STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PROGRAM AUDIT

PHYSICIANS REGULATED UNDER THE MEDICAL PRACTICE ACT

DEPARTMENT OF
PROFESSIONAL REGULATION

MAY 1997

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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 Physicians Regulated under the Medical Practice Act at the Department of Professional Regulation.

The audit was conducted pursuant to Legislative Audit Commission Resolution Number 107, which was adopted February 5, 1996. 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
May 1997

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REPORT DIGEST

ILLINOIS DEPARTMENT OF PROFESSIONAL REGULATION

PROGRAM AUDIT: PHYSICIANS REGULATED UNDER THE MEDICAL PRACTICE ACT

Release Date:

May 1997

State of Illinois
Office of the Auditor General

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SYNOPSIS

Legislative Audit Commission Resolution 107 directed the Auditor General to conduct a program audit of the Department of Professional Regulation's effectiveness in investigating complaints against physicians licensed under the Medical Practice Act of 1987, including the timeliness and adequacy of investigations and procedures for recommending and monitoring disciplinary actions.

In our review of cases from Fiscal Years 1995 and 1996, we found instances in which the Department lacked adequate management controls in its investigatory, disciplinary, and probationary processes. With regard to timeliness we found:

- Investigations were completed within the Department's 90-day time limit in only 14% of cases;
- 23% of cases in Investigations and 28% of cases in Prosecutions experienced delays of 3 months with no substantive activity;
- Cases which resulted in some type of discipline against the physician took an average of two years to complete.

In the area of investigatory adequacy, we found that the Medical Investigation Unit did not have guidelines on how an investigation should be conducted or what evidence should be included in case files. Additionally, the Department did not have a basic training program for its medical investigators.

We reviewed cases closed in Fiscal Years 1995 and 1996 to evaluate procedures for recommending disciplinary actions. We questioned the adequacy of 35% of closed cases in our sample, including:

- 17% closed without investigation;
- 13% in which investigations appeared inadequate;
- 4% in which disciplinary action taken appeared questionable; and
- two cases for which case files were missing.

We also found that almost 36% of probation cases included in our review were inadequately monitored. In addition, the Department does not monitor physicians whose licenses are placed on long-term suspension or revoked.

Our review of closed cases included 135 reports to the Department by professional liability insurers as a result of medical malpractice settlements. These settlements totaled more than $38 million. None of the physicians involved in these reports was disciplined.

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

REPORT CONCLUSIONS

The Department of Professional Regulation (Department) is responsible for reviewing complaints and issuing disciplines against physicians licensed under the Medical Practice Act, including medical doctors, osteopathic doctors, and chiropractors. In Fiscal Years 1995 and 1996 combined, the Department received a total of 3,661 complaints and disciplined 236 physicians.

We found that the Department lacked adequate management controls in its investigatory, disciplinary, and probationary processes. For instance, there were inadequate controls to ensure that cases are investigated, reviewed by the Medical Coordinator, and prosecuted in a timely manner. Only 14 percent of cases opened in Fiscal Years 1995 and 1996 (159 of 1,125) had investigations completed within the Department's 90-day time limit. To further test procedural timeliness, we reviewed sample cases to identify three-month periods during which no substantive activity on the complaint took place. We found time lapses at the Medical Investigations Unit in 23 percent of opened cases (81 of 348) and lapses at the Medical Coordinator in 12 percent of opened cases (43 of 348). In our testing of closed cases we found 28 percent (20 of 72) of cases in the Prosecutions Unit had three-month periods during which there was no substantive activity on the complaint.

Overall, from our sample of closed cases, the Department took an average of about ten months to close cases during Fiscal Years 1995 and 1996. However, cases which resulted in some type of discipline took an average of two years to complete. Failure to act in a prompt and thorough manner may increase the risk that a physician who has violated the Medical Practice Act will not be detected and disciplined. We recommended that the Department

adopt and enforce standards to ensure timely resolution of complaints.

The Medical Investigation Unit did not have guidelines on how an investigation should be conducted or what evidence should be included in case files. Additionally, the Department did not have a basic training program for its medical investigators. We recommended that the Department ensure that all cases are adequately investigated and supported by necessary documentation. We further recommended that the Department develop a training policy for its medical investigators.

We reviewed cases closed in Fiscal Years 1995 and 1996 to evaluate the adequacy of disciplinary actions. We found the Department has few written policies and procedures to ensure similar violations receive similar discipline. We questioned the adequacy of 35 percent (122 of 347) of the closed cases in our sample. Concerns included: cases closed without any investigation (59); inadequate investigations (46); questionable disciplinary actions (15); and missing case files (2). We recommended the Department and Medical Disciplinary Board develop criteria to help ensure their decisions in disciplinary actions are consistent.

Our review of closed cases included 135 reports to the Department by professional liability insurers as a result of medical malpractice settlements. These settlements totaled more than $38 million, including 22 settlements of at least $500,000 each. The Medical Disciplinary Board closed 76 of these 135 cases without investigating the allegation. None of the physicians involved in the 135 reports was disciplined.

Of the 236 physicians who were disciplined by the Department during Fiscal Years 1995 and 1996, we determined that 67 percent of cases (157 of 236) should not have required much investigative effort by the Department and should have been easy to prove. The two most common reasons for discipline were

physicians who had been disciplined in another state and physicians who failed to renew their licenses on time.

Discipline may include a probationary period during which the doctor must comply with a stipulated condition, such as submit to drug tests, perform community service or attend continuing education classes. We found that almost 36 percent (19 of 53) of the probation cases that we reviewed were inadequately monitored. In addition, the Department does not monitor physicians who have had their licenses placed on long-term suspension or revoked. We also noted that Probation/Compliance investigators work from their homes and have State vehicles assigned to them even though their duties appear to be mainly performed in the office, by mail or over the telephone. We recommended that the Department develop controls to ensure that probation cases are properly monitored and establish procedures for operation of the Probation/ Compliance Unit.

BACKGROUND

On February 5, 1996, the Legislative Audit Commission adopted Resolution Number 107 directing the Auditor General to conduct a program audit of the Department of Professional Regulation's effectiveness in investigating complaints against physicians licensed under the Medical Practice Act of 1987. Resolution 107 specifically asked us to determine:

- The Department's timeliness in initiating, carrying out, and completing investigations;
- The adequacy of the Department's investigatory procedures, including the identification and gathering of appropriate evidence;
- The Department's procedures for determining the need for, and nature of, any recommended disciplinary actions; and
- The Department's process for ensuring that its recommended disciplinary actions are implemented and

that any specified corrective steps are instituted. (pp.1-3)

MEDICAL PRACTICE ACT OF 1987

The Medical Practice Act guides the licensing and regulation of physicians in Illinois.

The Medical Practice Act (225 ILCS 60/1 *et seq.*) guides the licensing and regulation of physicians in Illinois who are doctors of medicine, osteopaths, or chiropractors. The Act contains provisions which specify the requirements for obtaining a medical license in the State, as well as the disciplinary actions that may be taken against the license when warranted.

The Act also creates the Illinois State Medical Disciplinary Board to oversee physicians in the State. Membership consists of five medical doctors, one osteopath, one chiropractor, and two non-voting public members. The Act also requires that the Director select a Chief Medical Coordinator and a Deputy Medical Coordinator, both licensed physicians, to be the chief enforcement officers of the Act.

Digest Exhibit 1
DISCIPLINARY ACTIONS
Fiscal Year 1996

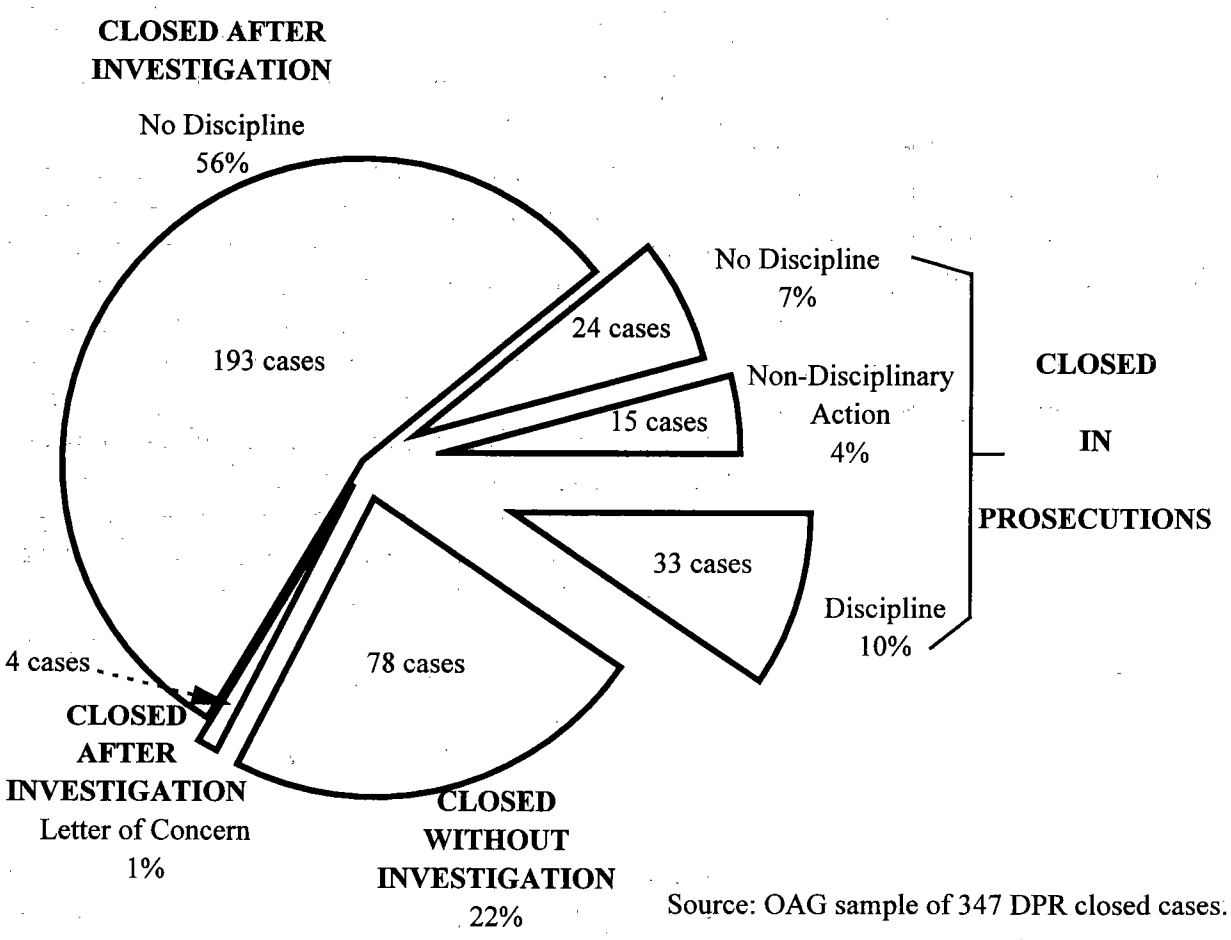
Revocation	15
Suspension	39
Probation	51
Fine	16
Reprimand	32
Total	153

Source: OAG analysis of DPR data.

In addition, the Act lists certain disciplinary actions that may be taken against the physician's license, including revocation, suspension, probation, and/or fine. It then lists the grounds for such actions. Among these are: dishonorable, unethical or unprofessional conduct likely to defraud or harm the public; gross negligence; disciplinary action in another state; overcharging or collecting fees for services not provided under the Public Aid Code; and immoral conduct related to the physician's practice. The Act contains a total of 40 separate grounds for disciplinary action (225 ILCS 60/22). Digest Exhibit 1 shows the total number of disciplinary actions by type taken against physicians in Fiscal Year 1996. These 153 actions were taken against 110 physicians. (pp. 3-4)

Digest Exhibit 2 shows graphically where cases were closed in our sample of 347 cases closed in Fiscal Years 1995 and 1996. The largest category of cases is the 193 cases that were closed after investigation with no disciplinary action. (pp. 28-29)

Digest Exhibit 2
WHERE CASES ARE CLOSED



Source: OAG sample of 347 DPR closed cases.

INVESTIGATIVE ADEQUACY

Only a small portion of the investigations we reviewed were inadequate.

Investigations are initiated when complaints are forwarded to the Chief of Medical Investigations from the Complaint Intake Unit. The Chief of Medical Investigations begins the investigation by forwarding the complaint case file to the Licensing Assistant for a background check on the physician. Background checks are done to ensure that a physician is licensed and to

determine if there were any prior complaints or disciplinary actions taken. Once background checks are completed, complaint case files are returned to the Chief of Medical Investigations. The Chief then assigns the case file to an Investigative Supervisor.

Although only a small portion of the investigations we reviewed were inadequate, improvements are still needed. We examined 348 cases which were opened during Fiscal Years 1995 and 1996 to determine whether the investigations of those cases were adequate. Of the 348 cases examined, we found 23 cases (7 percent) with inadequate investigations.

We recommended that the Department and the Medical Disciplinary Board develop criteria to determine when medical records are needed.

Digest Exhibit 3 shows that almost half (11 of 23) of the inadequate investigations were because relevant medical records were not obtained. We recommended that the Department and the Medical Disciplinary Board develop criteria to determine when medical records are needed. All 11 of these cases without medical records were mandatory reports, which are statutorily required reports received from various sources such as professional liability insurers. Unlike other complaints, mandatory reports are filed directly with the Medical Disciplinary Board. The Board then determines whether to close the case or to refer it for further investigation.

Digest Exhibit 3
REASONS FOR INADEQUATE INVESTIGATIONS
Sample of Cases Opened in FY95 and FY96

Medical Records Needed	11
Interviews Not Conducted	3
Existing Complaint Should Have Been Modified	2
Closed to Unrelated Complaints	2
Other Reasons	5
Total Inadequate	23

Source: Analysis of OAG investigation sample testing of 348 cases opened.

We also found that important interviews were not conducted in three cases. In two other cases Department records indicated that the existing complaint could not be

modified. In these cases, a new complaint was received after a formal complaint had already been filed against the physician. Instead of adding an additional count to that complaint or pursuing these allegations separately, the new complaint was closed. Two other cases were closed to unrelated complaints. These cases were combined into existing cases which were unrelated. For example, a case of non-therapeutic prescribing of drugs was combined into a case which alleged that a physician performed unnecessary surgeries.

The Medical Investigation Unit did not have guidelines on how an investigation should be conducted or what evidence should be included in case files. Additionally, the Department did not have a basic training program for its medical investigators. We recommended that the Department ensure that all cases are adequately investigated and supported by necessary documentation. We further recommended that the Department develop a training policy for its medical investigators. (pp. 9-16)

TIMELINESS

The Department lacked adequate standards and management controls to ensure that cases are investigated, reviewed by the Medical Coordinator, and prosecuted in a timely manner. In Medical Investigations, our testing showed no compelling reasons which would explain why the investigative process could not be completed in a timely manner. Investigator caseloads average 29 cases, which appears reasonable. Only 14 percent of cases opened in Fiscal Years 1995 and 1996 (159 of 1,125) had investigations completed within the Department's 90-day time limit. At the Medical Coordinator, for cases with completed investigations that had been forwarded for review and recommendation, we also identified timeliness problems. In Prosecutions, the Department has no standards for timeliness in initiating and completing the prosecutorial process. When a case resulted in disciplinary action, an average of 762 days elapsed from the date the complaint was received until a disciplinary order was signed. Overall, from our sample of closed cases, the Department took an average of about ten months to close cases during Fiscal Years 1995 and 1996.

The Department took an average of about ten months to close cases during Fiscal Years 1995 and 1996.

Three Months of Inactivity

Of the 348 cases we examined in our sample, we found 81 cases (23 percent) had at least one period of three months during which no substantive investigative activity took place. Of these 81 cases, 24 had more than one period of three months with no activity. In total, there were 113 three-month periods with no documented activity.

The Department also had serious problems in timeliness with cases awaiting review by the Medical Coordinator. Following completion of the investigation, cases are forwarded to the Medical Coordinator for review and recommendation. In our sample of cases, 12 percent (43 of 348) had at least one period of three months during which no activity by the Medical Coordinator was documented. A Report of Aged Cases produced by the Department's computerized case tracking system in November 1996 showed that there were 358 cases that had been assigned to the Medical Coordinator for 121 days or longer.

We recommended that the Department adopt and enforce standards to ensure timely resolution of complaints.

We also examined the cases referred to the Prosecutions Unit to identify lapses of three months during which no substantive activity took place. Of the 72 cases in our sample of cases closed that were referred to the Prosecutions Unit, 20 (28 percent) had at least one such lapse. Two cases each had ten three-month lapses with no substantive activity performed.

Physicians against whom complaints have been filed generally continue practicing medicine while the Department investigates and prosecutes the case. Lack of timeliness in bringing a case to conclusion could result in delayed discipline and unnecessary risk to the public. We recommended that the Department adopt and enforce standards to ensure timely resolution of complaints. (pp. 17-23)

ADEQUACY OF DISCIPLINARY ACTION

We noted several areas of concern regarding the adequacy of disciplinary actions in our review of 347 cases closed during Fiscal Years 1995 and 1996. We found 105 cases which were closed without investigation or had

inadequate investigations and 15 cases in which we questioned the disciplinary action taken. In addition, there were two case files which the Department could not locate.

The adequacy of disciplinary actions taken could not be ascertained for 30 percent of the closed cases we reviewed.

The adequacy of disciplinary actions taken could not be ascertained for 105 of 347 (30 percent) of the closed cases we reviewed, either because the case was closed without any investigation (59) or because the investigation was inadequate (46). Mandatory reports accounted for all of the cases closed without an investigation.

Of the 240 closed cases in which an investigation was conducted and the investigation was adequate, we found 15 cases (6 percent) in which we questioned the disciplinary action taken by the Department:

- 8 cases had no disciplinary actions when discipline appeared to be warranted,
- 6 cases did not appear to receive severe enough disciplinary actions, and
- 1 case appeared to receive a disciplinary action which was too severe.

We recommended that the Department and the Medical Disciplinary Board develop criteria to help ensure consistency in disciplinary actions.

There are few written criteria which help the Prosecutions Unit or the Medical Disciplinary Board determine the need for and the nature of any disciplinary action levied against physicians. We recommended that the Department and the Medical Disciplinary Board develop criteria to help ensure consistency in disciplinary actions. The Department believes that it would be difficult to develop criteria for determining the need for and type of disciplinary action warranted because each case is unique. The Medical Disciplinary Board makes suggestions for disciplinary action based upon similar cases and previous offenses, also taking into account the accused physician's remorsefulness, remediation, and ability to pay.

The Medical Disciplinary Board is a control agent and has some guidelines, but those guidelines cover only a small portion of the provisions of the Medical Practice Act. As a board composed of external individuals, it should be an objective mechanism to assure that discipline is appropriate. The Board has established a schedule of fines for physicians who let their licenses lapse. Although this schedule is

appropriate, there are many other potentially serious violations for which there is no guidance.

Mandatory Reports

When a professional liability insurer settles a claim of alleged negligence against a physician or a hospital revokes a doctor's privileges, a report is required to be made to the Medical Disciplinary Board. Other entities having knowledge of a physician's conduct are similarly required to file reports with the Board. These mandatory reports represent a large percentage of the total complaints against physicians received by the Department each year. In our sample of 347 closed cases, 145 or 42 percent were mandatory reports.

Overall, we determined the Department's handling of 64 percent of mandatory reports (93 of 145) was inadequate. We found that 59 mandatory reports were closed without investigation, 28 had inadequate investigations, 4 had questionable disciplinary actions, and 2 had case files which the Department could not locate.

Digest Exhibit 4
SETTLEMENT AMOUNTS BY PHYSICIANS

Range	Number
Less than $100,000	55
$100,000 - $499,000	58
$500,000 - $999,000	13
$1,000,000 and greater	9
Total number of settlements	135

Source: OAG sample of 347 DPR closed cases.

Of the 145 mandatory reports contained in our sample of closed cases, 135 were reports from professional liability insurers paying settlements on behalf of physicians who had been accused of negligence or some other misconduct. Digest Exhibit 4 shows the breakdown of the 135 settlement amounts paid by physicians' professional liability insurers. The Department took no disciplinary action in any of these 135 cases. (pp. 25-34)

The Department took no disciplinary action in any of the 135 cases with reports from professional liability insurers in our sample.

Types of Violations Resulting in Discipline

We determined that 67 percent of the physicians disciplined during Fiscal Years 1995 and 1996 were disciplined by the Department for reasons which would not require much investigative activity and would be easy to prove. The most common reason, accounting for 56 of the 157 doctors disciplined by the Department in those years, was a violation of a sister-state law by a physician also licensed in Illinois. Fourteen of the 20 physicians whose licenses were revoked during Fiscal 1995 or 1996 were disciplined for reasons that we considered easy to prove. (pp. 34-35)

PROBATION MONITORING

The Probation/ Compliance Unit monitors physicians who have been disciplined by the Department. In Fiscal Year 1995, the Probation/ Compliance Unit received 53 medical cases to monitor. In almost 36 percent (19 of 53) of cases that we reviewed, appropriate action had not been taken when disciplined physicians had not fulfilled the requirements of their probation. In addition, the Department does not monitor physicians who have had their licenses revoked or placed on long-term suspension. We also noted that Probation/Compliance investigators work from their homes and have State vehicles assigned to them even though their duties appear to be mainly performed in the office, by mail or over the telephone. We recommended that the Department develop controls to ensure that probation cases are properly monitored and establish procedures for operation of the Probation/ Compliance Unit. (pp. 37-41)

OTHER ISSUES

Since the Department of Professional Regulation's Enforcement Case Tracking System is being replaced, Department officials should ensure that the new system has the capability of assisting management in its efforts to control the adequacy and timeliness of various elements of the enforcement process.

Weaknesses in management controls over the evidence room were identified by management during the

course of audit work. The evidence room contains prescription drugs, guns, and money that have been confiscated in investigations of medical cases or cases relating to other professions. During our audit, Department officials noted significant potential problems in this area and took actions to account for items in the evidence room.

The Department of Professional Regulation has not established a policy that requires employees to remove themselves from a case if they have a conflict of interest. (pp. 43-47)

AGENCY RECOMMENDATIONS

The audit report contains 16 recommendations to the Department of Professional Regulation. The Department did not concur with 8 of the recommendations and concurred or concurred in part with the remaining 8 recommendations. The Department provided responses to the recommendations as well as other comments on the report. The Department requested that a short response be included after each recommendation with a reference to the Department's complete written response which is included as Appendix F of the audit report.

WILLIAM G. HOLLAND
Auditor General

WGH:EKW

May 1997

TABLE OF CONTENTS

CHAPTER SIX: OTHER ISSUES

APPENDICES

EXHIBITS

INTRODUCTION AND BACKGROUND

Chapter One

REPORT CONCLUSIONS

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Of the 236 physicians who were disciplined by the Department during Fiscal Years 1995 and 1996, we determined that 67 percent of cases (157 of 236) should not have required much investigative effort by the Department and should have been easy to prove. The two most common reasons for discipline were physicians who had been disciplined in another state and physicians who failed to renew their licenses on time.

Discipline may include a probationary period during which the doctor must comply with a stipulated condition, such as submit to drug tests, perform community service or attend continuing education classes. We found that almost 36 percent (19 of 53) of the probation cases that we reviewed were inadequately monitored. In addition, the Department does not monitor physicians who have had their licenses placed on long-term suspension or revoked. We also noted that Probation/Compliance investigators work from their homes and have State vehicles assigned to them even though their duties appear to be mainly performed in the office, by mail or over the telephone. We recommended that the Department develop controls to ensure that probation cases are properly monitored and establish procedures for operation of the Probation/Compliance Unit.

BACKGROUND

On February 5, 1996, the Legislative Audit Commission adopted Resolution Number 107 directing the Auditor General to conduct a program audit of the Department of Professional Regulation's effectiveness in investigating complaints against physicians licensed under the Medical Practice Act of 1987. Resolution 107 (see Appendix A) specifically asked us to determine:

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MEDICAL PRACTICE ACT OF 1987

The Medical Practice Act (225 ILCS 60/1 *et seq.*) guides the licensing and regulation of physicians in Illinois who are doctors of medicine, osteopaths, or chiropractors. The Act contains provisions which specify the requirements for obtaining a medical license in the State, as well as the disciplinary actions that may be taken against the license when warranted.

