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Georgia Composite Medical Board – Physician Oversight

Controls needed to ensure sufficient investigations and appropriate discipline

Why we did this review

The Georgia Composite Medical Board's (GCMB) mission is to protect the public by licensing healthcare professionals and enforcing requirements of the Medical Practice Act.

We conducted this performance audit to examine GCMB's overall structure and administration in comparison to best practices recommended by the Federation of State Medical Boards (FSMB). We also reviewed processes related to licensing, complaint reporting, investigations, and discipline in comparison to FSMB recommendations and other states.

About GCMB

GCMB regulates approximately 38,000 physicians through licensure and enforcement activities. GCMB reviews physician license applications to determine whether the applicant meets requirements and is fit to practice. GCMB also receives complaints related to standard of care, over-prescribing, impairment, sexual misconduct, and other issues. Staff investigate each complaint and submit for board review. The board may decide to close the case, send a non-disciplinary letter of concern, or impose formal discipline ranging from a reprimand to license revocation.

In addition to regulating physicians, GCMB oversees other healthcare professionals, such as physician assistants and acupuncturists.

What we found

The Georgia Composite Medical Board (GCMB) aligns with best practices and other states in many aspects related to board structure and administration, as well as its overall licensing and complaint investigation processes. However, improvements are needed to ensure that potential violations are reported, all complaints are sufficiently investigated, and the investigations result in appropriate and consistent disciplinary decisions.

Board structure and administration are largely consistent with recommended practices, but important items are not aligned.

GCMB aligns with recommendations of the Federation of State Medical Boards (FSMB) in most areas of board structure and administration, including the method of appointing members, election of officers, use of committees, and publishing of minutes.

GCMB does not align with other FSMB recommendations. GCMB does not control licensing revenue, remitting approximately $7 million to the state treasury but receiving less than $2.5 million in state appropriations. As a result, the board has limited control of the number and type of staff. Recent budget reductions have led to the elimination of positions, including an in-house medical director, an operations director, a legal services officer, and an investigator. We also noted GCMB has fewer non-physician board members than the recommended 25% and that annual reports do not include some relevant information regarding GCMB operations.

GCMB's licensing requirements are largely consistent with other states, with two exceptions.

Like other state boards, GCMB's licensing process involves an administrative review of credentials and an additional board review

if there are concerns, such as malpractice history or discipline by other state boards. All applicants must meet requirements pertaining to education, training, and medical examinations. However, Georgia requires fewer years of postgraduate training for graduates of approved international medical schools compared to best practices and other states. In addition, applicants have not been required to pass criminal background checks, but GCMB is in the process of implementing these checks now required by state law.

Complaints are likely underreported, and GCMB lacks controls to ensure that reported complaints are sufficiently investigated.

State law only requires reporting from liability insurance organizations and self-reporting by physicians for malpractice and felony convictions. In comparison, 96% of other state medical boards require reporting from more entities, including hospitals, peer licensees, law enforcement, courts, medical associations, and state and federal agencies. In addition, complaints from patients may be underreported due to limited outreach efforts to inform the public of the board's role in receiving and investigating complaints.

GCMB's overall complaint investigation process is similar to other states, but we identified areas for improvement. While GCMB has policies and procedures in each of these areas, we found that its complaint prioritization method is inconsistent, it could benefit from detailed investigative plans or checklists, and formal timeliness standards are needed. GCMB also lacks guidance regarding the medical director reviews of patient records and has fewer resources for conducting these reviews compared to other states. GCMB's efforts to monitor investigations have also been limited due to data system reporting capabilities.

GCMB rarely imposes disciplinary actions and has lower discipline rates than other states reviewed.

Almost all investigations (98%) are closed without formal disciplinary action. In fiscal year 2020, GCMB issued public disciplinary action in 18 cases (2%), resulting in a rate per 1,000 physicians that is lower than six other states reviewed. Letters of concern were issued in 17% of cases, while 81% were simply closed.

Differing rates may be due to variations in board culture, statutory requirements for reporting and discipline, and the investigative processes. However, while the board has discretion to determine whether discipline is warranted, GCMB currently lacks controls and processes that other states have implemented to ensure their decisions are appropriate and consistent. Additionally, when GCMB does discipline a physician, the information is often not clearly reported on the physician profile, which is intended to provide the public with information about a physician, including practice history and adverse actions.

