

An Empirically Based Structured Sanctioning System

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The authors are grateful to the Virginia Board of Medicine and the Virginia Board of Health Professions for having the courage and vision to allow this important research initiative to advance. For providing the leadership necessary to sustain this project, special thanks goes to Dr. Harold Beaver, Past-President, and Dr. Diane Reynolds-Cane, President, Virginia Board of Medicine. Also to Dr. William Harp, Executive Director, and Karen Perrine, Esq. Deputy Executive Director, along with other members of the staff of the Board of Medicine for graciously assisting in all aspects of the study. Very importantly, we wish to recognize Robert Nebiker, Agency Director, Virginia Department of Health Professions, for his unwavering support throughout the entire process. Kimberly Langston, M.S., Patrick Davis, MBA., and Brian Ostrom, Ph.D., skillfully assisted in the data analysis and planning phases of the study.

Abstract

The purpose of the study is to provide an empirical and systematic analysis of board sanctions and, based on the results, determine if reference points can be developed for board members. Reference points would serve as an “historical portrait” of previously adjudicated cases, providing insight into the factors found to be consistently important when determining how similarly situated cases had been sanctioned in the past. The following discusses the study’s theoretical framework and methodology, selected data analysis results, and one of the five offense-based worksheets and accompanying sanctioning grid.

Introduction

One of the most important functions of a state health regulatory board is the handling of disciplinary cases; perhaps the most difficult aspect of handling these cases is determining an appropriate sanction for those found in violation. Our state boards spend considerable time deliberating over appropriate sanctions -- “Board members devote a great deal of time and attention to overseeing the practice of physicians by reviewing complaints from consumers, malpractice data, information from hospitals and other health care institutions, and reports from government agencies.”¹

The sanctions imposed and the reasons they are imposed play a significant role in the board's ability to protect the public while ensuring that their actions are fair. Even though boards may make great efforts to sanction in a rational and proportional manner, there has been criticism suggesting that further improvements are needed. Criticism has come from respondents, attorneys, consumer groups, other government bodies, and scholars. Sanctioning has been viewed as too harsh, too lenient, or inconsistent across cases or over time. Some have indicated that sanctioning variation can be attributed to other undesirable influences, such as board member ID or board composition, respondent ethnicity, attorney presence, or location of hearing.

Such criticism has not, however, been supported by data collection and analysis which specifically focuses on the factors related to board sanctioning. Until now, no empirical work has

¹ *What is a State Medical Board?* Federation of State Medical Boards, <http://www.fsmb.org>

systematically reviewed the case circumstances that lead to mitigated or aggravated sanctions for specific types of cases.² Many have had their views of physician discipline and sanctioning shaped by a perceived harshness or leniency arising out of individual or high profile cases. A major study released in 2000 by Virginia’s legislative watchdog agency (JLARC) came to similar conclusions, citing the difficulty in assessing whether or not board sanctioning was “...consistent over time because most cases involved a unique set of factors...”³

Aware of the criticisms of board sanctioning, approximately 20 states have adopted or are studying the use of structured sanctioning systems. These systems all have similar goals and purposes (ensure consistency, reduce disparity, forecast resource needs, maintain discretion, etc.). Of these 20, only a few states have provided actual reference guides for physician sanctioning (Arizona, Ohio, Washington); however, no state has conducted a rigorous quantitative and qualitative analysis of historical sanctioning practices.

