Enforcement Monitor Final Report
Findings and Recommendations

Prepared by
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ALEXANRPM
Risk and Project Management Advisory Services

For
Department of Consumer Affairs
Medical Board of California

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Enforcement Monitor Introduction

Alexan RPM Inc. (Alexan) is a Small Business Enterprise (SBE) that was founded in 2014. The formation of Alexan is the result of the principal's three decades of business experience serving government, health care, education, high technology, and manufacturing organizations. Alexan predominantly provides a wide range of business and information technology solutions to state and local government clients. Alexan's comprehensive portfolio of services includes executive advisory counseling, project management, organizational and project assessments, risk management determination, business process reengineering, quality assurance, data management, cybersecurity and system development support. An example of Alexan client engagements in which business and technical analysis consulting services were provided include:

- California Secretary of State — California Automated Lobbyist and Campaign Contribution and Expenditure Search System (CAL-ACCESS) Replacement System (CARS) Project consulting services
- California Financial Information System for California (FI$Cal) — fit gap analysis
- California Department of Health Care Services — Provider Application for Validation and Enrollment (PAVE) independent verification and validation
- California Health and Human Services Agency Office of Systems Integration and California Department of Social Services — Appeals Case Management System consulting services
- California Department of Technology — business model assessment, development, and implementation consulting services

A fundamental differentiator of Alexan is its public-sector acumen and track record for helping organizations identify risks and conditions that impede the achievement of business objectives. Alexan adds value by helping organizations navigate their management and information technology needs by leveraging Alexan's structured methodologies and analysis approach.

Alexan's principal auditor (monitor) for the Medical Board of California's Enforcement Program engagement is a certified public accountant with 35 years of California state government experience. The monitor has performed a variety of financial and performance audits for numerous state agencies, investigating and evaluating the organizations' operations relative to compliance with the applicable governing statutory and regulatory provisions. Additionally, the monitor has directed and managed a diverse range of audit functions (performing over 400 audits annually) and has overseen development and implementation of technology initiatives in organizational units ranging from 20 to 300 staff members.

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Executive Summary

Introduction

This Executive Summary section of the *Enforcement Monitor Final Report* for the Medical Board of California (MBC or board) enforcement program summarizes additional findings and recommendations following the release of the *Enforcement Monitor Initial Report* issued March 7, 2023.

Senate Bill 806 (Roth, Chapter 649, Statutes of 2021) added Business and Professions Code (BPC) Section 2220.01, which mandates an independent enforcement monitor's evaluation of the board's enforcement activities with specific concentration on the handling and processing of complaints, and the timely application of sanctions or discipline imposed on licensees and persons to protect the public.

Alexan RPM (Alexan), the designated enforcement monitor (monitor), began conducting this evaluation on July 13, 2022, issuing its *Initial Report* on March 7, 2023. The *Initial Report* identified a series of strengths and weaknesses in the review of:

- MBC's initial complaint intake, triage and investigation by its Complaint Investigation Office (CIO)
- Formal investigations by the Department of Consumer Affairs (DCA) Division of Investigation (DOI) Health Quality Investigation Unit (HQIU)
- Administrative prosecutorial actions and processes by the Office of the Attorney General (OAG) Health Quality Enforcement Section (HQE)
- Technology platforms used in MBC program operations, and public reporting relative to complaint administration and adjudication

The *Initial Report* disclosed four findings that impede the enforcement program's operational effectiveness and efficiency in complaint adjudication. Specifically, the following findings were identified:

1. Inadequate investigator workforce staffing that has resulted in investigation delays, disruptions to workload assignments, inconsistency in investigation actions and other investigation deficiencies
2. Lack of structured collaboration between HQIU and HQE during investigation and administration action phases
3. A shortage of specialized medical experts who are necessary for proper mitigation of complaints
4. Insufficient funding for MBC program operations to provide mandated enforcement activities

The *Initial Report* offered recommendations relative to these four (4) findings for improving enforcement program performance. In this *Final Report,* the same recommendations for all the findings included in the *Initial Report* remain relevant and applicable.

Final Report Methodology

For the *Final Report* review, the monitor obtained and reviewed documentation that included MBC and DOI HQIU manuals; MBC and DOI HQIU forms; MBC and DOI HQIU policies and procedures; enforcement program laws, regulations and guidelines; MBC, DOI HQIU and OAG legal review letters; MBC, DOI HQIU, and OAG HQE workflow and process diagrams; organization charts for MBC and DOI HQIU; as well as enforcement program data residing in the BreEZe, QBIRT and CEMA systems. Additionally, the monitor interviewed staff and management from DCA, MBC, DOI HQIU and OAG HQE. Furthermore, the monitor interviewed former DOI HQIU investigators, six MBC board members, one member of the California Research Bureau of the California State Library, two members

of the public, and three licensed physicians who have participated in the medical expert program. Additional details on the monitor's review methodologies are provided in each of the sections in this *Final Report*.

It should also be noted that the monitor did not evaluate the appropriateness of legal decisions or disciplinary actions taken because the monitor does not possess the legal education, experience and skills necessary to make legal judgments. Additionally, while the monitor met with HQE leadership on multiple occasions, the monitor was not permitted to interview HQE field office prosecutors. The monitor also requested detailed supporting documentation data from HQE. While HQE withheld the documentation directly as a result of DOJ legal limitations that include laws governing patient privacy and professional ethics, the MBC supplied the necessary documents. Furthermore, the monitor was unable to meet with representatives from the Federation of State Medical Boards (FSMB) to identify best practices nationwide despite numerous requests to schedule a meeting.

MBC and HQIU provided all requested documentation for this review. MBC Information Systems Branch (ISB) staff generated queries that produced BreEZe data extracts and reports tailored to specific monitor requests. HQE provided summarized data contained in the published *OAG Annual Report.* However, the monitor was informed that the granular or detailed data associated with the summarized data is considered confidential per OAG policy and per Business and Professions Code (BPC) Section 312.2 and could not be provided.

Final Report Scope of Work

The scope of the monitor's *Final Report* assessment included the following:

- Review of 19 complaints[1] relative to serious injury or death and closed without a field investigation conducted by HQIU. The analysis included an evaluation to determine whether guidelines and business protocols of the Central Complaint Unit (CCU) were followed.
- Supplemental and detailed analysis of *Initial Report* finding number two (2) regarding HQIU investigations that were referred to the OAG's HQE. The monitor analyzed subsequent actions and dispositions for a sample of 50 investigations.
- Analysis of the recommendation(s) for *Initial Report* finding number three (3) for the purpose of identifying other appropriate and applicable recommendations to mitigate the medical expert program shortage.
- Review of MBC compliance with BPC Section 2229, including identifying deviations from the Manual of Model Disciplinary Orders and Disciplinary Guidelines in the board's application of sanctions or discipline.
- Analysis of licensed physician ethnicity data to determine the complaints, sanctions or disciplinary actions that were applied to physicians and surgeons based on their reported ethnicity.

Final Report Recommendation Summary

The *Final Report* documents the monitor's findings and recommendations as well as the strengths and weaknesses of the board's enforcement program. The

1 Sample size was 37 but documentation was available for only 19 of the 37 sample(s) selected.

recommendations for each section in the report are listed in a summary below. The body of this report contains additional information on the monitor's findings and recommendations.

Report Section 1 — CCU Complaints

Subsection 1.1 — CCU Serious Injury or Death Complaints Closed Without HQIU Investigation

Recommendation 1.1.1

The monitor's review of complaint file samples found that CCU's evaluation of complaints involving patient deaths is compliant with existing policies. However, these types of complaint documents should be retained for a reasonable amount of time so that documents supporting the actions taken are available for potential internal/external inquiries. Currently, the CCU retains the complaint documentation for one year if no issues are identified. The one-year retention period is insufficient to provide adequate historical documentation in the event of challenge(s) to the actions taken. The documentation collected and created by CCU staff and used to determine complaint outcomes should be maintained for longer than one year. Therefore, the monitor is recommending that the one-year record retention policy for complaints with no issues be lengthened.

Recommendation 1.1.2

The monitor recommends that the DCA's internal audit organization perform an internal audit to assess the risk(s) associated with the MBC's current data retention practices, which includes complaints regarding patient deaths as well as all high-priority complaints per BPC Section 2220.05.

Recommendation 1.1.3

Senate Bill (SB) 815 (Roth), as amended July 12, 2023, provides proposed legislation that requires an interview with the complainant, patient or patient representative involving quality of care before referral to field investigation. The monitor makes a similar recommendation that an interview with the patient representative or individual who filed the complaint be conducted for all complaints received involving patient deaths. Additionally, prior to its next Sunset Review, MBC should assess whether this process should be expanded to other types of complaints with serious allegations.

Subsection 1.2 — Complaint Tracking System (CTS) Project

Recommendation 1.2.1

MBC is planning to implement a Complaint Tracking System (CTS). Based on the monitor's interview with the MBC's Information Systems Branch (ISB) manager and review of the CTS project outline document, the project is planning to follow an accepted management and system development methodology. Furthermore, the project and the expected outcomes have significant public visibility. Therefore, CTS stakeholder expectations on complaint tracking functionality will need to be aligned with the system's planned requirements and delivered functionality. MBC will need to help ensure that legally allowable public visibility is achieved. Stakeholder alignment will be critical to the project's success.

The desired functionality was discussed during the two public sessions held earlier this year. However, the desired functionality will be vetted through a legal review that will help determine what information is permissible to share with complainants via this system. Sharing the permissible system functionality with public participants via future public meetings should align expectations.

Report Section 2 — Investigation and Discipline Process

Subsection 2.1 — HQE Referred Investigation Rejection and Returned for Supplemental Investigation Analysis

With the elimination of vertical enforcement (VE) in statute as of December 31, 2018, collaboration between HQIU investigators and HQE prosecutors ended. Since that time, HQE prosecutors do not communicate directly with HQIU investigators except for approved joint investigations. Additionally (as documented in the *Initial Report* and as originally identified as a key recommendation in the 2004 enforcement monitor's report) during both the investigation and subsequent accusation phases of a complaint, collaboration among investigators and prosecutors is essential in achieving supportable investigations for administrative actions. The recommendations for this subsection are listed below.

Recommendation 2.1.1

Maintain the sworn investigation function with HQIU and the prosecution function within OAG HQE. Establish a structured collaboration between HQIU investigation and HQE prosecution, ensuring the necessary, appropriate and timely communication throughout a complaint investigation. This collaboration should be structured regionally by specific HQIU and HQE field offices, aligning investigators from each HQIU office with prosecutors from their corresponding office.

Consequently, investigators will not rotate among prosecutors (as in VE) but will work with an assigned prosecutor (or a small unit of prosecutors), providing established and understood working relationships, gaining respect and, most importantly, trust. Specific key collaboration milestones and recommendations for implementing this recommendation are specified in the body of the report. One of the monitor's recommendations for implementation includes engaging an independent facilitator specializing in multi-organization structuring, operations and management to help guide and manage group discussions, and activities needed to achieve the goals and objectives of the restructuring.

Recommendation 2.1.2

The monitor recommends that if the collaboration in Recommendation 2.1.1 can't be achieved, restructuring the MBC Enforcement Program should be considered. Major investigatory process restructures have been previously discussed in historical published monitor reports[2] and other published reports. All options should be considered, including either moving the investigator functions to the California Department of Justice (DOJ) or back to MBC, or moving the prosecutor functions to MBC.

2.1.2.A — Moving Investigators to DOJ

If this recommendation is implemented, investigators would be embedded with prosecutors, following the established protocols, policies and procedures of the DOJ. The 2004 enforcement monitor's report identifies the necessity of investigation and prosecution functions, and emphasizes that they need to be seamless, especially due to the complexities, nuances and dynamics of medical standard of care investigations. Prior to moving any investigators to DOJ, a thorough workload and cost-benefit analysis should be conducted.

2.1.2.B — Moving Investigators to MBC

If this recommendation is implemented, HQE would consider the investigators to be within the attorney-client relationship it has with MBC. Therefore, investigators would

2 2004 and 2005 Initial and Final Monitor Reports. 2010 Medical Board of California Program Evaluation Report

interact with HQE personnel and have access to HQE documentation. Information and documentation could then be shared and not be considered privileged, which is the current practice with interactions between the HQIU and HQE.

In addition, this recommendation would require a thorough independent analysis of both budget and human resource impacts to MBC and DCA DOI, their existing commitments and organizational responsibilities.

2.1.2.C — Moving Prosecutors to MBC

MBC should evaluate the viability of combining all enforcement activities within the MBC, including sworn investigators and prosecutors if recommendation 2.1.1 can't be implemented. There may be comparable models at other state agencies, such as the Department of Real Estate, that could be evaluated as well to inform MBC if such a move would be a viable policy decision.

The monitor understands that transitioning the long-held HQE prosecutorial function under the jurisdiction of the OAG would be controversial, given the state's constitutional structure of the executive branch and OAG, and the 33-year HQE prosecutorial history.

Recommendation 2.1.3

The monitor recommends that DCA's internal audits office conduct a detailed analysis of the 16 cases provided by HQIU to the monitor. This analysis should include the necessary independent legal and medical expertise in evaluating and opining on the conclusions documented for each investigation.

Subsection 2.2 — Medical Expert Review

As the monitor reported in the *Initial Report*, the medical expert program does not have the necessary complement of medical experts with the required medical specialty or sub-specialty required for evaluating and opining on standard of care medical investigations. MBC has encountered medical expert shortages over many years.

The medical expert opinion is a critical component for determining if departures from the medical standard of practice have occurred in the treatment of a patient and the significance of such departures (simple or extreme). The medical expert opinion results in either the closure of the investigation or moving forward with an administrative action.

For this *Final Report,* the monitor reviewed additional documentation and conducted interviews that resulted in five (5) new recommendations, which are specified below. Detailed information further supporting the recommendations is in the body of this report.

