient care and treatment as required by this law.

(42) Entering into an excessive number of written collaborative agreements with licensed advanced practice nurses resulting in an inability to adequately collaborate and provide medical direction.

(43) Repeated failure to adequately collaborate with or provide medical direction to a licensed advanced practice nurse.

APPENDIX D
Agency Responses

Note: This Appendix contains the complete written responses of the Illinois Department of Financial and Professional Regulation. There are 11 numbered Auditor Comments that address matters raised in the Department's response. The numbers for the comments appear in the margin of the Agency Responses.

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

ROD R. BLAGOJEVICH
Governor

DEAN MARTINEZ
Secretary

Daniel E. Bluthardt
Director
Division of Professional Regulation

July 11, 2006

William G. Holland
Office of the Auditor General
State of Illinois
160 N. LaSalle, Suite 5-900
Chicago, IL 60601

Re: Medical Audit

Dear Auditor General Holland,

Enclosed please find the Department's response to the program audit. We have appreciated your staff's professionalism and cooperation throughout this lengthy process.

We specifically request that you include our introduction and background as part of our response.

We also kindly request that a member of your staff notify us once you know the exact date when you will tender your report to the House of Representatives or otherwise make your report public.

Sincerely,

Daniel E. Bluthardt, JML

Daniel E. Bluthardt
Director of the Division of Professional Regulation

Daniel E. Bluthardt
Director
Division of Professional Regulation
Department of Financial and
Professional Regulation
320 W. Washington Street
Springfield, IL 62786
217-782-9405

cc: Ed Wittrock

Enclosure

PROGRAM AUDIT RESPONSES

OF THE

ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

TO THE

OFFICE OF THE AUDITOR GENERAL REGARDING THE DISCIPLINING OF PHYSICIANS

July 11, 2006

INTRODUCTION AND BACKGROUND 1

The Department of Financial and Professional Regulation (hereinafter "Department") licenses and regulates over 1.2 million professionals and businesses in the State of Illinois, including physicians. There are currently over 40,000 physicians licensed in the State of Illinois. The Department fields over 1,600 complaints against physicians per year. Of those yearly 1,600 complaints, approximately 250 end with disciplines against physicians. The Federation of State Medical Boards (FSMB) compiles statistics of Medical Boards throughout the United States. The FSMB publishes an annual report that lists the number of disciplines issued by each state.

As of last year, the Department is proud to be ranked 13th in the nation. This is due to the increased prosecutorial and investigative aggressiveness of the Department, for the calendar year 2005. Illinois traditionally ranked in the bottom 40's prior to 2002.

Without a doubt, Illinois has steadily improved its performance over the past three years.

Even the independent medical watch-dog group *Public Citizen* has noted the Department's improvement. *Public Citizen* uses a three-year average to rank state medical boards. The Department's three year average ranking is 18th in the nation.

On August 25, 2005, Governor Rod Blagojevich signed the Medical Malpractice Reform Bill (PA 94-677). The Department took a leading role in Medical Malpractice Reform. The changes made to the Medical Practice Act enhanced the enforcement powers of the Department including extended statutes of limitations as well as enhanced violations sections. The Department has also streamlined some of its processes to speed up the investigation and prosecution of physicians.

The Department is committed to work hard to protect the People of the State of Illinois and to explore new ways to ensure that the People of the State of Illinois have access to excellent medical treatment. We welcome the Audit process and regard it as a way to improve the Department's procedures to better protect the People of the State of Illinois.

Auditor Comment 1: The introduction and background section, provided for the first time as an attachment to the Department's official response to our specific findings, contains information and conclusions that were not audited or verified by the auditors during the course of their audit work. In its response, the Department alludes to recent improvement in its ranking among state medical boards since 2002. Some of this improvement appears to come from the Department's new policy, implemented in 2004, of reporting Refuse to Renew orders as disciplines. This type of order is placed on sister state disciplines where the

individual's Illinois license is in <u>non-renewed or inactive</u> status. As a result, these are not disciplines on <u>active</u> licenses. Rankings the Department cites are based on serious actions per 1,000 active physicians. The Department issued 45 refuse to renew orders in FY04 and 128 in FY05 for a total of 173 or 35 percent of disciplines for the two years as is shown in Exhibit 3-2 in the report. Because we do not know what data other states report, we do not know whether only Illinois includes Refuse to Renew orders on non-active licenses in its discipline statistics or if it is a common practice among the states.

RECOMMENDATION 1
CASES CLOSED AT INTAKE

The Department of Financial and Professional Regulation should log all initial claims, forward them to Medical Investigations, and close them according to requirements in Administrative Rules.