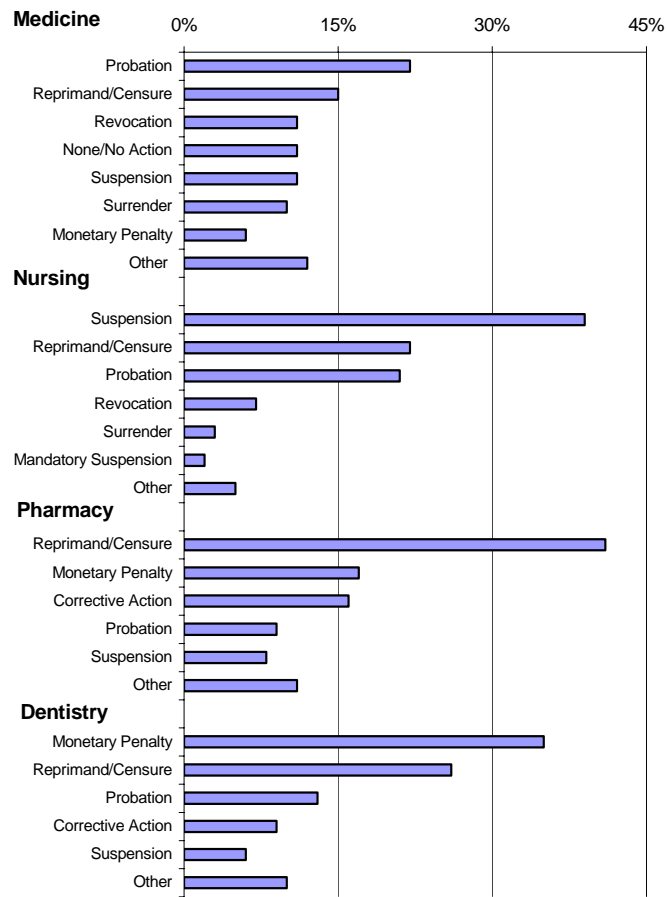
In April of 2001, the Virginia Board of Health Professions (BHP) approved a work plan to conduct an analysis of health regulatory board sanctioning and to consider the appropriateness of developing historically-based sanctioning reference points for health regulatory boards. The Board and project staff recognized the complexity and difficulty in sanction decision-making and indicated that for any sanction reference system to be successful, it must be “**developed with complete board oversight**, be **value-neutral and grounded in sound data analysis**, and be **totally voluntary**—that is, be viewed strictly as a board decision tool.”⁴ Recognizing that each health regulatory board has a distinct sanctioning “culture”, each Board’s sanctioning practices should be examined in their own right. For example, initial analysis shows sanction outcomes vary dramatically depending on which health regulatory boards are examined. The following graphic illustrates primary sanction outcomes for Virginia’s four largest health regulatory boards.

² Although little empirical work has been published on the issue of health regulatory sanctioning practice, there is considerable literature available on court related sanctioning practices. See Michael Tonry, *Sentencing Matters*, 1996; *Sentencing Commission Profiles*, National Center For State Courts, 1997; National Assessment of Structured Sentencing, Bureau of Justice Assistance, 1996; Andrew Von Hirsch *The Sentencing Commission and Its Guidelines*, June 1987.

³ Joint Legislative Audit and Review Commission, *Final Report: Review of the Health Regulatory Boards*, House Document No. 5, 2000.

⁴ Department of Health Professions Internal Committee & Staff, Fall 2001 organizational meeting.

Chart 1: Sanction Types Handed Down by Board



Virginia Board of Medicine Selected as Pilot Board

To begin the study in a manageable way, the Board of Medicine (BOM) was selected as the pilot board for study.⁵ Starting cautiously with a single board was important since no similar study had ever been performed. Taken together, the medicine and nursing boards (including nurse aides) comprise 70% of the entire DHP disciplinary caseload, so these two were given initial consideration when choosing appropriate boards to examine and when assembling an agency internal working committee. Using BOM cases also helped ensure an adequate number of cases and variation in case type during analysis. Piloting with a single board allowed analysts to test which study methods worked best before conducting further analysis across 13 distinct regulatory boards. It is also hoped that analytical efficiencies can be achieved before assessing each board.

Qualitative and Quantitative Study Approach

Qualitative

⁵ The Virginia Department of Health Professions houses 13 distinct boards for the following professions: Audiology & Speech, Counseling, Dentistry, Funeral Directors & Embalmers, Medicine, Nursing, Nursing Home Administrators, Optometry, Pharmacy, Physical Therapy, Psychology, Social Work, and Veterinary Medicine.

Analysts employed both quantitative and qualitative research methods to gain an understanding of sanctioning practice. On the qualitative front, researchers conducted 32 in-depth personal interviews of past and current Board of Medicine members (including key board staff and representatives from the Attorney General’s office). The interview results were critical for building consensus regarding the purpose and utility of a sanctioning reference system and to further frame the analysis. Additionally, interviews ensured that the factors board members consider when sanctioning were included during the quantitative phase of data collection⁶.

Research staff recognized that sanctioning is exclusively a board member function; as such, any sanctioning reference system that is workable must be developed *by* board members *for* board members. The interview process and continuous board oversight guaranteed that board input was maintained during all study phases. In essence, board member input was used to create a “Blueprint” to produce functional reference points based on a valid data analysis.

A number of options became available when selecting a methodology for examining board sanctioning and proposing reference points. Perhaps the most fundamental question was whether the sanctioning system should be grounded in historical data (*descriptive*) or whether it should be developed normatively (*prescriptive*) – that is, should the analysis reflect what policymakers feel sanction recommendations *have been* or what they *should be*? Reference points can also be developed using historical data analysis with normative adjustments to follow; this approach combines information from past practice with policy adjustments in order to change sanctioning practice to achieve a desired goal (to increase or decrease sanction severity, to direct persons into treatment programs, etc.).