Recommendation 2.2.1

Various recruiting methods are used in recruiting medical experts (e.g., newsletters, web presentations, licensure mailings and emails). The monitor understands that an effective method of recruiting is to hold the sessions in person and/or virtually, while emphasizing the significance of the medical expert function and how the function impacts the integrity of the MBC enforcement program.

Recommendation 2.2.2

Require all MBC medical experts to participate in expert training and eliminate the current two-tier pricing structure, which is $150/hour for experts not completing the MBC expert training and $200/hour for completing the expert training program. All medical experts must complete the expert training program to help ensure consistency in medical expert services.

Recommendation 2.2.3

MBC should establish a formal process for soliciting medical expert training feedback. This should include medical expert training content and structure. Periodically review completed medical expert training evaluation forms for the purpose of identifying the strengths and weaknesses of the program. Determine and incorporate viable changes and enhancements to the program based on expert training feedback. Establish and document measures that contribute to the success of the training program and use these measures as key performance indicators (KPIs). Monitor and report on the KPIs to MBC management on a periodic basis.

Recommendation 2.2.4

The Medical Board has attempted to and continues to seek an increase in medical expert compensation. This has not yet occurred. The monitor recommends that MBC conduct a medical expert compensation assessment that determines with a degree of certainty the level of compensation necessary to both attract candidates to the program and retain existing experts. If the necessary expertise does not exist within the board, retain a consultant who specializes in professional rate structures and protocols. Such a consultant, in addition to compensation, will likely determine other contributing factors generating increased participation, retention and suitability for the medical expert program. If additional authority is needed, either from control agencies or via statute, that authority should be sought by MBC.

Recommendation 2.2.5

MBC should increase its outreach efforts; however, if improvement to the MBC Medical Expert Program is not addressed by the next Sunset Review, required participation by licensees in the medical expert program should be considered. As part of the condition of medical licensing, an obligation to assist the medical program's integrity when called upon could be established. As indicated above, medical enforcement is dependent upon a medical expert's opinion in determining the validity and substance of a standard of care complaint. There is no acceptable alternative when adjudicating these investigations; an expert opinion is required.

Enacting a compulsory medical expert program, requiring participation of licensees meeting certain requirements, would be controversial. However, if the systemic shortage of medical experts continues to jeopardize the effectiveness of enforcement, it should be, at a minimum, evaluated as a potential option by MBC.

Subsection 2.3 — Manual of Model Disciplinary Orders and Disciplinary Guidelines in the Board's Application of Sanctions or Discipline

The monitor reviewed the guidelines and met with various MBC staff and management to discuss the genesis and the historical application of the guidelines. When imposing disciplinary action, guidelines help to ensure the uniformity, certainty and fairness of the enforcement program relative to its mandate of furthering public protection.

The monitor's review of the guidelines identified a highly structured protocol for imposing minimum and maximum disciplines relative to a specific violation of BPC Section 2229. However, both BPC Section 2229 and the guidelines allow for departures (deviations) for the identified discipline relative to the violation for mitigating circumstances, provided that public protection is not at risk. Such departures are known as justified departures (deviations).

The monitor selected a sample of cases and reviewed case documentation. The case documentation along with the appropriate

historical artifacts included the complaint, investigation documents, accusations, HQE legal review letters and case notes in the BreEZe system. The monitor did not note any exceptions in its review of the cases in the sample. However, the monitor has specified in the body of this report a recommendation that will help strengthen the imposition of discipline relative to the guidelines:

Recommendation 2.3.1

The monitor recommends a review of the guidelines (i.e., the minimum and maximum ranges of each discipline relative to each violation), and the procedures for departing from identified disciplines relative to associated violations, thereby potentially lessening the justified deviations. This review should include individuals with a full understanding of the enforcement program and the evolution of the guidelines, given that the guidelines' history is in its 12th edition. Modifications could have both intended and unintended outcomes, given the complexities and nuances of the enforcement program.

Report Section 3 — Physician and Surgeon Demographic Data Analysis

For this review, the monitor obtained self-identified physician and surgeon data that includes information on their race/ethnicity and compared the data to complaint and disciplinary action data that is associated with the physician and surgeon race/ethnicity data. The licensed physician and surgeon race/ethnicity data used for the monitor's analysis is self-identified data that is retained in the BreEZe system. The complaint and disciplinary data is also retained in the BreEZe system. Report Section 3 provides a comparison of physician and surgeon race/ethnicity group complaints and disciplinary actions for physician and surgeon licensees who self-identified their race/ethnicity information. For this *Final Report* section, the monitor's review resulted in one recommendation, which is specified below.

Recommendation 3.1

MBC should establish a formal process by which self-identified race/ethnicity information would be periodically extracted, analyzed, and reviewed by the Board to provide insight on demographic trends. This information should also be made publicly available.

SECTION 1:
CCU COMPLAINTS

1.1 CCU Serious Injury or Death Complaints Closed Without HQIU Investigation

Review Objective

The review objective is to determine the effectiveness of CCU's evaluation of complaints related to incidents of serious injury or death, specifically for complaints that were closed without formal HQIU investigation.

Scope and Methodology

Working with MBC's Information Systems Branch (ISB), the monitor determined the required data query parameters needed to generate a data extract that reflects complaints classified as Negligent Resulting in Serious Injury/Death with a disposition of Closed No Violation or Insufficient Evidence. The data query was executed in the BreEZe system by ISB staff. This extract is composed of six (6) years of complaint data from July 1, 2016, through June 30, 2022, and includes 2,362 complaints.

The monitor selected a sample of 37 complaints for review from the extract. The sample was randomly selected. Each complaint had an equal probability of being chosen. The monitor obtained and reviewed the sample's corresponding paper copy complaint files containing various artifacts, such as CCU complaint triage analysis describing efforts to secure medical record releases, medical records and CCU medical consultant evaluations of compiled records. The monitor also reviewed each complaint's electronic profile in the BreEZe system, including work notes that support complaint disposition(s). When questions surfaced regarding the review of complaint artifacts, the monitor then discussed complaint file and BreEZe system documentation requiring clarification with the CCU manager.

Analysis and Findings

The monitor's review of the complaint samples with CCU's evaluation of death complaints not resulting in field investigation considered the following criteria relative to the standard of care complaints:[3]

- When evaluating complaints alleging that the quality of care provided by a physician was negligent, the Medical Board must be able to substantiate that the physician's conduct departed from "the standard of practice of medicine" to establish a violation of the Medical Practice Act.
- Treatment determined to be negligent per the Medical Practice Act falls under one of two categories:
    - Gross negligence, which is defined as an extreme departure from the standard of practice and constitutes a violation of the Medical Practice Act.
    - A negligent act, which is defined as a "simple" departure from the standard of practice and must consist of two or more negligent acts or omissions before it can be considered a violation of the Medical Practice Act. A single negligent act (simple departure from the standard of practice) does not constitute a violation of the Medical Practice Act.
- Generally, a departure from the standard of practice is conduct that falls below the standard that a reasonable physician in that specialty would practice under the circumstances. An extreme departure from the standard of practice of medicine is conduct

3 Per interview with CCU Manager and CCU's standard complainant letter summarizing CCU's policies and procedures.

that is evidenced by a lack of the bare minimum of appropriate care of a patient. The determination about whether a departure from the standard is "simple" vs. "extreme" is made by a medical consultant. The medical consultant is a physician practicing in the same medical specialty as the physician named in the complaint.

- BPC Section 2220.08 provides:

  (a) Except for reports received by the board pursuant to Section 801.01 or 805 that may be treated as complaints by the board and new complaints relating to a physician and surgeon who is the subject of a pending accusation or investigation or who is on probation, any complaint determined to involve quality of care, before referral to a field office for further investigation, shall meet the following criteria:

  (1) It shall be reviewed by one or more medical experts with the pertinent education, training and expertise to evaluate the specific standard of care issues raised in the complaint to determine if further field investigation is required.

  (2) It shall include the review of the following, which shall be requested by the board:

  (A) Relevant patient records

  (B) The statement or explanation of the care and treatment provided by the physician and surgeon

  (C) Any additional expert testimony or literature provided by the physician and surgeon

  (D) Any additional facts or information requested by the medical expert reviewers that may assist them in determining whether the care rendered constitutes a departure from the standard of care

Moreover, Section 2220.08 (b) states that "if the board does not receive the information requested pursuant to paragraph two (2) of subdivision (a) within 10 working days of requesting that information, the complaint may be reviewed by the medical experts and referred to the field office for investigation without the information." Section 2220.08 (c) states that "nothing in this section shall impede the board's ability to seek and obtain an interim suspension order or other emergency relief."

Prior to 2017, CCU management stated that they found it difficult to secure releases for obtaining medical records. Without such medical records, a complaint involving a patient death can't be evaluated, which will cause such complaints to be closed based on insufficient evidence.

Interviews held with CCU management disclosed that CCU received mandatory reports, such as the Outpatient Surgery Patient Death report in years prior to 2017. In many instances, the physician submitted a report that contained information on a patient who passed away after discharge from the outpatient surgery within days of the surgery, but with death occurring at a medical facility. CCU often had difficulty obtaining releases and records from the physicians or the facility, thereby preventing a thorough review of patient care and treatment.

Effective January 1, 2017, BPC Section 2225(c)(1) was amended giving MBC more authority to request and obtain records involving patient deaths. Specifically, this amendment authorizes MBC when

conducting a patient death complaint to inspect and copy deceased patient medical records without the authorization of the beneficiary, personal representative, or without obtaining a court order. The purpose of this amendment is to determine the extent to which the death was the result of the conduct of the physician and surgeon in violation of the Medical Practice Act.

The amendment established three rules regarding how to obtain the medical records relating to patient death:

1. MBC must provide a written request to either the physician or surgeon, or the facility where the medical records are located or the facility where the deceased patient was treated.
2. The written request must include a declaration that MBC has been unsuccessful in locating or contacting the deceased patient's beneficiary or personal representative after reasonable efforts.
3. If the patient's beneficiary or personal representative has been contacted but refused to consent to MBC inspecting and copying the patient's medical records, a court order is required to access such records.

CCU has incorporated procedures for securing patient medical records under BPC Section 2225(c)(1) relative to patient death complaints. MBC policies and procedures for maintaining medical complaint data under CCU's file retention policy for death complaints are as follows:[4]

- One year for complaints involving no violation, no response, no jurisdiction, or inadequate evidence when the complaint is anonymous, and no party is located after attempting to identify a responsible party
- Five years for complaints in which evidence is deemed insufficient to forward for field investigation, or in which the complaint is closed but information has been retained on file

After February 2020, CCU staff primarily worked offsite due to the COVID-19 pandemic. CCU staff has access to electronic complaint file documentation that was scanned into a PDF format and uploaded to the complaint tab in the BreEZe system. The system used by CCU staff to maintain and retain patient documents is BreEZe. The BreEZe system's file size limitation is 10 megabytes. Medical consultant reports are uploaded as are other documents within the file size limitation. Consequently, not all reports and documents associated with a complaint file can be properly uploaded, thus limiting electronic access to essential information.

When physical files are purged via the retention schedule, corresponding complaint documents attached in the BreEZe system are also purged. However, the complaint in BreEZe is not deleted.

Monitor's Analysis of the Complaint Sample

The monitor requested complaint file documentation for the 25 complaints in the sample; however, CCU staff located and provided only 12 complaint file documents. The monitor was informed by CCU staff that the remaining files had been purged per the retention schedule (see above discussion regarding retention). The monitor then randomly selected an additional 12 complaints from the original data extract and requested the corresponding file documentation. Seven (7) of these files were provided and five (5) files had been purged. Consequently, only 19 of the 37 sample complaints requested were reviewed.

4 Refer to Recommendations 1.1.1 and 1.1.2 relative to improved record retention

The monitor's review of patient death complaints resulting in closure without field investigation focused on the following three review objectives:

1. CCU's due diligence in obtaining the necessary medical records
2. The relevance of the records obtained and the licensee's treatment report
3. The medical consultant's review and opinion of complaint file documentation

The monitor's review of the complaint sample files found that some of the 19 sample complaints did not contain the medical consultant's evaluation report. Consequently, the monitor used the complaint and medical consultant's report retained in the BreEZe system.

The result of the monitor's evaluation of the 19 sample complaints included review of the following:

- How the complaint was received
- Requesting patient medical records when representatives are identified
- Initiating second requests for records
- Contacting the licensee or facility following the protocols under 2225(c)(1) when appropriate
- Documenting when medical records are received
- Requesting and securing treatment statements from the licensee
- The appropriate medical consultant relative to the type of complaint
- The medical consultant's evaluation of documentation that rendered an opinion of "no field investigation is required"

Per the monitor's review of the documentation associated with the 19 complaints in the sample, it was determined that the processes outlined above were followed. Further, the medical consultant's evaluation and opinion were documented when a determination was made for no field review. Two of the initial medical consultant evaluations requested an additional medical consultant with a specialty aligned with circumstances of the complainant's medical treatment, in accordance with policy. The monitor did not find exceptions to the CCU's protocols and procedures in the sample of complaints reviewed.

Recommendations

Recommendation 1.1.1

The monitor's review of complaint file samples found that CCU's evaluation of complaints involving patient deaths is compliant with existing policies. However, these types of complaints should retain sufficient documentation to support actions taken. The one-year retention period is insufficient to provide adequate historical documentation. The documentation collected and created by CCU staff and used to determine complaints outcomes should be maintained for longer than one year. Therefore, the monitor is recommending that the one-year record retention policy for complaints with no findings be lengthened.

Recommendation 1.1.2

Additionally, the monitor recommends that the DCA's internal audit organization perform an internal audit to assess the risk(s) associated with the MBC's current data retention practices, which include complaints regarding patient deaths as well as all high-priority complaints per BPC Section 2220.05.