The Act also creates the Illinois State Medical Disciplinary Board to oversee physicians in the State. Membership consists of five medical doctors, one osteopath, one chiropractor, and two non-voting public members. The Act also requires that the Director select a Chief Medical Coordinator and a Deputy Medical Coordinator, both licensed physicians, to be the chief enforcement officers of the Act.

Exhibit 1-1
DISCIPLINARY ACTIONS
Fiscal Year 1996

Revocation	15
Suspension	39
Probation	51
Fine	16
Reprimand	32
Total	153

Source: OAG analysis of DPR data.

In addition, the Act lists certain disciplinary actions that may be taken against the physician's license, including revocation, suspension, probation, and/or fine. It then lists the grounds for such actions. Among these are: dishonorable, unethical or unprofessional conduct likely to defraud or harm the public; gross negligence; disciplinary action in another state; overcharging or collecting fees for services not provided under the Public Aid Code; and immoral conduct related to the physician's practice. The Act contains a total of 40 separate grounds for disciplinary action. A complete listing of these grounds is included as Appendix C. Exhibit 1-1 shows the total number of disciplinary actions by type taken against physicians in Fiscal Year 1996. These 153 actions were taken against 110 physicians.

The Act provides that citizens, physicians, or various medical associations and societies may report a possible violation of the 40 grounds listed in Appendix C to the Medical Disciplinary Board. Exhibit 1-2 summarizes total complaints received (including mandatory reports), mandatory reports, and disciplines given from Fiscal Years 1991 through 1996. Mandatory reports are required by the Act from various entities that submit reports on physicians' professional conduct and capacity. The entities which are required to report are health care institutions, professional associations, professional liability insurers, State's Attorneys, and State agencies.

Exhibit 1-2
COMPLAINTS AND DISCIPLINES
Fiscal Years 1991 through 1996

Year	Disciplines	Mandatory Reports *	Total Complaints
1991	161	675	1,393
1992	155	818	1,449
1993	143	880	1,614
1994	114	856	1,691
1995	193	702	1,712
1996	153	645	1,949

* Mandatory Reports are included in Total Complaints

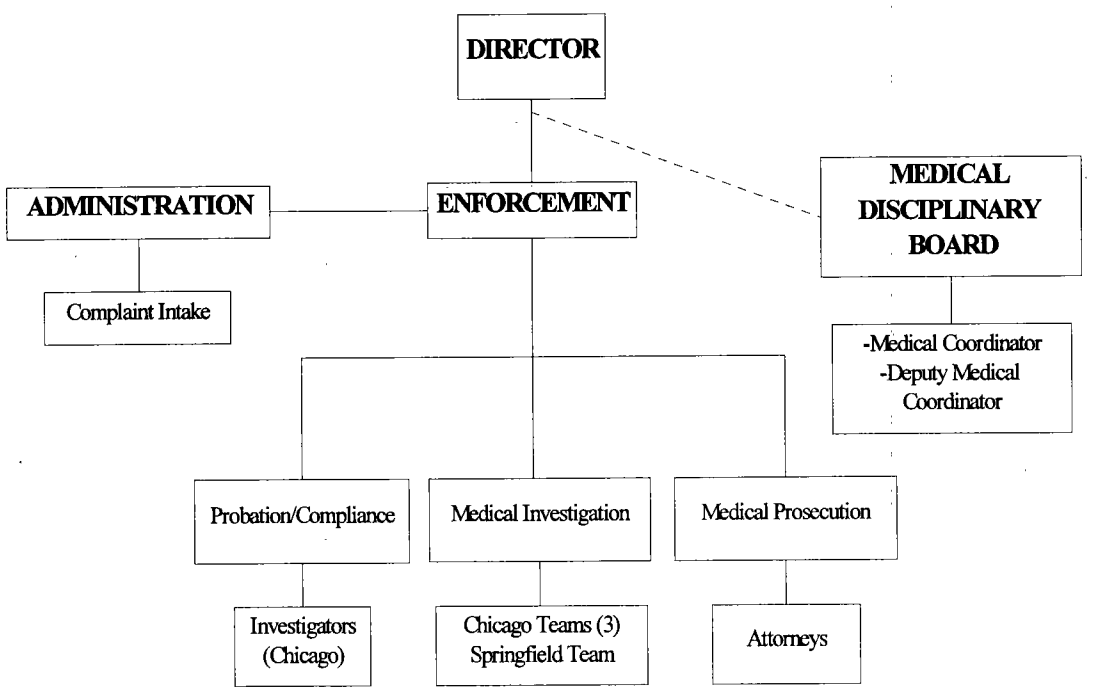
Source: DPR data summarized by OAG.

ORGANIZATION

Within the Department, responsibility for enforcing the 44 separate legislative acts governing various professions, including physicians, rests with the Division of Statewide Enforcement. Enforcement teams are organized under functions such as nursing, medical, design professions, or pharmacy. The Division is based in Chicago, with medical, nursing, and general investigations having offices in Springfield as well. During Calendar Year 1996, the Department received 15,331 complaints for all professions. Medical complaints accounted for less than 13 percent of total complaints (1,981 of 15,331).

Responsibility within the Division is further divided into Investigations, Prosecutions, and Probation/Compliance. For medical enforcement, an organization chart is shown in Exhibit 1-3. The Complaint Intake Unit, as shown in the Exhibit, is under the Administration Division. Citizen complaints for all professions are received by this unit, either by mail, telephone, or in person. The personnel enter the complaint into the Department's computerized tracking system, the Enforcement Case Tracking System (ECTS), then forward the complaint to the appropriate investigative unit, such as Medical Investigations.

Exhibit 1-3
ORGANIZATION CHART FOR MEDICAL ENFORCEMENT



Source: OAG analysis of the Medical Practice Act and DPR information.

The Medical Investigations Unit consists of four teams of investigators, each with a supervisor, and the Chief of Medical Investigations. There are three teams located in Chicago and one in Springfield. As the name implies, this Unit investigates the complaints received and determines whether the evidence indicates a potential violation of the Medical Practice Act and/or Department regulations. If there is not enough evidence to indicate a violation, the investigative case is normally closed. The Medical Investigations Unit is discussed in detail in Chapter Two. After investigation, the case will be reviewed by the Medical Coordinator who will make a recommendation to the Medical Disciplinary Board (Board) whether the case should be closed or prosecuted.

If there is sufficient evidence to indicate a violation, the Board refers the case to the Prosecutions Unit, where it is assigned to one of the staff attorneys. The attorneys then are to begin disciplinary proceedings. These proceedings may be an informal conference—which gives the parties an opportunity to settle the case by agreeing on the discipline—or a formal hearing, which is an administrative trial. Chapter Four examines the prosecutions process in further detail.

If discipline is imposed, it can take several forms. If the discipline is a probation that includes some conditions, the Probation/Compliance Unit monitors to ensure that the physician meets these requirements. These terms could include continuing education, drug screening, or practicing under the supervision of an approved physician. Once the physician has completed

the terms of his or her probation, the license is considered in good standing. For a complete discussion of the Probation/Compliance Unit, see Chapter Five.

When a case is ready to be closed or disciplined, the Medical Disciplinary Board should approves that closure or discipline. The Director of the Department has final approval on any discipline approved by the Board.

FUNDING

The Department's costs in regulating physicians are paid from the Medical Disciplinary Fund. This Fund receives moneys for physician license fees, as well as fines collected from individuals licensed under the Medical Practice Act. The fee to establish a license to practice medicine is $300, with a renewal fee of $100 per year with licenses being renewed every three years. Renewals are set so that all physician licenses are renewed at the same time. This explains the variation in receipts to the Fund, as shown in Exhibit 1-4. As shown in the Exhibit, both appropriations and expenditures from the fund are fairly constant but receipts vary significantly.

Exhibit 1-4
MEDICAL DISCIPLINARY FUND RECEIPTS, APPROPRIATIONS, AND EXPENDITURES
Fiscal Years 1991 to 1996 - in millions

Fiscal Year:	Receipts	Appropriations	Expenditures
1991	$5.6	$4.8	$4.4
1992	$1.2	$4.9	$4.6
1993	$3.6	$4.8	$4.5
1994	$8.3	$5.1	$4.9
1995	$1.3	$5.0	$4.6
1996	$2.8	$4.9	$4.7
5 years	$23.0*	$29.4*	$27.6*

* totals do not add due to rounding

Source: OAG financial and compliance audits and Comptroller information.

Beginning in Fiscal Year 1997, the Department was required to change how it allocates expenses to the Medical Disciplinary Fund and other dedicated funds for all professions it oversees. Public Act 89-204 requires the Department to determine the direct costs and indirect costs of each profession to prevent the Department from using excesses in one fund to cover shortfalls in another.

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.

We obtained and reviewed information from the Department from Fiscal Year 1990 through December 1996. Further, in our examination of the Department's computer system

called the Enforcement Case Tracking System, we obtained downloaded data from the system containing all cases which had activity from 1992 to August 1996. Several changes in personnel and policy have occurred in the last two years. Therefore, the bulk of our analysis was limited to Fiscal Years 1995 through 1996 to reflect changes made by the Department during this time period.

In conducting the audit, we reviewed the statutes and administrative rules governing the regulation of physicians in Illinois. We also examined the policies and procedures put in place by the Department of Professional Regulation. We interviewed responsible officials at the Department over all aspects of the disciplinary process for physicians, including receiving and investigating complaints, holding conferences/hearings with the physician involved, and monitoring disciplinary actions taken.

To identify standards for investigations, we contacted the Departments of State Police and Public Aid, the Illinois Office of the Attorney General, the Attorney Registration and Disciplinary Commission, Western Illinois University law enforcement program, the Federal Bureau of Investigation, the federal Department of Health and Human Services, the National Institutes of Justice, Health, and Law Enforcement, and the Los Angeles Police Department Training Center.

We also sent letters to the Illinois Chiropractic Society, the Illinois State Medical Society, and the Illinois Association of Osteopathic Physicians and Surgeons. As a result of our letters we were contacted by and met with the Illinois State Medical Society. In addition, we had contact with citizen groups including Families Advocating Injury Reduction (FAIR) and Public Citizen, and a medical malpractice insurer in Illinois.

Further, we surveyed other states with similar numbers of physicians and/or geographical proximity to Illinois to determine their practices and procedures for investigating complaints and disciplining physicians and reviewed the statutes of other states for provisions similar to the Medical Practice Act. States responding to the survey included California, Indiana, Kentucky, Massachusetts, Michigan, New Jersey, New York, Pennsylvania, and Texas. A detailed summary of the survey results is found in Appendix D.

We reviewed information provided by the Department, including policy and procedure manuals, internal audit reports, management reports generated by the computer case tracking system (ECTS) and information contained in the case files. Additionally, we selected two samples totaling 695 cases and examined the case files to obtain information about the complaint, the physician, the investigation, and the final disposition of the case. For a more detailed explanation of the methodology for selecting the two samples see Appendix B. We also reviewed available minutes of the Medical Disciplinary Board from Fiscal Years 1991 through 1995.

The previous three financial and compliance audits of the Department released by the Office of the Auditor General were reviewed to identify any issues related to complaints against physicians, including case tracking, compliance monitoring, and investigation timeliness.

We reviewed management controls relating to the four audit objectives which were identified in Audit Resolution Number 107 (see Appendix A). Our review and reviews done as part of OAG compliance audits showed some weaknesses in the controls. Those weaknesses in controls are included as findings in this report.

REPORT ORGANIZATION

The report is organized into six chapters. Included in the remaining chapters are case examples which illustrate issues or problems identified in our testing. The following chapters are:

CHAPTER TWO	-	***ADEQUACY OF INVESTIGATIONS***
CHAPTER THREE	-	***TIMELINESS OF THE PROCESS***
CHAPTER FOUR	-	***ADEQUACY OF DISCIPLINARY ACTIONS***
CHAPTER FIVE	-	***PROBATION MONITORING***
CHAPTER SIX	-	***OTHER ISSUES***

ADEQUACY OF INVESTIGATIONS

Chapter Two

CHAPTER CONCLUSIONS

The Department of Professional Regulation (Department) and the Medical Disciplinary Board do not have a procedure established to determine when medical records should be obtained in investigations. As a result, some cases with allegations of inappropriate medical care are closed without a review of the medical records.

We found that for 7 percent of opened cases sampled (23 of 348) that had investigations, we questioned the adequacy of the investigation. The most common weakness that we identified was medical records not being obtained. In addition, we found that the Department lacked appropriate policies and procedures to ensure that all investigations have adequate supervisory review and follow-up and that case files contain all appropriate documentation.

The Department closed cases in the Medical Investigation Unit without approval of the Medical Disciplinary Board (Board). Administrative Rules established by the Department require that all complaints be closed by the Board (68 Ill. Adm. Code 1285.215).

BACKGROUND ON INVESTIGATIONS

Investigations are initiated when complaints are forwarded to the Chief of Medical Investigations from the Complaint Intake Unit. The Chief of Medical Investigations begins the investigation by forwarding the complaint case file to the Licensing Assistant for a background check on the physician. Background checks are done to ensure that a physician is licensed and to determine if there were any prior complaints or disciplinary actions taken. Once background checks are completed, complaint case files are returned to the Chief of Medical Investigations. The Chief then assigns the case file to an Investigative Supervisor.

The Supervisor reviews the case file and assigns the case to an investigator. Assignments are based on geographical location and on the investigator's expertise. Investigations include complainant follow-up, physician and/or witness interviewing, and evidence gathering. Investigative activities are recorded on the Department's computer tracking system called the Enforcement Case Tracking System (ECTS). This chapter deals with the adequacy and thoroughness of investigations and Chapter Three deals with overall timeliness, including investigative timeliness.

CRITERIA FOR INVESTIGATION ADEQUACY

We judged the adequacy of the Department's investigations based on our review of the Department's Enforcement Manual and other sources that describe investigative completeness. The Medical Investigation Unit's written policies cover investigative report completion and review. Policies and procedures do not cover how an investigation should be conducted or what documentation should be included in case files. During the course of this audit, the Department was in the process of completing a new Enforcement Manual.

As stated in the Department's policies and procedures, investigators should document investigative activities in an investigative report or in a memorandum. An investigative report is a document used to record each investigative activity, including receipt of documents, surveillances, analyses, informal conferences, and interviews. Investigative reports should address questions such as who, what, when, where, why, and how. Investigators are required to give a complete and accurate account of the investigative activity that occurred.

According to a Department official, investigators usually conduct interviews with two primary persons—the complainant and the accused physician. Also, investigators generally obtain medical records on the care and treatment of patients. Investigators are required to submit completed investigative reports to their supervisor. The supervisor is required to review the reports for content, completeness, and accuracy.

Case Example 1

A pharmacist notified the Department that a doctor appeared to be prescribing drugs for non-therapeutic purposes. The case was closed because the doctor was not accepting new patients; therefore an undercover drug purchase could not be attempted.

According to investigation guidelines obtained from various other sources, investigations should include the following basic elements: interviews with all potential witnesses; an interview with the alleged victim; and an interview with the alleged perpetrator.

ADEQUACY OF INVESTIGATIONS

Although only a small portion of the investigations we reviewed were inadequate, improvements are still needed. We examined 348 cases which were opened during Fiscal Years 1995 and 1996 to determine whether the investigations of those cases were adequate. Of the 348 cases examined, we found 23 cases (7 percent) with inadequate investigations.

As shown in Exhibit 2-1, the most common reason cited for an inadequate investigation was that medical records were not collected (11 cases). (Failure to obtain medical records is discussed in more detail in the subsequent section on mandatory reports.) We also found that important interviews were not conducted in three cases. In two other cases Department records indicated that the existing complaint could not be modified. In these cases, a new complaint was received after a

formal complaint had already been filed against the physician. Instead of adding an additional count to that complaint or pursuing these allegations separately, the new complaint was closed. Two other cases were closed to unrelated complaints. These cases were combined into existing cases which were unrelated. For example, a case of non-therapeutic prescribing of drugs was combined into a case which alleged that a physician performed unnecessary surgeries.

Exhibit 2-1
REASONS FOR INADEQUATE INVESTIGATIONS
Sample of Cases Opened in FY95 and FY96

Medical Records Needed	11
Interviews Not Conducted	3
Existing Complaint Should Have Been Modified	2
Closed to Unrelated Complaints	2
Other Reasons	5
Total Inadequate	23

Source: Analysis of OAG investigation sample testing of 348 cases opened.

Mandatory Reports

As shown in Exhibit 2-1 almost half (11 of 23) of the inadequate investigations were because relevant medical records were not obtained. All 11 of these were mandatory reports, which are statutorily required reports received from various sources such as professional liability insurers. Unlike other complaints, mandatory reports are filed directly with the Medical Disciplinary Board. The Board then determines whether to close the case or to refer it for further investigation. Mandatory reports are received from:

- **Health Care Institutions** licensed by the Illinois Department of Public Health report when a physician's clinical privileges are terminated or restricted.
- **Professional Associations** of persons licensed under the Medical Practice Act (Act) report when the association renders a final determination that a person has committed unprofessional conduct related to patient care or that a person may be mentally or physically disabled so that patients are endangered.
- **Professional Liability Insurers** report the settlement of any claim or cause of action for negligence.
- **State's Attorneys** report when a licensed physician is convicted of a felony.
- **State Agencies** report violations of the Act or unprofessional conduct related to patient care.

Case Example 2

The Department received a mandatory report indicating a physician's alleged failure to timely diagnose and treat breast cancer. After a response was received from the physician, the case was closed by the Medical Disciplinary Board. No medical records were requested and no investigation was performed.

A physician who is the subject of a mandatory report is given the opportunity, but not required, to submit a written statement responding, clarifying, adding to, or proposing the amendment of a previously filed report. Based on information from the mandatory report and any supporting information, the Board determines whether there are sufficient facts to warrant further investigation. If the

Board determines that there are not sufficient facts to warrant further investigation, the case is closed.

During our examination of 348 cases opened in Fiscal Years 1995 or 1996, we reviewed 67 mandatory report cases that the Medical Disciplinary Board referred for further investigation. We determined that 55 of those cases had adequate investigations and 12 did not. Of the 12 cases with inadequate investigations, we found that 11 needed medical records to determine complaint validity. When allegations involve the appropriateness of medical treatment, we question how adequate evidence can be accumulated and reasoned decisions made without receiving the medical records relating to the report.

Recommendation Number One

The Department of Professional Regulation and the Medical Disciplinary Board should develop criteria to determine when medical records are needed and should ensure that medical records are obtained when necessary.

The Department did not concur with this recommendation. At the Department's request, "The Department's response to this recommendation, and the entire report, is appended to this report." See Appendix F for the Department's response and Auditor Comments.

Investigation adequacy can also be assessed by looking at various components of an investigation, including investigative reports, case documentation, and case review. These topics are addressed in the following sections.

Investigative Reports

During our examination of case files, we found that most investigative activities, such as an interview with a complainant, were documented on investigative reports. In addition, we determined that investigative reports were usually sufficient. Sufficiency was determined based on whether investigative reports answered questions such as who, what, when, where, why, and how. Of the 348 cases examined, 282 cases had sufficient investigative reports, 5 cases did not, and 61 cases did not require the completion of investigative reports. Investigative reports are not required, for example, when cases are closed because the conduct alleged is not prohibited by law or the complainant refuses to cooperate. Investigative reports found in each case file were not assessed independently, but collectively, in determining sufficiency. Of the five cases with inadequate investigative reports, we determined that three had inadequate investigations overall and two were adequate. Although the written investigative reports were missing, these two adequate investigations had some information documented in the ECTS which compensated for the inadequate reports.

Case Documentation

The Medical Investigation Unit does not have formal case file documentation requirements or a documentation checklist. According to a Department official, the following documentation should be kept in case files:

- Investigative Reports (which document investigative activity)
- Complaint Intake Background Information
- Complainant Interview
- Accused Physician Interview
- All other information related to the investigative activity (medical records, etc.)

In our sample of 348 cases, we generally found that investigative case files contained investigative reports and complaint intake background information. Although we found that 93 percent of cases (325 of 348) had adequate investigations, 5 of 325 cases were not properly documented. These cases had interviews with the accused physician and/or complainant which were not documented on investigative reports and placed in the case files.

Case Review

Supervisory case review for investigations is primarily documented by the supervisor signing the completed investigative reports. During our examination of investigative cases, we found that generally, investigative reports were signed as being reviewed by a supervisor. However, for the 23 cases that we found inadequate, supervisory review did not identify the problems we identified. For example, we did not find evidence of supervisory follow-up for cases where the accused physician and/or complainant were not contacted and should have been contacted. Also, there was no evidence of supervisory follow-up for those cases we determined needed medical records to evaluate the validity of the complaint.

According to the Department's Enforcement Division Manual, an investigator should submit completed investigative reports to his or her immediate supervisor for review. Supervisors should review investigative reports for content, completeness, and accuracy. Supervisors should return the report to the investigator with instructions for corrections if they find errors in the report or feel that appropriate investigative steps were not taken.

Recommendation Number Two

The Department of Professional Regulation should establish appropriate policies and procedures to ensure that all cases are adequately investigated, have adequate supervisory review and follow-up, and that case files contain all necessary documentation.

The Department did not concur with this recommendation. At the Department's request, "The Department's response to this recommendation, and the entire report, is appended to this report." See Appendix F for the Department's response and Auditor Comments.

CASES CLOSED BY THE INVESTIGATIONS UNIT

During our examination of 348 cases, we found that 126 cases (36 percent) were closed by the Medical Investigation Unit. Having complaint closure approved by anyone other than the Medical Disciplinary Board is a violation of the Department's administrative rules (68 Ill. Adm. Code 1285.215). According to the rules, no complaint shall be deemed closed except upon approval by the Board.

The number of cases closed by the Medical Investigation Unit and the reason for closure are:

• Administrative Closing	38
• No Violation Acts/Rules	27
• Complainant Refused to Cooperate	20
• Complaint Unfounded	17
• Closed to a Related Case	10
• Accused Physician Complied	6
• No Violation Per Medical Coordinator	5
• Statute of Limitations Had Expired When Received	2
• Referred to Other Agency	1
Total of Cases Closed by Medical Investigation Unit	126

According to a Department official, once a complaint is forwarded to the Medical Investigation Unit, the assigned investigator does a preliminary investigation. If the preliminary investigation reveals that the alleged conduct is not prohibited by statute, or if the complainant is uncooperative, the case may be recommended for closure by the Medical Investigation Unit. Such cases are closed with the approval of the Chief of Medical Investigations.

Recommendation Number Three

The Department of Professional Regulation should adhere to the rules of the Administrative Code and not close any cases without approval by the Medical Disciplinary Board.

The Department did not concur with this recommendation. At the Department's request, "The Department's response to this recommendation, and the entire report, is appended to this report." See Appendix F for the Department's response and Auditor Comments.

INVESTIGATOR STAFFING AND QUALIFICATIONS

The Medical Investigation Unit has a total of 25 medical investigators, including supervisors. The investigators are divided into four investigative teams and each team is headed by a supervisor. Teams I, II, and III are located in Chicago, and Team IV is located in Springfield. In November of 1996, analysis of the Department caseload reports showed that investigators and supervisors had an average of 29 cases each. The Medical Practice Act requires that the Department have at least one investigator for every 5,000 licensed physicians (225 ILCS 60/7 (G)). Therefore, seven investigators are required based on the 38,571 licensed physicians in 1996.

Investigators must be college graduates with at least two years of investigative experience or one year of advanced medical or dental education. Investigative supervisors are also required to be college graduates with at least three years of progressively responsible investigative experience, or one year of medical or dental education and one year of investigative experience. According to information provided by the Department, all investigators and supervisors meet these educational and investigative requirements.