In this study, the decision to proceed with a descriptive over a prescriptive model is based on a theoretical framework that is directly tied to the BHP and BOM’s purposes and goals of initiating sanction reference points. In Virginia, the goals & purposes most often cited by Board members included:

- Making sanctioning decisions more predictable
- Providing an education tool for new board members
- Adding an empirical element to a process or system that is inherently subjective
- Providing a resource for BOM staff and attorneys (both sides)
- “Neutralizing” sanctioning inconsistencies
- Validating board member or staff recall of past cases
- Constraining the influence of undesirable factors—e.g., board member ID, overall board makeup, race or ethnic origin.
- Helping predict future caseloads and need for probation services and terms

The above list defined the study’s theoretical framework, clarified research questions, and served as an anchor throughout the study period. Equally important, incorporating the stated goals impacted the form and structure of the sanctioning reference points. If disparity in sanctioning is found to exist, a goal could be to initiate reference points that ensure similarly situated respondents are sanctioned in similar ways; that is neutralizing sanctioning inconsistencies. If past sanctioning was deemed too lenient or harsh for a particular case type, a goal could be to

⁶ Interviews were conducted from January to April 2002. All candidates were given the opportunity to have the interview conducted at their location. The interview format consisted of 17 open-ended questions covering a wide range of sanctioning issues. Individual board member anonymity was maintained when reporting out results.

create sanctioning references that treat selected case types in a manner different from the past (normative adjustments to past practice). Given the goals and purposes articulated by the Board of Medicine, analysts began with a purely *descriptive* approach. This approach is also considered the most incremental and cautious approach to providing additional structure to the sanctioning process.⁷

Quantitative On the quantitative side researchers collected detailed information on a sample of disciplinary cases ending in violation and receiving a sanction (as opposed to cases dismissed, undetermined, or where the person was found not in violation). The sample consisted of all cases closed by consent order or informal or formal conference during the period 1996-2001.⁸ Analysts used data available through the agency case management system combined with hard copy files containing investigative reports, board notices and orders, and all other documentation available to board members when deciding a case disposition. Although current automated data provides general information on sanction types, it does not adequately describe the offense and respondent factors which board members say influence sanction outcomes. These include, but are not limited to: precise degree of injury (physical, emotional, or threatened), prior record, retention of attorneys, time in practice, employment record, history of substance abuse, patient or source presence at hearing, etc. There is also disagreement on how these factors affect sanction outcomes. For example, the presence of an attorney in a case is thought by some to help a respondent, while others indicate retaining an attorney could result in a more unfavorable outcome. The analysis was designed to identify the factors that *consistently* played a role in sanctioning.

Descriptive Results

The following table shows five general offense groups (identified under “case types”) that were derived from over 30 specific case types. The greatest number of cases are Fraud/Deception/Misrepresentation and Patient Care cases, together comprising two-thirds of the sample. Patient Care includes physician performance cases such as delay in treatment and improper or unnecessary surgery issues. Fraud/Deception/Misrepresentation cases include such matters as deceptive advertising, claims of superiority, improper use of trade names, and certain business practices cases.

⁷ As will be discussed later, some normative adjustments were considered to ensure sanctioning consistency and to neutralize certain factors identified in the statistical analysis that were deemed inappropriate by board members.

⁸ Quantitative analysis includes data collection and statistical analysis of all automated and non-automated files on a representative sample of cases. The analysis is intended to differentiate similarly situated cases (same case type, level of seriousness, history of recidivism, etc.) in terms of case outcomes and sanction. In total, 447 cases were identified with the final sample consisting of 258 sanctioning “events”. A comprehensive data collection instrument with 120 variables captured the factors identified as potentially impacting sanction decisions. Narrowing the sample involved removing reinstatement and compliance cases, mandatory suspensions, and actions by other states. Most of the narrowing was due to merging multiple cases handled in a single order into a single sanctioning “event”. The sanction event is more reflective of actual board work, as board members fashion sanctions based on the “totality” of behavior, not for each “case” docketed.