What we recommend

We recommend that GCMB improve its processes to better ensure that potential violations are reported and investigated properly. This includes expanding public outreach efforts and communication with the public and complainants, as well as more consistent prioritization, clearly outlined investigative steps, more in-depth medical reviews, formal timeliness standards, and increased monitoring.

To ensure consistent and transparent disciplinary decisions, GCMB should implement additional strategies, such as sanctioning guidelines and formal training for board members. It should also document whether there was sufficient evidence that a violation occurred for each complaint investigated. When discipline is imposed, GCMB should ensure that decisions are clearly presented on the physician profile.

We also recommend legislative changes including restricting GCMB's fee revenue to purposes related to board operations; requiring groups such as hospitals and peer licensees to report potential violations; and requiring the board to include additional public members to represent the patient perspective.

A more detailed listing of recommendations can be found in Appendix A.

Agency Response: *GCMB generally agreed with our recommendations. Specific responses are included after each finding.*

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Purpose of the Audit

This report examines the Georgia Composite Medical Board (GCMB). Specifically, our audit set out to determine the following:

1. Does Georgia's Medical Practice Act align with best practices for board structure and function as outlined by the Federation of State Medical Boards (FSMB)?
2. Are GCMB license requirements designed to ensure that only qualified candidates are licensed to practice medicine in Georgia?
3. Does GCMB protect the public through an accessible, efficient, and effective complaint process?
4. Does GCMB issue sanctions when necessary?

A description of the objectives, scope, and methodology used in this review is included in Appendix B. A draft of the report was provided to GCMB for its review, and pertinent responses were incorporated into the report.

Background

Program Description

Georgia's Medical Practice Act Covers:

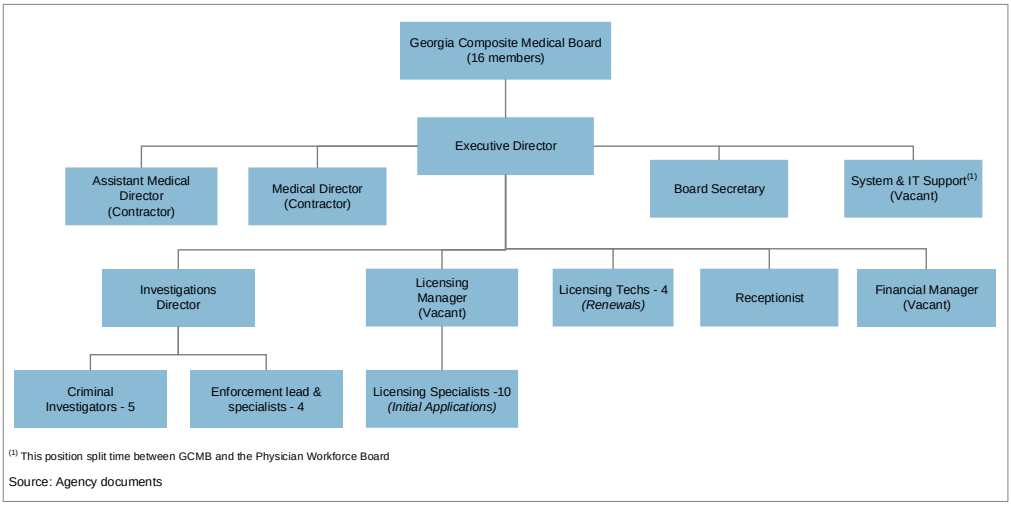
- *Unlicensed practice*
- *Types of licenses and requirements*
- *Delegation of authority to nurses*
- *Drug therapy management*
- *Vaccine protocol agreements*

The Georgia Composite Medical Board's (GCMB) mission is to protect the public by licensing healthcare professionals and enforcing requirements of the Medical Practice Act. Currently, GCMB regulates approximately 38,000 physicians by issuing and renewing licenses, investigating complaints, imposing disciplinary actions, and monitoring physicians on probation. GCMB also oversees approximately 16,000 licensees in 10 other healthcare professions, such as physician assistants.[1]

The 16-member board is composed of 13 physicians, two consumer members, and one physician assistant in a non-voting advisory role. The board has several committees including physician licensing that reviews applications and investigative that reviews complaints. In addition, the board is supported by an executive director and 29 staff positions organized into three primary units – licensing, operations, and investigations (see **Exhibit 1**). The board also contracts with a medical director and assistant medical director.

[1] Other professions regulated by GCMB include residents in training, respiratory care professionals, cosmetic laser practitioners, pain management clinics, acupuncturists, perfusionists, orthotists & prosthetists, genetic counselors, and auricular detoxification technicians.