Recommendation 1.1.3

Senate Bill (SB) 815 (Roth), as amended July 12, 2023, provides proposed legislation that requires an interview with the complainant, patient or patient representative

involving quality of care before referral to field investigation. The monitor makes a similar recommendation that an interview with the patient representative or individual who filed the complaint be conducted for all complaints received involving patient deaths. Additionally, MBC should assess whether this process should be expanded in the future to encompass other types of complaints with serious allegations.

1.2 Complaint Tracking System Project

Objective

MBC is in the planning stage for implementing MBC's Complaint Tracking System (CTS) solution. The final solution, when implemented, will offer complainants the ability to access (via a secured means) the status of their complaint, thus providing CTS milestone information. The monitor indicated in the *Initial Report* that this project may be further reviewed prior to the issuance of the monitor's *Final Report.* The monitor's objective for the *Final Report* was to review additional project documentation and interview project management to obtain information needed to further understand the project's planned processes, proposed functionality and status.

Scope and Methodology

For the *Final Report,* the monitor reviewed updated planning documentation and information associated with public outreach. The monitor also interviewed MBC's Information Systems Branch (ISB) manager and obtained information on the background and status of the project. Additionally, the monitor obtained the May 19, 2022, updated CTS project outline. The outline identifies the objectives of the planned system solution, its privacy and security protocols and information proposed to be made available to the complainant.

Analysis and Findings

The project's proposed objectives are identified in the outline and provide information on the complainants as well as the progression of each complaint through MBC's enforcement processes. The outline indicates that access to the system will be available via MBC's website 24 hours per day, seven (7) days per week, with minimal downtime. MBC believes that planned system availability will reduce the number of calls the MBC enforcement analysts receive during business hours and that the analysts will then more efficiently and effectively handle other workloads.

The outline states that ISB is following the project planning protocols established by the California Department of Technology's *Statewide Information Management Manual* (SIMM) and the Department of Consumer Affairs in seeking project approval and oversight. The project will utilize an agile system development and implementation methodology, thereby enabling the timely monitoring of project activities relative to project plans and budget throughout the project's lifecycle.

The monitor also was provided with documentation from two virtual interested party meetings that the project held with the public in March and June of 2023, soliciting feedback on functionality. Determining functional requirements is often a challenge for technology projects and is needed to help ensure that user requirements are understood and that user expectations are consistent with the application's functionally. Consequently, the Medical Board held two virtual "interested parties" meetings soliciting feedback from the public. The public comment and requirement gathering sessions are helping the board, CDT and DCA to achieve the project's application development objectives.

The monitor reviewed the compilation of data and found that a critical factor needed to help ensure the project's delivered functionality is the legal determination of what information can be provided during the deliberative process of complaint investigation, administrative action and ultimate complaint disposition. Visibility for the complainant on the complaint's progression is a worthy objective. However, this objective may be tempered with limitations on making such information available, given privacy statutes and confidentiality requirements.

Additionally, the board will have legal counsel review all proposed requirements gathered during the interested parties' meetings to determine if there were issues that would present privacy or other legal concerns, thus preventing the requirements from being included in the updated project proposal to board members. After legal review, a technical review will be performed to determine a proposed release chart for when all legally approved requirements can most efficiently and logically be implemented. At a public board meeting, staff will present to board members an updated proposal for the requirements for a Minimum Viable Product (MVP) Release 1. Public comment will be available to all attendees to express whether they support or disapprove of the project moving forward. If approved by the board members, the MVP requirements will be used to develop the CDT and SIMM Stage 1 Business Analysis Project Plan. This plan would then be submitted to the DCA and CDT for approval.

The monitor also understands that ISB's objective is to first implement core functionality that will operationalize the system. Enhancements to such core functions will then follow in subsequent releases. This is a recognized practice in system development: implementing system core functionality within specified timeframes and budget so that users embrace the system and provide feedback on a functioning system. Enhancements are then more reasonably estimated relative to development level of effort, cost and rollout time frame.

The monitor also found that the access management and security protocols, specifically two-factor authentication, are consistent with practices currently used relative to user authentication and authorization.

Recommendations

Recommendation 1.2.1

The project is following an accepted management and development methodology. There is high public visibility of this project; therefore, aligning the public's expectations of complaint tracking functionality with delivered, legally allowable functionality is critical to project success.

The public meetings held earlier this year obtained requested functionality. This however will be vetted though a legal review, determining what is permissible to share with complainants via this system. Sharing the permissible system functionality with public participants via future public meetings should align expectations.

SECTION 2: INVESTIGATION AND DISCIPLINE PROCESS

2.1 HQE Referred Investigation Rejection and Returned for Supplemental Investigation Analysis

Objective

As documented in the monitor's *Initial Report*, since the termination of vertical enforcement (VE) in December 2018, the percentage of investigations that HQE rejected and returned for supplemental investigation after MBC referral has increased significantly.

This increase in referred investigation rejections and returns is documented in the monitor's *Initial Report* in Table 2.1 — Disposition of MBC Investigation Submission to HQE. The information reflected in the *Initial Report*'s Table 2.1 is repeated in Table 2.1. Over five (5) years, the referred investigation rejects or returns percentage increased by a factor of seven (7), from 5.1% (1.4 % Rejected and 3.7% Returned) in FY 2017/18 to 35.0% (19.4% Rejected and 15.6% Returned) in FY 2021/22.

The monitor reviewed a sample of referred investigations that were rejected or returned for supplemental investigation by HQE. The objective of this analysis is to identify the cause documented in each sample investigation that HQE rejected and/or returned for supplemental investigation to the MBC, that if resolved could have allowed HQE to accept the investigation for prosecution.

Scope and Methodology

Table 2.1 identifies completed MBC investigations submitted to HQE for administrative action(s). The summarized investigation data is derived from the OAG annual reports by fiscal year, per the mandates of BPC 312.2. The numbers in the annual reports relate to instances of individual investigation transmittals received for legal review and may reflect that a single investigation has been transmitted more than once, and is returned, rejected or accepted for prosecution in that same fiscal year or in subsequent years. This data was presented in the monitor's *Initial Report* previously issued. The *Initial Report* identified rejected investigations and investigations returned for supplemental investigation. For the *Final Report* analysis, the monitor's desired approach was to select investigations from the HQE universe of investigations that were rejected or returned for supplemental investigation. The monitor requested the detailed supporting documentation data for the rejected investigations, as summarized in Table 2.1 from HQE. However, HQE would not provide the detailed investigation data due to legal limitations including laws governing patient privacy and professional

Table 2.1 — Disposition of Investigations (MBC and HQIU) Submitted to HQE for Administrative Action

Compilation of Investigation Submission by Fiscal Year										
	2017/18		2018/19		2019/20		2020/21		2021/22	
HQE Actions:	No.	%	No.	%	No.	%	No.	%	No.	%
Referred	513	–	604	–	550	–	616	–	469	–
Rejected	7	1.4%	28	4.6%	77	14.0%	124	20.1%	91	19.4%
Returned for Supplemental Investigation	19	3.7%	32	5.3%	62	11.3%	87	14.1%	73	15.6%

ethics. The monitor consequently relied solely on data from BreEZe.

Therefore, working with MBC's Information Systems Branch (ISB), the monitor obtained a data extract from the BreEZe system. This extract included 296 HQE referred investigations for fiscal years 2017/18 through 2021/22 that were rejected or returned for supplemental investigation by HQE.

For each fiscal year in the extract, the monitor first separated the 296 investigations by investigation outcome type/complexity and by disposition. The monitor then randomly selected 50 investigations, drawing investigations from each of the outcome types in the extract for review. Each of the investigations in every outcome type category had an equal probability of being chosen.

Original investigation documents (file folders) were obtained from MBC management. The investigation file folders contain various artifacts, documenting aspects of the investigation history. The investigation file includes the HQE legal review letter to MBC, HQIU or CIO reports of investigation and supporting documents, medical consultant or medical expert evaluations, email correspondence and other supporting documents. In addition, BreEZe investigation extracts were obtained, providing documented enforcement activities, time frames and work notes.

The primary document used for this review is the HQE legal review letter that specifically identifies the reasons for the investigation rejection that prohibited the filing of an accusation or that requests additional supplemental investigation that may provide information necessary for filing an accusation. The HQE legal review letter also identifies the recommended investigation adjudication action to the MBC chief of enforcement. When the legal review letter was not available, the monitor reviewed BreEZe investigation activities and work notes within the system. HQE was informed of investigations without a legal review letter and HQE subsequently conveyed six (6) legal review letters to MBC's chief of enforcement, who then provided these to the monitor.

Additional Information Provided by HQIU

During interviews with HQIU, management staff indicated that HQIU believes that 16 cases had inappropriate outcomes. HQIU provided the monitor with investigation information that falls into two (2) groups of investigations. The first group included nine (9) investigations and the second group included seven (7) administrative actions. The first group of investigations had been referred to HQE for accusations, but no accusation was filed. The second group consisted of investigations resulting in actions that were settled with imposed discipline, but which HQIU believes should have resulted in a higher level of discipline.

HQIU personnel indicated to the monitor that in their opinion, all 16 cases are pertinent for the monitor's review of actionable investigations relative to effective enforcement protocols and outcomes consistent with BPC Section 2229. However, the monitor did not evaluate the appropriateness of the legal decisions or disciplinary actions taken relative to these investigations because the monitor does not possess the legal education, experience and skills necessary to make legal judgments.

Analysis and Findings

Table 2.1.1 summarizes the monitor's 50-investigation sample by the number of declined investigations identified in the BreEZe extract, and the number of investigations rejected or returned for supplemental investigation by HQE selected in the monitor's sample. The table reflects the number of investigations by Fiscal Year.

Table 2.1.1 — BreEZe Extract of HQE Returned for Supplemental Investigations and Sample, by Fiscal Year

Fiscal Year (FY)	Number of Investigations in Breeze Extract	Number of Returned for Supplemental Investigations in Sample
2017/18	4	3
2018/19	15	6
2019/20	43	11
2020/21	113	15
2021/22	121	15
Totals	**296**	**50**

Table 2.1.2 represents the number of investigations by complexity type and the percentage for the 50 investigations in the monitor's sample. The complexity types are first assigned by the CCU based on the original complaint. The complaint protocol is to update complaints as they go through their lifecycle to reflect the proper classification. Consequently, the complaint as initially documented in BreEZe may not represent complaint complexity after HQIU investigation or HQE review of that investigation. The complexity types in the table are deemed high priority by MBC per BPC Section 2220.05.

Table 2.1.2 — Monitor's 50 Sample Investigations, Summarized by Complexity Type

Investigation Complexity Type	Number in Sample	Percentage
Negligence Resulting in Serious Injury or Death	6	12.0%
Negligence or Incompetence	17	34.0%
Excessive Prescribing	7	14.0%
Inappropriate Prescribing	2	4.0%
Sexual Misconduct During Treatment	6	12.0%
Sexual Misconduct	1	2.0%
Impairment — Mental or Physical	2	4.0%
Personal Conduct — Self Abuse by Drugs or Alcohol	1	2.0%
Unprofessional Conduct	8	16.0%
Total Investigations	**50**	**100%**

Monitor's Sample of 50 Investigations

Appropriate investigation artifacts that were reviewed included documents and protocols used during the investigation lifecycle. Specifically, the initial complaint is triaged and evaluated by the CCU medical consultant and includes report(s) of investigation, medical expert reviews, referral to HQE for accusation filing, HQE's legal review letter and/or emails to MBC explaining the actions after referral and HQE recommendations, and documents identifying ultimate investigation disposition.

The monitor, using the HQE legal review letters and/or emails from the supervising DAG to MBC management, compiled the causes identified by HQE investigation, rejection and/or return for supplemental investigation. In addition, the monitor delineated investigation outcome and the total duration in days from initial complaint to investigation closure. This information was compiled by MBC ISB and derived from the BreEZe system. Tables 2.1.3, 2.1.4 and 2.1.5 present the summarized analysis.

Table 2.1.3 represents the outcome type, number of investigations by outcome type and percentage of investigations by outcome type for the 50 investigations in the sample. There are nine (9) outcome types in this table. Column 4 in the table represents investigations in which accusations were filed by HQE. Column 5 in the table represents investigations in which the outcome of the original rejection or return resulted in discipline imposed.

Table 2.1.3 — Outcomes of Investigation Sample

Investigation Outcome Type	Number	Percentage	Accusation Filed (A)	Discipline Imposed (D)
Decline to Prosecute (Final Outcome)	15	30.0%	–	–
Pre-Accusation — Public Letter of Reprimand (PA-PLR)	14	28.0%	–	D
Citation or Fine*	11	22.0%	–	–
Stipulation — Public Reprimand (PR)	1	2.0%	A	D
Stipulation — Probation	3	6.0%	A	D
Stipulation — License Surrender	1	2.0%	A	D
ALJ Proposed Decision — Dismissed	2	4.0%	A	–
ALJ Proposed Decision — Total of 3 Actions: 2 Actions Dismissed; 1 Action Sustained Resulting in Public Reprimand	1	2.0%	A	D
Investigation Closed, Consolidated with Primary Investigation; Primary Investigation Closed, No Filing	2	4.0%	–	–
Total Investigation — Outcomes	**50**	**100%**		

* Citation and Fine are not considered a discipline, per BPC Section 2227.

Table 2.1.4 represents the average number of days for MBC to complete the disciplinary process. The data in the table is compiled from BreEZe and reported in MBC's published board meeting reports. The data in the table includes all complaint actions that have encountered the full lifecycle from the CCU intake process, HQIU/CIO investigation process, and HQE administrative action process. Some actions may also include the Office of Administration Hearings (OAH) process and the board action process (case). The monitor's use of the term "case" in this report refers to complaints filed, investigated, referred to HQE for filing of an accusation, and the OAH process (where applicable). The average number of days of duration for completing the full lifecycle is used for comparative analysis in Table 2.1.5.