Chart 2: Sample Profile & Description of Variables

	N	Mean	Std. Dev.
Case types			
Inappropriate Relationship/Sexual Abuse	33	.13	.33
Fraud/Deception/Misrepresentation	87	.34	.47
Patient Care	82	.32	.47
Impairment	30	.12	.32
Unlicensed activity	26	.10	.30
Injury			
No Injury	195	.76	.43
Physical injury	45	.17	.38
Death	18	.07	.26
Mental injury	23	.09	.29
Harms or Threatens without risk (Priority 5 & 6)	27	.10	.31
Harmful or threatens harm (Priority 3 & 4)	139	.54	.50
At least substantial danger (Priority 1 & 2)	92	.36	.48
Treatment			
Past alcohol treatment	26	.10	.30
Receiving treatment at time of order	79	.31	.46
Past drug treatment	42	.16	.37
Past Problems			
Past mental health problem	60	.24	.42
Past sexual deviance/boundary problems	32	.12	.33
Significant debt/financial problems	23	.09	.29
Past physical/capacity problem	12	.05	.21
Past drug or alcohol abuse	58	.22	.42
Respondent Characteristics			
Attorney present	116	.45	.50
Years in practice	---	17.86	11.93
Female	41	.16	.37
International graduate	48	.19	.39
Processing			
Days in Board stage (excluding APD)	---	335.69	293.78
Prior			
Prior board orders or decisions	38	.15	.36
Concurrent action (civil, malpractice, criminal)	63	.24	.43
Prior cases	114	.44	.50
Previous case similar to instant offense	67	.26	.44
Offense Factors			
Multiple cases	56	.22	.41
Patient Vulnerable	28	.11	.31
Impaired (drug, alcohol, mental, physical)	43	.17	.37
Multiple patients/sources/incident	142	.55	.50
Financial/material gain by respondent	24	.09	.29

Note: Except for years in practice and days in the board stage, the mean represents the average for dichotomous variables (coded 0,1).

The table shows physical or mental injury occurred in roughly 26% of the cases. Eighteen cases over the 6 year period involved patient death. The Virginia Department of Health Professions also evaluates complaints on a priority scale to help identify case seriousness. The table shows the six priority levels grouped into three categories ranging from the least serious Priority 5 & 6 (harm to the public without obvious risk) to the most serious Priority 1 & 2 cases (posing an imminent and substantial danger). All six of the priority levels are represented in the sample, with approximately 80% of the cases indicated as priority 2, 3 or 4. Priority 1 cases are represented in the study at a rate of 12%.⁹

About 40% showed evidence of some past substance abuse, mental health, boundary, or sexual deviance problems. Almost one-third of respondents were involved in counseling or some other type of self-corrective action at the time of their hearing. The vast majority of respondents were male, respondents had an attorney in 45% of the cases, 19% were international medical school

⁹ Physical and mental injury were first measured on separate scales. A case(s) could have both mental and physical injury associated with one or more patients.

graduates, and most had considerable experience practicing (on average, 18 years).¹⁰ Once reaching the board stage, the cases required an average of 11 months to process.

Roughly 4 of 10 respondents had at least one prior complaint filed against them (regardless of outcome), and 15% of the respondents had at least one prior board order or notice (reaching probable cause). About one-quarter of the respondents were involved in some concurrent action outside of the medical board's purview (malpractice, etc).

Patients were identified as especially vulnerable (e.g., juveniles, seniors, or mentally incapacitated) in about 10% of the cases, 17% of respondents were impaired at the time of the offense, and 9% realized some type of material gain from their actions. A little over half of the respondents had multiple patients or incidents associated with their offense(s).

Sanctions

The primary sanction types handed down by the Board are shown in Chart 3. Because the sanction reference system was designed to provide general guidance—not detailed and specific recommendations—the board members agreed to classify the more than 30 types of sanctions and terms available to them into four general categories. The 4 groups were created based on the underlying goals and purposes of sanctioning (e.g., protecting the public, reprimanding, treatment & monitoring, etc.). For example, approximately a quarter of the cases ended in a sanction primarily geared toward “protecting the public” by requiring the respondent to stop working for some period of time (e.g., suspension, revocation, or surrender of license).

In an additional 35% of the cases, the respondent received some set of terms (e.g. counseling, chaperone, practice restrictions) requiring specific treatment or monitoring. The conceptual design of the sanction reference system is to identify a broad category of sanctions as a recommendation from which the board selects one or more specific sanctions. Approximately a quarter of the cases ended in some type of loss of license. Almost 16% of cases ended in a violation where no sanction was given.

¹⁰ Although the board expressed interest in examining race and ethnicity, the information was not found in the case files nor was it collected on any agency or board related documents. Board members expressed an interest in modifying agency systems to collect race and ethnicity in the future.

Chart 3: Sanctions Handed Down*

	N	Mean	Std. Dev.
No sanction	41	.16	.37
Reprimand	68	.26	.44
Treatment/Monitoring	90	.35	.48
Loss of License (revocation, surrender, suspension)	59	.23	.42

* If multiple sanctions were handed down the most severe or most restrictive was used as the primary sanction type in the analysis.

The 258 sanction events that were studied were resolved by a Pre-Hearing (consent order), Informal Hearing, or a Formal Hearing. Respondents opted to sign a consent order in one out of five cases; this includes agreeing to the findings of fact, a disposition, and if ordered, a sanction. Informal Hearings were most common, where respondents chose to have their case heard by a panel of three board members. A Formal Hearing (requiring a minimum of 5 board members) occurred in roughly 12% of the cases.