DFPR RESPONSE:

The majority of initial claims are forwarded to Medical Investigations and processed according to the requirements in Administrative Rules. In response to this recommendation, the Department will change its procedure relating to initial claims that do not warrant further investigation upon receipt by the Complaint Intake Unit. They too will be processed and forwarded to the Complaint Committee and Medical Disciplinary Board, for review and final approval of closure.

The Department, on average, receives 1,600 initial claims annually and has developed and implemented a comprehensive and efficient Complaint Intake Unit which efficiently analyzes and processes each claim. Complaint Intake personnel are highly qualified to make preliminary analyses of claims and routinely treat each as potentially serious. After preliminary analysis of an initial claim is conducted, Complaint Intake personnel render a determination that further investigation is or is not possible and/or required.

There are limited but clearly and statutorily defined instances where it is not possible or required that a complaint case be opened on an initial claim. The majority of initial claims received by the Department, however, are opened as an official complaint case for further investigation. Because Complaint Intake personnel are only authorized to open complaint cases, at no time are complaint cases closed by Complaint Intake personnel.

2

Auditor Comment 2: For FY05, auditors found 54 initial claims that had been closed in Complaint Intake that we identified as medical. Although Complaint Intake does not close "complaint" cases, they have closed "claims." Also, as noted in the report, Complaint Intake does not log all initial claims received which would help ensure that claims are processed efficiently.

RECOMMENDATION 2
ADMINISTRATIVE CLOSURE OF CASES

The Department of Financial and Professional Regulation and the Medical Disciplinary Board should comply with the Administrative Code provisions requiring that closure of all initial claims and complaints be approved by the Board. This approval should be documented.

DFPR Response:

The Department complies with the Administrative Code provision requiring that closure of all complaints be approved by the Medical Disciplinary Board. However, the complaints are reviewed in the closed session of the Medical Disciplinary Board meeting and the discussion of these complaints is, therefore, not included in the Medical Disciplinary Board's general minutes for the audit years FY04 and FY05. The case closures from closed sessions of FY04 and FY05 are documented separately. This documentation provides the dates that the Chairman of the Board reviewed and approved each case for closure along with his or her initials. **3**

As stated in the Department's Response to Recommendation 1, initial claims that do not warrant further investigation will also be approved for final closure by the Complaint Committee and Medical Disciplinary Board.

Auditor Comment 3: Over the course of audit field work, auditors requested documentation of Board approval for closure on two occasions: first, on February 16, 2006; and later on March 7, 2006. It was not until the exit conference, on June 29, 2006, that the Department made documentation available for this finding. When auditors reviewed the information related to sample cases, auditors still found 2 of 15 cases where closing was not documented in the Board documentation provided.

RECOMMENDATION 3
TIMELY INVESTIGATIONS

The Department of Financial and Professional Regulation should develop management controls to ensure timely completion of investigations of complaints received by the Department. These controls should be in the form of written policies which include specific timeliness requirements. Any reports required should be reviewed by management personnel to ensure accuracy.

DFPR Response:

The Department is in the process of reviewing what timeliness requirements should be implemented to improve the quality of its enforcement of the Medical Practice Act as amended. The Department's Medical Investigations Unit reviews, investigates and processes 1,600 complaint cases per year. Because the nature of cases and the amount of investigation necessary to develop those cases vary significantly, the Department wants to make sure that timeliness requirements actually improve the quality of the cases it brings against physicians.

The investigation of a medical case is oftentimes extremely complex. While written policies regarding timeliness requirements are and shall continue to be as specific as possible, the Department must give careful consideration to each individual case as well as to due process requirements. **4**

Since the review may not determine that timeliness policy changes will improve the quality of medical investigations, the Department has implemented new tracking systems to signal potential timeliness issues. For example, the Department is developing an automated alert system within its upgraded computer system which will generate tracking reports to assist management personnel in addressing timeliness requirements.

The Department notes that, at no time during or since the audit period, has it been unable to prosecute a case due to timeliness issues. Cases pursued against physicians with serious complaints are typically open for 5 months or longer, as would befit complex medical investigations. The Medical Investigations Unit has been an effective force in conducting sound investigations of potentially serious violations of the regulations set forth in the Medical Practice Act and its Administrative Rules.

Auditor Comment 4: While the auditors agree that the Department must give careful consideration to each individual case, we do not agree that taking excessive time to complete a medical investigation is conducive to due process. As noted in the audit, 50 percent of the investigations took longer than the 5 months suggested by the Department's own policies, with one case taking 1,096 days.