Investigators' educational backgrounds varied. Investigators have Bachelors and Masters Degrees in some of the following categories: Public Administration, Biology, Corrections, Criminal Justice, Business Administration, and Law Enforcement Administration. In addition, investigative experience ranged from 2 to 35 years. Supervisors' investigative experience ranged from 5 to 16 years.

Training

The Department does not have a formal training program for investigators and investigators are not subject to any continuing education requirements. New investigators do not receive basic training on conducting medical investigations. According to a Department official, budget constraints have hampered training. On occasion, investigators go to one or two day training seminars covering such topics as sexual harassment or report writing. Sometimes the Department gets information from drug enforcement agencies regarding available training.

A national organization for regulatory agencies also sends the Department information regarding training conferences. These conferences usually last a week and are held three or four times a year in different states. Because of budget constraints, the Medical Investigation Unit sends only one investigator to a conference. A different investigator attends each training conference so that eventually all of the investigators have the opportunity to receive the training.

As part of their job-related duties, investigators conduct sensitive and potentially controversial investigations of physicians accused of violating the Medical Practice Act or Department regulations. Systematic and continuing professional training in areas related to job responsibilities could enhance employees' investigative skills.

Recommendation Number Four

The Department of Professional Regulation should develop a training policy to ensure that investigators are given systematic and continuing training in areas related to their professional duties.

The Department did not concur with this recommendation. At the Department's request, "The Department's response to this recommendation, and the entire report, is appended to this report." See Appendix F for the Department's response and Auditor Comments.

TIMELINESS OF THE PROCESS

Chapter Three

CHAPTER CONCLUSIONS

The Department of Professional Regulation (Department) lacked adequate standards and management controls to ensure that cases are investigated, reviewed by the Medical Coordinator and prosecuted in a timely manner.

Current Department standards require investigations to be completed within 90 days. Only 14 percent of the cases opened during Fiscal Years 1995 and 1996 (159 of 1,125) had completed investigations within the 90-day timeliness standard. Additionally, 23 percent of the cases in our sample (81 of 348) had time lapses of three months during which no substantive investigative activity took place.

Upon completion of an investigation, cases are forwarded to the Medical Coordinator for review and recommendation. Twelve percent of the cases in our sample (43 of 348) had time lapses of three months during which no activity by the Medical Coordinator was documented.

The Department also has no standards for timeliness in initiating and completing prosecutions. Of the 72 cases in our sample of closed cases that had been referred to the Prosecutions Unit, 28 percent (20 of 72) had time lapses of three months during which no substantive prosecutorial activity took place. When a case resulted in disciplinary action, an average of 762 days elapsed from the date the complaint was received until a disciplinary order was signed.

DEPARTMENT TIMELINESS STANDARDS

The Department of Professional Regulation does not enforce the timeliness standards that do exist and does not have timeliness guidelines for all aspects of the complaint process. While time limits for the completion of investigations have existed since 1989, investigators do not consistently comply with those standards. Further, once the investigation is completed, no timeliness guidelines have been established for review by the Medical Coordinator or action by the Prosecutions Unit.

As a result, from our sample of closed cases, the Department took an average of about ten months to close cases during Fiscal Years 1995 and 1996. Additionally, all cases that resulted in some type of disciplinary order in Fiscal Years 1995 and 1996 took an average of two years to close from the date the initial complaint was received by the Department.

While written timeliness standards do exist for medical investigations, management has not ensured that investigators comply with those guidelines. As the number of complaints received by the Department increases, timely completion of the investigation becomes even more important. Exhibit 3-1 shows the increase in complaints received over the last five years. When investigating a case takes a long period of time, the witnesses, the complainant, and the accused physician might forget details of the incident, move away, change jobs, or lose interest in the complaint. An investigation that is not conducted in a timely manner may result in the failure to detect and discipline a physician who has violated the Medical Practice Act.

Exhibit 3-1
COMPLAINTS RECEIVED
1991 through 1996

Fiscal Year	Complaints Received
1991	1,393
1992	1,449
1993	1,614
1994	1,691
1995	1,712
1996	1,949

Source: DPR Reports.

Until May 1996, the Enforcement Manual was the only source of documentation to guide the timeliness of a medical investigation. In May 1996, a Department memorandum changed the timeliness standards contained in the Enforcement Manual. Below are descriptions of the old and new timeliness standards.

The Enforcement Manual contained the old timeliness standards to guide the completion of investigations. First, the Complaint Intake Unit had three days following its receipt to enter the complaint into the case tracking system. Next, the investigations supervisor had seven days to assign the case to an investigator. Once investigators were assigned cases, they had 60 days to complete the entire investigation. Within that time, they had seven days to complete investigative reports after an investigative activity was performed. Investigative activities include interviewing the complainant and the accused physician, obtaining medical records or other documents, and performing undercover surveillance. Among the standards, the 60 days to complete the investigation was the most significant. A Department official noted difficulties in meeting these standards.

The Department issued a memorandum with new timeliness requirements for the investigators effective May 1, 1996. The timeliness guidelines were changed to the following:

- The Complaint Intake Unit will forward complaints to supervisors who then have ten days to assign the case to an investigator.
- The investigators have ten days to make an initial contact with the complainant.
- Investigative reports are to be completed and submitted to the supervisor within ten days of the investigative activity that generated the necessity of a report.

- Investigators should complete the investigation and submit it to their supervisor within 90 days of assignment.

- Supervisors should review cases every 60 days to assure that the 90 day time frame will be met. (This requirement was effective November 1995.)

A Department official also expressed concern about the feasibility of the new time requirements. As noted in the following section, the majority of investigations are not being completed within the extended 90-day time frame established in the recent guidelines.

Case Example 3

A mandatory report was received in December of 1995. The next activity was in April 1996 when it was verified that the physician's license was active. The next activity was in July of 1996 when an investigator called the physician.

INVESTIGATION TIMELINESS

The Department of Professional Regulation has not established management controls to assure that investigations are completed in a timely manner. As a result, we found many cases where three months had elapsed during which no substantive investigative activity took place. Additionally, an average case took approximately six months for the investigation to be completed—almost twice the Department's current 90-day standard. Only 14 percent of cases opened during Fiscal Years 1995 and 1996 were completed within the 90-day time limit.

Exhibit 3-2
CASES WITH PERIODS OF INACTIVITY

Periods of inactivity	
1 period	57
2 periods	17
3 periods	6
4 periods	1
Total Cases	81

Source: Analysis of OAG sample of cases opened.

Three Months of Inactivity

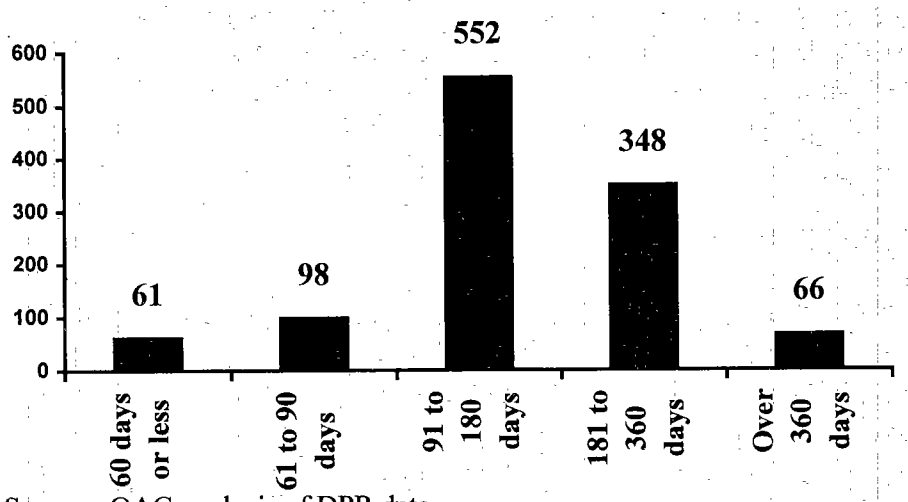
Of the 348 cases we examined in our sample, we found 81 cases (23 percent) had at least one period of three months during which no substantive investigative activity took place. Of these 81 cases, 24 had more than one period of three months with no activity. In total, there were 113 three-month periods with no documented activity. Exhibit 3-2 shows the total number of cases that had one, two, three, or four periods of three months during which there was no documented progress in the investigation.

Total Time to Complete an Investigation

For the 1,125 cases opened in Fiscal Years 1995 or 1996, it took an average of 179 days to complete an investigation and forward it to the Medical Coordinator for review. In only five percent of the cases we reviewed were investigations completed within the 60-day standard in effect until May 1996. Even applying the new 90-day standard, only 14 percent of investigations were completed in a timely manner.

Exhibit 3-3 shows how long it took to complete the investigations in all cases opened in Fiscal Years 1995 and 1996. We obtained data from the Department's Enforcement Case Tracking System (ECTS) and identified all cases opened in either year. We then determined at what point cases were forwarded to the Medical Coordinator and calculated the total time elapsed and the average for all of these cases.

Exhibit 3-3
TIME TO COMPLETE AN INVESTIGATION
Cases Opened in FY95 and FY96



Source: OAG analysis of DPR data.

In our sample of 348 cases opened, investigators took an average of 136 days, or about four and one-half months, to complete the investigation.

Management Controls

The Department's failure to complete investigations in a timely manner indicates a lack of management controls, including effective supervisory review. Similar inadequacies in case management were previously noted in the Auditor General's compliance audit of the Department for the two years ended June 30, 1995. In our testing of cases, we found no compelling reasons which would explain why investigations could not be completed in a timely manner. As noted in Chapter Two, investigator caseloads average 29 cases, which appears reasonable. 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.

The Department's computerized case tracking system (ECTS) produces reports that could be used by management to identify delays in a case's progress, but those reports are apparently not being utilized. Report details include the number of cases assigned to each unit and to each investigator or attorney, as well as the date and nature of the last case activity. The Report of Aged Cases, for instance, lists all cases assigned to a particular staff member or unit for which no activity has been performed for 60, 90 or 120 days. For each interval, the total number of cases having no activity is provided.

We requested the Staff Report of Aged Cases for the medical investigators as of November 1, 1996, and determined the number of cases with no activity for each interval as of that date. As shown in Exhibit 3-4, there were 118 cases where no activity had occurred in at least 60 days. In many of these cases, the last activity recorded in the tracking system was the assignment of the case to an investigator and no further action on the complaint, such as contacting the complainant, had yet taken place.

Exhibit 3-4
AGED CASES FOR MEDICAL INVESTIGATIONS
November 1996

Time with no activity	Cases
60 to 90 days	79
91 to 120 days	29
Over 120 days	10

Source: DPR management reports analyzed by OAG.

Management could gain valuable information on the status of cases by using the reports available from the ECTS system. These reports would be useful for both Medical Investigations and Prosecutions to determine which cases are not moving through the regulatory process in a timely manner.

Recommendation Number Five

The Department of Professional Regulation should establish management controls to ensure the timely completion of investigations. These controls should be in the form of written policies which are usable, meaningful, and consistently applied and enforced. Monitoring of compliance could be accomplished with computerized management reports.

The Department did not concur with this recommendation. At the Department's request, "The Department's response to this recommendation, and the entire report, is appended to this report." See Appendix F for the Department's response and Auditor Comments.

TIMELINESS AT THE MEDICAL COORDINATOR

The Department also had serious problems in timeliness with cases awaiting review by the Medical Coordinator. Following completion of the investigation, cases are forwarded to the Medical Coordinator for review and recommendation. In our sample of cases, 12 percent (43 of 348) had at least one period of three months during which no activity by the Medical Coordinator was documented. A Report of Aged Cases produced by the Department's computerized case tracking system in November 1996 showed that there were 358 cases that had been assigned to the Medical Coordinator for 121 days or longer.

The Medical Practice Act of 1987 (225 ILCS 60/7(G)) provides that the Director of Professional Regulation shall

Case Example 4

A complaint was received in September 1994. After conducting interviews and obtaining medical records, the investigator referred the case to the medical coordinator in November 1994. As of August 1996, the case was still waiting to be reviewed.

appoint a Chief Medical Coordinator and a Deputy Medical Coordinator. They serve as chief enforcement officers of the Act within the region of the State to which they are assigned. The medical coordinators review cases and make recommendations to the Medical Disciplinary Board (Board) on whether cases should be prosecuted or closed. The Act also allows the Board to use advisors to assist the medical coordinators with their work.

The Chief Medical Coordinator's position has been vacant for significant periods of time. The position was vacant from January through July of 1993 and from July 1995 through March of 1996. When the Chief Medical Coordinator's position is vacant, backlogs of cases develop which need to be reviewed. The Board keeps a list of physicians that is used when the Board needs expert opinion in a specialty area; however, the Department did not use the physicians on this list to review cases when the Chief Medical Coordinator position was vacant. If the Department and the Board had used these physicians to review cases during this time, backlogs could have been limited and timeliness could have been improved.

Recommendation Number Six

The Department of Professional Regulation and the Medical Disciplinary Board should take the steps necessary to assist the medical coordinators with backlogs and improve case timeliness.

The Department concurred with this recommendation. At the Department's request, "The Department's response to this recommendation, and the entire report, is appended to this report." See Appendix F for the Department's response and Auditor Comments.

TIMELINESS IN PROSECUTIONS

The Department's Prosecutions Manual contains no standards to guide the Prosecutions Unit on timeliness. To analyze the timeliness of cases which were referred to the Prosecutions Unit, we used results from our sample of 347 cases closed during Fiscal Years 1995 and 1996. We categorized the sample cases into two groups—all cases which were referred to the Prosecutions Unit, and cases which actually resulted in some kind of disciplinary action.

For the 72 cases sampled which were referred to the Prosecutions Unit, the average number of days from the date the complaint was received by the Department until the case was closed or a disciplinary order was signed by the Director was 634 days, as Exhibit 3-5 shows. The median number of days was 492. The average number of days from the date when the complaint was referred to the Prosecutions Unit until the case was closed or a disciplinary order was signed by the Director was 327 days. The median number of days was 231.

Case Example 5

The Board referred a case to the Chief of Prosecutions in January of 1993. No significant action was taken until April of 1994 when it was given back to the investigative supervisor and reassigned.

Exhibit 3-5
TIME TO CLOSE CASES
that Reached Prosecutions

	Average	Median
Number of days from when DPR received the complaint to when the case was closed	634	492
Number of days from complaint referred to Prosecutions to case closed	327	231

Source: OAG Analysis of DPR data.

Of the 72 cases, 33 cases received disciplinary action during Fiscal Years 1995 and 1996. The average number of days from the date the complaint was received until the Director signed an order was 762 days. The median number of days was 729. The average number of days from the date when the complaint was referred to the Prosecutions Unit until a disciplinary order was signed by the Director was 434 days. The median number of days was 296.

We also examined the cases referred to the Prosecutions Unit to identify lapses of three months during which no substantive activity took place. Of the 72 cases in our sample of cases closed that were referred to the Prosecutions Unit, 20 (28 percent) had at least one such lapse. Two cases each had ten three-month lapses with no substantive activity performed.

Physicians against whom complaints have been filed generally continue practicing medicine while the Department investigates and prosecutes the case. Lack of timeliness in bringing a case to conclusion could result in delayed discipline and unnecessary risk to the public.

Recommendation Number Seven

The Department of Professional Regulation should develop management controls to ensure that cases are reviewed by the Prosecutions Unit in a timely fashion. These controls should include timeliness standards.

The Department did not concur with this recommendation. At the Department's request, "The Department's response to this recommendation, and the entire report, is appended to this report." See Appendix F for the Department's response and Auditor Comments.

ADEQUACY OF DISCIPLINARY ACTIONS

Chapter Four

CHAPTER CONCLUSIONS

The Department of Professional Regulation (Department) and the Medical Disciplinary Board (Board) have not established criteria for determining the need for and nature of disciplinary action. There are few written policies and procedures to ensure similar violations are receiving similar discipline.

We questioned the adequacy of 122 of the 347 closed cases (35 percent) which we reviewed. Reasons cited included cases closed without investigation (17 percent), inadequate investigations (13 percent), questionable disciplinary actions (4 percent), and case files which the Department could not locate (1 percent).

Our sample of closed cases included 135 cases in which malpractice settlements, totaling more than $38 million, had been paid by professional liability insurers on behalf of physicians. Professional liability insurers are required to report such payments to the Board. In 22 of the 135 cases, the settlement amount was at least $500,000. The Department took no disciplinary action in any of these 135 cases.

We determined that 67 percent of the physicians disciplined during Fiscal Years 1995 and 1996 were disciplined by the Department for reasons which should not have required much investigative activity and should have been easy to prove. The two most common reasons were physicians who have been disciplined in another state and physicians who failed to renew their licenses on time.

Currently, information on cases closed without investigation by the Medical Disciplinary Board is not always available to Department employees. This information would be helpful in investigating and prosecuting subsequent complaints.

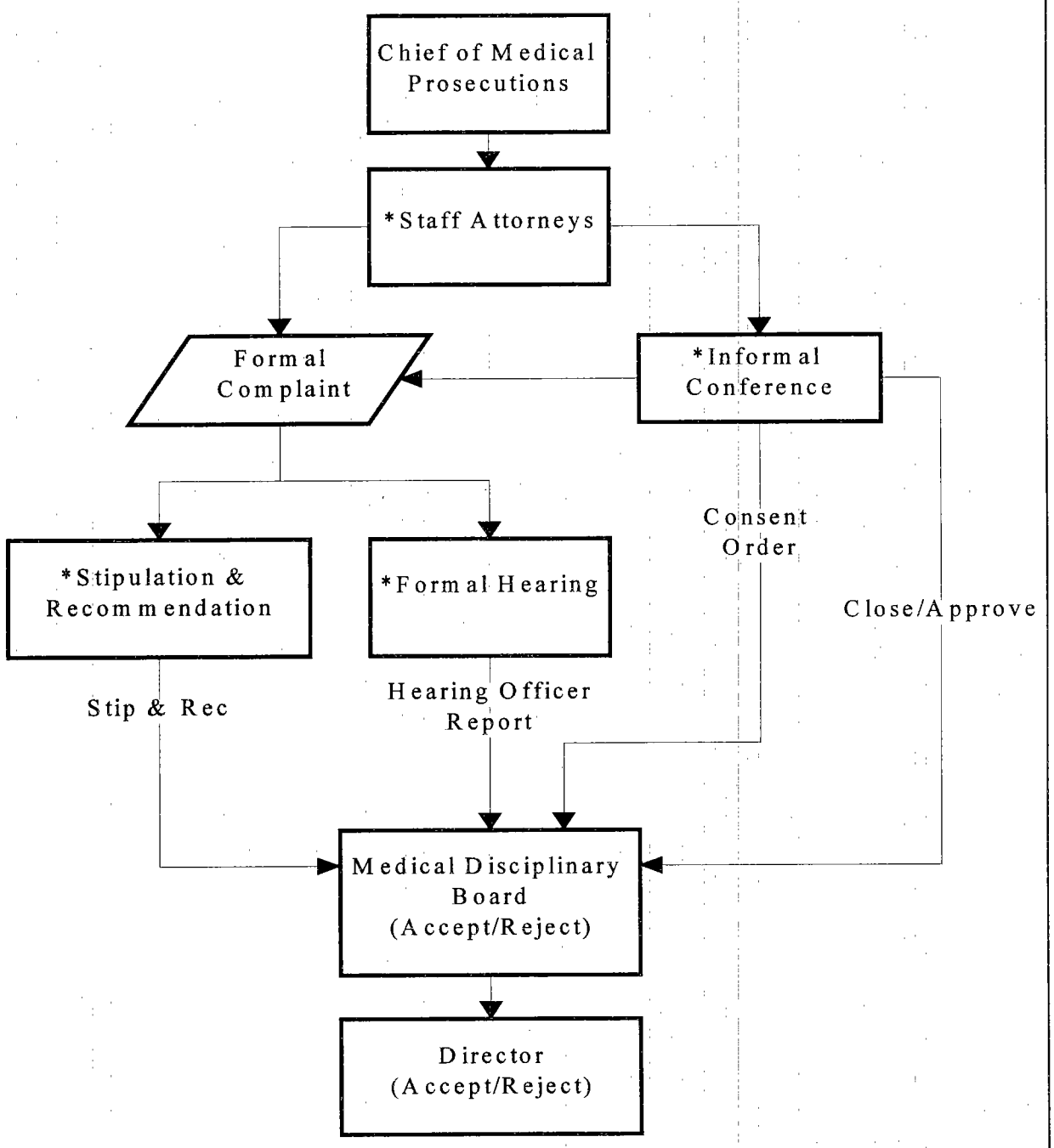
BACKGROUND

Completed investigations containing sufficient information to substantiate a violation of the Medical Practice Act are forwarded to the Prosecutions Unit by the Medical Disciplinary Board (Board). Medical cases are assigned to the Chief of Prosecutions who forwards them to the Chief of Medical Prosecutions. The Chief of Medical Prosecutions reviews the file and assigns a staff attorney to the case if there is reason to believe the accused violated the Medical Practice Act. The medical portion of the Prosecutions Unit is composed of the Chief of Medical Prosecutions and several attorneys.

We sampled 347 cases closed by the Department during Fiscal Years 1995 and 1996. Our sample was selected from a total of 3,503 cases closed in Fiscal Years 1995 and 1996, as reflected in the Department's Enforcement Case Tracking System.

Exhibit 4-1

FLOWCHART OF THE DISCIPLINARY PROCESS



* Case can be closed at this stage for various reasons, including inadequate evidence

Source: OAG analysis from DPR information.

NEED FOR AND NATURE OF DISCIPLINARY ACTION

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.

Disciplinary Process

The Department has three main processes it uses to conclude cases and determine possible disciplinary actions. These include an Informal Process, a Formal Process, and a settlement by stipulation and recommendation. Exhibit 4-1 illustrates how these processes are used by the Department to close cases.

The Informal Process offers the parties an opportunity to settle the case by agreement on discipline. The Informal Process consists of an informal conference attended by a Department attorney, the accused physician, the accused physician's attorney and a Medical Disciplinary Board member. The informal conference can be used as a question and answer session or to inform the physician generally what the Department's investigation has produced. If the parties are able to agree on discipline, the terms and conditions of the discipline are reduced to writing in the form of a Consent Order. The Consent Order is then presented to the Medical Disciplinary Board and the Director for consideration and approval (see Exhibit 4-1).

As shown in Exhibit 4-1, another way to resolve a case is through the Formal Process. The Formal Process consists of a formal complaint being filed by the Department against a physician, followed by a formal hearing of the complaint to determine what action should be taken. A formal hearing is an administrative trial which involves a hearing officer, a Board member, the accused physician and his or her attorney, and a Department prosecutor. At the conclusion of the trial, the hearing officer's report is presented to the Medical Disciplinary Board and the Director for consideration and approval.

According to Department officials, in some instances, the Department and the accused physician negotiate a settlement which is agreeable to both parties after a formal complaint has been filed. This is known as a settlement by stipulation and recommendation. Other participants in this process may include the hearing officer and a Medical Disciplinary Board member. Once an agreeable settlement is reached, the stipulation and recommendation is sent to the Medical Disciplinary Board for approval. If the Board does not approve the stipulation and recommendation, the case is either sent back for further consideration by those negotiating the stipulation and recommendation or it is sent to a formal hearing (Formal Process).

We asked Department officials how the person making a complaint against a physician (complainant) is involved in the disciplinary process. The Department stated that it does not represent the complainant. Once a complaint is made to the Department, DPR becomes the complainant. The original complainant may be used as a witness in the Formal Process. If a case is settled by an informal conference, the complainant is not used to testify; however the

complainant is interviewed to obtain any pertinent information which may be useful during the informal conference.

The Medical Practice Act states that the accused person and the complainant are to be given an opportunity to present any pertinent evidence that may be helpful in determining appropriate disciplinary action. The Department should consider including the person making a complaint against a physician in the settlement process. 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.

Recommendation Number Eight

The Department of Professional Regulation should develop procedures for including persons making complaints in the disciplinary process.

The Department did not concur with this recommendation. At the Department's request, "The Department's response to this recommendation, and the entire report, is appended to this report." See Appendix F for the Department's response and Auditor Comments.