Multivariate Results and Sanction Reference Point Development

After examining the BOM sample on a basic descriptive level, the empirical study proceeded in two stages. In the first stage, logistic regression was used to analyze the influence of all factors shown in Chart 2 on the board’s sanctioning decisions. Although it is impossible to predict with certainty the sanction a particular respondent will receive, logit analysis allows us to reasonably estimate the *probability* of a particular sanction by examining the statistical relationship between the characteristics of the respondent and the observed pattern of board decisions. That is, this analysis provided a clearer understanding of how, *in practice*, different sorts of factors influence board decisions. It identifies the factors board members emphasized most consistently. In the second stage, results from the logit analyses were used to craft a sanction reference system based solely on what the advisory group deemed to be legally relevant criteria.

To illustrate this approach, the left side of Chart 4 shows the results of a logit model used to determine which factors are significantly associated with the board’s decision that the respondent will “lose their license” (i.e., suspension, revocation, or surrender of license) versus receiving some other sanction.¹¹ The 30 individual factors are grouped into eight blocks with common properties. For example, the *Injury* block includes all factors related to the severity of injury and the level of risk of harm (priority level) to the patient. The coefficients indicate the relative

¹¹ Logit regression analysis controls simultaneously for the influence of *independent* variables on the likelihood of “loss of license”—the *dependent* variable. This enables researchers to determine the unique contribution of each case factor in explaining the type of sanction received. In addition to *logit*, analysis also involved using multinomial logistic regression. Where logit is appropriate with dichotomous dependent variables, multinomial logit was used when there were more than two categories of the dependent variable. The left side of Chart 4 shows the results when “sanction type” is coded as a dichotomous variable (“1” for loss of license, “0” if not) and right side shows the results when the case outcome was broken into four sanction categories.

influence of each independent variable on the probability a respondent will lose their license. A positive coefficient indicates that larger values of the independent variable are associated with an increased probability of losing their license, while a negative coefficient indicates a diminished probability. Individual factors that were found to be significantly related to an *increase* in the probability of the respondent losing their license include¹²: the case types of Fraud/Deception/Misrepresentation, Patient Care, Impairment;¹³ death of a patient; years in practice; days in board stage; prior board orders or decisions; and concurrent action (civil, malpractice, criminal, other). Some of the factors that are significantly associated with a *decrease* in the probability of the respondent losing their license include: past alcohol treatment, attorney presence, treatment at time of the order, and prior cases (not orders or violations).

Chart 4: Logit and Multinomial Logit Models

	Logit			Multinomial Logit	
	Coefficient	Wald	Significant	Chi-Square	Significant
Case types					
Fraud/Deception/Misrepresentation	2.75	2.94	X	10.90	X
Standard of Care	3.42	4.86	X	9.91	X
Impairment	2.83	2.98	X	6.29	X
Unlicensed activity	1.14	.37		4.15	
Injury					
Serious physical or physical injury	- .07	.00		1.46	
Death	2.60	7.11	X	5.28	X
Mental injury	1.63	1.92		9.68	X
Harmful or threatens harm (Priority 3 & 4)	- .05	.00		.22	
At least substantial danger (Priority 1 & 2)	1.40	1.58		2.23	
Treatment					
Past alcohol treatment	- 2.41	5.47	X	6.56	X
Receiving treatment at time of order	- 1.75	4.91	X	5.25	X
Past drug treatment	- .10	.01		.86	
Past Problems					
Past mental health problem	2.49	8.85	X	14.65	X
Past sexual deviance/boundary problems	2.12	4.46	X	8.22	X
Significant debt/financial problems	- .88	.97		6.48	X
Past physical/capacity problem	.11	.01		2.34	
Past drug or alcohol abuse	1.61	2.13		.94	
Respondent Characteristics					
Attorney present	- 4.16	25.12	X	19.55	X
Years in practice	.06	7.90	X	8.00	X
Female	.83	1.50		3.12	
International graduate	- .22	.10		1.22	
Processing					
Days in Board stage (excluding APD)	.00	8.42	X	6.79	X
Prior					
Prior board orders or decisions	1.79	4.95	X	10.03	X
Concurrent action (civil, malpractice, criminal)	1.07	2.94	X	7.75	X
Prior cases	- 1.36	2.88	X	6.94	X
Previous case similar to instant offense	1.01	1.62		3.21	
Offense Factors					
Multiple cases	.80	1.59		5.83	X
Patient vulnerable	- .01	.00		4.21	
Impaired (drug, alcohol, mental, physical)	.90	1.62		3.37	
Multiple patients/sources/incident	.28	.31		.57	
Financial/material gain by respondent	.79	.84		.30	

X = statistically significant at .10 level.