RECOMMENDATION 4
PRIOR COMPLAINT INFORMATION

The Department of Financial and Professional Regulation should include requirements in their procedures that prior complaint information be incorporated in files and should assure that information is included.

DFPR Response:

Medical investigators and prosecutors have access to all prior complaint and case information. In most cases, once the information has been reviewed, copies of relevant cases are incorporated into the working case file maintained by each investigator. However, during Fiscal Years 04 and 05, investigators were unable to use much of that information in the development of current cases due to statute of limitations constraints that have since been lifted.

Working files do contain prior complaint information for each case such as the Respondent and Complainant history. Reports for the chronologies and historical information is always checked in the computer system, printed, and forwarded to the investigator for inclusion in the working file. This allows the investigator to determine if any previous complaint information is related to or helpful in investigating the current case. If a chronology is not present in a working file, it was either not required by guidelines or it was not applicable to conducting a thorough investigation. Working files are highly detailed and will contain the appropriate information that the medical investigator requires to conduct a complete investigation. **5**

Unfortunately, when the Auditor General requested the investigative file, they were not given the working files and instead reviewed the historical file which did not contain the prior complaint information. This was the Department's error.

Auditor Comment 5: We requested the most complete files for each case and were told the files provided contained the most complete record of each case. The Department's response that "historical files" were provided instead of "working files" illustrates the weakness in the Department's ability to retrieve complete case information when requested, as discussed in Chapter Six and Recommendation 20. For two cases tested, auditors specifically requested prior complaint information from the Department after our review. For those cases, no additional documentation was provided by the Department.

RECOMMENDATION 5
DOCUMENT INVESTIGATION ACTIVITIES

The Department of Financial and Professional Regulation should develop controls to ensure that all investigative activities are properly conducted and documented in both the case file and the computer system.

DFPR Response:

The opening and investigating of medical complaints requires appropriate documentation and tracking. As part of the new computer system being implemented, all citizen complaints received via e-mail, sister state disciplines and mandatory reports will be automatically logged and linked to the licensed physician's intradepartmental computer file. When cases are opened based on phone conversations or other non-computerized means, the Department will develop controls to ensure these cases are also logged into the system immediately upon receipt.

RECOMMENDATION 6
MANDATORY REPORT INFORMATION FOR INVESTIGATORS

The Department of Financial and Professional Regulation and the Medical Disciplinary board should make information related to mandatory reports closed by the Board prior to investigation available to assist in the investigation and prosecution of physicians who demonstrate patterns of behavior.

DFPR Response:

On August 25, 2005, the Governor signed the Medical Malpractice Reform Bill (PA 94-677) which expanded the statute of limitations to include older Mandatory Reports for review and inclusion in investigative cases to show a pattern of practice. At the time of the audit period, which covered FY04 and FY05 and ended on June 30, 2005, information contained in prior Mandatory Reports would not have been admissible and therefore, were not made available to investigators. **6**

When PA 94-677 became effective, the Department began the process of making prior Mandatory Reports available to investigators for inclusion in medical investigations cases.

Auditor Comment 6: Until this response, the Department had not indicated that it had been prohibited by law from using prior mandatory reports to determine whether a physician demonstrated a pattern of practice or other behavior which demonstrates incapacity or incompetence to practice under the Act. In fact, the Department concurred with a similar recommendation in our 1997 program audit. Further, even before Public Act 94-677, the Medical Practice Act provided that "[a]ny information reported or disclosed shall be kept for the confidential use of the Disciplinary Board, the Medical Coordinators, and Disciplinary Board's attorneys, the medical investigative staff, and authorized clerical staff. . . (emphasis added)" (225 ILCS 60/23 (B)). However, as reported in this audit, such mandatory reports were not always made available to investigators.

RECOMMENDATION 7
MEDICAL COORDINATOR

The Department of Financial and Professional Regulation should take the steps necessary to assist the Medical Coordinators with backlogs and improve case timelines.

DFPR Response:

As of July 1, 2006, there is no backlog at the Medical Coordinators level. For a portion of the audit period, there was only one Part-Time Medical Coordinator on staff. Since that time, the Department has hired an additional Full-Time Medical Coordinator and the number of cases at the Medical Coordinators level has been significantly reduced from nearly 600 to less than 200, which the Department does not consider to be a backlog.