Table 2.1.5 provides the case completion duration in days range for the 50 cases in the monitor's sample. The monitor obtained documentation (BreEZe system query) for each case in the sample that specified the number of days to complete the case. The monitor associated each sample case's total days of duration with the case completion duration in the range of days depicted in column 1. Column 2 shows the number of sample cases within the specified range. Column 3 indicates the number of cases in the range that required supplemental investigation. Twenty-two of the 50 cases involved supplemental investigations. Of the 10 cases falling into the two ranges of greater than 1,200 days to complete, seven (7) of those cases required supplemental investigation. Note that 40 of the 50 cases did not result in an accusation filing and post-accusation processes as described in Table 2.1.4's annual average enforcement duration in days. However, a majority of the sample cases that did not incorporate these additional processes still had durations longer than the Table 2.1.4 average annual durations. This condition may indicate a lack of collaboration, causing inefficient and ineffective case processing.

Table 2.1.4 — MBC FY Average Enforcement Time Frames (in Days)

Fiscal Year (FY)	Average Number of Days to Complete a Case — Complaint Intake to Closure
2017/18	926
2018/19	1,016
2019/20	1,090
2020/21	1,128
2021/22	1,167

Table 2.1.5 — Sample of 50 Cases, Duration in Days, by Range

Range — Case Completion Duration in Days	Number of Cases in Duration Range	Number of Cases Requiring Supplemental Investigations
Fewer than 600	5	2 of the 5
600 to 900	9	3 of the 9
901 to 1,200	26	10 of the 26
1,201 to 1,500	5	3 of the 5
Greater than 1,500	5	4 of the 5
Total Cases	**50**	**22 of the 50**

In evaluating the referred investigations, HQE prosecutors identified investigation deficiencies preventing acceptance for prosecution for the drafting of an accusation for filing by the MBC. These deficiencies include but were not limited to concerns with evidentiary matter or medical expert opinions. For example, evidentiary issues identified by HQE included:

- Investigations lacking critical evidence, such as:
  - Certified medical records from all pertinent entities involved in the investigation
  - CURES reports
  - Pertinent mandatory reporting entities' admissible documentation
  - Civil action depositions and other relevant documentation
  - Documents from executed Subpoena Duces Tecum (SDT), including patient notices improperly served or never served
  - Pertinent witness or subject interviews, including interviews providing independent corroboration of documented evidence
- Investigation reports that present contradictory information within the report of investigation (ROI)
- Witnesses deemed not credible
- Witness statements or actions conflicting with other factual evidence
- Witnesses unwilling to testify or witnesses supporting the physician subject
- Multiple witnesses whose witness statements materially conflict with each other

In addition, medical expert inadequacies identified include:

- Expert lacking necessary medical training, experience, and/or background for rendering opinion on the investigation type
- Opinion based on incomplete medical records and/or documentation
- Opinion based on documentation or information that should have been excluded from the expert's review to avoid bias
- Opinion that is incomplete (i.e., not addressing all investigation subject matter), or incorporating contradictory statements within the opinion, or conclusionary statements without factual predicates
- Expert conducting independent research and introducing bias in evaluation
- Multiple experts retained for an investigation in which their opinions are materially in conflict. In all but one investigation, HQE had requested the second expert

For the 15 "decline to prosecute" investigations in Table 2.1.3 — Outcomes of the Investigation Sample with an investigation outcome type identified as "decline to prosecute," the monitor reviewed the HQE legal review letters and noted evidentiary or medical expert problems, including:

- Investigation Evidentiary Issues:
  - Interviews with patient, subject physician, and/or applicable witness did not occur or were deficient in posing salient areas of inquiry
  - Unable to locate key witness
  - Uncooperative or unreliable patient or witness
  - Missing medical records, certified records and hospital records
  - No CURES Report

- Medical Expert Issues:
  - Two expert opinions that materially conflict
  - Expert did not have proper medical specialty or sub-specialty to review and render a reliable opinion in a particular investigation
  - Expert did not cite appropriate medical standards
  - Expert evaluation or opinion had contradictory statements
  - Records supplied to the expert were incomplete or non-certified, therefore rendering such opinions as not based on all applicable records

Prosecutors evaluate many legal parameters when determining prosecutorial options in filing an administrative action and in the subsequent events following the filing of an accusation (i.e., post-filing). Many different types of conditions may occur during the post-filing period that directly affect a prosecutor's actions. The monitor's review is limited to conditions that were identified and documented upon an MBC investigation referral that resulted in either a rejection or a request for supplemental investigation work to be performed.

The monitor's analysis for this review identified issues that have occurred over the past five (5) years. Data metrics compiled from this analysis include:

- Rejections and returns for supplemental investigation of referred investigations to HQE have increased by a factor of seven (7), from 5.1% to 35.0% since FY 2017/18. This data is reflected in Table 2.1.
- Per OAG annual reports, 574 MBC/HQIU referred investigations were rejected or returned for supplemental investigation over four (4) years, FY2018/19 through FY 2021/22.
- MBC's annual average enforcement time frame for completing cases that resulted in discipline accusations, accusations withdrawn or dismissed cases rose from 926 days in FY 2017/18 to 1,167 days in FY 2021/22. The difference of 241 days constitutes a 26% increase over this period.
- Of the 50-case sample, HQE requested supplemental investigations for 22 investigations that were originally declined for prosecution. Four (4) of these 22 investigations required two (2) supplemental investigations.
- Of the 50-case sample relative to duration:
  - 20% of the cases (10 of 50 cases) took longer than the FY 2021/22 average of 1,167 days to complete or resolve.
  - 74% of the cases (37 of 50 cases) took longer than the FY 2017/18 average of 926 days for cases that resulted in discipline, accusation withdrawn or dismissal.
- Of the 50 investigations referred to HQE for filing of an accusation that were originally declined for prosecution, 80% (40 of the 50 investigations) resulted in "no accusation" being filed.
- Of the 50 investigations referred to HQE for the filing of an accusation that were originally declined for prosecution, 40% resulted in licensee discipline (20 of 50 investigations).

The monitor believes that the lack of formal communication between HQE and HQIU since December 31, 2018, contributes to the issues identified in this review. This finding is supported by the number and type of evidentiary and expert deficiencies identified in the HQE legal review letters assessed for this review. The monitor believes that a significant number of these deficiencies would have been mitigated

before the completed investigation was referred to HQE for accusation filing if HQE communicated directly with HQIU investigators. That is, if prosecutors had worked collaboratively and contemporaneously with investigators during the investigation process, they would have become aware of such deficiencies and could have taken corrective measures before moving an investigation forward. Prior to 2019, HQE rejected and returned for supplemental investigation approximately 5% of the total referred investigations for accusation, as indicated in Table 2.1.

Both HQIU and HQE are statutorily tasked with conducting MBC investigations. Business and Professions Code Section 159.5 provides that the "primary responsibility of [HQIU] is to investigate violations of law or regulation within the jurisdiction of the Medical Board…." And Government Code Section 12529 provides that "[t]he primary responsibility of [HQE] is to investigate and prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board…." The law suggests that due to their common interest conducting MBC investigations there should be enhanced collaboration between the two; nevertheless, since the termination of VE, these facts indicate that the opposite has occurred.

The lack of collaboration between HQE and HQIU is not the only cause for the increase in rejected MBC investigations since 2018. As identified in the *Initial Report*, the multiple problems noted in Finding 1 in maintaining a viable and experienced sworn investigation staff, and in Finding 3 in overcoming the systemic shortage of specialized medical experts contribute to the volume of investigations rejected by HQE. Due to these conditions, the monitor finds that it is critically important for prosecutors to immediately collaborate with investigators upon referral of the complaint to HQIU for formal investigation.

Moreover, over the past three years, a significant number of HQIU investigations had short statute of limitation (SOL) deadlines because of staffing shortages; priority changes and/or increases in active HQIU investigations; and extended timeframes within CCU's complaint evaluation process. It should be noted that MBC embarked on a death certificate project that resulted in complex death investigations being referred to HQIU for investigation. This contributed to a temporary increase in investigations with short SOL timeframes. As a result, investigations were referred to HQE with short SOL deadlines, which reduced the time allotments for prosecutors to manage workload assignments. This compressed scheduling, according to HQE, may have resulted in declining to prosecute some investigations and/or issuing PA-PLR or citation/fine(s). Documentation reviewed disclosed that some referred investigations exceeded the SOL deadline (i.e., SOL was incorrectly determined; HQE upon referral reviews the SOL deadline). As a result, some investigations were closed without accusation filings or other disciplinary actions.

Consequently, the outcomes listed in Table 2.1.3 are affected by the lack of an investigator-prosecutor collaboration, an impacted investigative workforce, critical shortages of experienced medical experts and, in some investigations, by compressed SOL deadlines.

Based on the analysis of the documentation, many of the identified evidentiary or medical expert deficiencies listed above likely would have been either prevented or mitigated during the investigation phase if the prosecutors had been actively collaborating with investigators.

Recommendations

Over the past 25 years, much has been analyzed, discussed, written and legislated relative to achieving the correct operational relationship between medical enforcement investigation and OAG HQE prosecution. Since the 1990s operational models have followed a sequence: handoff, deputy attorney general (DAG) in district office (DIDO), vertical prosecution/enforcement (VE), and back to handoff with VE's termination in 2018.

Once in 2006 and once again in 2014, the transition of MBC sworn investigators to the Office of the Attorney General (OAG) was proposed. Much organizational and operational analysis was performed outlining the strongly recommended reorganization. However, in both 2006 and 2014, the intended transition did not occur.

In 2006, sworn investigators remained under the MBC. The existing DIDO protocol was replaced by VE, which was legislatively enacted based on the strong recommendation of the 2004 enforcement monitor. In 2010, a study of VE's three-year implementation documented the strengths and weaknesses of VE's statewide rollout. This review found operational weaknesses in which VE was not achieving its intended benefits within certain offices and regions of the state.

In 2014, MBC sworn investigators were transitioned to DCA's DOI in which a new unit, the Health Quality Investigation Unit (HQIU), was established and continued with the established VE protocol. As the monitor reported in its *Initial Report Finding 2*, the way VE operated had both positive features and drawbacks. Divergent views on maintaining, modifying or eliminating VE continued and were debated in legislative hearings in 2017 and 2018, culminating in VE's termination effective December 31, 2018.

Consequently, on December 31, 2018, HQE prosecutors stopped communicating directly with HQIU investigators because only MBC is the litigation client. HQE's protocol is limited to client communication (i.e., MBC), and such communication is privileged. And since HQE views HQIU as a separate organization (i.e., a non-client), HQE does not communicate with HQIU. HQE requests for supplemental investigation specifying additional needed actions or criteria are documented and transmitted to MBC, which then forwards such requests to HQIU. This communication structure is cumbersome and contributes to a lack of collaboration and communication. But the monitor is not in a position to evaluate whether this communication structure is required by law due to HQE's view that HQIU is not its client or within the scope of an applicable privilege when it performs investigations on behalf of the MBC.

HQE's legal review letters detailing the reasons for investigation rejection are not provided to HQIU by MBC. Consequently, HQIU does not have access to specific HQE-identified investigation deficiencies nor is there a communication path to correct current or future identified deficiencies. MBC enforcement management does meet with HQIU management to discuss trends and issues. However, fully comprehending specific deficiencies identified by prosecutors would enable HQIU to proactively improve investigation protocols and procedures and build good working relationships.

The fundamental tenet of both DIDO and VE is collaboration between investigators and prosecutors during both the investigative and prosecutorial phases of an actionable investigation. The *Initial Report* largely concurs with the 2004 enforcement monitor's finding of an increased need for investigator-prosecution collaboration. However, the monitor does not recommend a return to VE with the OAG directing HQIU activities.

The *Initial Report* found that the medical enforcement business model is very similar to other business models in which a highly complex, multi-faceted, sequenced process using multiple professional disciplines throughout the process lifecycle requires collaboration and communication among such disciplines. Such critical communication is required within certain intervals and at key milestones.

Without such collaboration and communication between investigators and prosecutors, the effectiveness of building a sustainable, viable enforcement action is jeopardized. The monitor was informed by DOI leadership that other boards, including their investigative staffs when developing actionable investigations, communicate with OAG prosecutors, which results in actionable investigations. Additionally, efficiencies in completing investigation and prosecution activities punctually, accurately and completely are diminished. The 2004 monitor's enforcement report strongly recommended collaboration via the vertical prosecution model, given the complexities, dynamics and challenges faced when conducting medical complaint investigations. The monitor's *Initial Report* analysis also supports that the handoff model is inherently ineffective and inefficient for enforcement due to the lack of collaboration between prosecutors and investigators. This analysis finds that:

- Currently one-third of existing referred investigations are rejected or returned for supplemental investigation.
- Time frames to complete investigations and possible adjudication are impacted, causing problems in meeting SOL deadlines, thereby adding additional pressure on investigators and/or prosecutors.
- Supplemental investigations correcting previous work or requiring expanded activities, and the additional prosecutorial reviews of such subsequent work, incur added expense, disruptions to staff workloads and scheduled planned activities, staff frustration and morale issues. As documented in the *Initial Report Finding 1*, these factors contribute to continued investigator turnover, thereby exacerbating the investigator staffing issues. This directly correlates to quality issues in completed investigations.

Recommendation 2.1.1

Maintain the sworn investigation function with HQIU and the prosecution function within OAG HQE.

If the recommendation is implemented the following additional processes are recommended:

- Establish a structured collaboration between HQIU investigation and HQE prosecution, ensuring the necessary, appropriate and timely communication throughout a complaint investigation.
- This collaboration should be structured regionally by specific HQIU and HQE field offices, aligning investigators from each HQIU office with prosecutors from their corresponding office. Consequently, investigators will not rotate among prosecutors (as in VE) but will work with an assigned prosecutor (or a small unit of prosecutors), providing established and understood working relationships, gaining respect and, most importantly, trust.