Chart 5 shows how well the Logit model predicts the board decision to revoke/suspend a respondent's license. The model accurately predicted 88% of the cases (88% is computed from the shaded cells, $188 + 39 = 227 \div 258$ total cases). This percentage is compared to the "null

¹² The standard level of statistical significance is $<.10$ (one-tailed test). The Wald statistic is calculated for every independent variable by dividing the coefficient estimate by its standard error. The Wald statistic is used to test the significance of each coefficient with an "x" indicating significance for the Wald statistic.

¹³ The reference category for case types is Inappropriate Relationship/Sexual Abuse, and Level 5 & 6 for Priority (under Injury).

hypothesis,” defined as the most frequent outcome, which in this case is “no loss” (77% or 199 out of 258). Overall, we conclude that the model has significant explanatory capability. More importantly, we see that an empirical analysis of past sanctioning practices provides a way (1) to identify which factors have been historically important and can be used in a reference system and, (2) for the BOM to assess the legitimacy and fairness of past sanctioning practice.

Chart 5: Accuracy of Predictions of Logistic Regression Model

		Predict		Total
		No Loss	Loss of license	
Actual	No Loss	188	11	199
	Loss of license	20	39	59
Total		208	50	258

Looking back to the right hand side of Chart 4, the final step in developing a more sophisticated perspective on the sanctions respondents receive is displayed. This model moves beyond a simple loss/no loss outcome and instead focuses on four discrete sanctioning outcomes meted out by the board:

- No sanction
- Reprimand
- Treatment/monitoring
- Loss of license

As mentioned earlier, multinomial logit is a statistical technique used when there are more than two nominal categories. The results under the column headed “chi-square” show the significance of each factor in distinguishing which of the four broad sanction types is imposed by the board.¹⁴ Comparing the logit with the multinomial logit results shows that more factors become significant as we move from two general sanction categories to four. We view this result as confirmation that the four general sanction categories developed by the board have both *intuitive* and *substantive* meaning.

Not all individual factors are significant and not all significant factors met with board approval for inclusion in the sanction reference system. The size of the chi-square statistic allows one to assess the relative importance of each factor. Scanning the magnitude of the chi-square statistics shows relatively high values for such factors as past mental health problems, prior board orders and attorney presence at the board hearing. These results provided the board with the first multi-variate look at past sanctioning practice and set the stage for determining which factors should be included in the sanction reference system. For example, the board determined that the four factors in the group labeled Respondent Characteristics should not be explicitly considered as part of a structured sanctioning system. That is, factors like respondent gender or whether a respondent has an attorney present should not have a consistent impact on sanctioning decision. Such factors are often termed “extra-legal” because they are “extra” to the issues of respondent culpability and the need for treatment and monitoring. However, board members did acknowledge the legitimate role of some factors that were labeled extra-legal. For example, most agreed that a skilled attorney helped frame the case and often helped to clarify the facts and case

¹⁴ The standard level of significance is <.10 (one-tailed test).

circumstances. This was especially true for physicians with poor communication or presentation skills. But the board felt that the presence of an attorney should not, in itself, greatly influence the final sanction. Instead, the board wanted to ensure that recommended sanctions were based more consistently on “legal” factors.

To further assist the board in this assessment process, analysts examined the significance of the eight groups (or blocks) of independent variables: case types, injury, treatment, past problems, respondent characteristics, processing, prior record, and offense factors. As shown in Chart 6, the groups of factors labeled “past problems” and “respondent characteristics” had the most significant impact on the sanction type decision, although seven of the eight blocks were found to be consistently related to sanctioning decisions.

Chart 6: Block Tests for Multinomial Logistic Regression Model

Block	Chi-Square	Significance
Casetypes	17.72	0.02
Injury	24.56	0.01
Treatment	12.43	0.05
Past problems	31.83	0.00
Respondent characteristics	32.63	0.00
Processing	6.79	0.03
Prior	23.33	0.04
Offense Factors	14.06	0.17

All components of the multi-variate analysis had several important implications for the development of sanction reference points. First, many types of factors are shown to be significant in the sanction decision process. Second, sanction choice has historically been determined by a mix of legal and extra-legal factors. Third, case type was important, so that the development of a separate offense specific (e.g., patient care, impairment, unlicensed activity) set of reference points was worth pursuing.

From Data Analysis to Sanction Worksheets

Factors found to be statistically important were translated into offense and respondent attributes that could be scored on a worksheet in order to derive a sanction. To adhere as closely as possible to a descriptive model, the worksheet scores were proportionate to their relative importance in the models. However, in several instances the board made normative adjustments to the scores. The first type of adjustment involved removing all “extra-legal” factors, those that the Board felt should not be consistently scored on a worksheet. For example, the presence of an attorney, years in practice, respondent gender, and case processing time were not considered for scoring, even though they did help explain sanctioning variation in certain instances for certain offense groups. The second type of adjustment occurred when statistical weights did not intuitively match current board practice. For example, while patient injury was important, the statistical models did not discriminate between different levels of injury. This could have been due to the small number of cases with injury, or because this factor was not used consistently in

past board decisions. In this case, the board worked with analysts to derive injury scores that made the most logical sense, with death being the most serious.