NUMBER OF DISCIPLINARY ACTIONS TAKEN

In our sample of closed cases, 21 percent of the cases (72 of 347) were referred to the Prosecutions Unit to pursue disciplinary action. As shown in Exhibit 4-2, in 33 of the 347 closed cases we sampled, the Department took some type of disciplinary action during Fiscal Years 1995 or 1996. Disciplinary actions available include: license revocation, various periods of suspension, various periods of probation with conditions, reprimands and fines. In our sample, the Department suspended 15 licenses, reprimanded 9 licenses, placed 7 licenses on probation and revoked 2 licenses. Disciplinary actions are not mutually exclusive. Physicians can have more than one disciplinary action levied against them at a time.

Exhibit 4-2
VIOLATIONS RECEIVING DISCIPLINARY ACTIONS
in FY95 and FY96

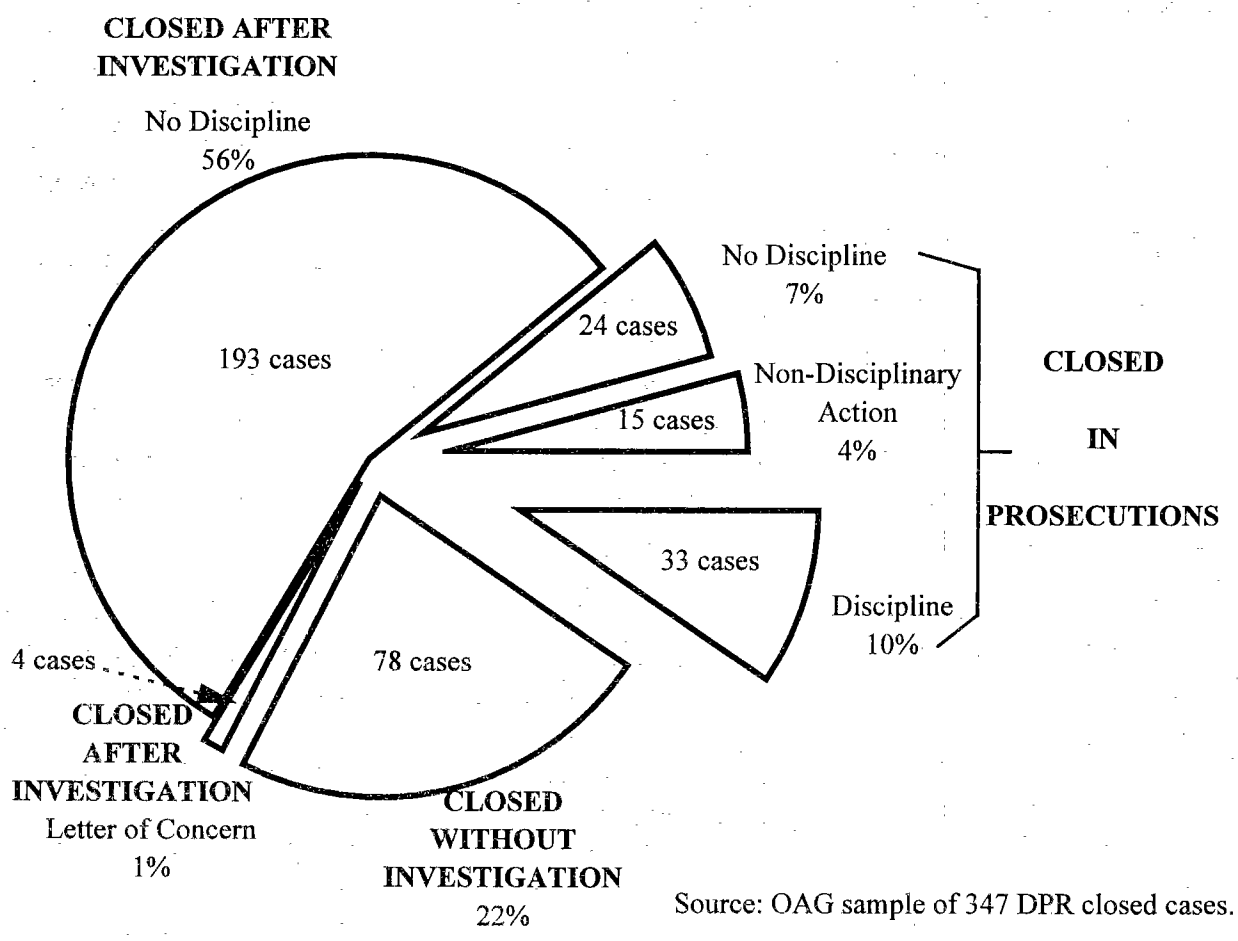
Violation Type	Number
Unprofessional or Unethical Conduct	10
Drugs - Non-therapeutic Prescribing	7
Unlicensed Practice	4
Medical Illness/Physical Disability	3
Other/Unknown	2
Drug or Alcohol - Personal Use	2
Immoral Sexual Conduct	2
Negligence	1
Delinquent Taxes & Probation Violation	1
Billing Dispute	1
Total	33

Source: OAG sample of 347 DPR closed cases

Exhibit 4-2 shows the violation type of each of the 33 disciplinary actions taken by the Department as categorized by the OAG. The most common violation resulting in disciplinary

action was unprofessional or unethical conduct. This represented 30 percent (10 of 33) of the total actions taken by the Department found in our sample. Examples of allegations classified as unprofessional or unethical conduct include patient abandonment and felony convictions.

Exhibit 4-3
WHERE CASES ARE CLOSED



Source: OAG sample of 347 DPR closed cases.

The remaining 39 cases referred to the Prosecutions Unit did not receive discipline during Fiscal Years 1995 or 1996. However, 15 of the 39 cases received non-disciplinary actions: 4 administrative warning letters, 4 letters of concern, 5 license reinstatements and 2 refusals of renewal. In addition, as shown on Exhibit 4-3, there were 4 letters of concern which were issued by the Medical Disciplinary Board without being referred to the Prosecutions Unit. A letter of concern is sent by the Medical Coordinator to educate or forewarn a physician. It is an instructive device and references a specific incident. An administrative warning letter is more stern. In such instances, the Department closes the case but maintains the right to further review the incident if a similar complaint is filed against the physician in the future.

ADEQUACY OF DISCIPLINARY ACTION

We noted several areas of concern regarding the adequacy of disciplinary actions in our review of 347 cases closed during Fiscal Years 1995 and 1996. We found 105 cases which were closed without investigation or had inadequate investigations and 15 cases in which we questioned the disciplinary action taken. In addition, there were two case files which the Department could not locate.

The adequacy of disciplinary actions taken could not be ascertained for 105 of 347 (30 percent) of the closed cases we reviewed, either because the case was closed without any investigation (59) or because the investigation was inadequate (46). Mandatory reports accounted for all of the cases closed without an investigation. The Department's and the Medical Disciplinary Board's handling of mandatory reports is discussed later in this chapter.

Of the 240 closed cases in which an investigation was conducted and the investigation was adequate, we found 15 cases (6 percent) in which we questioned the disciplinary action taken by the Department:

- 8 cases had no disciplinary actions when discipline appeared to be warranted,
- 6 cases did not appear to receive severe enough disciplinary actions, and
- 1 case appeared to receive a disciplinary action which was too severe.

Case Example 6

In one case referred to Prosecutions, drugs were obtained by an undercover investigator five times. On the first visit, the undercover investigator told the physician he needed the medication because he had been taking it since 1988. The investigator was then able to obtain the same prescription on four more occasions. The Medical Coordinator reviewed this case and, believing a violation of the Medical Practice Act had occurred, referred it to the Prosecutions Unit. The prosecuting attorney indicated that the case needed further investigation and suggested the case be returned to Investigations or closed. The investigative supervisor suggested the case be closed and the Medical Disciplinary Board subsequently recommended closing the case. The evidence in this case appears to show a clear violation of the Medical Practice Act.

There are few written criteria which help the Prosecutions Unit or the Medical Disciplinary Board determine the need for and the nature of any disciplinary action levied against physicians. The Department believes that it would be difficult to develop criteria for determining the need for and type of disciplinary action warranted because each case is unique. The Medical Disciplinary Board makes suggestions for disciplinary action based upon similar cases and previous offenses, also taking into account the accused physician's remorsefulness, remediation and ability to pay.

The Medical Disciplinary Board is a control agent and has some guidelines, but those guidelines cover only a small portion of the provisions of the Medical Practice Act. As a board composed of external individuals, it should be an objective mechanism to assure that discipline is appropriate. The Board has established a schedule of fines for physicians who let their licenses

lapse. Although this schedule is appropriate, there are many other potentially serious violations for which there is no guidance.

One potential problem which could result from the Department having few written criteria for determining the need for and nature of disciplinary action is physicians who commit similar violations of the Medical Practice Act receiving different outcomes. For example, our sample had two different cases with similar allegations that physicians were prescribing controlled substances for non-therapeutic purposes. In both of these cases, Department investigators were able to procure drugs for non-therapeutic purposes during undercover visits. In one case the physician's controlled substance license was indefinitely suspended. The other case was closed based on the recommendation of a Department attorney that no violation of the Medical Practice Act had occurred. Written guidelines, containing appropriate factors to be considered in each case, could help ensure that similar violations of the Act do not result in dissimilar discipline unless clear justification is provided.

Exhibit 4-4
QUESTIONABLE DISCIPLINES AND INVESTIGATIONS

Case Example 7: The Drug Enforcement Administration informed the Department that a physician was prescribing controlled substances for non-therapeutic purposes. DPR made 5 undercover drug purchases. No disciplinary action taken. (681 days to close case)

Case Example 8: Laceration of the left cheek of a newborn due to alleged negligent scalpel handling during emergency cesarean section. This case was closed without an investigation. (462 days to close case)

Case Example 9: Physician's license was reprimanded and fined for providing chiropractic treatment to a canine pet. Discipline too severe. (324 days until action taken)

Source: DPR case files.

During the audit we surveyed other states and found two states which had general criteria in place to help determine what type of disciplinary actions should be taken for certain violations by physicians. In California, the Medical Board which determines disciplinary action has developed a manual of disciplinary guidelines. This manual lists minimum and maximum penalties for different inappropriate acts committed by physicians. For example, the minimum penalty for excessive prescribing is five years probation with a maximum penalty of revocation. Similarly, the minimum penalty for sexual misconduct is seven years probation with a maximum penalty of revocation. In Michigan, the statute related to disciplining physicians contains a list of appropriate disciplines which can be administered for different violations.

Recommendation Number Nine

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

The Department did not concur with this recommendation. At the Department's request, "The Department's response to this recommendation, and the entire report, is appended to this report." See Appendix F for the Department's response and Auditor Comments.

MANDATORY REPORTS

When a professional liability insurer settles a claim of alleged negligence against a physician or a hospital revokes a doctor's privileges, a report is required to be made to the Medical Disciplinary Board. Other entities having knowledge of a physician's conduct are similarly required to file reports with the Board. These mandatory reports represent a large percentage of the total complaints against physicians received by the Department each year. In our sample of 347 closed cases, 145 or 42 percent were mandatory reports.

Overall, we determined the Department's handling of 64 percent of mandatory reports (93 of 145) was inadequate. We found that 59 mandatory reports were closed without investigation, 28 had inadequate investigations, 4 had questionable disciplinary actions, and 2 had case files which the Department could not locate. This differs considerably from the 14 percent of non-mandatory report cases we found to be inadequate. Exhibit 4-5 compares the number of inadequate cases and the number of disciplinary actions taken for mandatory report cases and all other cases in our sample.

Exhibit 4-5
MANDATORY REPORTS COMPARED TO OTHER CASES SAMPLED

	Number	Number Inadequate	Percentage Inadequate	Number of Disciplines	Percentage of Disciplines
Mandatory Reports	145	93	64 %	4	2.8 %
Other Cases	202	29	14 %	29	14.4 %
Total	347	122	35 %	33	9.5 %

Source: OAG sample of 347 DPR closed cases.

When the Department receives a mandatory report from a professional liability insurer, the Medical Disciplinary Board often closes the case after receiving a written response from the physician. These cases are not investigated by the Department and, in many instances, no attempt to verify the physician's written response is made. Further, in 84 of the 93 mandatory reports we found to be inadequate, medical records were not obtained by the Department. These records could have helped determine the validity of an allegation (see Recommendation One in Chapter Two).

Case Example 10

A mandatory report was received by DPR containing the allegation of death due to failure to properly treat and monitor aortic constriction. The only documentation in the mandatory report file was the mandatory report received from the physician's professional liability insurer and the written response from the physician. This case was closed by the Medical Disciplinary Board without investigation even though there had already been a $500,000 settlement paid on behalf of the physician by the professional liability insurer.

Of the 145 mandatory reports contained in our sample of closed cases, 135 were reports from professional liability insurers paying settlements on behalf of physicians who had been accused of negligence or some other misconduct. In these 135 cases, insurers reported paying a total of over $38 million to claimants. The largest settlement amount in our sample was $2.5 million. No disciplinary action was taken by the Department against any of the physicians involved in these 135 mandatory reports. The Department did take five non-disciplinary actions, including two letters of concern, two administrative warning letters and one refusal to renew. The Medical Disciplinary Board closed 76 of these cases without investigating the allegation. Exhibit 4-6 shows the breakdown of the 135 settlement amounts paid by physicians' professional liability insurers.

Exhibit 4-6
SETTLEMENT AMOUNTS BY PHYSICIANS

Range	Number
Less than $100,000	55
$100,000 - $499,000	58
$500,000 - $999,000	13
$1,000,000 and greater	9
Total number of settlements	135

Source: OAG sample of 347 DPR closed cases.

REPORTING OF DISCIPLINARY ACTIONS

In Fiscal Years 1995 and 1996, the Department disciplined 236 physicians and took 346 disciplinary actions. There were 110 more disciplinary actions taken than physicians disciplined. This difference is attributable to the fact that the Department sometimes takes multiple disciplinary actions against a single physician. An example of DPR taking multiple disciplinary actions would be a physician being both reprimanded and fined for not renewing his license in a timely fashion. Another example would be a physician being indefinitely suspended and then placed on probation following the suspension. A third example would be a physician having his medical license placed on probation and his controlled substance license suspended. In all three of these examples, the Department would have taken two disciplinary actions even though the actions would be against only one physician. This could cause the public to misinterpret the actual number of physicians disciplined because the Department reports the number of disciplinary actions taken.

The Medical Practice Act requires the Department to at least annually publish a list of the names of all persons disciplined under the Act in the preceding 12 months. The Department documents the disciplinary actions taken against all the professions it regulates in a monthly report called the Illinois Department of Professional Regulation News. During our review of physicians disciplined in Fiscal Years 1995 and 1996, we found a few physicians disciplined by the Department who were not included in DPR's monthly reports. Disciplinary actions omitted from the monthly reports included a revocation, two suspensions, and several probations. By failing to report all physicians disciplined, the Department is in violation of a statutory requirement.

Recommendation Number Ten

When reporting disciplinary actions, the Department of Professional Regulation should distinguish between the number of disciplinary actions taken and the number of physicians disciplined. Furthermore, the Department should comply with statutory reporting requirements for reporting physicians who were disciplined.

The Department concurred with this recommendation. At the Department's request, "The Department's response to this recommendation, and the entire report, is appended to this report." See Appendix F for the Department's response and Auditor Comments.

Types of Violations Resulting in Discipline

Of the 236 physicians who were disciplined by the Department in Fiscal Years 1995 and 1996, only 79 physicians were disciplined by the Department for reasons such as prescribing non-therapeutic drugs, acting in an unethical or unprofessional manner, or committing gross negligence against a patient. Cases such as these generally require investigation by the Department.

In many cases, however, the Department acts against a physician based on information provided by a sister State, the Department of Public Aid, the Department of Revenue or other external sources. These cases, which accounted for 157 (67 percent) of the 236 physicians disciplined by the Department during Fiscal Years 1995 and 1996, required little or no investigation by the Department and were generally easily proven.

Exhibit 4-7
PHYSICIANS DISCIPLINED FOR REASONS EASILY PROVEN
From cases receiving discipline in FY95 and FY96

Reason for Disciplinary Action	Count	Average Days to Order
Sister-State Violation	56	592
Untimely License Renewal	42	349
Disciplined by an external entity	15	829
Conviction	11	921
Failure to comply with previous Order	10	502
Personal history question	10	192
Failure to pay taxes	7	562
Failure to pay student loans	3	666
Failure to comply with DPR request	2	880
Failure to report adverse actions	1	628
Total	157	545

Source: OAG analysis of DPR data.

Examples of these types of violations include physicians licensed in Illinois who were disciplined by other states (sister-state violation) and physicians who failed to pay taxes or student loans or to renew their licenses in a timely manner.

Exhibit 4-7 shows the number of physicians disciplined in Fiscal Years 1995 and 1996 for violations requiring little or no effort by the Department to prove. The most common reason, accounting for 56 of the 157 doctors disciplined by the Department in those years, was a violation of a sister-state law by a physician also licensed in Illinois. Fourteen of the 20 physicians whose licenses were revoked during Fiscal Year 1995 or 1996 were disciplined for one of the reasons listed in Exhibit 4-7.

PRIOR AND SUBSEQUENT COMPLAINTS

Many of the physicians from our sample of 347 cases closed had prior and/or subsequent complaints made against them. We found 164 cases where the physician named had been the subject of at least one other complaint. The 164 physicians in these cases had a total of 671 other complaints against them, 544 of which occurred prior to the sample case and 127 of which occurred subsequent to the sample case. In these 164 cases in which the accused physician was the subject of multiple complaints, the Department issued 18 disciplinary actions and 9 non-disciplinary actions.

Of the 164 sample cases where we found that physicians had at least one other complaint made against them, 50 contained related complaints. For these 50 cases, we found 202 related complaints made against the physician named in our sample case. During Fiscal Years 1995 and 1996, there were 9 disciplinary and 2 non-disciplinary actions taken by the Department in these 50 cases.

Case Example 11

DPR was notified in January 1995 by an insurance company of a settlement on behalf of a physician for allegedly performing unnecessary surgery. The Medical Disciplinary Board closed this case without an investigation. The physician in question has a history of excessive billing and performing unnecessary surgery including 8 related complaints. One of these related complaints resulted in the physician's license being revoked in August 1996 for a minimum of 18 months. It is unclear why the Medical Disciplinary Board would close a case without an investigation where the physician had a related complaint made against him.

Prior and Subsequent Complaints Related to Mandatory Reports

When determining what disciplinary actions are appropriate, the Medical Disciplinary Board considers many factors, including how many prior incidents the physician has had against them. Similarly, when an investigative supervisor receives the initial complaint file on a physician from the Chief of Medical Investigations, it contains any available information on prior complaints made and disciplinary actions taken against the physician.

In many instances, however, information on settlements that were the subject of prior mandatory reports to the Department will not be available to the investigator of a new complaint against the same physician. According to the Department, the Medical Disciplinary Board does not release information on mandatory report settlements which are closed without being investigated.

Seventy-eight of the 145 mandatory reports included in our sample were closed without any investigation. Consequently, new complaint files may lack information on prior mandatory reports involving the same physician. For instance, an insurer could pay settlements on behalf of the same physician on multiple occasions but the investigator's case file may have no documentation of these prior incidents. This type of information should be available to investigators to identify whether a pattern of possible misconduct exists, as well as to assist the Department and the Board in determining the appropriate level of discipline for a violation.

Recommendation Number Eleven

The Department of 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.

The Department concurred with this recommendation. At the Department's request, "The Department's response to this recommendation, and the entire report, is appended to this report." See Appendix F for the Department's response and Auditor Comments.

PUBLIC INFORMATION

The Department's administrative rules distinguish between the "initial claim" filed by a citizen or mandatory reporter against a physician and the "formal complaint" filed by the Department or Medical Disciplinary Board against a physician. All proceedings and documents prior to the filing of a formal complaint are deemed confidential by the Department's rules (68 Ill. Adm. Code 1285.310). The vast majority of complaints against physicians are resolved without a formal complaint being filed. For instance, in our sample of 347 cases closed during Fiscal Years 1995 and 1996, only 29 cases (8 percent) involved formal complaints. As a consequence, only a small percentage of complaints against physicians under the Medical Practice Act ever become public information.

PROBATION MONITORING

Chapter Five

CHAPTER CONCLUSIONS

The Department of Professional Regulation (Department) has not established adequate management controls to assure that its probation monitoring process works effectively and efficiently. This is demonstrated through a lack of written policies and a lack of management control over Probation/Compliance Unit employees.

In almost 36 percent (19 of 53) of cases that we reviewed, appropriate action had not been taken when disciplined physicians had not fulfilled the requirements of their probation. In addition, the Department does not monitor physicians who have had their licenses revoked or placed on long-term suspension.

Probation/Compliance investigators work from their residences and have State vehicles assigned to them without a clear reason. Their assignments involve primarily office work, such as receiving compliance reports, scheduling drug tests, updating case files, and working with the Enforcement Case Tracking System (ECTS). Most of the investigators' monitoring duties could be performed more efficiently and effectively from the Chicago office, since the computer system and the case files are located there.

PROBATION/COMPLIANCE UNIT

The Probation/Compliance Unit (Unit) monitors physicians who have been disciplined by the Department. In addition, the Unit monitors probation for other professions regulated by the Department. In Fiscal Year 1995, the Probation/Compliance Unit received 53 medical cases to monitor. We reviewed all of these cases to test how well the Department monitored physicians who have been disciplined. Disciplines monitored consist of probations and short-term suspensions that are followed by a probationary period. The Probation/Compliance Unit does not monitor physicians who have had their licenses revoked or placed on long-term suspension. The Unit consists of a supervisor, five investigators, and an office associate. The investigators are assigned to the Chicago office, but often work from their residences. The supervisor and investigators have State vehicles assigned to them.

The process begins when the Unit receives a disciplinary order that has been signed by the Director. Probation/Compliance is notified whenever a case requires monitoring. An investigator is then assigned to the case. Assignments are based on investigator caseloads. The investigator sends a notification letter to the physician specifying that he or she has five business

days to respond. The letter contains the name and telephone number of the Probation/Compliance investigator.

The investigator and physician meet to discuss the conditions of the probation. Examples of these conditions are continuing education, drug testing or treatment, and community service. The physician is responsible for fulfilling the requirements of his or her probation, and the investigator monitors the physician's progress. While monitoring the physician, the investigator receives items such as certificates of completion for education courses, progress reports relating to rehabilitation, and drug test results. If the physician must submit to drug testing as a condition of probation, the investigator may be responsible for scheduling the tests. If a physician fails to fulfill the conditions of the probation, the case is referred back to the Prosecutions Unit for further legal action, as seen in Case Example 12.

Case Example 12

A physician failed to submit drug screens and to meet the required conditions of his probation. The Probation/Compliance investigator then sent the case back to the Prosecutions Unit for further disciplinary action.

Fines may be assessed as part of the disciplinary process. While the Prosecution Unit attorneys collect fines that are paid during prosecution, the Probation/Compliance investigators receive fine payments that are paid in installments. All fine money, whether collected by attorneys or investigators, is forwarded to the Probation/Compliance Unit and maintained by the office associate until the Director signs the Disciplinary Order. The payment is then sent to the fiscal unit and an entry is made in the Enforcement Case Tracking System.

INADEQUATE CASE MONITORING

In almost 36 percent (19 of 53) of the cases that we reviewed, appropriate action had not been taken when disciplined physicians had not fulfilled the requirements of their probation. We tested the 53 medical cases received by the Probation/Compliance Unit during Fiscal Year 1995. These cases fell into one of six categories, as seen in Exhibit 5-1. Exhibit 5-2 describes the problems we identified in the 19 cases.

Exhibit 5-1
CATEGORIES OF PROBATION/COMPLIANCE CASES
Starting Probation in FY95

	All Cases	Inadequate Follow-up
Disciplined by Another Entity	20	5
Drugs - Improper Prescribing	14	8
Drugs - Personal Use	8	3
Other	5	1
Improper Sexual Conduct	3	0
Negligence	3	2
TOTAL	53	19

Source: DPR data categorized by OAG.