To better execute complex medical complaints referred for formal sworn investigations, particularly standard of care cases deemed high-priority public protection cases per BPC Section 2220.05, the following collaborative milestones may result in effective and efficient investigative outcomes:

- Investigation Initiation:
  - To determine complexities and the anticipated level of efforts needed to move forward with the investigation, immediately conduct an initial evaluation of the complaint filed.
  - Develop a coordination and communication plan between HQIU and HQE to define roles and set expectations for investigations.
  - Establish complaint investigation coordination by engaging assigned investigators and corresponding prosecutors. This coordination should include how information will be shared and analyzed. This provides that all appropriate information, including medical records, mandated reports and CCU medical consultant evaluations are requested, received and distributed punctually.
  - Reach agreement on the strategy, methods and sequences of conducting the investigation. Document the agreed-upon approach in this investigation plan.
- Investigation Duration and Summation:
  - Establish and monitor specific milestones for collaboration. Each milestone should be identified as a reportable event that will document consistent communication and identify actions taken to support the investigation status. These may vary by investigation type and complexity, and should include:
    - A summary analysis by both the investigator and prosecutor of the relevant documentation obtained and examined
    - The additional needed documentation and necessary methods (i.e., SDT) for securing such records
    - All interviews conducted and remaining interviews
    - Retention of a medical expert, vetting of documentation to the expert, and review of expert evaluation and opinions
  - Ensure that the necessary periodic ad-hoc collaboration occurs at key investigative milestones. Ad hoc meetings may be required when investigator and prosecutor compare notes; discuss evidentiary problems, non-compliance issues, and potential risk in real time; and determine tactical approaches and methods for overcoming such issues.
  - Perform a real-time assessment of completed investigative milestones to determine the investigation's viability and whether continuing the investigation is warranted. The assessment should be conducted by the investigator and prosecutor, concurring whether to continue the investigation.
  - Provide the completed investigation information to MBC's chief of enforcement for approval and referral to HQE. This concurrent collaboration by investigator and prosecutor throughout the investigation lifecycle provides the chief of enforcement greater assurance (in comparison to the current handoff model) that all necessary elements required for referral and accusation filing have been met.

Recommendations for Implementation:

A. The structured working relationship between HQIU and HQE should be codified in a memorandum of understanding issued, approved and governed by MBC. It should identify the working relationships, the roles and responsibilities of each organization, and the key performance indicators at the appropriate level of specificity for tracking, monitoring, evaluating and reporting investigation activities between the two organizations. This provides the necessary flexibility for modification if operational circumstances require a change. In all events HQE prosecutors should serve in a consultative role, but not provide oversight or direction to HQIU investigators as was done during VE.

   Since HQE maintains the view that it may not communicate directly with HQIU investigators, it may be necessary to enact legislation when establishing this working relationship among MBC, HQIU and HQE, as was done with VE in 2006, providing the statutory authority. A possible amendment to Business and Professions Code Section 2020(b) noting expressly that the attorney general is legal counsel to the board and HQIU for purposes of conducting MBC investigations may suffice, or an amendment may be made to Section 2006 to authorize MBC investigations to include investigations conducted by HQIU. The specific wording of proposed statutory changes, however, is outside the monitor's scope.

B. As documented in the *Initial Report*, the MBC's QBIRT analytic application has implemented several specific management reports extracting applicable data from the BreEZe system. These reports provide the detailed monitoring of investigation activities and time frames, providing real-time information to both MBC and HQIU personnel. Upon implementation of this recommendation, it may likely require additional reporting needs based on the enacted working relationships among MBC, HQIU and HQE.

C. The monitor recommends that the MBC engage an independent facilitator specializing in multi-organization structuring, operations and management to help guide and manage group discussions and activities needed to achieve the goals and objectives of this recommendation. Independent facilitation will assist MBC, HQIU and HQE in effectively identifying, addressing and resolving the issues for successfully implementing this recommendation. A facilitator will provide an objective viewpoint and help the teams guide themselves as well as promote open communication among members of each organization.

D. The monitor recommends that the MBC appoint an enforcement subcommittee to oversee the implementation of this recommendation. The subcommittee can serve as an expert resource and advisory body to the members of the board regarding the enforcement program. Consequently, in this

capacity, both the subcommittee and the board will be apprised of all pertinent issues during this organizational transition and will assist in building the necessary consensus required for implementation.

E. When legal impediments are found to prevent the full collaboration between MBC, HQE and HQIU, statutory changes should be pursued to remove or limit those impediments. MBC should take a lead role on seeking these legislative changes.

Recommendation 2.1.2

If the collaboration in Recommendation 2.1.1 above cannot be achieved, restructuring the MBC Enforcement Program should be considered. Major investigatory process restructures have been previously discussed in historical published monitor reports and other reports. All options should be considered, including either moving investigator functions to the DOJ or back to MBC, or moving the prosecutor functions to MBC.

2.1.2.A Moving Investigators to DOJ

The monitor believes that the analysis performed in 2004–2006 leading to the proposed transition of MBC sworn investigators to DOJ is a viable option to implement. This prior recommendation based on the documentation and actions taken over the past 17 years appears to support the concept that investigative staff must have access to and work with corresponding DOJ prosecutors.

Investigators would be embedded with prosecutors, following the established protocols, policies and procedures of the DOJ. The 2004 enforcement monitor's report identifies the necessity of investigation and prosecution functions, and emphasizes that they need to be seamless, especially due to the complexities, nuances and dynamics of medical standard of care investigations.

In addition, had the investigators been transferred to the DOJ, the systemic problem of maintaining a stable, experienced and viable sworn HQIU investigation staff since 2014 as documented in the *Initial Report Finding 1* may not have occurred. It is the monitor's understanding that historically the DOJ maintains both a stable and viable investigation workforce. It appears that ongoing staff turnover, and all disruptive effects and outcomes of such turnover, do not occur at the DOJ. Prior to moving any investigators to DOJ, a thorough workload and cost benefit analysis should be conducted.

Moreover, the ongoing turbulence of vertical enforcement throughout its lifecycle of 2006 through 2018, as documented in the 2010 and 2016 reviews, and recapped in the legislative hearings of 2017 (as captured in *Initial Report Finding 2*), may not have occurred if sworn investigators had joined the DOJ in 2006. The inefficiencies and ineffectiveness of VE, as documented in the reviews and testimonies, could have been avoided if investigators had been placed within the DOJ.

Significantly, the above recommendation failed to be legislated twice. The monitor was not involved in the 2006 and 2014 discussions, but challenges exist when transferring over 100 positions between two constitutional offices.

2.1.2.B Moving Investigators to MBC

HQE should consider the investigators to be within the attorney-client relationship it has with MBC. This relationship would allow investigators to interact with HQE personnel and access HQE documentation. Information and documentation could be shared and not be considered privileged, which is the current practice with interactions between the HQIU and HQE.

There may be benefits to processing complaints and completing investigations with all enforcement staff placed within the MBC organization. Investigations that under current practices go to HQIU, could instead remain with MBC. Having enforcement staff under the control of MBC may result in greater efficiencies.

This would require a thorough independent analysis of both budget and human resource impacts to MBC and DCA DOI, their existing workload commitments and organizational responsibilities.

2.1.2.C Moving Prosecutors to MBC

The lack of a structured collaboration between medical enforcement investigation and prosecution results in ineffective and inefficient outcomes. The metrics indicate investigations referred for accusation are not filed and the duration in completing investigations has increased substantially, providing additional workload management problems, staff frustration, additional cost and investigations that are closed without adjudication due to SOL thresholds.

As documented in the *Initial Report* and previous medical enforcement evaluations, collaboration between investigators and prosecutors is the critical factor when successfully (i.e., completely, accurately and punctually) conducting a high-priority standard of care investigation, ensuring the medical board mandate of public protection.

The monitor believes it would be appropriate to evaluate combining all enforcement activities within the MBC, including sworn investigators and prosecutors. There may be comparable models at other state agencies, such as the Department of Real Estate, that could be evaluated to inform MBC if such a move would be the best policy decision.

The monitor understands that transitioning the long-held HQE prosecutorial function under the jurisdiction of OAG would be controversial, given the state's constitutional structure of the executive branch and OAG, and the 33-year HQE prosecutorial history.

The examination of existing board structures within the state of California, or other medical boards within the nation operating under this all-inclusive model, is outside the scope of the monitor's MBC enforcement process evaluation.

Recommendation 2.1.3

The monitor recommends that DCA's internal audits office conduct a detailed analysis of the 16 case investigations provided by HQIU to the monitor. This analysis should include the necessary independent legal and medical expertise in evaluating and opining on the conclusions documented for each case investigation.

2.2 Medical Expert Review

Objective

The review objective is to conduct additional analysis of medical expert processes and provide additional recommendations associated with the *Initial Report* Finding 3: Shortage of Specialized Medical Experts.

Scope and Methodology

The monitor obtained additional documentation on medical expert program activities from MBC's manager of the Medical Consultant and Expert Reviewer Program (MBC Manager). Additionally, MBC management coordinated interviews with the monitor and three (3) licensees, enabling the monitor to discuss the existing medical expert program with licensees; obtain their opinions on the program's benefits, strengths and weaknesses; and collect additional information on the

systemic specialized medical expert availability issues and potential solutions for overcoming this problem.

Analysis and Findings

As presented in Finding 3 of the monitor's *Initial Report*, the opinion of the retained medical expert determines whether a standard of care complaint will result in an actionable investigation during the investigation phase. The expert's opinion forms the basis for accusation(s) brought by an HQE prosecutor or determines that there is no warranted action, and the investigation is closed.

Consequently, the expert opinion is the most critical evidential component of a actionable quality of care investigation. HQE's decision to accept an investigation for prosecution drafting an accusation depends specifically on the quality and soundness of the expert's opinion, which must be credible, unbiased and based on admissible evidence.

The practitioners interviewed support the enforcement medical expert protocol because it enforces the integrity of the state's overall enforcement program. When complaints are filed, it provides the independent evaluation of whether licensed physicians and surgeons are performing within the established medical standard of care protocols. This process supports compliance with the medical board's governing statutes and guidelines along with contributing to the integrity of the enforcement program and public protection.

The licensees performing expert evaluations should be seasoned practitioners in good standing with years of quality professional medical experience. Having this medical expertise will enable appropriate relevant and timely evaluations for the complex medical complaint investigations. MBC's recruiting and retaining of experts has consistently proven challenging, given the professional demands of medical practitioners. During the interviews, the practitioners specifically mentioned the challenge of providing expert testimony along with managing their own demanding jobs and maintaining "work-life" balance. This significantly lessens their availability in becoming a medical expert.

To the extent that a licensee's available time is limited, the current state compensation rate of $200 per hour is not comparable to market rates for consulting as a medical expert in either criminal or particularly civil cases. Market rates range from $500 to $800 per hour. Consequently, when given a choice, experts may accept opportunities only with higher compensation rates. While this is likely not the principal detriment for failing to recruit additional experts, it is a contributing factor. The licensees interviewed indicated that increasing compensation rates will likely result in increased participation in the program. Projecting the increase in terms of applying a percentage of improvement is currently not quantifiable.

Given the ongoing shortage of medical experts and the detrimental effects to the enforcement program, the monitor asked the licensees' professional opinion of requiring physicians and surgeons to act as a medical expert when called upon by the enforcement program (i.e., required participation). All indicated that they were not opposed to such a concept, given their standing as medical professionals, the importance of the medical profession in society and maintaining its integrity in view of public scrutiny. The interviewees indicated that this expert requirement concept could be justifiable as a condition of licensure.

However, all indicated that such a requirement would be controversial. In addition, the process to enact this requirement (i.e., the parameters of how a licensee would be selected, allowance for exclusion,

conditions relative to length of service, and other factors) would need to be fully evaluated and vetted before implementing.

Recommendations

Recommendation 2.2.1

Various recruiting methods are used in recruiting medical experts (e.g., newsletters, web presentations, mailing with licensing and emails). The monitor recommends that recruiting be held in person and/or virtually because it will allow potential candidates to ask questions of program staff. This will provide an opportunity to emphasize the significance of the medical expert function and how the function impacts the integrity of the MBC enforcement program.

Recommendation 2.2.2

Require all MBC medical experts to participate in expert training and eliminate the current two-tier pricing structure, which is a $150/hour pay scale for experts not completing the MBC expert training and $200/hour for completing the expert training program. All medical experts must complete the expert training program to help ensure consistency in medical expert services.

Recommendation 2.2.3

Establish a formal process for soliciting medical expert training feedback. This should include medical expert training content and structure. Periodically review completed medical expert training evaluation forms for the purpose of identifying the strengths and weaknesses of the program. Determine and incorporate viable changes and enhancements to the program based on expert training feedback. Establish and document measures that contribute to the success of the training program to be used as key performance indicators (KPIs). Monitor and report on the KPIs to MBC management on a periodic basis.

Recommendation 2.2.4

Conduct a medical expert compensation assessment that determines with a degree of certainty the level of compensation necessary to both attract candidates to the program and retain existing experts. If the necessary expertise does not exist within the board, retain a consultant who specializes in professional rate structures and protocols. Such a consultant, in addition to compensation, may determine other contributing factors generating increased participation, retention and suitability for the medical expert program.

If additional authority is needed, either from control agencies or via statute, that authority should be sought by MBC.

Recommendation 2.2.5

If improvement to the MBC Medical Expert Program is not addressed by the next Sunset Review, required participation by licensees in the medical expert program should be considered. As part of the condition of medical licensing, an obligation when called upon in assisting the enforcement program's integrity could be established. As indicated above, medical enforcement is dependent upon a medical expert's opinion in determining the validity and substance of a standard of care complaint. There is no acceptable alternative when adjudicating these investigations; an expert opinion is required.