The remaining process of applying scores to each factor was an iterative and often complex exercise involving fine-tuning the factors and their relative scores. The accuracy of this process was measured by how well predicted sanctions on the worksheets matched actual sanctions handed down over the past 6 years. This was accomplished by retrospectively scoring all respondents (all 258 sanction events) using the worksheet scores. Grid recommendations were then derived by arraying all respondents in the sample on a two-dimensional grid using their offense and respondent scores (see sample Impairment worksheet below). The cell recommendations (No Sanction, Reprimand, Treatment/Monitoring, and Remove from Practice) were placed in each cell so the reference point recommendations will encompass, on average, about 70% of past historical sanctioning decisions; an estimated 30% of future sanctions will fall above or below the sanction point recommendations. This allows considerable flexibility when sanctioning cases that are particularly egregious or less serious in nature. Additionally, one of the most important features of this system is its voluntary nature; that is, the board is encouraged to depart from the grid recommendation when aggravating or mitigating circumstances exist.

Implementation

The Virginia Board of Medicine will pilot test the sanction reference points for a period long enough to allow for an evaluation of the project's utility. The reference points have an accompanying manual with detailed scoring instructions for each worksheet and grid. Although compliance with recommendations is strictly voluntary, the Board has agreed to complete worksheets in cases that are heard by an informal conference committee.¹⁵

As mentioned above, the Sanctioning Reference Points are organized into 5 offense groups. The scoring factors found within a particular offense group are those which proved important in determining historical sanctions for that offense category. When multiple cases have been combined into one "event" (one order) for disposition by the Board, only one offense group worksheet will be completed that covers the entire sanctioning event. If a case has more than one offense type, one worksheet is selected according to the offense group which appears highest on the following table. For example, a physician found in violation of both fraud and a treatment-related offense would have their case scored on a Patient Care worksheet, since Patient Care is above Fraud/Deception/Misrepresentation on the table.¹⁶ The table also assigns the various case categories brought before the Board to one of the 5 offense groups.

¹⁵ There are five exceptions: formal hearings, consent orders, mandatory suspensions, compliance and reinstatement cases, and cases that are the result of an action by an out-of-state board or other entity.

¹⁶ The hierarchy of offenses was established by comparing the loss of license rate for the five offense groups. Impairment cases had a loss rate approaching 43% while unlicensed activity cases were about 4%.

Chart 7: Offenses Covered by the Reference Points

<u>Offense Group</u>	<u>Case Categories</u>
Impairment	Drug Related-Obtaining Drugs by Fraud Drug Related-Personal Use Inability Safely Practice - Incapacitated Inability Safely Practice – Impairment Impairment-Other
Patient Care	Delay in Treatment Alternative Treatment Treatment Related-Other Improper Performance of Surgery Unnecessary Surgery Supervision - neglect Inappropriate or Excessive Prescribing/Dispensing Inspection Deficiencies/Facility Violation Records release Medical Record Keeping
Inappropriate Relationship/Sexual Abuse	Relationship - inappropriate Abuse (including sexual)
Fraud/Deception/Misrepresentation	Advertising-deceptive/misleading Claim of Superiority Improper Use of Trade Name Fail to Disclose Full Fee when Advertising Discounts Omission of Required Wording/Ad Element Advertising-Other Inappropriate Use of Specialty or Board Certification Financial Fraud Student loan default Fail to provide tax plan or estimate
Unlicensed Activity	Misdemeanor conviction No valid license-qualified to practice Practice beyond the scope of license Aiding/abetting unlicensed activity

The following is the current worksheet used for Impairment cases. After calculating an offense and respondent score, the person completing the worksheet finds the intersection of the two scores on the grid at the bottom of the page.