Exhibit 5-2
INADEQUATE PROBATION/COMPLIANCE CASES
Starting Probation in FY95

During testing, we determined that 19 of the 53 cases tested were inadequately monitored:

- Eight cases involved physicians who were prescribing controlled substances improperly. It is the investigator's job to determine if the physician is meeting the conditions of his or her probation. Investigators failed to monitor these physicians to assure they were completing required educational hours, and submitting required reports.
- Five cases were against physicians whose license was disciplined by an outside entity. These outside entities for the most part are other states, but can also be disciplines by a hospital or by the Drug Enforcement Administration. The investigator often has to contact the other entity to verify that the physician is meeting the terms of the probation. The physician is usually required to send reports and drug screens to Illinois. In these cases, various types of required reports were missing from the case file.
- Three cases were against physicians for personal drug or alcohol problems. These disciplinary conditions require significant monitoring by the investigator. In these types of cases, the investigators may schedule the random drug tests and receive reports from several individuals including the treating physician, support group sponsor, supervisor, and the physicians themselves. Inadequacies noted were the lack of drug tests and/or missing reports.
- Two cases involved negligence. These cases required the physicians to complete educational courses. These courses must be approved by the medical coordinator in advance. In these cases, documentation showed that educational hours were not completed within the period specified in the disciplinary order.
- One case fell into the "other" category. The order required the physician to take a licensing exam and to submit quarterly reports. There was no evidence that these conditions were met.

Source: OAG testing of 53 Professional Regulation Probation case files.

The Probation/Compliance Unit does not monitor physicians who have had their licenses placed on long-term suspension or revoked. As a result, the Department cannot be certain that these physicians are not practicing medicine and potentially harming the public. The Department's Mission Statement declares, "We must be sensitive to the professions we regulate consistent with our responsibility to protect the public." The Department's ability to protect the public is diminished by not monitoring long-term suspensions and revocations.

Recommendation Number Twelve

The Department of Professional Regulation should develop management controls to ensure that cases in the Probation/Compliance Unit are properly monitored. The Department should also implement procedures to ensure that physicians whose licenses have been either suspended for a long term or revoked are not continuing to practice.

The Department concurred in part with this recommendation. At the Department's request, "The Department's response to this recommendation, and the entire report, is appended to this report." See Appendix F for the Department's response and Auditor Comments.

LACK OF CONTROL OVER PROBATION EMPLOYEES

The Department has failed to establish adequate management controls for the Probation/Compliance Unit. Prior financial and compliance audits conducted by the Auditor General (for the two years ended June 30, 1995, and June 30, 1993) have noted a lack of policies and procedures for the Enforcement Division. The Department's internal auditors have also identified problems in the Probation/Compliance Unit. The Probation/Compliance Unit has no written policies or procedures to aid investigators in performing their monitoring duties. The only written guidance for investigators is contained in the Enforcement Case Tracking System Manual or the Enforcement Manual. As a result, there are no relevant policies and procedures for probation management or time keeping. Therefore, investigators manage cases in different ways.

Probation/Compliance investigators work from their residences and have State vehicles assigned to them without a clear reason. They monitor physicians whose licenses have been put on probation. This involves primarily office work, such as receiving compliance reports, scheduling drug tests, updating case files and the Enforcement Case Tracking System (ECTS). Unlike medical investigators who perform many of their duties—such as conducting interviews and undercover investigations—outside of the office, Probation investigators appear to have duties performed primarily in the office, by telephone or mail. Work outside the office generally occurs when the Unit employee conducts an initial interview with a physician who is beginning probation. In Fiscal Year 1995 there were 53 physicians who started probation.

Case Example 13

A physician failed to submit drug tests and to meet the required conditions of his probation. After moving to another State, the case was closed in the Probation/ Compliance Unit.

All Probation/Compliance investigators are based in Chicago and are assigned to cover the entire State. For a three month period, from June through August 1996, the four investigators together recorded only a total of 223 hours of travel time for 63 trips. One-third of the 63 trips

were for 2 hours or less. Most of the investigators' monitoring duties could be performed more efficiently and effectively from the office, since the computer system and the case files are located at the Chicago office.

In Fiscal Year 1995, the Probation/Compliance Unit received 53 medical cases from the Prosecutions Unit. Of these 53 cases, we concluded that 19 were monitored inadequately. We also determined that 18 cases were against physicians who had been disciplined by entities outside of Illinois. For these cases, initial interviews would have been conducted by telephone. Therefore, 34 percent of cases received in Fiscal Year 1995 did not appear to require case-related travel.

Recommendation Number Thirteen

In establishing management controls for the Probation/Compliance Unit, the Department of Professional Regulation should develop written policies and procedures and should reevaluate the need for Probation investigators to work from their homes and be issued a State vehicle.

The Department concurred in part with this recommendation. At the Department's request, "The Department's response to this recommendation, and the entire report, is appended to this report." See Appendix F for the Department's response and Auditor Comments.

OTHER ISSUES

Chapter Six

CHAPTER CONCLUSIONS

Since the Department of Professional Regulation's (Department) Enforcement Case Tracking System is being replaced, Department officials should ensure that the new system has the capability of assisting management in its efforts to control the adequacy and timeliness of various elements of the enforcement process.

Weaknesses in management controls over the evidence room were identified by management during the course of audit work. The evidence room contains prescription drugs, guns, and money that have been confiscated in investigations of medical cases or cases relating to other professions. During our audit, Department officials noted significant potential problems in this area and took actions to account for items in the evidence room.

The Department of Professional Regulation has not established a policy that requires employees to remove themselves from a case if they have a conflict of interest.

ENFORCEMENT CASE TRACKING SYSTEM

The Enforcement Case Tracking System (ECTS) is the computer system that the Department uses to track cases through the administrative process. The system is used for medical cases as well as cases from other professions regulated by the Department. The system is no longer supported by the manufacturer because the Department does not have updated versions of the software.

Prior OAG audits have found problems with ECTS, such as the data within the system being inaccurate and the Department's employees being able to override timeliness controls within the system. Our testing during this audit did not reveal significant weaknesses with the accuracy of the data within the system.

During the course of our audit work the Department contracted with a firm to review the process for regulating professionals. One of the contractor's findings was that the ECTS system was obsolete and inadequate for the Department's needs.

Although the Auditor General's office has also reported weaknesses with the system and acknowledges that the system needs to be updated, we found that the current system was not being used to its fullest capacity. In particular, we noted that there are existing management

reporting and control capabilities available with ECTS that are not currently used to monitor timeliness and enhance accountability.

The Department is in the early stages of updating and replacing the enforcement tracking system. In this process, Department officials should consider reporting and control capabilities which can be built into the system to assist in assuring that management can monitor the quality and timeliness of the enforcement process.

Recommendation Number Fourteen

The Department of Professional Regulation should ensure that the replacement system for the Enforcement Case Tracking System has the capability to help management to better control the quality and timeliness of the enforcement process.

The Department concurred with this recommendation. At the Department's request, "The Department's response to this recommendation, and the entire report, is appended to this report." See Appendix F for the Department's response and Auditor Comments.

EVIDENCE ROOM

Weaknesses were noted in management controls over the evidence room. The Department's Chicago office has an evidence room which is used to store prescription drugs, records seized for evidence purposes and, on occasion, cash and guns that have been confiscated in investigations of medical cases or cases relating to other professions. During the course of our audit, Department officials noted significant problems in this area and took corrective measures to properly account for and inventory items in the evidence room.

Weak Management Controls over the Evidence Room

The evidence custodian has changed frequently at the Department. During our audit fieldwork, the Chief of Medical Investigations became custodian of the evidence room. For the beginning of 1996, the Chief of Health Related Investigations was the evidence custodian. Prior to the Health Related Chief, Administrative Management staff were evidence custodians. To date, the Department has not implemented a formal policy for back-up custodians. The evidence custodian is the only person with a key to the evidence room. If an investigator has evidence that needs to be stored in the evidence room and the custodian is out of the office, the investigator should keep the evidence in a place that can be secured and locked until the custodian returns.

During the audit, we requested a copy of an inventory of the evidence room completed by the Chief of Health Related Investigations in February of 1996. The inventory was an item-by-item check of the evidence room from 1987 through 1996, and an item-by-item check of the old inventory system prior to 1987. The inventory report listed over one hundred items which were unaccounted for or missing from the evidence room. However, the inventory report was not very informative because the items were mentioned by inventory numbers and the inventory items

were not identified. Control of evidence can be important to assure cases can be prosecuted. Weak controls over evidence can make a case difficult to prosecute.

Included with the inventories provided were listings of items held in the safe of the evidence room. The safe contained prescription drugs, guns, and $900 in cash. These items had been in the safe at least since July of 1994. Department officials should assure that procedures cover the appropriate handling of cash and the proper disposition of drugs and guns.

Policies and Procedures for Evidence Handling and Disposition

The Department has policies and procedures for evidence handling and disposition. Guidelines cover the safeguarding and proper disposition of evidence, including collection, handling, inventory and control of property.

According to Department policies and procedures, investigators are required, immediately upon acquisition of property, to take custody of the property and ensure its safe keeping. They should transport the property to the appropriate office at the earliest opportunity during the next normal working hours and turn over custody of the property to the evidence custodian, unless the property is to be turned over to another agency or laboratory. Some drugs that are confiscated are sent directly to the State Police's crime lab or the Chicago Police Department's crime lab.

Once evidence is given to the evidence custodian, it is logged into an inventory book and assigned an inventory number. Evidence is usually placed in a plastic evidence bag that can be sealed, and the bag is tagged with an inventory number. In addition, investigators have to complete a property inventory report form. This form contains information pertaining to the inventory number, date inventory was recovered, case number, respondent's name, investigator's name, and a brief description of the evidence. Whenever investigators and attorneys take evidence out of the room, they are required to sign out the evidence. This should be done by indicating the date the evidence is signed out and the date it is returned on the back of the property report.

Management Improvements

Management improvements have been noted regarding the evidence room. In July and August 1996, another inventory of the evidence room was conducted by the current evidence custodian, along with two Administrative Management staff who were former evidence custodians. Because the prior inventory report was not very informative, a member of the OAG audit staff observed the inventory of the evidence room. During the inventory process, information contained in the evidence room's log book was reconciled to the property inventory reports. Also, all items stored in the evidence room were reconciled to the inventory log book and the property inventory reports. In addition, an inventory of the evidence safe, located in the evidence room, was also observed. All items mentioned on a prior inventory of the safe, conducted in January 1996, were still in the safe.

When the inventory of the evidence room was completed, most of the evidence was accounted for (either found in the room, signed out, or destroyed as stated in the log book or on the property inventory reports). However, there were five instances where evidence was not accounted for. In those instances, an inventory number was issued but the evidence was neither found in the room nor documented as being either signed out or destroyed. For evidence unaccounted for, the custodian and his inventory staff checked the ECTS to determine whether the case was still open. They also asked the investigator who had confiscated the evidence about the evidence's whereabouts. Follow-up with the evidence custodian regarding the missing evidence revealed that the evidence listed on four property inventory reports had been signed out, and the evidence listed on another property inventory report had been located and was in the evidence room.

In addition, property reports were organized by year and placed into separate file folders under categories of evidence room, evidence signed out, evidence destroyed, and miscellaneous. All evidence that was previously stored in boxes and labeled by year was organized by year and placed either on the evidence room's shelves or on the floor.

We tested 19 property inventory reports which indicated that evidence was signed out from the evidence room. After inquiring, we found that evidence for three cases had been returned to the evidence room. For 11 cases the evidence had been turned over to another entity, such as a State's Attorney, a medical school for testing, or a drug enforcement official. For the remaining five cases, Department officials reported that the evidence had been destroyed; however, destruction information was not documented as required by Department policies and procedures. The evidence for each of these five cases included prescription drugs.

According to officials, the Department is currently in the process of rewriting policies and procedures for the evidence room and establishing procedures to destroy evidence that is no longer needed. Destruction of unneeded evidence could eliminate at least 70 percent of the inventory in the evidence room.

Recommendation Number Fifteen

The Department of Professional Regulation should continue its efforts to improve controls over the evidence room. These controls should include procedures covering proper handling and disposition of cash, prescription drugs, and guns. The Department should also ensure that the destruction of evidence is properly documented.

The Department concurred with this recommendation. At the Department's request, "The Department's response to this recommendation, and the entire report, is appended to this report." See Appendix F for the Department's response and Auditor Comments.

IMPAIRMENT DISCLOSURE POLICY

The Department has no written policy that requires employees to remove themselves from a case if they have a conflict of interest. A conflict of interest could arise if an employee has a relationship with a physician who had a complaint filed against him or her. Examples include an employee who is a friend or relative of the accused physician, is the patient or business partner of the physician, or has some financial relationship with the physician.

Case Example 14

The Medical Coordinator noted in a memo making a recommendation about a case that the accused physician had worked under his supervision and was a very good doctor. Although his opinion on the case was supported by the evidence, his relationship may give the appearance of a conflict of interest.

Department officials stated that there is an unwritten rule that investigators should inform their supervisor if they become aware of a conflict. During the course of our audit work, we identified two cases where the Director had removed herself from a case because she had a conflict of interest. In those cases, the Deputy Director signed the disciplinary order.

However, Department policies do not contain written guidelines for disclosing impairments or removing employees having conflicts from cases. In our survey of other states, five of seven had policies to disclose and handle such conflicts of interest.

Recommendation Number Sixteen

The Department of Professional Regulation should develop policies that require employees to report conflicts of interest. The policy should include provisions to exclude these individuals from investigation, prosecution, and decision-making on cases where a significant conflict of interest arises.

The Department concurred with this recommendation. At the Department's request, "The Department's response to this recommendation, and the entire report, is appended to this report." See Appendix F for the Department's response and Auditor Comments.

APPENDICES

APPENDIX A
Resolution Number 107

RESOLUTION NO. 107
Presented by Senator Demuzio

WHEREAS, the Department of Professional Regulation has established its mission to serve, safeguard and promote the public welfare by ensuring that qualifications and standards for professional practices are properly determined and appropriately applied;

WHEREAS, among the professions regulated by the Department is physicians licensed under the Medical Practice Act of 1987;

WHEREAS, in the most recent audit of the Department, testing of the Department's regulation of physicians noted some deficiencies in the timeliness and documentation of investigative and prosecutorial duties;

WHEREAS, between calendar years 1991 to 1993, the number of complaints against physicians filed with the Department increased by 7%, whereas the number of disciplinary actions against physicians signed into effect by the Department during that time frame decreased by 8%;

WHEREAS, according to published reports, the recent trend nationally is an increase of 38% in disciplinary actions taken against physicians; therefore, be it

RESOLVED, BY THE LEGISLATIVE AUDIT COMMISSION that the Auditor General be directed to conduct a program audit of the Department of Professional Regulation's effectiveness in investigating complaints against physicians licensed under the Medical Practice Act of 1987; and be it further

RESOLVED, that this program audit include, but not be limited to, the following determinations;

- The Department's timeliness in initiating, carrying out and completing investigations;
- The adequacy of the Department's investigatory procedures, including the identification and gathering of appropriate evidence;
- The Department's procedures for determining the need for, and nature of, any recommended disciplinary actions; and
- The Department's process for ensuring that its recommended disciplinary actions are implemented and that any specified corrective steps are instituted; and

BE IT FURTHER RESOLVED that all State and other entities which may have information relevant to this audit shall cooperate fully and promptly with the Office of the Auditor General in the conduct of this audit; and

BE IT FURTHER RESOLVED that the Auditor General commence this audit as soon as possible and report his findings and recommendations upon completion to the Legislative Audit Commission, the Governor and members of the General Assembly in accordance with the provisions of the Illinois State Auditing Act.

Adopted this 5th day of February, 1996.

Senator Aldo A. DeAngelis
Cochairman

Representative Terry W. Deering
Cochairman

APPENDIX B
Audit Sampling and Methodology

APPENDIX B
AUDIT SAMPLING AND METHODOLOGY

During fieldwork, we obtained a data file from the Department of Professional Regulation (Department) from the Enforcement Case Tracking System. This data file contained information on all medical complaint cases in the system where any activity had been recorded since Fiscal Year 1992. We used this file to select two random samples of case files to test at Professional Regulation. Both samples were statistically significant with a 95 percent confidence level and a margin of error of 5 percent.

Using fields from a collection instrument developed to compile information from the case files, a database was created using the information collected in the samples. The data was verified before our analysis was conducted.

Investigations Sampling Methodology

The file obtained from the Department contained 3,667 files opened in Fiscal Year 1995 and Fiscal Year 1996. This was the universe of cases used in selecting the sample for testing investigations. Random sampling by a computer random number generator was used to select the sample of 348 cases and additional spares to be used as needed.

For this sample, we examined investigative case files to determine the investigation and documentation completeness, investigation timeliness, supervisory review, and the overall adequacy of the investigative activities.

Disciplinary Adequacy Sampling Methodology

The universe for the sample of disciplinary adequacy files consisted of 3,503 files closed in Fiscal Year 1995 and Fiscal Year 1996, identified from the file obtained from Professional Regulation. We used a random number generator to select the sample of 347 cases and additional spares to be used as needed.

Testing for this sample included examining investigative files, prosecution files for cases referred to Prosecutions, and records division files where a formal complaint had been filed by the Department. We reviewed the files for documentation completeness, previous complaints, any disciplinary actions taken, and the adequacy of any disciplinary action taken or not taken.

Probation/Compliance Sample

For our original sample of Probation/Compliance files, we reviewed cases that were disciplined in our Disciplinary Adequacy Sample. Because there were a small number of cases and inadequacies with those cases, we expanded the sample. We requested the Probation Log Books for 1994-1996. There were 122 total cases that reached the Probation/Compliance Unit as documented in the three Log Books. We initially tested a stratified random sample of 20 cases. Because of the number of inadequacies identified in this sample, we again concluded that a larger sample group was needed. We then decided to test all cases received by the Unit during Fiscal Year 1995, or 53 cases. Testing Fiscal Year 1995 cases allowed at least a year to pass since the physician was disciplined in which Department officials could monitor compliance with the disciplinary order.

APPENDIX C
Medical Practice Act
Grounds for Disciplinary Action

APPENDIX C
MEDICAL PRACTICE ACT
GROUNDS FOR DISCIPLINARY ACTION

Following is the portion of the Medical Practice Act of 1987 which describes disciplinary actions that can be taken and the grounds for disciplinary actions.

225 ILCS 60/22 DISCIPLINARY ACTIONS

A. 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, 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 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 Director, 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 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 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 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;

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 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.

APPENDIX D
Survey of Other States

APPENDIX D
SURVEY OF OTHER STATES

METHODOLOGY

For this audit we conducted a survey of other state's medical licensing agencies. Two states were initially sent a questionnaire style survey. Based on the response received, modifications were made to the survey instrument. We sent the modified survey by fax to 12 other state's medical licensing agencies.

A total of thirteen surveys were sent to other states medical licensing agencies of large and border states. Nine states (69%) returned the surveys to the Office of Auditor General. The states participating in the survey are listed in Exhibit D-1. We added Illinois data to the survey responses for comparability. The Department of Professional Regulation provided the information regarding Illinois physicians.

Exhibit D-1
STATES RESPONDING TO SURVEY

1. California
2. Indiana
3. Kentucky
4. Massachusetts
5. Michigan
6. New Jersey
7. New York
8. Pennsylvania
9. Texas

During the month of January 1997, we contacted by telephone the nine states that responded to the survey and asked several follow-up questions. Original and follow-up questions and the other states responses are included on the following pages.

QUESTIONS AND RESULTS

1. *How many physicians did your Department license in Fiscal Year 1996?*

Exhibit D-2
NUMBER OF PHYSICIANS LICENSED
Fiscal Year 1996

	Osteopaths	Chiropractors	Physicians	Total
California	**	**	54,607	54,607
Illinois	*	**2,966**	**35,605**	**38,571**
Indiana	1,059	818	18,388	20,265
Kentucky	NA	**	12,027	12,027
Massachusetts	*	**	27,000***	27,000***
Michigan	5,514	2,365	27,046	34,925
New Jersey	4,192	**	51,617	55,809
New York	*	5,097	68,273	73,370
Pennsylvania	5,828	3,347	44,607	53,782
Texas	2,511	NA	42,831	45,342

* These states do not distinguish DO's from MD's.

** These licenses are regulated by separate agencies.

*** Estimated information.

NA - Information was not available.

2. *What are the initial and yearly licensing fees for physicians?*

Exhibit D-3 **LICENSING FEES**			
	Type	Initial	Yearly
California	MD	$300	$300
Illinois	**All**	**$300**	**$100**
Indiana	All	$40	$15
Kentucky	MD, OS	$225	$100
Massachusetts	MD	$350	$250
Michigan	All	$140	$90
New Jersey	MD	$565	$320
New York	All	$735	$300
Pennsylvania	MD	NA	$80
Pennsylvania	OS	NA	$140
Pennsylvania	DC	NA	$210
Texas	MD, OS	$800	$300

All fees are stated on an annual basis for comparability.

MD - medical doctor OS - osteopath DC - chiropractor

NA - information not provided

3. *Does your Department have written time requirements for conducting investigations or completing cases?*

No written time requirements (62.5%) - Most of the states surveyed do not have any documented guidelines for conducting investigations into physician misconduct.

Statute imposed time requirements (25%) - The statutes in California and Michigan have time requirements for conducting investigations. California should complete investigations within six months from receipt of the complaint. More complex medical or fraud cases should be

investigated within one year. Michigan law requires the completion of all investigations within 90 days after the investigation is initiated; however, one written extension can be filed extending the investigation 30 more days.

Other Guidelines (12.5%) - Pennsylvania has documented guidelines for timeliness of investigations not imposed by statute, administrative rules, or department written rules.

Illinois - Effective May 1, 1996, Department issued a memo requiring the conclusion of investigations within 90 days after assignment to an investigator.

4. Does the Department have any criteria for determining what type of discipline should be administered for a given offense?

No criteria (56%) - Most states in the survey lacked criteria for determining the type of discipline to administer for offenses of that state's professional regulation laws.

Department written criteria (33%) - The medical licensing agencies in California, New York, and Texas write their own guidelines for determining what type of discipline to administer for offenses of that states laws. California can impose, in most cases, a minimum and maximum sanction for each violation of the professional licensing laws. In some instances, California will only sanction a physician by revoking the license. The guidelines from New York and Texas are not as detailed as California's guidelines. The guidelines set by Texas indicate what factors in a case merit more severe and less severe disciplinary actions. New York's guidelines set general criteria, and require an analysis of each case. Neither New York or Texas guidelines state what discipline to administer for specific violations of the statutes.

Statute imposed criteria (11%) - Michigan is the only state surveyed to have criteria for determining what type of discipline to administer written in the states statutes. Michigan's statutes specifically impose, for violations of their statutes, one or several sanctions.

Illinois - DPR does not have any criteria for determining what type of discipline to administer for infractions of the law.

5. Does probation always include terms to be met by the physician?

Yes (100%) - Eight, of the nine states surveyed, responded that probation does include terms that the physician must follow. One state did not respond to the question on the survey.

Illinois - DPR does not include conditions for all probations. The agency has reporting and non-reporting probations.

6. *What standard of evidence does your department use in the adjudicative process?*

Preponderance of evidence (78%) - Most states surveyed use preponderance of evidence in the adjudicative process.

Clear and Convincing (11%) - California uses the clear and convincing standard of evidence in administrative proceedings. Case law established this standard in California.

Reasonable Doubt (11%) - Texas uses beyond a reasonable doubt as the standard of evidence in the adjudicative process.

Illinois - DPR uses clear and convincing as the standard of evidence.

7. *Does your department require the medical board, investigators, and management to disclose impairments that might interfere or give the appearance of impropriety?*

Yes (71%) - Of the seven states that responded to this question, five indicated that the medical board, investigators, and management disclose impairments.

No (29%) - Two of the seven states that responded to this question do not require disclosure of impairments for the medical board, investigators, and management.

Illinois - DPR requires the Medical Board to disclose impairments. Investigators and management are not required to disclose impairments.