As the monitor's *Initial Report* analysis indicates, 32 medical expert specialties have been identified for meeting the enforcement program needs. Approximately 12 specialties and sub-specialties are continually short of medical experts. The need for medical expert by specialty is not static, but changes over time. Without the timely availability of an expert, investigations cannot be completed, which subjects the investigation to closure via the SOL deadline.

Enacting a compulsory medical expert program, requiring participation of licensees meeting certain requirements, would be controversial. However, if the systemic shortage of medical experts continues to jeopardize the effectiveness of enforcement, the monitor believes it should be, at a minimum, evaluated as a potential option.

2.3 Manual of Model Disciplinary Orders and Disciplinary Guidelines in the Board's Application of Sanctions or Discipline

Objective

Senate Bill 806, codified in Business and Professions Code (BPC) Section 2220.01 item 4, specifies that the independent monitor shall review compliance with BPC Section 2229, including deviations from the Manual of Model Disciplinary Orders and Disciplinary Guidelines in the board's application of sanctions or discipline.

The review objective is to determine if the imposition of disciplinary actions on licensees for identified violations is in accordance with MBC's Manual of Model Disciplinary Orders and Disciplinary Guidelines (guidelines).

Scope and Methodology

The monitor reviewed the guidelines and met with various MBC staff and management to discuss the genesis and the historical application of the guidelines. Guidelines when imposing disciplinary action helps ensure the uniformity, certainty and fairness of the enforcement program relative to its mandate of furthering public protection.

Working with MBC's Information Systems Branch (ISB), a report from MBC's BreEZe licensing and enforcement database system identifying adjudicated cases for which discipline could likely be imposed was obtained. The report identified all the adjudicated cases. From this universe of adjudicated cases, a judgmental sample of 50 cases was selected for detailed review. Case documentation along with the appropriate historical artifacts (complaint, investigation documents, accusations, HQE legal review letters and BreEZe case notes) were reviewed.

Analysis and Findings

The *Manual of Model Disciplinary Orders and Disciplinary Guidelines, 12th Edition* (published in 2016), consists of:

- Three (3) model disciplinary orders (revocation single cause, revocation multiple causes, standard stay order)
- 23 "optional conditions," each directing the licensee to either a prohibited action or a specified course of action. The use of these conditions depends on the nature and circumstances of the case
- 11 standard conditions, each directing the licensee to a prohibited action or a specified course of action. These conditions generally appear in all probation cases
- Recommended range of penalties for violations:
    - Identification of 37 violations, each of which references the applicable BPC section(s).
    - Each violation specifies a minimum and maximum penalty.
    - Each violation specifies the appropriate optional conditions from the list of 23 optional conditions. For example, the section on violation of "prescribing to addicts" (BPC Section 2242) identifies a maximum penalty of license revocation, and a minimum penalty of "stayed revocation" with five (5) years' probation and 10 optional conditions.

- For one violation (in cases charging repeated negligent acts with one patient) a public reprimand may be ordered in appropriate circumstances.

Per the published guidelines:

- "Business and Professions Code Section 2229 mandates protection of the public shall be the highest priority for the Medical Board and for the Administrative Law Judges of the Medical Quality Hearing Panel. Section 2229 further specifies that, to the extent not inconsistent with public protection, disciplinary actions shall be calculated to aid in the rehabilitation of licensees."
- "Consistent with the mandates of Section 2229, these guidelines set forth the discipline the Board finds appropriate and necessary for identified violations. In addition to protecting the public and, where not inconsistent, rehabilitating the licensee, the Board finds that imposition of the discipline set forth in the guidelines will promote uniformity, certainty and fairness, and deterrence, and, in turn, further public protection."

A key governing provision of the guidelines states:

- "The Board expects that, absent mitigating, or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake Board-ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure."

Consequently, departures (or deviations) from recommended discipline relative to identified violations can occur if mitigating or other appropriate circumstances warrant such action, and if facts identify and support such deviations. These are known as justified departures.

Monitor's Sample of 50 Cases

The monitor's sample selection of 50 cases from the BreEZe report listing adjudicated cases over the period FY 2017/18 through FY 2021/22, by complaint complexity type is summarized in Table 2.3.1:

Table 2.3.1 — Monitor's 50 Sample Cases, Summarized by Complexity Type

Case Complexity Type	Number	Percentage
Negligence Resulting in Serious Injury or Death	10	20.0%
Negligence or Incompetence	11	22.0%
Excessive Prescribing	11	22.0%
Inappropriate Prescribing	1	2.0%
Sexual Misconduct During Treatment	5	10.0%
Sexual Misconduct	1	2.0%
Unprofessional Conduct	3	6.0%
Criminal Charge/Conviction	7	14.0%
Discipline by Another Agency	1	2.0%
Total Cases	**50**	**100%**

The results of the monitor's analysis of sample cases are compiled in Table 2.3.2.

The monitor further stratified the testing outcomes, eliminating cases in which no violations were found, and therefore no discipline was imposed. This provides a more focused review on the outcomes of imposed discipline in Table 2.3.3.

The review of the cases in which violations were determined via stipulation or formal hearing (i.e., Table 2.3.3, 33 cases) determined:

- 42% of cases resulted in discipline imposed within the minimum/maximum range of discipline for the identified violation per the guidelines.
- 58% of cases resulted in discipline departing from the guidelines. However, such disciplines are deemed justified departures per the provision of the guidelines. This allows for departure from the disciplinary guidelines provided that the departures are identified and supported by the facts. These are allowed as "mitigating or other appropriate circumstances" if protection of the public does not outweigh the rehabilitation of the licensee relative to the licensee's actions.
- In all 19 cases the monitor identified as justified departures, the supporting documentation (i.e., HQE legal review letters or ALJ-proposed decisions from hearings) detailed the facts and circumstances within each case allowing for the recommended departure. The reasons for the justified departures varied by case but were sufficiently detailed in supporting the mitigating or appropriate circumstances discipline recommendation; the recommendations were then board adopted.

In one case the board rejected the ALJ's proposed decision, in which the ALJ decision favored the licensee and recommended dismissal of the accusation charges.

Table 2.3.2 — Imposition of Discipline per Guidelines, Testing Outcomes

Results of Sample Test - Outcomes	Number	Percentage
No Violation Found/No Discipline Imposed	17	34.0%
Discipline Imposed per Guidelines	14	28.0%
Justified Departure from Guidelines	19	38.0%
Deviations from Guidelines	0	0.0%
Total Cases	**50**	**100.0%**

Table 2.3.3 — Imposition of Discipline per Guidelines, Testing Outcomes Excluding Sample Cases with No Violations

Results of Sample Test - Outcomes	Number	Percentage
Discipline Imposed per Guidelines	14	42.4%
Justified Departure from Guidelines	19	57.6%
Deviations from Guidelines	0	0.0%
Total Cases	**33**	**100.0%**

The board found justification for imposing a stayed license revocation, and probation with various optional and standard conditions.

Recommendations

Recommendation 2.3.1

State entities (i.e., agencies, departments, boards, commissions and other units) are legally authorized to operate programmatic activities under 29 different codes containing statute (e.g., government code, business and professions code, health and safety code). This higher-level statutory authority is then further defined in regulations adopted, amended or repealed by state agencies pursuant to the Administrative Procedures Act (APA). Properly adopted regulations that have been filed with the office of the Secretary of State have the force of law. Regulations are the foundation and the guidelines, setting the operational parameters, when conducting program activities. Such regulations promote uniformity, consistency, clarity and equal application of program activities to all program participants.

The *Manual of Model Disciplinary Orders and Disciplinary Guidelines, 12th Edition* (guidelines) are adopted in regulation (16 CCR Section 1361) and have the legal force of regulations, directing the medical board disciplinary activities relative to identified violations under the mandate of BPC Section 2229. As stated in the guidelines, "In addition to protecting the public, and where not inconsistent, rehabilitating the licensee, the Board finds that imposition of the discipline set forth in the guidelines will promote uniformity, certainty and fairness, and deterrence and, in turn, further public protection."

As stated in the analysis, the guidelines are highly structured, 37 violations identified each associated with the discipline, with the minimum and maximum range. The structure of the guidelines is consistent with the objective of uniformity, certainty and fairness. However, in the sample of 33 cases in which identified violations were found, 58% of the cases imposed a discipline deviating from the guidelines' specified discipline.

The monitor understands that BPC Section 2229 and the guidelines allow for a proposed decision or a settlement that departs from the disciplinary guidelines but indicates that it shall identify the departures and the facts supporting the departure. In the monitor's review of these 19 cases (58%), which departed from the applicable guideline discipline, each case stated the departure and the facts supporting the departure, thereby justifying the deviation. Some justified deviations included detailed facts, circumstances and mitigating actions in more detail than others. The facts and circumstances of each case are evaluated, and the mitigating factors are also considered when determining the imposed discipline.

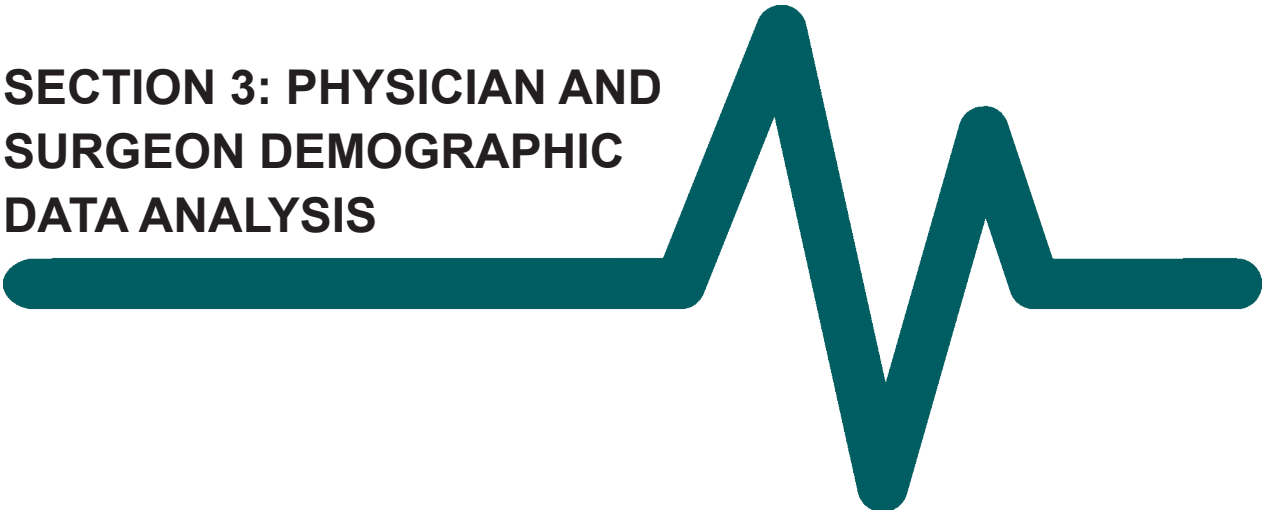
However, when the majority of cases fall under "justified deviation" from guidelines, it gives the appearance of undermining the guidelines' objective of uniformity, and certainty and fairness. In reaching the decisions of justifiably deviating from the guidelines' specified discipline, the analysis supporting the deviation is not publicly disclosed; consequently, this contributes to the question of a fair, uniform, and consistent application of imposing discipline.

It is universally recognized that when administering government programs, a certain amount of latitude is needed relative to imposing sanctions, recognizing mitigating facts and circumstances and the totality of the situation. BPC Section 2229 and the guidelines recognize this, allowing for the departure from the specified discipline minimum-maximum relative to the associated violation. However, when the

number of departures is significant and the corresponding justification is not publicly disclosed, this can have detrimental effects on the objectivity of the enforcement program. This leads to the public discounting of the effectiveness of the governing artifact, in this case the guidelines.

Consequently, the monitor recommends a review of the guidelines (i.e., the minimum-maximum ranges of each discipline relative to each violation), and the procedures for departing from identified disciplines relative to the associated violation, thereby potentially lessening the justified deviations. Since modifications could have both intended and unintended outcomes given the complexities and nuances of the enforcement program, this review should include individuals with a full understanding of the enforcement program and the evolution of the guidelines, given the history of the guidelines, is in the 12th edition.

SECTION 3: PHYSICIAN AND SURGEON DEMOGRAPHIC DATA ANALYSIS



Objective

The monitor's objective is to obtain self-identified physician and surgeon data that includes information on their race/ethnicity and compare the data to complaint and disciplinary action data that is associated with the physician and surgeon race/ethnicity data.

Background Information

MBC Race/Ethnicity Survey and Compilation of Data

The board collects self-identified race/ethnicity information from physician and surgeon licensees upon initial licensing or at license renewal. The MBC Physician Survey was used to collect the race/ethnicity information used in this analysis. The MBC Physician Survey data used for this analysis was collected prior to the implementation of the Health Care Access and Information (HCAI) survey on July 14, 2022. The HCAI was formerly known as the Office of Statewide Health Planning and Development. The HCAI survey implementation was the result of the passage of Assembly Bill (AB) 133 (Chapter 143, Statutes of 2021). HCAI uses the data to produce an annual report that includes the diversity of the health care workforce, by specialty (including, but not limited to, data on race, ethnicity and languages spoken).

The available values for race and ethnicity on the MBC Physician Survey match the values implemented in the HCAI Survey to help ensure that historical data can be compared to future data. Prior to the implementation of the HCAI survey, the data from the MBC Physician Survey was stored in the BreEZe system; thus the data for the monitor's analysis was extracted from the BreEZe system.