📄 IMPAIRMENT WORKSHEET			
Offense Score	Points	Score	
<ul style="list-style-type: none"> • Circumstances <i>(score all that apply)</i> <ul style="list-style-type: none"> a. Impaired - Inability to practice 25 b. Patient especially vulnerable 20 c. Financial or material gain from offense 20 d. Multiple patients involved 30 • Injury Level <i>(score only if applicable)</i> <ul style="list-style-type: none"> a. Physical Injury - death 100 b. Physical Injury - medical care 50 c. Mental Injury 50 • Priority Level <i>(must score one)</i> <ul style="list-style-type: none"> a. Priority A or B 75 b. Priority C 30 c. Priority D 20 	<div style="text-align: right; margin-top: 10px;"> Total Offense Score <input style="width: 50px;" type="text"/> </div>	<div style="text-align: right; margin-top: 10px;"> <input style="width: 50px;" type="text"/> </div>	
Respondent Score	Points	Score	
<ul style="list-style-type: none"> • Circumstances <i>(score all that apply)</i> <ul style="list-style-type: none"> a. Concurrent action 60 b. Past mental health problems 50 c. Past inappropriate relationship/sexual problems 50 d. Past alcohol problems 25 e. Past drug problems 25 • Prior Orders/Notices with Violation <i>(score all that apply)</i> <ul style="list-style-type: none"> a. One or more prior board violations 60 b. Any prior "similar" board violations 50 	<div style="text-align: right; margin-top: 10px;"> Total Respondent Score <input style="width: 50px;" type="text"/> </div>	<div style="text-align: right; margin-top: 10px;"> <input style="width: 50px;" type="text"/> </div>	
<div style="text-align: right; margin-top: 10px;"> ↓ <i>Locate Offense and Respondent scores in grid below for sanction recommendation.</i> </div>			
Sanction Grid			
Respondent Score	Offense Score		
	0-50	51-100	101 or more
0-50	No Sanction Reprimand	Reprimand Treatment/Monitoring	Treatment/Monitoring Recommend formal or accept surrender
51-100	Treatment/Monitoring	Treatment/Monitoring Recommend formal or accept surrender	Treatment/Monitoring Recommend formal or accept surrender
101 or more	Treatment/Monitoring Recommend formal or accept surrender	Recommend formal or accept surrender	Recommend formal or accept surrender
Respondent: _____ License Number: _____			

Management and Use of Worksheets

Instructions are provided for each line item of each worksheet to ensure accurate scoring for a specific factor.¹⁷ The scoring weights assigned to a factor on the worksheet cannot be adjusted. The scoring weights can only be applied as ‘yes’ or ‘no’ with all or none of the points applied. In instances where a scoring factor is difficult to interpret, the board has final say in how a case is scored.

If the board feels the sanctioning grid does not recommend an appropriate sanction, the board is encouraged to depart either high or low when handing down a sanction. If the Board disagrees with the sanction grid recommendation and imposes a sanction greater or less than the recommended sanction, a written departure explanation will be recorded on a separate cover sheet. The explanation will identify the factors and the reasons for departure. It is hoped that this process will ensure that worksheets are revised appropriately to reflect current Board practice. If a particular reason is continually cited, the Board can examine the issue more closely to determine if the worksheets should be modified to better reflect board practice.

Aggravating and mitigating circumstances that may influence Board decisions can include, but should not be limited to, such things as:

- Prior record
- Dishonesty/Obstruction
- Motivation
- Remorse
- Victim vulnerability
- Restitution/Self-corrective action
- Multiple offenses/Isolated incident

As shown earlier, the sanction grids have four separate sanctioning outcomes: remove from practice, reprimand, treatment/monitoring and no sanction. Chart 8 lists the most frequently cited sanctions under the four sanctioning outcomes that are part of the sanction grid. After considering the sanction grid recommendation, the Board will fashion a more detailed sanction based on the individual case circumstances.

¹⁷ See *Sanction Reference Points Instruction Manual*, July 2003, Virginia Department of Health Professions.

Chart 8: Specific Sanction Options Available Under Each Grid Recommendation

<u>Sanction Grid</u>	<u>Available Sanctions</u>
Remove from Practice	Recommend formal (revocation or suspension may result) Recommend Accept Surrender
Reprimand	Monetary Penalty Reprimand Censure
Treatment/Monitoring	Stayed Suspension Continue on Terms Mental or Physical Evaluation- § 2915 (b) Probation <u>Examples of Terms:</u> Continuing education Audit of practice or chart/record review Special examine (SPEX) Prescribing log Evaluation HPIP Chaperone Oversight by monitor/ supervisor Therapy Other
No Sanction	No Sanction

Summary

Under the proposed research approach, the development of useful and credible sanction reference points depends largely on the ability to closely integrate both quantitative and qualitative methods. The consensus building within and across the different health regulatory boards helps to direct and narrow the scope of the study, and feedback from in-depth interviews and exercises is used to formulate research goals and to guide the data analysis. Preliminary research shows that the development of empirically based sanctioning reference points is possible in an effort to ensure consistency and reduce disparity in sanctions.

Perhaps as important to recommending a sanction, the system allows each respondent to be evaluated against a common set of factors, making sanctioning more predictable, providing an educational tool for new board members, and neutralizing the possible influence of “inappropriate” factors (e.g., race, sex, attorney presence, identity of board members). Future plans call for evaluating the proposed system to determine if board members, health professionals, and the general public have benefited from the new policy.