8. *How many disciplinary actions were there against physicians in Fiscal Year 1995 and Fiscal Year 1996?*

Exhibit D-4 displays disciplinary actions for Fiscal Year 1995. Exhibit D-5 shows disciplinary actions for Fiscal Year 1996.

Exhibit D-4

Total Disciplinary Actions

Fiscal Year 1995

	Probation	Suspension	Revocation	Fine	Reprimand	Emergency Suspension	Surrender	Restriction	Other	Total
California	141	2	65	57	25	24	62	NA	58	434
Illinois	**65**	**44**	**8**	**16**	**27**	**0**	**1**	**0**	**0**	**161**
Indiana	9	5	10	0	1	9	4	0	3	41
Kentucky	23	5	10	NA	1	0	4	6	15	64
Massachusetts	9	9	14	8	7	8	7	2	14	78
Michigan	17	19	7	7	0	16	2	13	0	81
New Jersey *	12	24	17	NA	39	NA	16	0	0	108
New York *	91	19	94	2	22	10	75	14	7	334
Pennsylvania	9	51	13	9	25	5	8	2	21	143
Texas	80	35	29	9	18	0	0	0	0	171

NA - Information was not available.

* State compliles data by calender year.

Exhibit D-5

Total Disciplinary Actions

Fiscal Year 1996

	Probation	Suspension	Revocation	Fine	Reprimand	Emergency Suspension	Surrender	Restriction	Other	Total
California	**129**	**1**	**62**	**152**	**67**	**37**	**52**	**NA**	**34**	**534**
Illinois	**49**	**34**	**13**	**11**	**24**	**1**	**1**	**0**	**9**	**142**
Indiana	**17**	**10**	**7**	**0**	**3**	**10**	**9**	**0**	**0**	**56**
Kentucky	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**
Massachusetts	**9**	**12**	**7**	**15**	**15**	**0**	**10**	**2**	**23**	**93**
Michigan	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**
New Jersey*	**14**	**38**	**19**	**NA**	**52**	**NA**	**15**	**0**	**0**	**138**
New York**	**57**	**14**	**63**	**3**	**5**	**6**	**65**	**9**	**3**	**225**
Pennsylvania	**2**	**32**	**4**	**3**	**2**	**2**	**2**	**1**	**2**	**50**
Texas	**75**	**27**	**21**	**16**	**18**	**0**	**0**	**13**	**0**	**170**

NA - Information was not available.

* State compiles data by calander year. ** Disciplines from January to Sepember 1996.

9. What percentage of total disciplinary actions are against out-of-state doctors?

Four of the nine states surveyed responded to this question. California indicated that approximately 25 percent of the disciplinary actions are against out-of-state doctors. Indiana responded that 44 percent of the disciplines in that state are against out-of-state doctors. New York indicated that 45 percent of the disciplines are against out-of-state doctors in 1995. Further, 48 percent of the disciplines are against out-of-state physicians from January to September 1996. Texas responded that 15 percent of disciplines in that state are against out-of-state doctors.

Illinois - DPR officials told us that they do not collect this information. OAG analysis showed that almost 20 percent of disciplines for Fiscal Year 1996 are against out-of-state physicians.

10. How are complainants used in the disciplinary process?

Witness (67%) - Most states use the complainant as a witness in the disciplinary process.

Other (33%) - Kentucky, New Jersey, and Texas use the complainant in a variety of different ways. New Jersey rarely uses the complainant as a witness. Texas will use the complainant if their testimony will help the state's case.

Illinois - DPR uses the complainant as a witness only if their testimony will aid the case.

11. Are investigative reports signed by the complainant?

No (56%) - Five of the states surveyed indicated that the complainant does not sign the investigative reports.

Yes (44%) - Four of the states surveyed responded that the complainant does sign the investigative reports.

Illinois - DPR does not have the complainant sign the investigative reports.

APPENDIX E
Complaints and Disciplines by County

APPENDIX E
COMPLAINTS AND DISCIPLINES BY COUNTY

for Fiscal Year 1996

To determine total medical complaints and disciplines by county for this appendix we used data downloaded from the Department of Professional Regulation's Enforcement Case Tracking System. That system contains a location code that identifies the county or other state of the complaint. For complaints, many of the location codes were N/A. In this Appendix we identified the location of these complaints as unknown. The number of complaints is based on all cases with a complaint received date that fell within Fiscal Year 1996. These cases were opened in Fiscal Year 1996 but were not necessarily closed.

Disciplines we report are the number of physicians who were disciplined during Fiscal Year 1996. The numbers from the Department's tracking system were reconciled to other reports of disciplines that we received from the Department. The number of disciplines is a count of physicians disciplined in Fiscal Year 1996. Because cases resulting in discipline often take a significant amount of time to complete, complaints for these disciplined physicians were usually received before Fiscal Year 1996. Because of this, a county could have more disciplines given in the year than there were complaints received in the year.

This Appendix contains four exhibits which show complaints or disciplines received by the Department. Exhibit E-1 shows complaints by county in a table. Exhibit E-2 shows complaints by county on a map of Illinois. Exhibit E-3 shows physicians disciplined by county in a table. Exhibit E-4 shows physicians disciplined by county on a map of Illinois.

Exhibit E-1

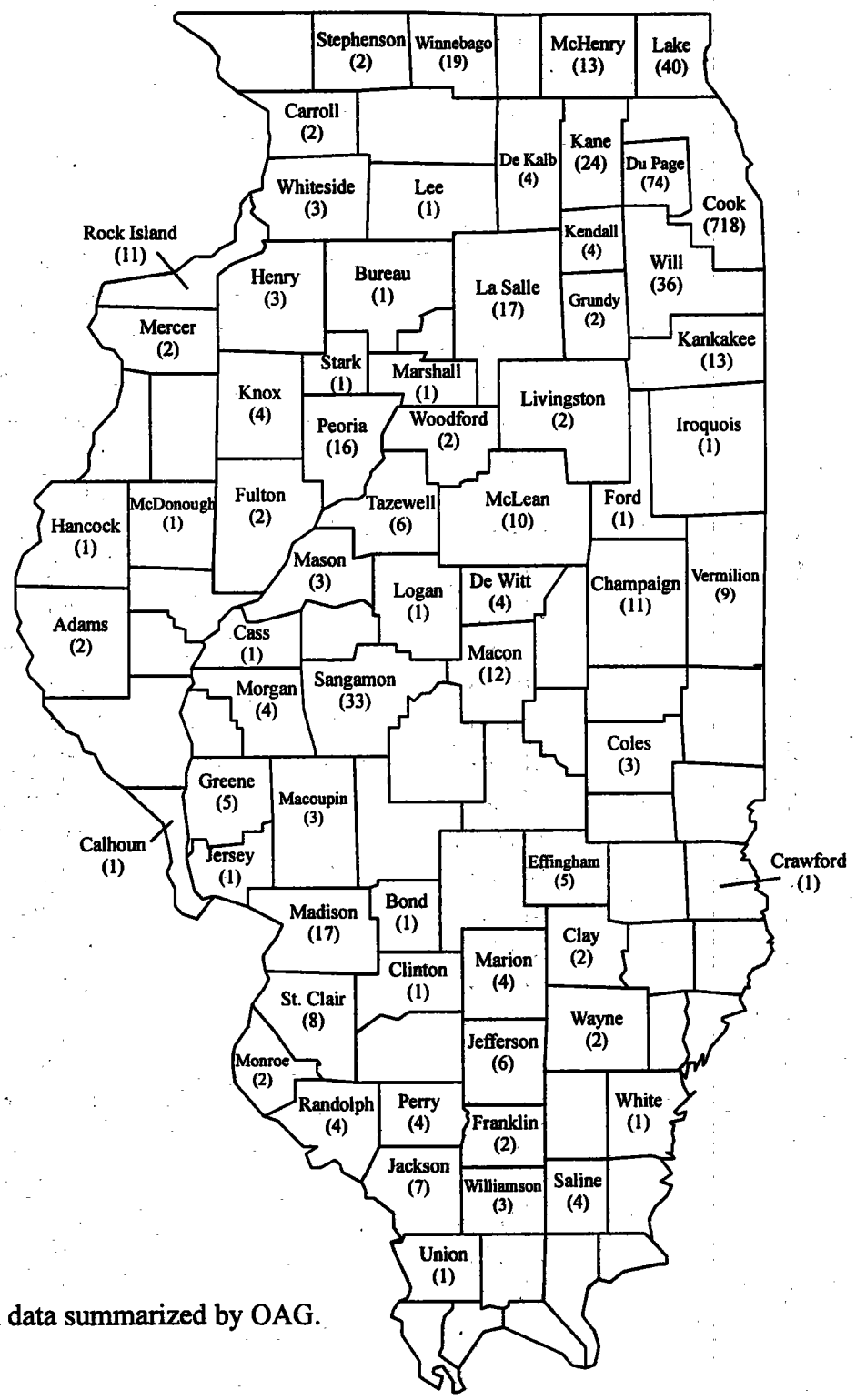
COMPLAINTS RECEIVED IN FISCAL YEAR 1996

Adams	2	Henry	3	Perry	4
Alexander	0	Iroquois	1	Piatt	0
Bond	1	Jackson	7	Pike	0
Boone	0	Jasper	0	Pope	0
Brown	0	Jefferson	6	Pulaski	0
Bureau	1	Jersey	1	Putnam	0
Calhoun	1	Jo Daviess	0	Randolph	4
Carroll	2	Johnson	0	Richland	0
Cass	1	Kane	24	Rock Island	11
Champaign	11	Kankakee	13	Saline	4
Christian	0	Kendall	4	Sangamon	33
Clark	0	Knox	4	Schuyler	0
Clay	2	Lake	40	Scott	0
Clinton	1	LaSalle	17	Shelby	0
Coles	3	Lawrence	0	St. Clair	8
Cook	718	Lee	1	Stark	1
Crawford	1	Livingston	2	Stephenson	2
Cumberland	0	Logan	1	Tazewell	6
DeKalb	4	Macon	12	Union	1
DeWitt	4	Macoupin	3	Vermilion	9
Douglas	0	Madison	17	Wabash	0
DuPage	74	Marion	4	Warren	0
Edgar	0	Marshall	1	Washington	0
Edwards	0	Mason	3	Wayne	2
Effingham	5	Massac	0	White	1
Fayette	0	McDonough	1	Whiteside	3
Ford	1	McHenry	13	Will	36
Franklin	2	McLean	10	Williamson	3
Fulton	2	Menard	0	Winnebago	19
Gallatin	0	Mercer	2	Woodford	2
Greene	5	Monroe	2		
Grundy	2	Montgomery	0	Out of State	31
Hamilton	0	Morgan	4	Unknown	713
Hancock	1	Moultrie	0		
Hardin	0	Ogle	0	TOTAL	1949
Henderson	0	Peoria	16		

Exhibit E-2

ILLINOIS MAP OF COMPLAINTS RECEIVED

Fiscal Year 1996



Source: DPR data summarized by OAG.

Exhibit E-3

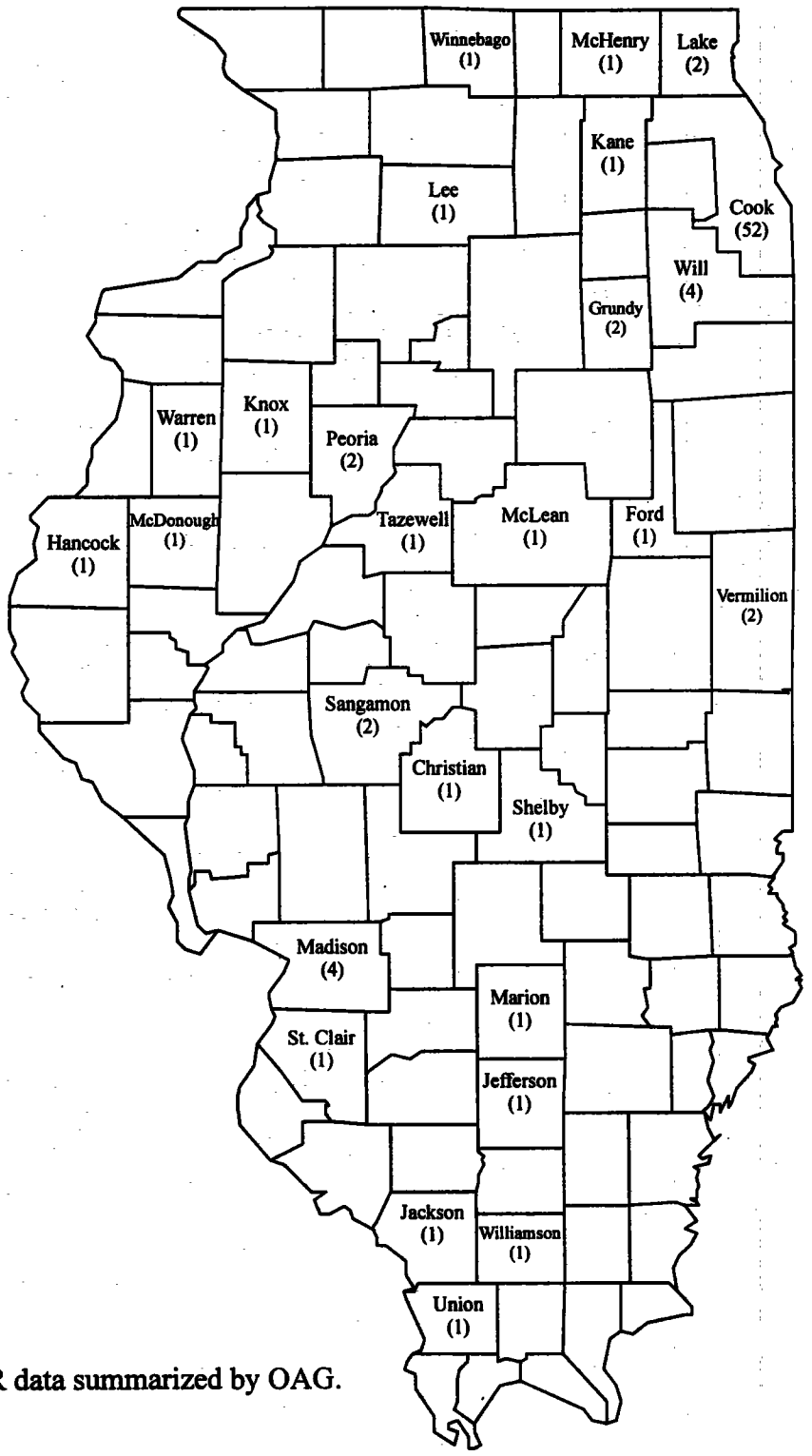
PHYSICIANS DISCIPLINED BY COUNTY IN FISCAL YEAR 1996

Adams	0	Henry	0	Perry	0
Alexander	0	Iroquois	0	Piatt	0
Bond	0	Jackson	1	Pike	0
Boone	0	Jasper	0	Pope	0
Brown	0	Jefferson	1	Pulaski	0
Bureau	0	Jersey	0	Putnam	0
Calhoun	0	Jo Daviess	0	Randolph	0
Carroll	0	Johnson	0	Richland	0
Cass	0	Kane	1	Rock Island	0
Champaign	0	Kankakee	0	Saline	0
Christian	1	Kendall	0	Sangamon	2
Clark	0	Knox	1	Schuyler	0
Clay	0	Lake	2	Scott	0
Clinton	0	LaSalle	0	Shelby	1
Coles	0	Lawrence	0	St. Clair	1
Cook	52	Lee	1	Stark	0
Crawford	0	Livingston	0	Stephenson	0
Cumberland	0	Logan	0	Tazewell	1
DeKalb	0	Macon	0	Union	1
DeWitt	0	Macoupin	0	Vermilion	2
Douglas	0	Madison	4	Wabash	0
DuPage	0	Marion	1	Warren	1
Edgar	0	Marshall	0	Washington	0
Edwards	0	Mason	0	Wayne	0
Effingham	0	Massac	0	White	0
Fayette	0	McDonough	1	Whiteside	0
Ford	1	McHenry	1	Will	4
Franklin	0	McLean	1	Williamson	1
Fulton	0	Menard	0	Winnebago	1
Gallatin	0	Mercer	0	Woodford	0
Greene	0	Monroe	0		
Grundy	2	Montgomery	0	Out of State	20
Hamilton	0	Morgan	0	Unknown	1
Hancock	1	Moultrie	0		
Hardin	0	Ogle	0	TOTAL	110
Henderson	0	Peoria	2		

Exhibit E-4

ILLINOIS MAP OF PHYSICIANS DISCIPLINED

Fiscal Year 1996



Source: DPR data summarized by OAG.

APPENDIX F
Agency Responses

Note: This Appendix contains the complete written responses of the Department of Professional Regulation. The Department did not concur with eight recommendations in the audit report and concurred or concurred in part with the remaining eight recommendations. In this Appendix the Department's responses appear on the left hand pages. The right hand pages contain Auditor Comments that respond to some of the issues raised by the Department. Because the Department's analysis involved cases between our two major samples, the Auditor Comments were prepared after we requested case identifier information from the Department to identify cases.

Illinois Department of Professional Regulation

Nikki M. Zollar
Director

Jim Edgar
Governor

May 2, 1997

William G. Holland
Office of the Auditor General
740 E. Ash
Illes Park Plaza
Springfield, Illinois 62703-3154

Dear Mr. Holland:

Enclosed is 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 not reprint the Department's response to your recommendations within the body of your report. Instead, we request that the following appear directly beneath each recommendation:

> "The Department's response to this recommendation, and the entire report, is appended to this report."

As a final request, I ask that a member of your staff notify me once you know the exact date when you will tender your report to the Legislative Audit Commission or otherwise make your report public.

Yours truly,

Nikki M. Zollar
Director

NMZ:vat

cc: Ed Wittrock
Michael Elvin

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RESPONSE OF THE

DEPARTMENT OF PROFESSIONAL REGULATION

TO THE AUDITOR GENERAL'S

PROGRAM AUDIT

May 2, 1997

Nikki M. Zollar
Director

TABLE OF CONTENTS

I. INTRODUCTION

More than fifteen months ago, the legislature passed Resolution No. 107, calling for a sweeping audit of the Department of Professional Regulation's ("Department") handling of medical cases. In the intervening time, the auditors have spent countless hours pouring over hundreds of Department files. The results: (1) a policy-based attack on the Illinois Medical Practice Act ("Act") first enacted by the legislature in 1987 and recently re-enacted; (2) a series of subjective, largely incorrect conclusions about the Department's investigative and prosecutorial process; and (3) recommendations that amount to no more than suggested development of procedural guidelines which are not appropriate under the circumstances.

Notwithstanding the limited nature of their actual factual findings, the Office of the Auditor General has concluded in an often times misleading report that the Department mismanages its investigation and prosecution of physicians and other doctors who may have violated the Medical Practice Act ("Act"). The Department objects to the content, tone, and methodology underlying the auditors' report. In this response, we present a more balanced presentation of the material gathered by the auditors and highlight those areas where the auditors' analysis is suspect.

Overall, the report is misleading because it sets forth negative conclusions squarely at odds with the actual factual findings in the report. For example, in Chapter Two, where the auditors criticize the adequacy of the Department's investigations,

Our conclusions are well supported by the evidence accumulated during the audit and presented in the audit report. To arrive at our conclusions we tested a total of 748 cases in three different samples. The results of our testing of cases were discussed in detail with the Department during the audit process. The Department's written responses specifically discuss only 42 of the cases that we tested. Throughout the Department's written responses we have included auditor comments to respond to some of the claims raised by the Department.

The factual findings and conclusions are based on statistically valid sampling methodologies. Our methodology involved random sampling of cases that were statistically significant with a 95 percent confidence level and a margin of error of 5 percent. More information concerning the sampling methodology is presented in Appendix B.

they found that "only a small portion" of the reviewed investigations were inadequate (p. 2-2); "93 percent of cases (325 of 348) had adequate investigations" (p. 2-5); and "most investigative activities...were documented on investigative reports [that] were usually sufficient" (p 2-4).

In Chapter Three, where the auditors discuss timelines, they found that the Department completed its investigation of an "average case" in approximately six months (p. 3-3) and that the median time for the Department to either close a case or enter a disciplinary order after referral to the prosecutions unit was seven months (p. 3-6).

In Chapter Four, which addresses the Department's disciplines, the auditors challenged the disciplines imposed, or not imposed, in only six percent of the audited cases. This chapter also contains an implied criticism that the Department should discipline more physicians given the increased number of complaints of late. The auditors fail to mention, however, the recently implemented Complaint Intake Unit, which receives and captures <u>all</u> consumer complaints irrespective of merit. The rise in complaints corresponds to the new unit, and in the Department's experience, the rise in total complaints does not equate to a rise in complaints with merit.

In Chapter Five, the auditors address the Department's former probation unit. Because the Department disbanded that unit prior to receiving the report, we do not specifically address the auditors' criticism.

As part of our balanced presentation, we did noted that the majority of investigations conducted by the Department in this one sample appeared to be adequate. However, we also noted problems with the adequacy of investigations in 13% of the cases included in our second sample (See page 25 of the report). Further, in that sample we note that 17% of closed cases received no investigation at all.

The Probation/Compliance Unit was disbanded **after** the completion of our fieldwork testing. However, the recommendations in Chapter Five relate to monitoring physicians who have been placed on probation or suspended and to having appropriate controls over employees working from their homes. These issues are important regardless of the organization shifts within the Department. The Department concurred in part with both recommendations contained in Chapter Five.

In Chapter Six, the auditors comment on the Department's evidence vault, computer system, and policies regarding impairment disclosure. Although we agree with the observations about the agency's new computer system as well as a need for a disclosure policy, we are particularly puzzled by the criticism of the evidence vault as the auditors themselves note management improvements and could not point to unaccounted for evidence.

In the following Sections II-VI, we address respectively the auditors' chapters about the adequacy of our investigations, our timeliness, the adequacy of our disciplines, our probation monitoring and other issues. In each section except for that addressing probation (Section V), we begin by reciting facts found by the auditors that refute their negative conclusions. In Sections II-IV, those addressing timeliness and adequacy of investigations and discipline, we then show that the auditors' criticism is largely incorrect. We conclude each section by specifically addressing each of the auditors' recommendations.

Although we gave the Department credit for taking action, their actions were not timely. A Department employee wrote a memo to his superior noting unaccounted for or missing items from the evidence vault in February of 1996. These missing items included prescription drugs. The Department did not conduct a new inventory until July and August of 1996 after our inquiries in June.

II. THE DEPARTMENT PROPERLY INVESTIGATED THE MAJORITY OF CASES IDENTIFIED BY THE AUDITORS, AND THE FACTS AS UNCOVERED BY THE AUDITORS BELIE THEIR CONCLUSIONS

Department's Conclusion

In Chapter Two, the auditors blanketly criticize the Department for its lack of procedures about (a) obtaining medical records and (b) investigative supervisory review and criteria to ensure that case files contain all necessary materials. **The auditors found, however, that the Department adequately investigated 93 percent of audited cases, which we do not believe supports any negative conclusions about the Department's process.**

It is literally correct that the Department does not have a set "procedure" to determine when medical records are necessary or to guide the progress of investigations. The auditors, however, reach incorrect conclusions that the Department should adopt such procedures. As shown below, the auditors do not have empirical support for the proposition that the lack of a written procedure regarding investigative techniques compromises the quality of the Department's work.

Our analysis of the cases reviewed by the auditors revealed that the Department correctly handled the vast majority of cases characterized by the auditors as deficient. In Chapter Two, the auditors criticized the Department's investigation of 23 cases, 11

of which are mandatory report cases.[1] They criticized the Department for failure to obtain medical records. (We address this in our response to Chapter Four where there is a full and complete discussion of the proper handling of mandatory report cases.) We address, in this section, the remaining 12 non-mandatory report cases, as well as 17 non-mandatory report cases outlined in the Auditor's Chapter Four [section] where the criticism leveled is actually about the investigation. We refute the auditors' criticism of 24 of the 29 cases and show that the Department acted reasonably and properly in the vast majority of the cases identified by the auditors as inadequately investigated. **Our conclusion: The Department's investigation was inadequate in only 5 of 453 cases, a 98.9% adequacy rate.**[2]

Specifically, we show that the auditors based their criticism of the vast majority of the non-mandatory report cases on subjective disagreement with the Department's handling of these cases rather than some objective shortfall in the investigation.