The Medical Malpractice Act (PA 94-677), as amended on August 25, 2005, authorizes the Department to hire an additional Deputy Medical Coordinator to assist in case preparations which will further streamline the disposition of disciplinary cases. It is important to note that the Medical Coordinator's primary role is to ensure that when cases are sent to the Board for review, the cases are as complete as possible. In light of that, the Medical Coordinator may require additional investigation or medical records before presenting cases to the Board, thus extending the time a case is in the Medical Coordinator's control.

RECOMMENDATION 8
CRITERIA FOR DISCIPLINARY DECISIONS

The Department of Financial and Professional Regulation and the Medical Disciplinary Board should develop general criteria to help guide their decisions in disciplinary actions. Such criteria would help to ensure that similar violations under similar circumstances receive similar discipline.

DFPR Response:

One of the most important functions of the Medical Disciplinary Board is to determine an appropriate discipline for those found to be in violation of the Medical Practice Act. The Board is, by statute, composed of a range of medical and non-medical members who are required by the Medical Practice Act to carefully consider each case on its own merits and provide advice to the Director with regard to disciplinary matters.

Neither the Medical Disciplinary Board nor the Department has the authority to institute "sentencing guidelines." Should the General Assembly amend the Medical Practice Act providing for such authority, the Department would look forward to developing "sentencing guidelines." **7**

Rather, the Department and the Medical Disciplinary Board make their decisions in disciplinary actions on a case by case basis. Their decisions are based on multiple factors including, most importantly, the evidence available to prove the allegations against a Respondent Physician. Each complaint received or instituted by the Department is unique and the investigative file and evidence obtained is different for each file. The Department and the Medical Disciplinary Board strive for consistency of disciplinary actions based on soundly investigated cases.

Auditor Comment 7: The Department is responsible for taking action against physicians who violate the Act. It is imperative that the Department be able to demonstrate that its actions are not arbitrary or capricious. General guidelines followed by appropriate documentation supporting its decision in each case would help establish the validity of the actions taken by the Department. While the auditors do not recommend "sentencing guidelines," we do recommend that the Department either follow general guidelines applying similar discipline to similar violations under similar circumstances or document its rationale for applying disparate disciplines. In the absence of such guidelines and documentation, the general public may view the Department as treating some physicians who violate the Act more favorably than others. Further, development of such guidelines is within actions necessary and proper to administer the Act, is consistent with the breadth and scope of other policies developed by the Department, and may not require specific legislation to implement. As noted by the Department in its response to Recommendation 10, it has the "power and duty to formulate rules and regulations necessary for the enforcement of any Act administered by the Department." Therefore, we continue to recommend, as we first did in the 1997 program audit, that the Department implement general guidelines for physician disciplines.

RECOMMENDATION 9
OUT OF STATE COMPLAINTS

The Department of Financial and Professional Regulation should assure that complaints received about out of state physicians are forwarded to the licensing board of the appropriate state.

DFPR Response:

By statute, the Department has jurisdiction only over physicians licensed in Illinois and for the licensed physicians' actions that occur within Illinois. The Department has no statutory authority to institute cases for events involving physicians licensed, or actions that occurred, in other states. Records indicated that only five (5) of the total number of complaints received were about out of state physicians. In lieu of implementing this recommendation, the Department has provided all staff of the Intake Unit with a list of Medical Boards throughout the United States so that citizens can be directed to appropriate State's Complaint Intake Unit.

RECOMMENDATION 10
INVOLVE COMPLAINANTS IN DISCIPLINE PROCESS

The Department of Financial and Professional Regulation should develop procedures for involving people making complaints in the disciplinary process.

DFPR Response: **8**

To the extent allowed by statute in the Illinois Medical Practice Act, pursuant to 225 ILCS 60/37, the Department does involve complainants in the disciplinary process. In order to protect the privacy of the complaining party and the due process of the physician under investigation, the Department is limited in the extent to which it can share information.

Under the Illinois Medical Practice Act, "at the time and place fixed in the notice, the Disciplinary Board provided for in this Act shall proceed to hear the charges and both the accused person and the complainant shall be accorded ample opportunity to present in person, or by counsel, such statements, testimony, evidence and argument as may be pertinent to the charges or to any defense thereto." See Section 225 ILCS 60/37. The "notice" referenced to in this section of the Act is attached to every formal complaint filed by the Department in the form of a Notice of Preliminary Hearing. Once a Notice of Preliminary Hearing and Formal Complaint are filed, the Department's allegations against the Respondent Physician become public[1] and litigation begins. Once a case is scheduled for a Formal Hearing before the Medical Disciplinary Board and Administrative Law Judge, the Department issues subpoenas to all witnesses it will call. If a case is received by way of a Mandatory Report, the Department will subpoena its expert witness and the patient involved. In the majority of cases received by way of Mandatory Reports, the patients are no longer living or they do not wish to cooperate with the Department's case. If a case is received by way of Citizen Complaint, the Department will subpoena the complainant to testify.