Exhibit 1
GCMB Organizational Chart (As of October 2020)



(1) This position split time between GCMB and the Physician Workforce Board

Source: Agency documents

Licensing

GCMB reviews initial license applications to determine whether the applicants are qualified and fit to practice medicine. In making this determination, GCMB staff reviews information related to education, training, and experience and, if there are any concerns, will submit to the board for review. GCMB reviews approximately 2,600 initial license applications annually. GCMB also processes approximately 16,000 renewal applications, which generally do not require an in-depth review.

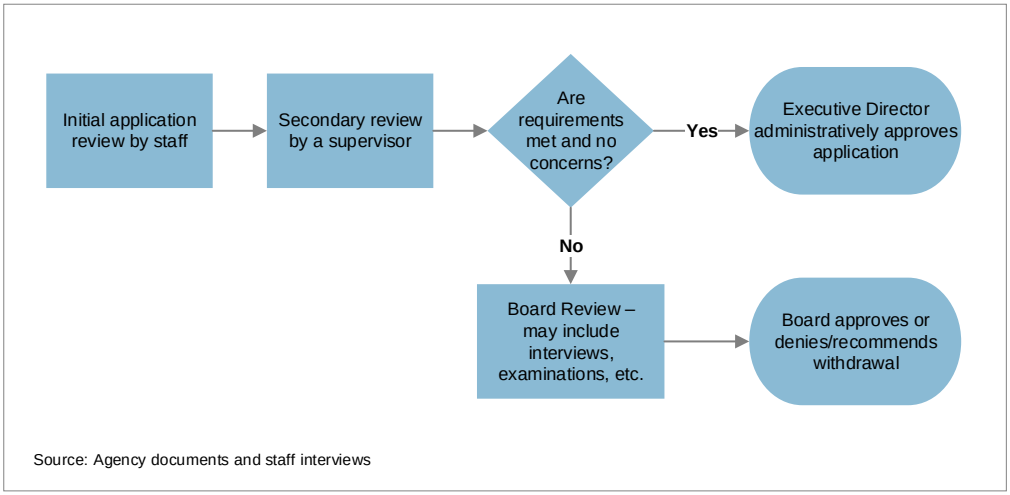
Documentation for Initial Licensure Include:

- *Medical education transcripts*
- *Postgraduate training*
- *Examination scores*
- *Resumes*
- *Verification of licenses in other States*
- *Proof of citizenship*

Applicants for initial licensure must provide extensive documentation of their credentials. Additionally, applicants must provide reference forms showing evidence of "good moral character" and complete a questionnaire regarding any potential criminal background history, disciplinary history, and substance abuse. As shown in **Exhibit 2**, the application materials are reviewed and verified by a licensing specialist. A secondary staff review is conducted to ensure all documentation is included and no issues are overlooked. If requirements are met and there are no concerns, the executive director may administratively approve a physician license application.

GCMB requires an additional board review of applicants with concerns, such as other state disciplinary actions, malpractice history, criminal convictions, or bad references. As part of this review, the physician licensure committee may require an applicant to appear for an interview, provide additional information, or complete evaluations of their clinical skills or physical and mental state. The committee then determines whether the application should be approved or denied. The committee could also recommend that the physician withdraw their application to avoid being denied a license.

Exhibit 2
Licenses May Be Administratively Approved or Board-Reviewed



Source: Agency documents and staff interviews

While initial licensure involves a detailed documentation review, the renewal process is largely automated. Every two years, physicians must complete a questionnaire, pay the renewal fee, and attest to completing 40 hours of continuing medical education. All required information can be submitted online, and the review and approval are automated. To verify continuing education requirements, GCMB audits a sample of licensees each year.