A. Cases combined with others for procedural reasons

The auditors criticize the Department's handling of 4 cases

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[1]Section 23 of the Act requires health care institutions, professional associations, professional liability insurers, state's attorneys and other state agencies to report to the Department, for example, the termination or restriction of a physician's privileges, final determinations of unprofessional conduct, settlements or judgments in civil actions, conviction for a felony and other unprofessional conduct, respectively. These reports are referred to as "Mandatory Reports" and form the basis of many of the Department's cases.

[2]The auditors' Case Example 1 is one of the 5 cases.

where the Department combined the cases with other pending cases for procedural reasons. **As shown below, the procedural combination of cases had no bearing on the ultimate outcome, and the auditors' criticism is misplaced.**

The Department closed two cases without investigation where adding the complainants' allegations to a pending complaint would have served no purpose other than to delay the Department's pending case. When the Department received the two complaints, it already had a formal complaint on file against the physician based on similar allegations of many other individuals. The Department's proceeding was stayed pending a federal criminal case based on the same allegations. The Department held the two additional cases in investigations pending the outcome of the federal criminal trial.

When the jury in the federal criminal case convicted the physician, the federal court lifted the stay on the Department's proceeding. At that point, the Department elected to close the additional two cases because (a) adding new counts to the formal complaint or naming additional witnesses would have further delayed the Department's proceeding; and (b) the Department attorney did not believe that two additional counts or witnesses would change the ultimate discipline. The Department revoked the physician's license for a minimum of six years with conditions for restoration. This outcome confirmed the wisdom of the Department's decision to close the two new cases rather than delay its proceeding.

The auditors criticize two other cases because they were "[c]losed to [u]nrelated [c]omplaints." Translated, this means

These two cases were closed because the Department concluded that they could not or should not modify an existing formal complaint. The cases were closed **before** the Department imposed any discipline on the physician based on the earlier complaints.

that rather than conduct two independent parallel investigations against the same physician, the Department closed the newer case and investigated the allegations in the context of the initial case. In the first case allegedly closed to an unrelated case, the Board recently approved a stipulation and recommendation imposing an indefinite suspension. The Department closed the second case criticized by the auditors after the mutual complainant refused to cooperate. **The practice of closing and relating cases is entirely proper and serves to consolidate and focus the Department's efforts.**

B. Cases with appropriate limited investigation

The auditors fault the Department for conducting only limited investigations in 13 cases. The auditors apparently subscribe to the theory that the investigative process requires one to proceed blindly through a series of tasks, like a robot, even where (a) anonymous complaints provide insufficient information to proceed; (b) information provided by the complainant, assumed to be true, showed there to be no violation of the Act; (c) the Department had either an alternative to an investigative interview with, or sufficient information from, a respondent; and (d) either the complainant or a material witness refused to cooperate. We show below that the Department appropriately limited its investigation in each scenario.

(1) Cases with anonymous complainants

In two cases criticized by the auditors, an anonymous complainant provided insufficient information to proceed,

In both of these cases, the case we were testing was closed to a case where the allegations were completely different. Although we agree that combining related cases is proper, we saw no evidence that the allegation in our test case was considered after it was closed. In the first case the allegation was for inappropriate prescribing while it was combined with multiple allegations of unnecessary surgery. In the second case the complaint was combined with a case made against a different physician.

In all of these cases, our review indicated that there were individuals who should have been interviewed or information that should have been obtained to have suitable evidence for the case. Our review did not require robotic collection of evidence, but when an allegation had not been proven or disproven, and evidence sources were still available but were not used, we considered the investigation inadequate.

therefore, the Department subsequently closed the case. In one case, an anonymous complainant made vague, general allegations about rude behavior by a physician. In the absence of a named complainant from whom to elicit more specific information, the Department elected to close the case because general allegations of rudeness do not rise to the level of violating the Act.

In the other case, the complainant was a physician who received an anonymous telephone call from a nurse with respect to medical care provided at a certain hospital. The complainant could identify neither the physician nor the patient, and in the absence of more detailed information the Department closed the case.

(2) Cases with sufficient information from complainant

In three cases, the Department limited its investigation where the information from the complainant indicated no possible violation of the Act. The Department closed one case without interviewing either the respondent or the complainant because the complainant submitted a detailed, written complaint about the fee charged by the physician. The written complaint, on its face, showed that the fee was within an acceptable billing range and therefore did not constitute overbilling, the only possible violation of the Act in fee dispute cases. Similarly, the Department terminated its investigation of two other cases after it determined that the alleged physician conduct did not violate the Act. Further investigation in each case was, therefore, unnecessary.

These two anonymous complaints had enough specific information to allow the Department to continue investigations. In the first case the complainant did allege rudeness. In addition, the complainant alleged the physician caused stress to pregnant women and disregarded remarks of pain from Public Aid recipients. The Department could have sent someone to the office as an observer or could have contacted the respondent. In the second case the complainant provided patient identification numbers from a hospital. No attempt to use the patient identification number to identify the physician was documented in the case files.

In the first case the complainant alleged possible insurance fraud. Contrary to the Department's written response, the Department's records indicate that the case was closed because the complainant was not cooperative, not because the Department had sufficient information to make a decision. In fact, the complainant's phone number was available but no attempt to call had been documented. In one of the remaining two cases, no attempt was made to follow up on an allegation that a physician was practicing without an Illinois license. In the final case, no attempt was made to identify a physician through pharmacy records.

(3) Respondent interview cases

In two cases the Department did not interview the respondent because it either elected to defer the respondent interview or already had a written statement from the respondent. In the first case, the Department's medical coordinator reviewed materials from an insurance company and concluded that the respondent had engaged in a pattern of overbilling. The Department currently is prosecuting the case and elected to hear the respondent's story in the context of an informal conference rather than an investigative interview. Because the Department's rules clearly state that fact finding is an appropriate objective for an informal conference, electing to hear the respondent's story at an informal conference should not subject the Department to criticism. In the second, the respondent provided a detailed written response sufficient to answer the coordinator's questions, and therefore no reason existed to interview the respondent.

(4) Refusal to cooperate cases

The Department closed six cases with limited investigation where either the complainant or a material witness refused to cooperate. In one case, the complainant complained about (a) the fee charged and (b) an alleged failure to diagnose a condition that a subsequent treater diagnosed. The Department determined that the fee was within the normal, expected range, but nevertheless attempted to contact the complainant to pursue the other

In the first case, there was not documentation that the interview was consciously delayed. Because Department policies do not cover how an investigation should be conducted, no guidance is available on when investigators should delay an interview with the respondent. When we reviewed this case, it had been referred out of Investigations to the medical coordinator, but no informal conference had been held. The second case was a mandatory report for which medical records were not obtained and the respondent was not interviewed. Although the medical coordinator recommended a letter of concern, we concluded that, without the noted additional evidence, the investigation was inadequate.

- In this case, the Department's own supervisory review notes, on two separate occasions, state that the respondent should be contacted but respondent was never contacted.

allegation. When the complainant failed to cooperate the Department closed the case.

The Department terminated five other investigations after material witnesses would not cooperate. In each of the cases, when the witness refused to cooperate, the Department determined that (1) the uncooperative witness was essential to successful prosecution and the witness's unwillingness to testify made further investigation a futile exercise; or (2) the uncooperative witness, coupled with other information obtained in the investigation, rendered the case unprovable.

C. Cases where the Department's investigation was sufficient for the coordinator to exercise his medical judgment

The auditors criticized the Department's investigation of 7 cases even though the coordinator recommended closing after reviewing the investigative file. Each of the files in these cases contained sufficient information for the coordinator to exercise his medical judgment, including, but not limited to, interviews of material witnesses, medical records, pre- and post-operative photographs and AMA profiles. It is impossible for the auditors to criticize the Department's investigation in these cases, and appear credible, without offering a contrary medical opinion, which they have not done.

Set forth below are the Department's responses to the auditors' recommendations 1-4.

In these five cases, other witnesses were available, evidence was available but not obtained, or attempts to contact a witness were not documented in case files. In one case, a woman made an allegation of an improper breast exam against a specialist. The complainant was considered uncooperative because she would not sign a release for the medical records of her primary physician who was not involved or present at the time of the alleged incident; however, she did sign a release form for the medical records of the accused physician.

In these seven cases, there were three cases where medical records were not obtained, there were three cases where a physician or physicians had conflicting opinions but were not contacted, and there was one case where a witness to the allegation was not contacted. Two of these cases had no substantive activity for over two years.

In our testing we did not make medical judgments nor did we question the medical judgment used in these cases. What we did question was whether all relevant evidence was collected to aid medical experts in their decision. When we concluded that significant, relevant evidence had not been collected which could impact a medical judgment, such as relevant medical records or other physicians' opinions, we questioned the adequacy of the case.

1. The Department of Professional Regulation and the Medical Disciplinary Board should develop criteria to determine when medical records are needed and should ensure that medical records are obtained when necessary.

The Department does not concur with recommendation 1. The Act vests the responsibility for determining violations of the Act with the medical coordinator and the Board. The coordinators are physicians, as are a majority of Board members. The legislature apparently based the statutory scheme on the wisdom that physicians are best able to judge the conduct of other physicians. For this reason, the Department believes that physicians are best able to determine when medical records are, or are not, necessary to decide whether a physician's conduct violated the Act. The Department's current practice, permitting the coordinator and Board members to decide the necessity for obtaining medical records, is consistent with the Act and therefore proper.

2. The Department of Professional Regulation should establish appropriate policies and procedures to ensure that all cases are adequately investigated, have adequate supervisory review and follow-up, and that case files contain all necessary documentation.

The Department does not concur that its current practice, permitting the coordinator to evaluate the sufficiency of the investigative file, is inadequate. In fact, its current practice is consistent with the Act and therefore proper. The Department concurs that cases must be adequately investigated, have supervisor review, and have complete case files.

3. The Department of Professional Regulation should adhere to the rules of the Administrative Code and not close any cases without approval by the Medical Disciplinary Board.

The Department does not concur that the cases closed by the medical unit demonstrate a material violation of the Code. The medical unit closed most of the cases identified by the auditors between the initial receipt of information from a complainant and the initiation of a case in investigations. The medical unit closed the cases for a variety of proper reasons, including already expired statutes of limitations; inapplicability of any provision of the Act; the complainant's refusal to cooperate; and lack of Department jurisdiction over the dispute. The Department does agree, however, that it must comply with the rules of the Administrative Code and it therefore intends to seek a rule change in the future.

4. The Department of Professional Regulation should develop a training policy to ensure that investigators are given systematic and continuing training in areas related to their professional duties.

The Department does not concur that it needs a training policy. Its investigators, all of whom have law enforcement experience, and many of whom have academy training, receive training on an as-needed basis and where appropriate.

III. THE DEPARTMENT WAS TIMELY IN INVESTIGATIONS AND PROSECUTIONS, AND THE AUDITORS' CLAIM TO THE CONTRARY IS WRONG

Department's Conclusion

In Chapter Three, the auditors conclude that the Department lacks adequate "standards" and "management control" to ensure timeliness in investigations, coordinator review or prosecutions. **The auditors found, however, an average six month time period in investigations and prosecutions.[3] We do not believe that this time frame suggests a need to enact new procedures.**

A. Investigations

The primary basis for the auditors' criticism of the Department's timeliness in investigations is a May 1996 memorandum setting a 90 day time limit on investigations. This Department directive was part of an on-going attempt on the part of management to "push the envelope" on timeliness. However, before Department management even received a draft of this report, it realized that a 90 day time frame was not feasible and in fact could compromise the quality of investigations by setting a non-realistic time frame. For these reasons, in November 1996, the Department rescinded the May 1996 memorandum and later issued a new guideline that sets no specific time frame on investigations. The

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[3]Case Examples 3-5 all reflect substantial periods of inactivity. With respect to examples 3 and 5, given the median time periods the auditors identified for investigations and prosecutions, the Department believes the auditors also could have selected cases handled expeditiously by the Department had they desired to present a balanced view of the Department. Case example 4 involved delay with the coordinator, a situation the Department has corrected.

Case examples were selected from our random statistically valid sample of cases. More information on our statistical sampling methodology is contained in Appendix B.

Department's current policy, which is to not impose specific time limits, is consistent with that of the majority of states responding to the auditors' survey.

B. Medical Coordinator

The Department concurs with the auditors' criticism of the medical coordinators' timeliness in fiscal years 1995 and 1996. As the auditors correctly observe, the Department lacked a coordinator during substantial time periods over those two years. The Department, however, has corrected the problem and expects to be timely in the future. To illustrate, as of April 30, 1997, fewer than 5 cases awaited review by the medical coordinator, only one of which was assigned to him prior to April 1997. The Department has also hired an additional coordinator on a part-time and "as needed" basis.

C. Prosecutions

First, we do not believe that a median time of 7 months from "referral" to "prosecutions" to "order entry" warrants criticism.

Second, for the reasons stated below the auditors' analysis of prosecutions' timeliness is flawed. It is inappropriate and incorrect to charge the prosecutions unit with responsibility for the full period of time between review by the medical coordinator and entry of the final order by the Director. The only period of time over which the prosecutors have complete control is between assignment and the filing of a formal complaint or the serving of notice of informal conference.

Our analysis of the timeliness of prosecutions was done with two methods. First we analyzed average and median times for portions of the process that we clearly identified. Second, we analyzed cases to identify periods of three months during which no substantive activity took place. Of the 72 cases in our sample of cases closed that were referred to the Prosecutions Unit, 20 (28 percent) had at least one such lapse. Two cases each had ten three-month lapses with no substantive activity performed.

Unfortunately, it appears the auditors failed to even examine the entire disciplinary process as no questions were asked of, or determinations made regarding, the hearing officers or Director's involvement. Without having considered these parties as major factors in the disciplinary process, it is difficult to believe any conclusion reached by the auditors is sound.

Once the Department files a formal complaint, it must afford the physician **due process** in the subsequent hearing proceedings.[4] Similarly, if the Department elects to conduct an informal conference, it cannot compel a swift resolution of the matter.

In either scenario referenced above, the Department often confronts attorneys who use due process to delay the proceedings; who force the Department to brief the issues and to respond to numerous motions; who know what errors will allow a reviewing court to reverse the Department's decision and thereby require the Department to respond accordingly; who endlessly review and negotiate every provision in a consent order; and who generally, under the auspice of protecting their client's interests, enact every imaginable obstacle in the path to discipline. Any analysis

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[4]Due Process in this context is provided for under the Administrative Procedure Act. The Administrative Procedure Act ("APA") requires the Department to adopt rules for procedures in contested hearings, 5 ILCS 100/10-5 (1996), and sets forth detailed notice provisions, 5 ILCS 100/10-25 (1996). The Department's rules, promulgated pursuant to the APA, provide for the service of a complaint and accompanying notice of initial hearing; the requirement that the respondent answer in writing; the exchange of discovery; the opportunity to file no fewer than 14 types of motions, when applicable; preliminary and evidentiary hearings; pre-hearing conference; and determination of factual issues by the appropriate Board.

The fact that we made no recommendation about hearing officers or the Director's review does not mean that we did not examine this area. We reviewed the entire process, that we described as prosecutions.

We understand the concept of due process. In our analysis, we looked for periods with no substantive activity. If the process was delayed for appropriate reasons, including due process, and was documented in the Department's files, we did not consider it a period of inactivity. For example, if the file contained a note that a hearing was continued for some reason, we counted that as a substantive activity.

of timeliness related to the prosecutions unit that ignores these facts, as the auditors' does, is inherently flawed.

Set forth below are the Department's responses to the auditors' recommendations 5-7.

5. The Department of Professional Regulation should establish management controls to ensure the timely completion of investigations. These controls should be in the form of written policies which are usable, meaningful, and consistently applied and enforced. Monitoring of compliance could be accomplished with computerized management reports.

The Department does not concur that it needs further management controls on timeliness in investigations. Even though the Department does not intend to further quantify its time policy, it is actively and effectively managing the investigators' caseloads and expects to meet or exceed its current timeliness standard in the future.

6. The Department of Professional Regulation and the Medical Disciplinary Board should take the steps necessary to assist the medical coordinators with backlogs and improve case timeliness.

The Department concurs that assisting the medical coordinator with timeliness and reducing backlogs are worthy objectives; however, the Department has already accomplished these goals and has squarely addressed the time delays and backlogs that were a remnant of the times it was without a coordinator. The Department

◀ The Department notes that they expect to meet or exceed current timeliness requirements. However, they note on page 13 of their response that as of November 1996 they have "...a new guideline that sets **no specific time frame** on investigations." [Emphasis added]

fully expects that the coordinators will continue to review cases assigned to them in 1997 and forward promptly.

7. The Department of Professional Regulation should develop management controls to ensure that cases are reviewed by the Prosecutions Unit in a timely fashion. These controls should include timeliness standards.

The Department does not concur with recommendation 7, but acknowledges that timeliness is of the utmost importance.

IV. THE DEPARTMENT IMPOSES APPROPRIATE DISCIPLINE, AND THE FACTS REFUTE THE AUDITORS' CRITICISM

Department Conclusion

In Chapter Four, the auditors extensively discuss and criticize the Department's process for handling mandatory report cases. **Again, the auditors completely ignore the mandatory reporting provisions in the Act and thus incorrectly conclude that when the Department does not obtain medical records in mandatory report cases, the Department does not obtain a discipline when it should.**

Once again, it is literally correct that the Department has no set policies for either obtaining medical records or imposing disciplines. As we show below, though, the Act specifically mandates the Department's mandatory report practice, and the auditors are incorrect in their criticism of the Department's disciplines.

Additionally, the auditors conclude that the Department lacks policies for ensuring similar disciplines in like cases - this is also incorrect. In those instances in which factual situations lend themselves to similar discipline the Department has always operated with standard guidelines.

A. The mandatory report/medical record myth

The cornerstone of the auditors' criticism of the Department is the handling of mandatory report cases. We have no quarrel with the auditors' description of how and under what circumstances mandatory reports come to the Department. We strongly disagree,

We are aware of the provisions of the Medical Practice Act that allow the Board to close mandatory report cases. When we tested cases we looked to see if sufficient, relevant evidence had been collected to allow a reasoned decision on whether to close a case. Where there was not, we questioned the adequacy of that case.

however, with the auditors' assertion that the Department inadequately investigated mandatory report cases because it did not obtain medical records.

In each of the cases cited by the auditors, the Department closed the case or referred it to prosecutions only after the Board considered the mandatory report, the physician's response, or both. As demonstrated below, the law (wholly ignored by the auditors) specifically contemplates the Department's practice in the 99 mandatory report cases criticized by the auditors for failure to obtain medical records.

Section 60/23(E) of the Act (reprinted in its entirety in Appendix 1) states in pertinent part:

> Upon the receipt of any report called for by this Act, other than those reports of impaired persons licensed under this Act required pursuant to the rules of the Disciplinary Board, the Disciplinary Board shall notify in writing, by certified mail, the person who is the subject of the report. Such notification shall be made within 30 days of receipt by the Disciplinary Board of the report.
>
> * * *
>
> The person who is the subject of the report shall be permitted to submit a written statement responding, clarifying, adding to, or proposing the amending of the report previously filed.
>
> * * *
>
> The Disciplinary Board shall review all reports received by it, together with any supporting information and responding statements submitted by persons who are the subject of reports.

We are aware of the provisions of the Medical Practice Act that allow the Board to close mandatory report cases. When we tested cases we looked to see if sufficient, relevant evidence had been collected to allow a reasoned decision on whether to close a case. Where there was not, we questioned the adequacy of that case.

* * *

> When the Disciplinary Board makes its initial review of the materials contained within its disciplinary files, the Disciplinary Board shall, in writing, make a determination as to whether there are sufficient facts to warrant further investigation or action. Failure to make such determination within the time provided shall be deemed to be a determination that there are not sufficient facts to warrant further investigation or action.
>
> Should the Disciplinary Board find that there are not sufficient facts to warrant further investigation, or action, the report shall be accepted for filing and the matter shall be deemed closed and so reported. The individual or entity filing the original report or complaint and the person who is the subject of the report or complaint shall be notified in writing by the Disciplinary Board of any final action on their report or complaint.

As we show, the law not only permits the Department's practice in mandatory report cases but contemplates it.

By its terms, the Act calls for:

(a) the Board to notify the subject physician about the report;

(b) the physician, if he or she desires, to submit a response; and,

(c) the Board to review all materials "submitted by persons who are the subject of reports."

Based on the mandatory report and possibly the physician's response or other "submitted" materials, the Board "shall" determine whether there is an indicated need for further investigation and "shall" close the case if the materials fail to indicate that need. This is precisely the procedure followed by the Board in the 99 cases criticized by the auditors.

In the majority of the cases challenged by the auditors (69), the Board closed the case or referred the case to prosecutions after its initial review of the mandatory report file. Always among the materials found in the file is the actual mandatory report (a representative sample of which is attached as Appendix 2). The report requires various detailed information, including a description of the alleged negligent conduct by the physician. The Board referred the remaining 30 cases for further investigation because the file did not contain a physician response. When the investigations unit received responses, many of which were quite detailed and contained relevant portions of the patient's medical records, it tendered these files to the coordinator for review. Thus, as shown above, in each case challenged by the auditors the Department followed the Act, which invokes the extensive professional expertise of the Board, the majority of whom are physicians.

In essence, the auditors really are contending that the Board must obtain medical records in all mandatory report cases. If the legislature had desired the scheme suggested by the auditors, to obtain medical records in all cases, it could have easily mandated such. Strong policy considerations, however, militate against this methodology. First, it would vitiate the professional expertise and judgment of the Board. Second, the taxpayers would pay for unnecessary investigations. Finally, obtaining unnecessary medical records would increase the length of time needed to assess the case and thereby require the accused physician to wait for the result of

We have not advocated that medical records be obtained in all mandatory report cases. In fact, we found some mandatory report cases in our sample in which no medical records were obtained and we considered the case adequate. However, in many allegations which involve the appropriateness of medical treatment, we question how adequate evidence can be accumulated and reasoned decisions made without receiving the medical records relating to the mandatory report. As a result, we recommended that a policy be established to provide guidance.

an unnecessary investigation of a questionable case which could have been quickly decided by a medically informed panel. All things considered, the legislature chose wisely when it put the current system in place.

The tacit, flawed assumption underlying the auditors' mandatory report criticism is that either a judgment or a settlement in a civil action against a physician indicates a likelihood that the physician violated the Medical Practice Act. For two reasons, this assumption is wrong. First, civil malpractice actions require only that the plaintiff prove simple negligence by a preponderance of the evidence. The Act, however, requires proof of gross negligence by clear and convincing evidence. An allegation of negligence in a civil action, therefore, is far easier to prove than a violation of the Act. For this reason, settlement or verdict in a civil case does not equate to a provable case for the Department. Second, defendant physician/insurers often settle cases for reasons that have little to do with the underlying facts of the case in question. Fear of unduly sympathetic juries often results in settlements, and this is especially true in medical malpractice cases involving deaths or long term (and costly) disabilities. This fear of juries is heightened in areas of the state which have a reputation for favorable plaintiffs' verdicts.

The auditors' case examples themselves illustrate the Department's point. In case example 2, one of the disputed 11 inadequate investigation cases involving mandatory reports, the

- Although we do not assume that a malpractice settlement indicates that a physician has violated the Medical Practice Act, we do believe that it indicates that they **may** have violated the Act. As a result, we tested to determine whether there was sufficient evidence to make a decision to close the case.