Under the Illinois Medical Practice Act, 225 ILCS 60/36, "all information gathered by the Department during its investigation including information subpoenaed under Section 23 or 38 of this Act and the investigative file shall be kept for the confidential use of the Secretary, Disciplinary Board, the Medical Coordinators, persons employed by contract to advise the Medical Coordinator or the Department, the Disciplinary Board's attorneys, the medical investigative staff, and authorized clerical staff, as provided in this Act and shall be afforded the same status as is provided information concerning medical studies in Part 21 of Article VIII of the Code of Civil Procedure, except that the Department may disclose information and documents to a federal, State, or local law enforcement agency pursuant to a subpoena in an ongoing criminal investigation." As such, the Department is prohibited from sharing any information related to the investigation of a complaint received by it to anyone except those listed in Section 60/36. The list does not include complainants.

The practice of the regulated professional, trades, and occupations in Illinois is hereby declared to affect the public health, safety and welfare of the People of the State of Illinois and in the public interest is subject to regulation and control by the Department of Financial and Professional Regulation. See the Civil Administrative Code of Illinois, 20 ILCS 2105-10. The Department represents the "People of the State of Illinois." The Department does not represent individual complainants. For this reason, the Department cannot involve complainants in settlement negotiations.

The Department has the power and duty to formulate rules and regulations necessary for the enforcement of any Act administered by the Department. See the Civil Administrative Code of

[1] Patients' identities are never identified and are referenced to in a Formal Complaint by initial only.

Illinois, 20 ILCS 21/05-15(a)(7). Under this authority granted by the Civil Administrative Code, the Department implemented Rule 1285.220 of the Rules for the Administration of the Medical Practice Act which states:

a) An informal conference is the procedure established by the Division to resolve complaints, licensing issues, or conflicts prior to initiating any action requiring a formal hearing. Informal conferences are for the purposes of compliance review, fact finding, and discussion of the issues.

b) Notice of an informal conference shall be sent to the respondent not less than 10 days before the conference is scheduled. The notice shall include a brief statement of the alleged violations.

c) Informal conferences shall be conducted by a Division attorney and shall include a member of the Disciplinary Board or his or her designee.

d) The respondent may bring an attorney or other representative to the informal conference.

e) The respondent shall have an opportunity at the informal conference to make an oral statement and to present any documents that might be relevant to the matter.

f) Results of Informal Conference. The informal conference shall result in one or more of the following recommendations being made to the Board:

1) The case be closed.
2) The case be investigated further.
3) A consent order be entered.
4) The matter be referred for a formal hearing.

The informal conference process is analogous to a settlement conference. The informal conference process could not allow for the complainant to be involved because it would be in violation of Section 60/36 which prohibits the Department from sharing information obtained through the Department's investigation.

The process of litigation inherently involves settlement negotiations and the Department engages in settlement negotiations in the process of litigation. Settlement negotiations are not mandated by the Illinois Medical Practice Act. Settlement negotiations should not be mandated or regulated by statute because there may be times where the Department does not want to engage in settlement negotiations. For example, if the allegations against a Respondent Physician are so egregious and the Department's evidence is overwhelming and/or substantial, the Department will not want to enter into settlement negotiations.

For the reasons stated above, the Department does sufficiently involve the complainant in the disciplinary process to the extent that it is allowed under the law. Should the General Assembly amend the Medical Practice Act to further involve complainants in the disciplinary process, the Department would look forward to implementing this procedure.

Auditor Comment 8: Contrary to the Department's assertion, the Department does <u>not</u> have a process to involve people making complaints in the disciplinary process. The Department also notes limitations to the complainant being involved in the process unless the Department subpoenas them as a witness. Involving the complainant by subpoena, at the Department's discretion, does not accord the complainant the "ample opportunity" required by statute. Regardless of the elements that make involving the complainant in the disciplinary process difficult to implement, the Medical Practice Act of 1987 still requires:

> ***. . . at the time and place fixed in the notice, the Disciplinary Board provided for in this Act shall proceed to hear the charges and both the accused person and the complainant shall be accorded ample opportunity to present in person, or by counsel, such statements, testimony, evidence and argument as may be pertinent to the charges or to any defense thereto. (225 ILCS 60/37)***

In summary, the General Assembly has already directed the Department to involve the complainant in the disciplinary process and the Department should amend its current practices to do so.