During the assessment process the monitor found, based on interviews with MBC staff, that besides ensuring that race/ethnicity data is available for HCAI reporting, the MBC does not analyze or produce reports associated with the self-identified race/ethnicity survey data.

A one-time study of potential racial bias in MBC's disciplinary process was conducted by the California Research Bureau (CRB), California State Library, and published in January 2017 as the *Demographics of Disciplinary Action by the Medical Board of California*. The report disclosed that:

> *Although limitations with the study prevent the Research Bureau from providing a definitive answer, the data does show a correlation between physician race and the pattern of complaints, investigations, and discipline. After controlling for a number of other variables, Latino/a and Black physicians were both more likely to receive complaints and more likely to see those complaints escalate to investigations. Latino/a physicians were also more likely to see those investigations result in disciplinary outcomes.*
>
> *On the other hand, other minority physicians — in particular Asian physicians — actually saw reduced likelihoods of receiving complaints, or of those complaints escalating to investigations. These observations remained even after controlling for age, gender, board certification, and number of hours spent on patient care.*
>
> *While the overall likelihood of an investigation resulting in discipline also appears to be contingent on which executive director is currently serving, as well as which disciplinary panel is assigned, these effects are consistent across all physicians, regardless of race.*
>
> *Finally, these findings should be taken with the caveat that this is an observational study, and many variables affecting the perception of physician performance*

(for instance, "bedside manner") could not be taken into account. While there is evidence of disparate outcomes, there is no evidence that any actor has specifically applied racial bias to achieve these outcomes.

Scope and Methodology

To conduct a review of self-identified race/ethnicity information, the monitor obtained three (3) data extracts from MBC's Information System Branch (ISB). The three data extracts are described below.

- Licensee data with self-identified race/ethnicity designations for 167,417 active physician and surgeon licensees, as of July 13, 2022. The race/ethnicity designation categories in the data extract are indicated below:
  - 126,647 physicians and surgeons designated one race/ethnicity type
  - 3,793 physicians and surgeons designated "Other (not listed)"
  - 28,098 physicians and surgeons designated "Declined to State"
  - 8,879 physicians and surgeons designated "2 or More"
- Physician and surgeon licensee discipline data for a six-year period, FY 2016/17 through FY 2021/22. Initially the extract contained 2,884 records when received from MBC. The monitor removed 421 records that were duplicate records to arrive at 2,463 unique licensee records. The 2,463 licensees completed the MBC Physician Survey used to collect race/ethnicity information. The race/ethnicity designation categories for the 2,463 records are indicated below:
  - 1,698 physicians and surgeons designated one race/ethnicity type
  - 60 physicians and surgeons designated "Other (not listed)"
  - 343 physicians and surgeons designated "Decline to State"
  - 108 physicians and surgeons designated "2 or More"
  - 254 physicians and surgeons could not be associated with a discipline type and were listed as "Not Identified"
- Physician and surgeon licensee complaint data for the six-year period, FY 2016/17 through FY 2021/22. The physician and surgeon record count listed on the extract summary page received from MBC identified 62,424 records. However, the detailed extract provided by MBC consisted of only 48,134 records because the monitor requested MBC to remove the non-jurisdictional complaints when generating the detailed extract. The monitor removed another 220 records from the detailed extract which were either duplicate or non-physician or surgeon records to arrive at the 47,914 physician and surgeon complaint records used for this analysis. The 47,914 complaints are not unique to a single physician or surgeon. Of the 47,914 complaints, 26,426 are unique licensee complaints. Therefore in some instances, physicians or surgeons will have more than one complaint. It should also be noted that complainant race/ethnicity information is not collected by MBC and is not considered for this analysis. The race/ethnicity designation categories in the data extract for the 47,914 complaints are indicated below. The totals for each category do not represent unique physicians and surgeons.
  - 34,138 complaints for physicians and surgeons designated one race/ethnicity type

- 1,335 complaints for physicians and surgeons that designated “Other (not listed)”
- 7,901 complaints for physicians and surgeons that designated ”Decline to State”
- 2,287 complaints for physicians and surgeons that designated “2 or More”
- 2,253 physicians and surgeons could not be associated with a complaint and were listed as “Not Identified”

The monitor used the data extracts received from MBC to filter, sort and array the data to derive summaries of physician and surgeon self-identified race/ethnicity comparisons. The data summaries are presented in the analysis and findings section below.

As mentioned in the background section above, the race/ethnicity data obtained for the licensed physicians and surgeons is self-identified by the physicians and surgeons and is retained in the BreEZe system. This data is unaudited by the monitor and accepted as reported in the BreEZe system for this analysis.

The monitor did not review, assess, or analyze the integrity of the data in the BreEZe system and relied on the quality of data in the BreEZe databases. In performing this review, the monitor did not assess the reliability of electronic data files extracted from the BreEZe system for the purpose of identifying race/ethnicity information for licensees. However, to accomplish this assessment, the monitor conducted other data verification steps that provided reasonable assurance that the data obtained from BreEZe may be relied on for this review.

Additionally, the monitor is aware of the California State Auditor (DCA) 2016-046 report that disclosed BreEZe system weaknesses in the controls used to validate data upon entry into the system. Specifically, BreEZe does not require staff members to enter activities into the system following DCA’s established business process. The monitor did not identify instances of this condition during the monitor’s assessment. Therefore, there is sufficient evidence in total to support the review findings, conclusions, and recommendations.

Analysis and Findings

Using data from the three data extracts (i.e., licensee self-identified race/ethnicity designations, complaints received and imposed discipline), the monitor compiled, analyzed, and compared physician and surgeon demographic data. The monitor’s data compilation is presented below in tables 3.2 through 3.8. The data in tables 3.2 through 3.8 include only physicians and surgeons that indicated one race/ethnicity type and the “Other (not listed)” categories.

The monitor believes the data presented in this section is foundational for conducting further demographic analysis relative to potential bias in disciplinary actions. However, such analysis requires a more in-depth study of initial complaint data and all the subsequent actions through completion of the ultimate investigation outcomes. Consequently, this analysis does not make judgments regarding potential bias or prejudicial behaviors.

Table 3.1 displays the 39 race/ethnicity classifications in the BreEZe system. To streamline the presentation of the data in Tables 3.2 through 3.8 below, the monitor categorized 26 of the 39 race/ethnicity classifications from BreEZe into three (3) HCAI race/ethnicity groups. Ten of the remaining 13 BreEZe classifications also have a one-to-one relationship with the HCAI race/ethnicity groups and are presented in Tables 3.2 through 3.8. The “Decline to State,” “2 or More” and “Not Identified” classifications are in the BreEZe system, but are not presented in the following tables.

Table 3.1 — MBC BreEZe Race/Ethnicity Classifications Aligned With HCAI Race/Ethnicity Groups

BreEZe Extract Classifications	HCAI Race/Ethnicity Groups
Cambodian Chinese Filipino Indian Indonesian Japanese Korean Laotian/Hmong Malaysian Pakistani Taiwanese Thai Vietnamese Other Asian	Asian
Fijian Guamanian Hawaiian Samoan Tongan Other Pacific Islander	Native Hawaiian/Pacific Islander (NHPI)
Central American Cuban Mexican Puerto Rican South American Other Hispanic	Hispanic/Latino/Spanish Origin
African	African
African American	African American
Alaska Native	Alaska Native
American Indian	American Indian
Black	Black
European	European
Middle Eastern	Middle Eastern
Native American	Native American
White	White
Other (not listed)	Other (not listed)
Decline to State	Decline to State
2 or More	
Not Identified*	

*The Not Identified attribute is named Null in BreEZe

Table 3.2 displays the 130,440 physician and surgeon licensees that designated one race/ethnicity type or "Other (not listed)." The 130,440 physician and surgeon licensees include the 3,793 physicians and surgeons that designated "Other (not listed)." The columns in the table display the following:

- Column 1 — Licensed physician and surgeon self-identified race/ethnicity groups
- Column 2 — The number of physicians and surgeons for each self-identified race/ethnicity group
- Column 3 — The licensed physician and surgeon race/ethnicity group's percentage of the total number of licensed physicians and surgeons that designated one race/ethnicity type or "Other (not listed)." The percentage of total number of licensed physicians and surgeons is used in the Table 3.4 comparative analysis.

Table 3.2 — Licensee Totals by Self-Identified Race/Ethnicity Groups

Self-Identified Race/Ethnicity	Number of Physicians and Surgeons	% of Total Number of Licensed Physicians and Surgeons
African	807	0.62%
African American	3,780	2.90%
Alaskan Native	15	0.01%
American Indian	273	0.21%
Asian	44,279	33.94%
Black	646	0.49%
European	8,136	6.24%
Hispanic/Latino/Spanish Origin	8,025	6.15%
Middle Eastern	5,003	3.84%
Native American	200	0.15%
Native Hawaiian/Pacific Islander (NHPI)	217	0.17%
Other (not listed)	3,793	2.91%
White	55,266	42.37%
Total	**130,440**	**100%**

Table 3.3 displays the number of physician and surgeon licensees that designated one race/ethnicity type or designated "Other (not listed)" that had licensee-imposed disciplines over six fiscal years (FY 2016/17 through FY 2021/22). The columns in the table display the following:

- Column 1 — Licensed physician and surgeon self-identified race/ethnicity groups. The Alaskan Native race/ethnicity group is not reflected in this table due to not having discipline activity.
- Column 2 — The number of disciplined physicians and surgeons is shown for each self-identified race/ethnicity group.
- Column 3 — The disciplined physician and surgeon race/ethnicity group's percentage to the total number of licensed physicians and surgeons that designated one race/ethnicity type or "Other (not listed)." The percentage of the total number of disciplined physicians and surgeons is used in the Table 3.4 and Table 3.6 comparative analysis.

Table 3.3 — Licensee Imposed Discipline by Race/Ethnicity Groups

Self-Identified Race/Ethnicity	Number of Disciplined Physicians and Surgeons	Disciplined Physicians and Surgeons (% of the Total)
African	19	1.08%
African American	77	4.38%
American Indian	2	0.11%
Asian	458	26.05%
Black	14	0.80%
European	95	5.40%
Hispanic/Latino/Spanish Origin	113	6.43%
Middle Eastern	85	4.84%
Native American	4	0.23%
Native Hawaiian/Pacific Islander (NHPI)	2	0.11%
Other (not listed)	60	3.41%
White	829	47.16%
Total	**1,758**	**100%**

Table 3.4 displays a comparison of the percentage of disciplined physicians and surgeons for each self-identified race/ethnicity group to the percentage of licensed physicians and surgeons for each self-identified race/ethnicity group. The columns in the table display the following:

- Column 1 — Licensed physician and surgeon self-identified race/ethnicity groups.
- Column 2 — Displays the disciplined physician and surgeon race/ethnicity group's percentage of the total number of licensed physicians and surgeons that designated one race/ethnicity type or "Other (not listed)." The data in column 2 is the same data reflected in column 3 in Table 3.3.
- Column 3 — Displays the licensed physician and surgeon race/ethnicity group's percentage of the total number of licensed physicians and surgeons that designated one race/ethnicity type or "Other (not listed)." The data in column 3 is the same data reflected column 3 in Table 3.2.
- Column 4 — Displays the disciplined and licensed percentage difference for each self-identified race/ethnicity group. A positive percentage number indicates a larger percentage of imposed discipline compared to the licensee race/ethnicity group's percentage. A negative number indicates a smaller percentage of imposed discipline compared to the licensee race/ethnicity group's percentage.

Table 3.4 — Comparison of Discipline to Licensee Percentages by Race/Ethnicity Groups

Self-Identified Race/Ethnicity	Disciplined Physicians and Surgeons (% of Total)	Licensed Physicians and Surgeons (% of Total)	Disciplined vs. Licensed Physicians and Surgeons (% Difference)
African	1.08%	0.62%	0.46%
African American	4.38%	2.90%	1.48%
Alaskan Native	0.00%	0.01%	-0.01%
American Indian	0.11%	0.21%	-0.10%
Asian	26.05%	33.94%	-7.89%
Black	0.80%	0.49%	0.31%
European	5.40%	6.24%	-0.83%
Hispanic/Latino/Spanish Origin	6.43%	6.15%	0.28%
Middle Eastern	4.84%	3.84%	1.00%
Native American	0.23%	0.15%	0.07%
NHPI	0.11%	0.17%	-0.05%
Other (not listed)	3.41%	2.91%	0.51%
White	47.16%	42.37%	4.79%
Total	**100%**	**100%**	

Table 3.5 displays the 35,473 complaints associated with physician and surgeon licensees that designated one race/ethnicity type or "Other (not listed)." The 35,473 physician and surgeon licensees include the 1,335 physicians and surgeons that designated "Other (not listed)." The columns in the table display the following:

- Column 1 — Licensed physician and surgeon self-identified race/ethnicity groups
- Column 2 — The number of complaints received by physicians and surgeons for each self-identified race/ethnicity group
- Column 3 — The percentage of licensed physician and surgeon race/ethnicity groups that received complaints relative to the total number of licensed physicians and surgeons that designated one race/ethnicity type or "Other (not listed)." The percentage of total number of licensed physicians and surgeons is used in the Table 3.6 comparative analysis.