- The Department's summary of this case is based on the written statement of the physician who allegedly violated the Medical Practice Act. Since the allegation involved the timeliness of a medical diagnosis, we believe that medical records would have provided additional evidence on which to judge the allegation. (Case Example 2)

Department received a response from the physician, but did not secure medical records. The patient in this case presented to her physician with post-partum bleeding from the nipple. She chose not to follow her physician's advice to have a biopsy performed, as she was breast feeding. When she returned for the biopsy, the physician diagnosed cancer. Because the mandatory report and the physician's response set forth these facts, the coordinator determined that the medical records would neither (a) alter the facts nor (b) change the finding that the physician did not violate the Act. For these reasons, it is incorrect to state that the Department failed to "investigate" this case.

In case example 8, a mandatory report case allegedly closed "without an investigation," the medical coordinator determined, based solely on the mandatory report, that the injury, a cut to the infant's cheek, was a known complication of an emergency C-section and not gross negligence.

In case example 10, another mandatory report case closed supposedly "without investigation," based on the report and the respondent's response, the medical coordinator found no violation of the Act. In this case, the physician never was consulted on the case but merely performed two echocardiograms on the patient at the primary physician's request, three years apart and two years prior to the patient's death. His diagnosis of congenital aortic stenosis was never disputed; he was not the patient's primary physician; and he reported his accurate findings to the primary

◀ The Department's summary of this case is based on the written statement of the physician who allegedly violated the Medical Practice Act. Although it may be a known complication, we believe that medical records would provide better evidence on which to determine whether the physician took due care to avoid the laceration to the newborn. (Case Example 8)

◀ The Department's summary of this case is based on the written statement of the physician who allegedly violated the Medical Practice Act. Since the allegation involved the adequacy of medical treatment, we believe that medical records would have provided additional evidence on which to judge the allegation. (Case Example 10)

physician. The coordinator determined that these facts did not evidence a violation of the Act.

In case example 11, likewise allegedly closed "without investigation," as shown below the Department acted correctly. Despite the respondent's history with the Department (mentioned by the auditors), this unique case did not merit further investigation beyond examining the adverse action report and the physician's response. **A dog bit a person. The bite victim had surgery to repair the wound caused by the bite. The subject of the report performed the surgery, the quality of which was never questioned. The victim, however, sued the dog owner; in an apparent effort to limit his expenses, the dog owner sued the doctor, alleging that the surgery was unnecessary. Ultimately, this ridiculous series of legal posturing ended with a nuisance settlement of $10,000.** These facts, as determined correctly by the medical coordinator without the need for medical records, provided no conceivable violation of the Act. As for the doctor, the auditors correctly note that the Department has since revoked his license for many other transgressions. Contrary to the auditors' claim, the Department did not view the violations leading to the revocation as related to the dog bite episode.

For these reasons, the Department believes that the criticism levelled by the auditors against the Board's handling of mandatory report cases is baseless. The Board follows the mandate of the law precisely. The auditors' suggestion regarding the proper handling

The allegation was that unnecessary surgery was performed. With no investigation, the Department closed the case even though there were other complaints against the same physician alleging unnecessary surgery. (Case Example 11)

of mandatory report cases is more properly addressed to the legislature.

B. The Department's disciplines are appropriate

The auditors questioned the disciplinary action taken by the Department, or lack thereof, in only 15 of 240 audited cases. Of those 15, the Department maintains that it and the Board appropriately handled each of the cases. The Department submits that the auditors would have reached a different conclusion had they not confined their analysis to the naked allegations by the complainant and not ignored the Department's burden to prove violations of the Act by clear and convincing evidence.

In 8 cases the auditors concluded that "discipline appeared to be warranted." Those cases resulted in no discipline for various reasons, including that the Department attorney determined that we could not meet our burden of proof and that a Board member concluded that the respondent physician was not negligent. The auditors' conclusion that discipline seemed appropriate in these cases ignored the medical and legal judgment needed to successfully prosecute a case.

Case examples 6 and 7, where the auditors suggest that supposedly clear Act violations resulted in no discipline, actually illustrate the Department's argument. In case example 6, the Department determined that it could not sustain its burden of proof with respect to this "undercover" non-therapeutic prescription case because the physician had strong evidence of a therapeutic purpose for prescribing. Ultimately, the Department decided to close the

These 8 cases without discipline included three cases with multiple undercover drug purchases by the Department's investigators, one case where the physician admitted a tragic error, one allegation of substance abuse by a physician, one of allegation of substandard care resulting in death, one allegation of inappropriate breast fondling, and one allegation of surgery to the wrong knee.

It is unclear how the non-cooperation of the initial complainant would be important after significant undercover work by the Department's investigators. Given the success of the investigator in obtaining drugs on 5 separate occasions, we still question whether some disciplinary action should have been taken. However, if taking a history from a patient or conducting a physical examination raises sufficient doubt to undermine an allegation of non-therapeutic prescribing of drugs, then we question why Department resources were used to obtain drugs on 4 subsequent visits. This illustrates the need for additional investigative policies and training in this area, which we recommended in the audit report, for which the Department did not see the need. (Case Example 6)

case due to uncooperative witnesses and limited undercover success. In case example 7, after an informal conference, the Department decided that it could not prove the alleged non-therapeutic prescribing by clear and convincing evidence because the respondent took an extensive history from the undercover investigator and performed an extensive physical examination. We submit that the Department handled both cases correctly and that nothing more could have been done to discipline the physician within Department rules.

In the 6 cases where the auditors questioned the discipline as not "severe enough," the disciplines ranged from a multiconditioned probationary order to a suspension. In each of these 6 cases, the Board considered the evidence supporting the Department's case, the evidence produced in defense of the respondent, as well as matters in aggravation and mitigation. The Board then weighed these factors in light of other <u>similar</u> cases, and arrived at the stated discipline.[5] The auditors have neither offered similar cases with greater discipline nor suggested more appropriate disciplines.

Set forth below are the Department's responses to the auditors' recommendations 8-11.

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[5] In the remaining case, Case Example 9, the auditors found that the Department too severely sanctioned a chiropractor who provided treatment to a canine. While a reprimand is in fact the least severe discipline available to a respondent, the Department does not take practicing beyond the scope of a medical license lightly, nor should the auditors.

After an allegation of non-therapeutic prescribing by a federal agency, the Department's investigator obtained drugs on 5 separate occasions from this physician. Given the success of the investigator in obtaining drugs on 5 separate occasions, we still question whether some disciplinary action should have been taken. However, if taking a history from a patient or conducting a physical examination raises sufficient doubt to undermine an allegation of non-therapeutic prescribing of drugs, then we question why Department resources were wasted on obtaining drugs on 4 subsequent visits. This illustrates the need for additional investigative policies and training in this area, which we recommended in the audit report, for which the Department did not see the need. (Case Example 7)

In these 6 cases, the severity of the allegation caused us to question the adequacy of discipline. These cases involved personal alcohol and drug problems, non-therapeutic prescribing, and performing unnecessary services. Some involved multiple allegations of a similar nature. Because there are no criteria to guide decisions in disciplinary actions, we also considered <u>similar</u> cases but found circumstances in these cases that made us question the adequacy of discipline.

8. The Department of Professional Regulation should develop procedures for including persons making complaints in the disciplinary process.

The Department does not concur with recommendation 8. First, our staff normally speaks with the complainant in order to understand the nature of the complaint. Second, the Act provides for complainants to submit any materials they believe relevant. Next, complainants receive a series of letters advising them about changes in the status of the case generated by their complaint. Having complainants sign investigative reports, as the auditors suggest, would serve no useful purpose and would only delay the Department's investigation, invite countless time-consuming inquiries from complainants and be exceedingly costly.

As the auditors observe in their Appendix D, the Department currently uses complainants as witnesses where their testimony would "aid" the Department's case. This is accurate - we cannot imagine another scenario where the Department would use the complainant as a witness, and therefore we see no reason to change our current practice.

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

The Department does not concur with recommendation 9. The Department notes that the auditors' assertion that the Department has "few" policies and procedures to guide its discipline process is incorrect. Where appropriate--in relatively non-complex,

standard matters such as non-payment of taxes, student loans and child support cases--the Department has standard disciplines. In other more complex cases, it would not be appropriate to enact standard guidelines. In order to impose fair disciplines the Board needs the latitude (a) to consider the facts proved by the Department, the physician's defense, and evidence in aggravation and mitigation and (b) to weigh all these factors against prior cases.

The Department believes that the few cases questioned by the auditors show that the Board imposes appropriate disciplines, and there is no reason to enact a rigid, guideline-based discipline system. The Department further notes that its system is consistent with that of the majority of the states surveyed by the auditors.

10. When reporting disciplinary actions, the Department of Professional Regulation should distinguish between the number of disciplinary actions taken and the number of physicians disciplined. Furthermore, the Department should comply with statutory reporting requirements for reporting physicians who were disciplined.

The Department concurs that it should comply with the statutory requirements for reporting disciplined physicians and states that it does. The Department further states that it (a) attributes the "few" instances where it neglected to include a discipline in its monthly report to human imperfection rather than systemic statutory non-compliance and (b) publishes disciplines, a sample copy of which is attached as Appendix 3, according to physicians rather than number of disciplines. Thus, the auditors'

AUDITOR COMMENTS

Our analysis found physicians missing from the DPR news, not simply disciplines. As the report notes, the missing information included one case where the physician's license was revoked and two cases where physicians' licenses were suspended.

concern about the Department issuing misleading information is misplaced.

11. The Department of 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.

The Department concurs with recommendation 11.

V. THE PROBATION UNIT NO LONGER EXISTS

Department's Conclusion

In Chapter Five, the auditors criticize the former probation/compliance unit for, among other things, the fact that probation cases require little work out of the office, and yet the probation investigators had state vehicles. Months ago, however, Department management recognized the problems with the probation unit and disbanded it.[6]

Set forth below are the Department's responses to the auditors' recommendations 12-13.

> 12. The Department of Professional Regulation should develop management controls to ensure that cases in the Probation/Compliance Unit are properly monitored. The Department should also implement procedures to ensure that physicians whose licenses have been either suspended for a long term or revoked are not continuing to practice.

The Department concurs in part. With respect to the first sentence in recommendation 12, the Department states that effective February 1997 it disbanded the probation unit; that it has assigned medical probation cases to the medical investigations unit; and

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[6]Two of the auditors' Case Examples address probation cases. Case Example 12 is not critical and accurately describes the Department's procedure. We do not understand the point of Case Example 13, but submit that (a) the file contained all documentation required under the probation order and (b) the issue of in what state the physician resided is immaterial, because by the order's terms the probation expired when the Illinois temporary license expired. At that point, we closed the case.

- The Probation/Compliance Unit was disbanded **after** the completion of our fieldwork testing.

that the Chief of Medical Investigations and the coordinator are responsible for ensuring that the cases are properly monitored. The Department concurs with the second sentence in recommendation 12.

13. In establishing management controls for the Probation/Compliance Unit, the Department of Professional Regulation should develop written policies and procedures and should reevaluate the need for Probation investigators to work from their homes and be issued a State vehicle.

The Department concurs in part and states that effective February 1997 it disbanded the probation unit.

VI. THE AUDITOR'S "OTHER ISSUES" DEMONSTRATE NO MATERIAL WEAKNESSES IN THE DEPARTMENT'S PRACTICES

Department's Conclusion

In Chapter Six, the auditors discuss the Department's computer system, impairment disclosure policy, and evidence vault. Their observation with respect to the new computer system is well intentioned, however, it is misplaced as the point of going to a new system is precisely for the reason they have suggested in their recommendation. Additionally, the Department agrees with the recommendation to adopt an impairment policy, as well as a conflict of interest policy.

As for the evidence vault, the auditors state that they observed "weakness" in the Department's management controls. The auditors' factual findings, however, refute their conclusion: (1) the Department has policies and procedures; (2) management over the vault has improved; (3) all evidence in the vault was reconciled to the log book; and (4) when inventoried, all of the vault evidence was accounted for.

Set forth below are the Department's responses to the auditors' recommendations 14-16.

14. The Department of Professional Regulation should ensure that the replacement system for the Enforcement Case Tracking System has the capability to help management to better control the quality and timeliness of the enforcement process.

Although we gave the Department credit for taking action, their actions were not timely. A Department employee wrote a memo to his superior noting unaccounted for or missing items from the evidence vault in February of 1996. These missing items included prescription drugs. The Department did not conduct a new inventory until July and August of 1996 after our inquiries in June.

The Department currently is implementing a new computer program for all of its enforcement units, including the medical unit, and therefore concurs that the new system should incorporate all necessary features for management.

15. The Department of Professional Regulation should continue its efforts to improve controls over the evidence room. These controls should include procedures covering proper handling and disposition of cash, prescription drugs, and guns. The Department should also ensure that the destruction of evidence is properly documented.

The Department concurs with recommendation 15, but states that the auditors failed to uncover a single case compromised by the handling of evidence; and that the Department intends in the near future to issue a new evidence policy and destroy unneeded evidence.

16. The Department of Professional Regulation should develop policies that require employees to report conflicts of interest. The policy should include provisions to exclude these individuals from investigation, prosecution, and decision-making on cases where a significant conflict of interest arises.

The Department concurs with recommendation 16.

Respectfully submitted,

The Department of Professional Regulation

By: Nikki M. Zollar

Its Director

(E) Deliberations of Disciplinary Board. Upon the receipt of any report called for by this Act, other than those reports of impaired persons licensed under this Act required pursuant to the rules of the Disciplinary Board, the Disciplinary Board shall notify in writing, by certified mail, the person who is the subject of the report. Such notification shall be made within 30 days of receipt by the Disciplinary Board of the report.

The notification shall include a written notice setting forth the person's right to examine the report. Included in such notification shall be the address at which the file is maintained, the name of the custodian of the reports, and the telephone number at which the custodian may be reached. The person who is the subject of the report shall be permitted to submit a written statement responding, clarifying, adding to, or proposing the amending of the report previously filed. The statement shall become a permanent part of the file and must be received by the Disciplinary Board no more than 30 days after the date on which the person was notified of the existence of the original report.

The Disciplinary Board shall review all reports received by it, together with any supporting information and responding statements submitted by persons who are the subject of reports. The review by the Disciplinary Board shall be in a timely manner but in no event, shall the Disciplinary Board's initial review of the material contained in each disciplinary file be less than 61 days nor more than 180 days after the receipt of the initial report by the Disciplinary Board.

When the Disciplinary Board makes its initial review of the materials contained within its disciplinary files, the Disciplinary Board shall, in writing, make a determination as to whether there are sufficient facts to warrant further investigation or action. Failure to make such determination within the time provided shall be deemed to be a determination that there are not sufficient facts to warrant further investigation or action.

Should the Disciplinary Board find that there are not sufficient facts to warrant further investigation, or action, the report shall be accepted for filing and the matter shall be deemed closed and so reported. The individual or entity filing the original report or complaint and the person who is the subject of the report or complaint shall be notified in writing by the Disciplinary Board of any final action on their report or complaint.

IMPORTANT NOTICE: Completion of this form is necessary to comply with the requirements of Chapter 111, Paragraph 4437, of the Illinois Revised Statutes. This form has been approved by the Forms Management Center.	RETURN TO: Mandatory Report File Custodian MEDICAL DISCIPLINARY BOARD ILLINOIS DEPARTMENT OF PROFESSIONAL REGULATION Post Office Box 7006 Springfield, Illinois 62791 Mark envelope "Personal and Confidential"

PROFESSIONAL LIABILITY INSURERS

PROFESSIONAL CONDUCT AND DISABILITY REPORT

GENERAL INSTRUCTIONS

Every insurance company which offers policies of professional liability insurance to persons licensed under the Illinois Medical Practice Act or any other entity which seeks to indemnify the professional liability of a person licensed under the Act must report to the Medical Disciplinary Board the settlement of any claim or cause of action, or final judgment rendered in any cause of action, which alleged negligence in the furnishing of medical care by such licensed person when such settlement or final judgment is in favor of plaintiff.

This report contains two parts.

Part I seeks basic information concerning the person making the report, the physician who is the subject of the report, and any patient who may have been injured or endangered as a result of the physician's conduct or disability.

Part II seeks specific information concerning the conduct or disability of the physician and any administrative or judicial action which may have resulted.

Both parts must be filled out completely. Where requested, identify and attach explanatory documentation which will be helpful to the Medical Disciplinary Board in determining whether further investigation is warranted, including medical records, except that no medical records may be revealed without the written consent of the patient.

The law requires that this report be kept strictly confidential. All communications regarding this report should be addressed only to authorized persons.

The law further provides that any individual or organization acting in good faith, and not in a willful and wanton manner, in complying with this law by providing any report or other information to the Board, or assisting in the investigation or preparation of such information, or by participating in proceedings of the Board, shall not, as a result of such actions, be subject to criminal prosecution or civil damages.

IL 486–1040 7/88 (MDB)

PROFESSIONAL LIABILITY INSURERS

PROFESSIONAL CONDUCT AND DISABILITY REPORT

PART I – BASIC INFORMATION

OFFICIAL USE ONLY		
CODE	MEDICAL REPORT NUMBER	TRANS. TYPE
3	MR –	

A. SOURCE OF INFORMATION – (Individual making report)

NAME: _____ (Last / First / Middle Initial)

PROFESSIONAL TITLE AND/OR JOB TITLE: _____

NAME OF INSURANCE CO.
OR INDEMNIFYING ENTITY: _____ TELEPHONE NO: _____ (Include Area Code)

ADDRESS: _____ (Street Address / City / State / ZIP Code)

B. SUBJECT OF REPORT – (Individual licensed under the Medical Practice Act. Please complete a separate report for each individual.)

NAME: _____ (Last / First / Middle Initial)

ADDRESS: _____ (Street Address / City / State / ZIP Code)

PROFESSIONAL
LICENSE NO.: _____ TELEPHONE NO: _____ (Include Area Code)

C. CLAIMANT INFORMATION – (If more than one patient is involved, please check the appropriate box and provide information regarding additional patients on "Multiple patients Report" on page 4 of this form.)

CLAIMANT OR
PLAINTIFF NAME: _____ (Last / First / Middle Initial)

ADDRESS: _____ (Street Address / City / State / ZIP Code)

DATE OF OCCURRENCE
GIVING RISE TO CLAIM: _____ TELEPHONE NO: _____ (Include Area Code)

If patient is other than the claimant or plaintiff, complete the following; otherwise, enter "same as above."

PATIENT NAME: _____ (Last / First / Middle Initial) MULTIPLE PATIENTS? [ ]

PART II – SPECIFIC INFORMATION

A. NEGLIGENCE ALLEGED BY CLAIMANT OR PLAINTIFF – In the space below, please provide a brief description of any acts or omissions alleged to have caused injury and the extent of any injury including the dates of any occurrences (identify and attach any appropriate documents including pleadings and medical records, if applicable):

Did the injury result in the death of the claimant? [ ] Yes [ ] No

B. SETTLEMENT OR FINAL JUDGMENT INFORMATION

Amount of settlement or final judgment paid in behalf of the subject of the report: _____

Amount paid in behalf of any other persons against whom a claim was made or lawsuit filed for the occurrence being reported: _____

Date of settlement or final judgment: _____

C. COURT ACTION – (Attach copies of any appropriate pleadings you may have including any appearances and orders.)

Did the act or acts result in any court action?

[ ] Yes [ ] No If yes, please identify.

Case Name: _____

_____

Court in which filed: _____

_____

Docket Number: _____

Date Filed: _____

Status of Court Action: _____

_____

D. CLAIM HISTORY OF SUBJECT OF REPORT

Number of previous claims or lawsuits filed against the subject: _____

With respect to each such claim, briefly describe its nature including the dates of any occurrences giving rise to the claim, and its disposition including the date and amount of any settlement or judgment:

PART III – SIGNATURE			OFFICIAL USE ONLY
NAME	TITLE	DATE	

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in Chapter 111, Paragraph 4425, of the Illinois Revised Statutes. This form has been approved by the Forms Management Center.

RETURN TO:
STATE OF ILLINOIS
DEPARTMENT OF PROFESSIONAL REGULATION
ATTENTION: MEDICAL DISCIPLINARY BOARD
P.O. Box 7006
Springfield, Illinois 62791

OFFICAL USE ONLY

MULTIPLE PATIENTS REPORT

ATTACH DESCRIPTION OF FACTS THAT PERTAIN TO EACH CASE AND, IF APPLICABLE, ATTACH MEDICAL RECORDS.

A.
PATIENT NAME: _____ (Last) _____ (First) _____ (Middle Initial)
ADDRESS: _____ (Street Address) _____ (City) _____ (State) _____ (ZIP Code)
DATE OF OCCURRENCE: _____ TELEPHONE NO.: _____ (Include Area Code)

B.
PATIENT NAME: _____ (Last) _____ (First) _____ (Middle Initial)
ADDRESS: _____ (Street Address) _____ (City) _____ (State) _____ (ZIP Code)
DATE OF OCCURRENCE: _____ TELEPHONE NO.: _____ (Include Area Code)

C.
PATIENT NAME: _____ (Last) _____ (First) _____ (Middle Initial)
ADDRESS: _____ (Street Address) _____ (City) _____ (State) _____ (ZIP Code)
DATE OF OCCURRENCE: _____ TELEPHONE NO.: _____ (Include Area Code)

D.
PATIENT NAME: _____ (Last) _____ (First) _____ (Middle Initial)
ADDRESS: _____ (Street Address) _____ (City) _____ (State) _____ (ZIP Code)
DATE OF OCCURRENCE: _____ TELEPHONE NO.: _____ (Include Area Code)

E.
PATIENT NAME: _____ (Last) _____ (First) _____ (Middle Initial)
ADDRESS: _____ (Street Address) _____ (City) _____ (State) _____ (ZIP Code)
DATE OF OCCURRENCE: _____ TELEPHONE NO.: _____ (Include Area Code)

F.
PATIENT NAME: _____ (Last) _____ (First) _____ (Middle Initial)
ADDRESS: _____ (Street Address) _____ (City) _____ (State) _____ (ZIP Code)
DATE OF OCCURRENCE: _____ TELEPHONE NO.: _____ (Include Area Code)

G.
PATIENT NAME: _____ (Last) _____ (First) _____ (Middle Initial)
ADDRESS: _____ (Street Address) _____ (City) _____ (State) _____ (ZIP Code)
DATE OF OCCURRENCE: _____ TELEPHONE NO.: _____ (Include Area Code)

IL486–1002 7/88 (MI)

Illinois Department of Professional Regulation

Nikki M. Zollar
Director

Jim Edgar
Governor

Contact: Maureen Squires
Public Information Officer
217/524-8195

Springfield, IL, April, 1997 – Nikki M. Zollar, Director of the Illinois Department of Professional Regulation, announced the following actions taken by the Department for the month of **March, 1997.**

320 West Washington
3rd Floor
Springfield, Illinois 62786
217/785-0800
TDD 217/524-6735

James R. Thompson Center
100 West Randolph
Suite 9-300
Chicago, Illinois 60601
312/814-4500

MEDICAL

John Doe , **Port Byron** -- chiropractor license reprimanded due to alleged gross negligence in the care of a patient.

Jane Doe, **Hoffman Estates** - physician and surgeon license and controlled substance license summarily suspended pending proceedings before the Medical Disciplinary Board due to alleged mental illness.

John Doe , **Lincolnwood** -- physician and surgeon license and controlled substance license placed on indefinite probation due to diverting controlled substances for his own use.

John Doe , **Aurora** -- physician and surgeon license placed on indefinite probation for failing to comply with a mandatory review agreement with a hospital, failing to adequately chart two patient records and leaving a mark on a six-year-old patient's face while trying to stop the patient, who was having blood drawn, from moving.

John Doe , **Chicago** -- physician and surgeon license reprimanded and fined $500 for failure to report two adverse settlements to the Department arising from professional liability claims and failure to furnish information requested by the Department in connection with one of these claims.

John Doe , **Canton** -- physician and surgeon license and controlled substance license placed on probation for three years for prescribing controlled substances for other than therapeutic purposes, failing to provide effective controls in the inventory and storage of controlled substances and failing to report to the Department his employment discharges from Henry Hill Correctional Center and Cottage Hospital.

John Doe , **Clarendon Hills** -- physician and surgeon license reprimanded for failure to report his involuntary termination from the Medical Assistance Program by the Department of Public Aid.