RECOMMENDATION 11
TIMELY PROSECUTION ACTIVITIES

The Department of Financial and Professional Regulation should develop and implement management controls to ensure that Prosecution activities are timely and properly documented.

DFPR Response:

The medical case tracking system will be upgraded to the same case tracking system used by the other professions regulated by the Department. As an additional safety measure under the upgraded system, the Department will be developing an automatic alert for the Chief of Medical Prosecutions that a specific action needs to be taken.

However, because the life of a case in prosecution and litigation is typically dominated by factors out of the control of the prosecution attorney, the Medical Practice Act and its governing Rules are intentionally silent relating to specific timeframes for documentation. Just some of the factors that exclude the feasibility of specific timeframes for documentation include the schedules of the Medical Disciplinary Board Members, the schedules of the Respondent Physicians and/or their attorneys and the Administrative Law Judges' court docket.

Except for the specific statute of limitations dates, neither the Illinois Medical Practice Act nor the Rules for the Administration of the Medical Practice Act specify a particular timeframe for the completion of prosecution activities or documentation of prosecution activities. The Department has implemented management controls to ensure that Prosecution activities are timely and properly documented. Medical Prosecutions staff have not missed any statutes of limitations nor failed to file necessary documents in a timely manner. Most importantly, the Medical Prosecutions staff has not placed the People of the State of Illinois in jeopardy for failing to timely and properly prosecute a Respondent Physician. **9**

In spite of the schedule constraints enumerated above, the Department has efficiently managed its medical prosecutions caseload. The auditors have even found in their sample of cases that a case in prosecutions took an average of 258 days, which is less than one year. Even more telling is that the State of Illinois Department of Financial and Professional Regulation has risen from 46 to 18 in ranking for the nation in number of disciplinary actions taken against Physicians as determined by the independent watch-dog group *Public Citizen*. Also, according the Federation of State Medical Boards of the United States, the total number of actions taken against Physicians in 2000 was 110 and in 2005 the total number of actions taken against Physicians rose to 281 disciplines. **1**

Auditor Comment 9: Auditors recognize that there are elements related to the timeliness of prosecutions which are outside of the Department's control. However, having management controls to encourage timeliness and to ensure proper documentation is essential. Case examples show that there were cases with long periods with no documented activity. The Department asserts that the Medical Prosecutions staff has not placed the People of the State of Illinois in jeopardy for failing to timely and properly prosecute a Respondent Physician. However, long periods of time with no documented activity and no documented reason for that inactivity do create the risk that people of the State of Illinois could be in jeopardy from an incompetent physician who continues to practice.

Also see Auditor Comment 1 about Illinois' rank.

RECOMMENDATION 12
PROBATION MONITORING AND DOCUMENTATION

The Department of Financial and Professional Regulation should devote sufficient resources to ensure that physicians' compliance with terms of disciplinary orders are adequately monitored, including that physicians who have had their licenses suspended or revoked are not practicing. Furthermore, the Department should ensure that probation files contain all required documentation and that staff follow-up when required documentation is not required.

DFPR Response:

The Probation Unit monitors all of the professions regulated by the Department. Due to increased enforcement activity in all of the professions that the Department regulates the Department has contracted with a Third Party Administrator to facilitate the scheduling, collection and testing of urine samples for drug and alcohol testing. This program is fully funded by the probationers that are being tested. Once this program is fully functional, employees in the Probation Unit will have more time to dedicate to scheduling, monitoring and overseeing other probationary responsibilities.

RECOMMENDATION 13
INITIAL INTERVIEWS AND SUPERVISORY REVIEW

The Department of Financial and Professional Regulation should take actions to ensure that initial interviews are conducted within 30 days and adequately documented and that files receive appropriate supervisory review.

DFPR Response:

The Department will take appropriate steps to update our policies and procedures.

RECOMMENDATION 14
ADMINISTRATIVE RULES

The Department of Financial and Professional Regulation should make its Administrative Rules (68 Ill Adm Code 1285.225) relating to the definition of disciplinary and non-disciplinary actions consistent with requirements of the Medical Practice Act (225 ILCS 60/2 (4)).

DFPR Response:

Though the Medical Practice Act and its Administrative Rules differ on reportable disciplinary actions and non-disciplinary actions, the Department has been consistent in reporting its monthly disciplinary actions per the Administrative Rules. The Department would look forward to working with the General Assembly to develop the Administrative Rules relating to the definition of disciplinary and non-disciplinary actions so they are consistent with the requirements of the Medical Practice Act.