Enforcement

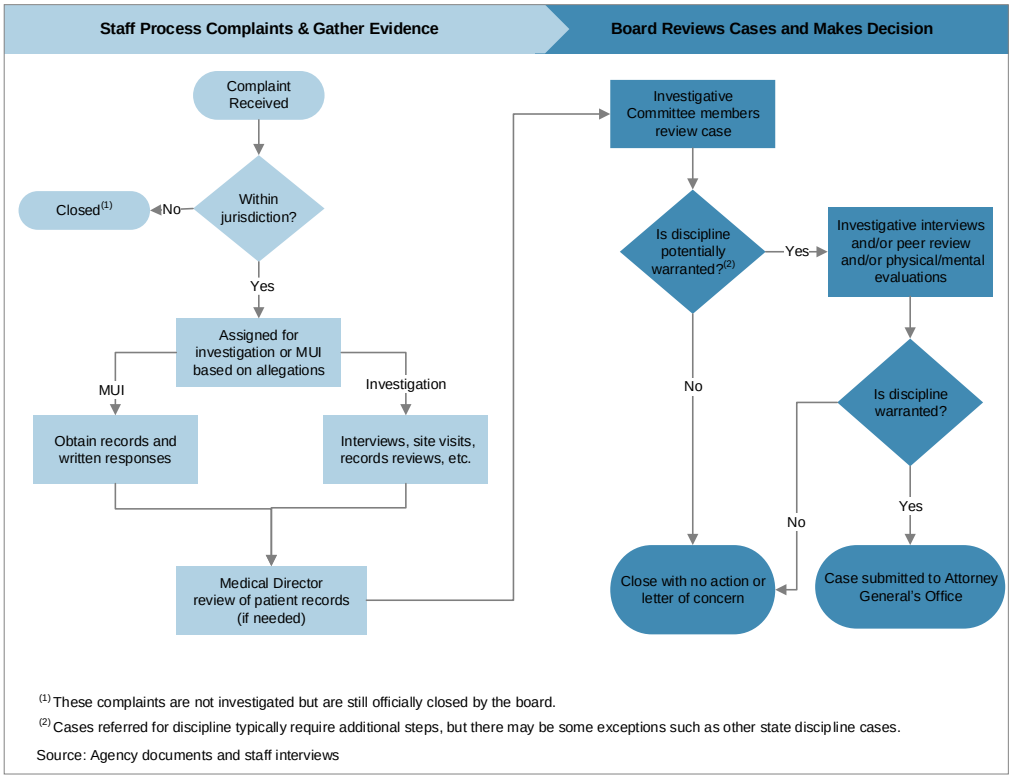
GCMB typically receives 1,500 to 2,500 complaints against physicians each year. Complaints are investigated by GCMB staff and then submitted for board review. The board can decide to close the case or pursue discipline, which requires additional steps.

Complaints and Investigations

GCMB receives complaints from sources including patients, malpractice insurance agencies, healthcare facilities, and other state medical boards. The complaints involve a wide range of allegations, such as quality of care and malpractice, sexual misconduct, impairment, improper prescribing, and other types of unprofessional conduct. It is not uncommon for a complaint to involve multiple types of allegations.

After a complaint is received, GCMB staff triages the complaint at intake, conducts the investigation/review, and then submits the case for board review. Each of these steps is discussed below and shown in **Exhibit 3**.

Exhibit 3
Complaints are Investigated by Staff and Reviewed by the Board



(1) These complaints are not investigated but are still officially closed by the board.
(2) Cases referred for discipline typically require additional steps, but there may be some exceptions such as other state discipline cases.
Source: Agency documents and staff interviews

During intake, staff review each complaint to determine whether it falls within GCMB's jurisdiction, and if so, how it should be assigned. Approximately 20% of complaints are outside the board's jurisdiction (e.g., billing disputes or poor customer services) or lack sufficient information for investigation and are recommended for closure immediately. Complaints not immediately closed are assigned to staff as a "matter under inquiry" (MUI) or an investigation, as described below. It should be noted that while GCMB distinguishes between these two pathways, we broadly use the term "investigation" in this report to refer to all complaint reviews.

- **MUIs** – MUIs are cases that usually involve quality of care, malpractice, or discipline imposed in other states. These cases are handled by the central office's enforcement specialists, who request necessary documentation including physician responses and patient records. If the patient records require an assessment of the care provided, GCMB's medical director or assistant medical director also reviews the case.

- **Investigations** – Complaints related to sexual misconduct, impairment, criminal actions, unlicensed practice, and over-prescribing are typically assigned to one of GCMB's POST-certified investigators[2] located throughout the state. These cases generally involve more in-depth investigative work,

[2] POST-certified refers to the Peace Officer Standards and Training Council's certification process. Certified peace officers are responsible for enforcing criminal laws and preventing and investigating crimes.

including unannounced site visits and interviews with complainants, witnesses, and physicians. Investigations may also require a medical assessment of the care, which is conducted by one of the medical directors.

After staff complete the investigations and MUIs, the cases are reviewed by the board's investigative committee. Committee members are assigned specific cases to assess before each monthly meeting. At the meeting, the investigative committee discusses and determines whether cases should be closed or discipline should be pursued. As part of this decision-making process, the committee may request an interview with the physician or a peer review by an outside expert to evaluate the care provided; however, these additional steps do not occur for most cases.