Table 3.5 — Compaints Received by Self-Identified Race/Ethnicity Groups

Self-Identified Race/Ethnicity	Number of Physicians and Surgeons Complaints Received	Physician and Surgeon Complaints Received (% of the Total)
African	283	.80%
African American	999	2.82%
American Indian	34	0.10%
Asian	13,510	38.09%
Black	194	0.55%
European	1,479	4.17%
Hispanic/Latino/Spanish Origin	2,354	6.64%
Middle Eastern	2,182	6.15%
Native American	21	0.06%
Native Hawaiian/ Pacific Islander (NHPI)	37	0.10%
Other (not listed)	1,335	3.76%
White	13,045	36.76%
Total	**35,473**	**100%**

Table 3.6 displays a comparison of disciplined physician and surgeon percentages to the percentage of physician and surgeon complaints received for each self-identified race/ethnicity group. The columns in the table display the following:

- Column 1 — Licensed physician and surgeon self-identified race/ethnicity groups. The Alaskan Native race/ethnicity group is not reflected in this table due to the absence of discipline activity.
- Column 2 — Displays the disciplined physician and surgeon race/ethnicity group's percentage of the total number of licensed physicians and surgeons that designated one race/ethnicity type or "Other (not listed)." The data in column 2 is the same data reflected in Table 3.4, column 2.
- Column 3 — Displays the percentage of complaints received for physician and surgeon licensees that designated one race/ethnicity type or designated "Other (not listed)". The data in column 2 is the same data reflected in Table 3.5, column 3.
- Column 4 — Displays the discipline and complaints received percentage difference for each self-identified race/ethnicity group. A positive percentage indicates a larger percentage of imposed discipline compared to the complaint received race/ethnicity group's percentage. A negative number indicates a smaller percentage of imposed discipline compared to the complaint received race/ethnicity group's percentage.

Table 3.6 — Comparison of Discipline to Complaints Received Percentages by Race/Ethnicity Groups

Self-Identified Race/Ethnicity	Disciplined Physicians and Surgeons (% of Total)	Physicians and Surgeons Complaints Received (% of Total)	Disciplined Physician and Surgeon vs. Physician and Surgeon Complaints Received (% Difference)
African	1.08%	0.80%	0.28%
African American	4.38%	2.82%	1.56%
American Indian	0.11%	0.10%	0.01%
Asian	26.05%	38.09%	-12.04%
Black	0.80%	0.55%	0.25%
European	5.40%	4.17%	1.23%
Hispanic/Latino/Spanish Origin	6.43%	6.64%	-0.21%
Middle Eastern	4.84%	6.15%	-1.31%
Native American	0.23%	0.06%	0.17%
NHPI	0.11%	0.10%	0.01%
Other (not listed)	3.41%	3.76%	-0.35%
White	47.16%	36.76%	10.40%
Total	**100%**	**100%**	

Table 3.7, Displays a comparison of percentages of MBC complaints received (filed against) physicians and surgeons to the percentages of licensed physicians and surgeons for each self-identified race/ethnicity group. The columns in the table display the following:

- Column 1 — Licensed physician and surgeon self-identified race/ethnicity groups
- Column 2 — Displays the complaints received by each physician and surgeon race/ethnicity group expressed as a percentage of the total complaints received that designated one race/ethnicity type or "Other (not listed). The data in column 2 is the same data reflected in Table 3.5, column 3.
- Column 3 – Displays the percentage of physician and surgeon licensees that designated one race/ethnicity type or designated "Other (not listed)." The data in column 3 is the same data reflected in Table 3.2, column 3.
- Column 4 – Displays the complaints received and licensed physician and surgeon percentage difference for each self-identified race/ethnicity group. A positive percentage indicates a larger percentage of complaints received compared to the licensed physician and surgeon race/ethnicity group's percentage. A negative number indicates a smaller percentage of complaints received compared to the physician and surgeon race/ethnicity group's percentage.

Table 3.7 — Comparison of Complaints Received Percentages to Licensee Percentages by Race/Ethnicity Groups

Self-Identified Race/Ethnicity	Complaints Received Physicians and Surgeons (% of Total)	Licensed Physicians and Surgeons (% of Total)	Complaints vs. Licensed Physician and Surgeon (% Difference)
African	0.80%	0.62%	0.18%
African American	2.82%	2.90%	-0.08%
Alaskan Native	0.00%	0.01%	-0.01%
American Indian	0.10%	0.21%	-0.11%
Asian	38.09%	33.94%	4.15%
Black	0.55%	0.49%	0.06%
European	4.17%	6.24%	-2.07%
Hispanic/Latino/Spanish Origin	6.64%	6.15%	0.49%
Middle Eastern	6.15%	3.84%	2.31%
Native American	0.06%	0.15%	-0.09%
Native Hawaiian/Pacific Islander	0.10%	0.17%	-0.07%
Other (not listed)	3.76%	2.91%	0.85%
White	36.76%	42.37%	-5.61%
Total	**100%**	**100%**	

Table 3.8 displays the number of imposed disciplines by discipline types for physicians and surgeons that designated one race/ethnicity type or "Other (not listed)." This table reflects the total number of physicians and surgeons who had incurred disciplines among the 10 discipline types by the physicians and surgeons' self-identified race/ethnicity groups. The Alaskan Native race/ethnicity group is not reflected in this table due to the absence of discipline activity.

Table 3.8 — Number of Imposed Disciplines, by Discipline Type, for Race/Ethnicity Groups

Self-Identified Race/Ethnicity	Revocation	Automatic Revocation	Surrender	Surrender on Probation	Probation with Suspension	Probation	Public Reprimand	Public Letter of Reprimand	Probationary License Issue	Other Decision	Totals
African	2	–	4	–	–	8	5	–	–	–	19
African American	8	–	8	–	2	35	14	10	–	–	77
American Indian	–	–	1	–	–	1	–	–	–	–	2
Asian	33	1	82	4	6	168	94	59	10	1	458
Black	2	–	3	1	–	5	–	3	–	–	14
European	10	1	28	1	1	30	15	9			95
Hispanic Latino	16	–	14	–	1	47	14	10	10	1	113
Middle Eastern	4	1	5		1	35	25	11	3		85
Native American	–	–	–	–	–	1	1	2	–	–	4
NHPI	–	–	1	–	–	1	–	–	–	–	2
Other (not listed)	6	–	11	1	–	17	17	7	1	–	60
White	81	5	192	6	9	290	130	93	21	2	829
Totals	**162**	**8**	**349**	**13**	**20**	**638**	**315**	**204**	**45**	**4**	**1,758**

Recommendation

The potential of bias in the complaint process along with the corresponding discipline is a complex issue that requires detailed data analytics. As evidenced by the CRB study published in January 2017, the effort required in analyzing bias data is substantial given the necessary data collection and the number of potential variables that affect any derived outcome. Based on the limited analysis conducted the monitor recommends the following:

Recommendation 3.1

MBC should establish a formal process by which self-identified race/ethnicity information would be periodically extracted, analyzed, and reviewed by the Board to provide insight on demographic trends. This information should also be made publicly available.

SECTION 4: ADDITIONAL ENFORCEMENT PROGRAM ISSUES

The following three (3) issues were identified in the monitor's *Initial Report* as potential program enhancements improving enforcement protocols and procedures. The monitor is providing updates to these issues in this *Final Report.*

Issue 1: "Clear and Convincing Proof to a Reasonable Certainty" vs. "Preponderance of Evidence"

MBC contends that the higher standard of proof required in California, when compared to medical board enforcement in 41 (forty-one) other jurisdictions within the nation using the lower proof standard, results in investigations that are needlessly more time consuming and costly. This was one of a series of proposals MBC submitted to the Legislature on January 5, 2022, seeking statutory changes.

On May 6, 2022, before the Oversight Hearing of the Senate Committee on Business, Professions and Economic Development, this proposal to adopt the Preponderance of Evidence standard was presented as Agenda Item #4, indicating "the board is at a significant disadvantage, in comparison to most other medical boards, when attempting to investigate and prosecute a licensee suspected of failing to properly care for their patients or otherwise act in an unprofessional manner" under the current Clear and Convincing standard. The Federation of State Medical Boards, in its "Stand of Proof Overview" study dated August 2022 indicates:

- 44 boards exclusively use the preponderance of evidence standard
- 10 boards exclusively use a clear and convincing evidence standard
- 2 boards use a standard that is different from the above
- 11 boards have standards that vary according to the nature of the violation

When differences in outcomes could be based only on supposition, such as in this instance, the monitor didn't perform further analysis comparing MBC's enforcement adjudications to other jurisdictions. Such analysis would also require assistance from the legal profession versed in medical prosecutions and possibly from the Federation of State Medical Boards.

Final Report Update:

While Senate Bill (SB) 815 (Roth) as amended July 12, 2023, proposes to change the legal standard of proof retaining the clear and convincing evidence standard for license suspension and revocation actions and lower the standard of all other actions to preponderance of the evidence. The bifurcated standard of proof language may create confusion and may fail to improve efficiency and effectiveness of the board's enforcement program.

Issue 2: No Pause of the Statute of Limitations While Issuing or Enforcing Subpoenas

MBC contends that refusal to pause the running of the statute of limitations (SOL) has a detrimental effect on investigations and subsequent actions. Delays in obtaining documentation and conducting subject or witness interviews compound efforts in compiling, analyzing and completing both investigative and subsequent administrative accusations, in part due to pressure regarding the "clock running out."

The monitor reported in the *Initial Report* that an analysis of that contention could be conducted relative to jurisdictions pausing SOL deadlines for subpoena enforcement versus those jurisdictions like California that do not pause the SOL. Such a study could compare lengths of investigation completions and subsequent actions. This analysis would require the assistance of the investigators, prosecutors and potentially the

Federation of State Medical Boards using their compilation of medical enforcement jurisdictions within their national database.

Final Report Update

This issue is now being addressed in SB 815 (Roth) as amended July 12, 2023. As currently written, this proposal would pause the SOL for a licensee or health facility for failing or refusing to comply with a court order until such time that the subpoenaed records are produced. This addresses MBC's long-held position that failing to pause the SOL is a detriment to effective enforcement actions.

Issue 3: Patient Consent for Access to Medical Records

Without a signed release from the patient, medical records cannot be obtained from a doctor or medical entity, thereby terminating the initial complaint evaluation and any subsequent investigation incorporating a medical expert review. Subpoenas or search warrants may be executed in obtaining such records. However, without securing medical records the complaint is recorded, but suspended, with no further action taken. Consequently, the patient consent requirement may compromise MBC's mission of protecting the public relative to standard of care violations.

However, California ensures an individual's right of privacy and confidentially through statutory and constitutional protections and has a long history of such protections.

Consequently, further analysis is required to identify and quantify if the lack of access to medical records without consent is a significant problem causing harm to the public. The monitor believes that such analysis could be performed; however, it would be time-consuming because individual investigations would need to be correlated over multiple time periods.

Final Report Update

This issue is not further addressed in the current proposed legislation.

Additional Enforcement Program Issues

Final Report Issue 1

MBC Program Funding: the critical issue of a program funding shortage, as documented in the Initial Report Finding 4, is being addressed in Senate Bill 815 as amended July 12, 2023. Current and projected revenue is not adequate for sustaining medical board program operations, as well as meeting statutory obligations and stated mission and objectives. Approximately 98% of program funding is derived from biennial license renewal fees or initial license fees. However, periodic fee increases authorized via legislation have not occurred relative to increased program expenses.

The monitor agrees, as currently proposed, that the licensing fee increase will significantly aid the MBC in addressing its annual operational funding needs.

Final Report Issue 2

Complainant Outreach (interview) by CCU: as documented in Section 1 of this report, BPC Section 2220.08 provides specific actions required in the evaluation of a complaint by CCU before referring the complaint for field investigation.

SB 815 (Roth) as amended July 12, 2023, provides proposed legislation that requires an interview with the complainant, patient or patient representative for an investigation involving quality of care before referral to field investigation. This change will be an operational improvement, thus strengthening CCU's ability to evaluate complaints before further investigation by field office personnel.

APPENDIX: Glossary of Terms, Abbreviations, and Acronyms

Accusation	Administrative action prepared by OAG HQE for filing by MBC against licensee
ALJ	Administrative Law Judge
ALJ Proposed Decision	Administrative Law Judge decision after a licensee hearing issues a proposed decision for adoption or rejection by the board
BPC	Business and Professions Code
CCU	MBC Central Complaint Unit
CIO	MBC Complaint Investigation Office
Citation or Fine	A sanction that usually includes a monetary fine imposed by the board for technical violations of the law
CRB	California Research Bureau
CTS	MBC proposed-Complaint Tracking System
DAG	Deputy Attorney General
Decline to Prosecute	Decision by OAG HQE against proceeding with an administrative action against a licensee
DCA	Department of Consumer Affairs
Departure (guidelines)	Any proposed decision or settlement that departs from the disciplinary guidelines. The MBC produced the *Manual of Model Disciplinary Orders and Disciplinary Guidelines, 12th Edition* in 2016 for the intended use of those involved in the physician disciplinary process.
DOI	DCA Division of Investigation
DOJ	California Department of Justice
FSMB	Federation of State Medical Boards
HCAI	California Department of Health Care Access and Information
HQE	OAG's Health Quality Enforcement Section
HQIU	DCA's Health Quality Investigation Unit
ISB	MBC's Information Systems Branch
KPIs	Key Performance Indicators
Legal Review Letter	OAG HQE evaluation of a referral for administrative action issued to MBC
MBC	Medical Board of California
MVP	Minimum Viable Product

OAG	Office of the Attorney General
PA-PLR	Pre-Accusation Public Letter of Reprimand
ROI	Report of Investigation
SIMM	Statewide Information Management Manual, as administered by the California Department of Technology
SOL	Statute of Limitation
Stayed License Revocation	The revocation is “stayed” or temporarily set aside pending successful completion of probation. If the licensee violates probation, the MBC may lift the “stay” and revoke the license.
Stipulation — License Surrender	A written agreement between the parties as to all matters covered by the stipulation resulting in the surrender of the physician or surgeon license
Stipulation — Probation	A written agreement between the parties as to all matters covered by the stipulation resulting in the physician or surgeon placed on probation
Stipulation — Public Reprimand	A written agreement between the parties as to all matters covered by the stipulation resulting in the issuance of a public reprimand against a physician or surgeon licensee
VE	Vertical Enforcement, a process by which prosecutors and investigators work together as a team from the day a case is assigned for investigation.

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