RECOMMENDATION 15
REPORTING TO THE PUBLIC

The Department of Financial and Professional Regulation should ensure that the public is fully informed of Department disciplinary actions on a timely, accurate, and consistent basis.

DFPR Response:

The Department issues monthly disciplinary reports with brief descriptions of actions taken by the Medical Unit and all other professions licensed by the Division of Professional Regulation. In addition to providing the report on-line, it is sent directly to persons who request to be added to the monthly subscription at no cost. Finally, due to improvements in the records unit, electronic copies of the public case file can be provided to anyone seeking additional information about a case.

As reflected in the Auditor General's notes, the Department was successful in getting the Civil Administrative Code, 20 ILCS 2105-205, amended to reflect the current practice. The Department is continuing to push for changes to the Medical Practice Act to reflect this requirement. Additionally, the Department is pursuing additional levels of review to ensure that public reporting procedures are accurate.

RECOMMENDATION 16
SUMMARY REPORTS

The Department of Financial and Professional Regulation should send required summary reports of final actions taken upon disciplinary files to every licensed health care facility, medical association, and liability insurers as required by the Medical Practice Act of 1987.

DFPR Response:

The Department provides a monthly disciplinary report of final actions taken upon disciplinary files which is available either upon request or online at the Department's website. Current law mandates that the report be sent to every licensed health care facility, medical association and insurer as required by law. However, the current law was written and adopted decades before the availability of current technological advances the Department utilizes such as the World Wide Web and/or email. Therefore, the Department acknowledges that we are out of "technical compliance" with this provision of the law; however, we are in compliance with the *intent* of the law, which is to make disciplinary information available to the public and health care employers.

The Department, in conjunction with the Illinois Medical Society, has sought and will continue to seek an amendment to legislation (SB 2608) that will abolish the requirement that summary reports be mailed to every licensed health care facility, medical association and insurer. The new law will instead require the Department to post the summary reports on its website for immediate viewing. The Department, while awaiting the outcome of the new legislation, will continue to post the monthly disciplinary reports on its website and will also send the link via email directing its intended receivers to the monthly report. With the passing of the new legislation, the Department will administer the newly enacted requirements for posting the monthly disciplinary report.

RECOMMENDATION 17
IMPLEMENTING PUBLIC ACT 94-677

The Department of Financial and Professional Regulation should continue to work to comply with amendments to the Medical Practice Act made by Public Act 94-677, including promulgating rules to accomplish these requirements.

DFPR Response:

The Medical Malpractice Reform Bill (PA 94-677) was signed by the Governor on August 25, 2005. The Department has taken significant and appropriate steps to comply with all provisions of the new legislation. The Department worked with the Administration and key sponsors of the bill to ensure that it included provisions sought by the Department, including a lengthening of the statute of limitations and additional authority to expand its investigative authority. As a result, the Department has acted quickly to begin implementing the amendments to the Medical Practice Act and will continue to do so.

RECOMMENDATION 18
PHYSICIAN PROFILE

The Department of Financial and Professional Regulation should continue to work to make available to the public, through the Internet, and, if requested, in writing, a profile of each physician licensed by the Department as required by Public Act 94-677.

DFPR Response:

The Department maintains an internet website through which the public can learn the licensure status of a physician licensed in Illinois. In fact, the data is deemed so accurate it can be used, by law, to prove a licensee's status for purposes of employment. The website also allows the general public to view press releases, alerts, disciplinary actions and licensing requirements. The Department has been responsive in taking advantage of new technologies as required so that the citizens of Illinois have information they need as quickly as possible through such vehicles as the Department's website.

The Medical Malpractice Act (PA 94-677) was signed by the Governor on August 25, 2005, requiring the posting of physicians' profiles on the Department's website. The Department has found that stock software available on the market would not provide the capacity and flexibility needed to post profiles as required by law, and has begun to develop the program required to fulfill the statute's requirements. With this new technology and information, the Department will be an exceptional resource for the citizens of Illinois as well as the larger public.

RECOMMENDATION 19
MEDICAL DISCIPLINARY BOARD MEMBERS

The Department of Financial and Professional Regulation should work to assure that all members, including public members, are appointed to the Medical Disciplinary Board as required by the Medical Practice Act.

DFPR Response:

The Department will work to assure that any vacant position on the Medical Disciplinary Board, including those for public members, is filled as allowed by the determinants of the selection and appointment process. Any state advisory board member is typically selected for his or her contributions and professional expertise in a chosen field as well as other achievements. The process of nomination, selection and appointment for any state advisory board is rigorous. Though many are considered, only a few can be selected for their outstanding qualifications to serve.