Disciplinary Actions & Monitoring

O.C.G.A. § 43-34-8 stipulates the grounds for discipline and the types of disciplinary actions that GCMB can impose. The law provides an extensive list of violations warranting discipline, including failure to meet the minimum standards of care, impairment, felony convictions and crimes of moral turpitude, unethical conduct, and other state disciplinary action. If the board finds a preponderance of evidence that a violation occurred, it may impose sanctions, including public and private reprimands, probation, and license suspensions and revocations. GCMB can also issue confidential letters of concern that are not considered disciplinary action. A description of violations and authorized actions is provided in Appendix C.

When the board decides to pursue discipline, GCMB staff and the Attorney General's Office draft a consent order stipulating the sanctions. The licensee has the right to request an administrative hearing before an administrative judge. If either the board or the licensee does not agree with the final decision of that hearing, an appeal can be made to the superior court.

If the disciplinary process results in probation, the board is responsible for monitoring the physician to ensure requirements are followed. These requirements could include the use of chaperones and supervising physicians or treatment programs for substance abuse and mental health concerns. In the latter case, the monitoring may be imposed by the board or the licensee may opt to be monitored by the Georgia Professional's Health Program through treatment and drug screenings.

Information for Consumers

As part of its responsibility to protect patients, GCMB provides comprehensive physician information in the online physician profile. The Patient Right to Know Act requires these profiles to include fields for adverse actions such as malpractice cases, loss of hospital privileges, criminal convictions, and disciplinary actions by GCMB and other state medical boards. In addition to adverse actions, the Act requires the profiles to include more general information related to medical education and training, practice location, current hospital privileges, and malpractice insurance coverage.

Financial Information

As shown in **Exhibit 4**, GCMB's funding consists primarily of state appropriations, with a smaller portion derived from administrative fees. While GCMB retains revenue related to some administrative fees (e.g., requests for additional IDs), it remits all fee revenue related to the issuance and renewal of licenses. GCMB remitted over $7 million in fees to the treasury in fiscal year 2020.

GCMB's budget has decreased in recent years. Between fiscal years 2018 and 2020, GCMB's expenditures decreased from $3.4 million to $3.0 million (11%). Decreases were present in most expenditure categories, including contractual services, personal services, and regular operating expenses.

Exhibit 4
GCMB Revenues and Expenditures, Fiscal Years 2018-2020

Fiscal Year	2018	2019	2020	% Change FY18-2020
Expenditures by Fund Source				
State Funds	$2,424,885	$2,221,117	$2,085,379	-14%
Other (Admin fees)[1]	971,686	1,110,932	935,499	-4%
Total	**$3,396,571**	**$3,332,049**	**$3,020,878**	-11%
Expenditures by Class				
Personal Services	$2,194,539	$2,124,991	$2,041,527	-7%
Regular Operating Expenses	204,527	297,341	191,840	-6%
IT Expenditures	82,973	90,388	84,991	2%
Real Estate Rentals	101,685	123,491	126,638	25%
Voice/Data Communication Services	100,465	118,133	108,490	8%
Contractual Services	712,382	577,704	467,391	-34%
Total	**$3,396,571**	**$3,332,049**	**$3,020,878**	-11%

1. Includes approximately $4,000 in COVID-19 funds in fiscal year 2020.

Source: TeamWorks budget comparison reports

Findings and Recommendations

Finding 1: While GCMB's board structure and responsibilities align with best practices in some respects, changes could be made to improve board composition, funding, and administration.

GCMB's board structure aligns with Federation of State Medical Boards (FSMB) recommendations in many aspects related to board membership and administrative processes. However, state law or GCMB actions do not align with recommendations in other areas, including the number of non-physician board members, the use of license revenue, the presence of a conflict of interest policy, and the information provided to the public about board operations and licensed physicians.