RECOMMENDATION 20
DOCUMENTATION

The Department of Financial and Professional Regulation should sufficiently document its decisions and activities. The Department should also ensure that the replacement system for the Regulatory and Enforcement System has the capability to help management better control the adequacy of the Enforcement process.

DFPR Response:

The Department is in the process of upgrading its computer system from RAES (Regulatory and Enforcement System) to ILES (Illinois Licensing and Enforcement System). Because ILES software expands RAES' capacity to monitor adequacy and performance of enforcement processes, the Department will be able to develop even better management controls. The program contains a database, word processing and case document retaining system which allows the Department to automatically document and track files and cases for all of its professions.

Because of the sensitive nature of the medical documents and cases, the Department's IT unit will continue to develop the ILES program for implementation and transference of the professions under the Medical Practice Act in stages. Already being developed for future implementation are check lists for investigators and prosecutors, automated alert systems for management, and other tracking aids. It is expected that the ILES system will be fully implemented by the end of 2006.

RECOMMENDATION 21
SECONDARY EMPLOYMENT

The Department of Financial and Professional Regulation should closely monitor employees engaging in secondary employment by reviewing and approving request on an annual basis.

DFPR Response:

The Department has developed an agency-wide policy for secondary employment. The agency-wide policy supersedes that of the Enforcement Manual, which is currently under review, and applies to all Department employees, not just those in Enforcement. The Department will revise its Enforcement Manual to correctly reflect the Department's agency-wide policy on secondary employment. **10**

Auditor Comment 10: No Departmental policies on secondary employment other than those included in the Enforcement Manual were provided to the auditors during the course of the audit.

RECOMMENDATION 22
TRAINING

The Department of Financial and Professional Regulation should establish appropriate training programs for medical investigators as directed in its own policies and procedures.

DFPR Response:

The Department has developed a series of training opportunities for its investigative staff and will continue to work with local, state and federal authorities to expand opportunities for its investigators to improve their skills. Plans are being developed to offer Department investigators recurring training opportunities including seminars by the Secretary of State on Identity Theft, training specifically related to the new ILES system, sexual harassment training, policy and personnel rules review, Sheriff's Association Law Enforcement Training Board and DEA training seminars. Controlled Substance Inspectors received armed weapons training which included two scheduled qualifications for the year. With the passage of the Ethics Reform bill employees were mandated to complete ethics training and successfully pass a computer based ethics test.

The Department, through its Training Coordinator, will continue to develop and arrange for training for the medical investigators.

RECOMMENDATION 23
CONFLICTS OF INTEREST

The Department of Financial and Professional Regulation should require its employees to disclose potential conflicts of interest as required by its Enforcement Manual.

DFPR Response:

The Department has a stringent agency wide policy with regards to conflicts of interest which applies to all employees as well as Board members. Though this policy differs slightly from the policy as written in the Enforcement Manual, it will supersede that of the Enforcement Manual. The Department will revise its Enforcement Manual to correctly reflect the Department's policy on conflict(s) of interest. The Department is developing future agency wide trainings to address current and any new policies and procedures related to conflict(s) of interest. **11**

In addition to the Department's written policy, each employee and Board member is required to report any potential conflict(s) of interest on his or her Statement of Economic Interest. This form is completed, returned and filed with the Illinois Secretary of State's Office. In addition, under the Governor's Ethics Reform Legislation, each employee is required to complete and successfully pass a computer based ethics training course. Within the ethics training course, conflict(s) of interest are addressed again with directives to report any such conflict(s) of interest to the state agency's Ethics Officer.

Auditor Comment 11: No Departmental policies on conflict of interest other than those included in the Enforcement Manual were provided to the auditors during the course of the audit.

RECOMMENDATION 24
TIMESHEETS

The Department of Financial and Professional Regulation should require employees, including medical investigators, to prepare timesheets as required by the State Officials and Employees Ethics Act. Timesheets should also help management to more closely monitor medical investigators' time.

DFPR Response:

In January of this year, the Department implemented an additional timekeeping system for approximately 200 of its Merit Compensation Employees. This electronic system requires employees to input the time they spend on state business to the nearest quarter hour, and contains controls to ensure that submission of the timesheet each week results in the employees, in effect, certifying their timesheet. This Department policy was communicated via e-mails and training sessions.

The Department plans to begin negotiations with the union to expand this timekeeping system to all union employees, including investigators and attorneys, later this year. Once this is completed, a formal, written policy will be introduced. We will then revise the Enforcement Manual to reflect these changes.