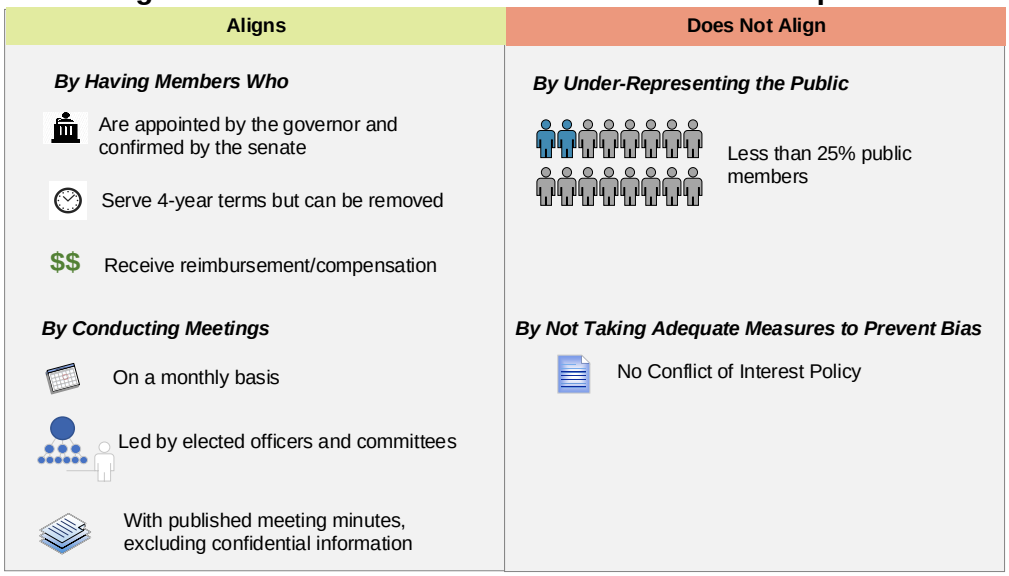
FSMB is a non-profit organization that provides services including guidance documents, reports on regulatory trends, and physician data.

While FSMB guidelines provide a detailed blueprint covering a range of topics, we focused on the aspects more likely to impact the board's processes and effectiveness.[3] For example, structural characteristics related to composition, funding, and staffing have been shown to influence the effectiveness of disciplinary processes. Also, inadequate public reporting in annual reports and physician profiles limits transparency and consumer protection.

Board Structure

GCMB aligns with most FSMB best practices for board membership and administrative processes related to meetings, officers, and committees. However, GCMB has fewer consumer board members than recommended and lacks a formal conflict of interest policy, as shown in **Exhibit 5**.

Exhibit 5
GCMB Aligns to FSMB Recommendations with Some Exceptions



Source: FSMB documents, state law, agency documents and interviews

[3] FSMB best practices not reviewed include aspects such as board member immunity and practices related to limited forms of licensure.

- **Board Membership** – GCMB follows FSMB recommendations related to board member selection, term length/removal, and compensation. GCMB board members are appointed by the governor and confirmed by the senate for a four-year term but can be removed if necessary. Board members receive reimbursement for expenses and $100 compensation per board meeting.

  While GCMB aligns with some board membership best practices, it has fewer public members compared to FSMB recommendations and most other state medical boards. According to FSMB, public members (i.e., non-physicians) should account for at least 25% of the board. However, the Georgia Medical Practice Act stipulates only two public members for the 16-member board, or 12.5%. Of the 68 other state medical boards,[4] 60 have a higher percentage of public members than Georgia, with 33 boards meeting or exceeding FSMB's recommended 25%.

  With fewer public members, GCMB may not be adequately representing the patient perspective in the decision-making process. Research suggests that the number of public board members could influence disciplinary decisions, because public members may be more consumer-protection oriented and more likely to act when violations occur. GCMB's board composition is one of several potential factors that could be contributing to a low disciplinary rate, as discussed on page 25.

- **Officers, Committees, and Meetings** – GCMB follows most FSMB recommendations regarding officers, committees, and meetings. GCMB elects a chair and vice chair and appoints standing committees for physician licensing, investigations, wellness, and public outreach. GCMB also meets monthly and posts meeting minutes to the website while keeping certain information confidential.

  While GCMB aligns with most FSMB recommendations in these areas, GCMB has not established a conflict of interest policy. It is important to note that board members are provided informal guidance by the board attorney, and meeting minutes indicate that members routinely recuse themselves from certain cases. However, the lack of a formal policy could lead to uncertainty and a greater risk that members may not recuse themselves despite a potential bias. A policy would also communicate expectations to future board members and the board attorney.

Funding & Staffing

FSMB recommends that boards establish fees and utilize the revenue solely for board operations. While GCMB has established fees, this revenue is remitted to the state general fund, and a significant portion is redirected for purposes unrelated to the board.[5] This redirection of revenue has contributed to staffing and resource constraints for GCMB.

As shown in **Exhibit 6**, GCMB's fees generate significantly more revenue than is appropriated in the agency's budget.

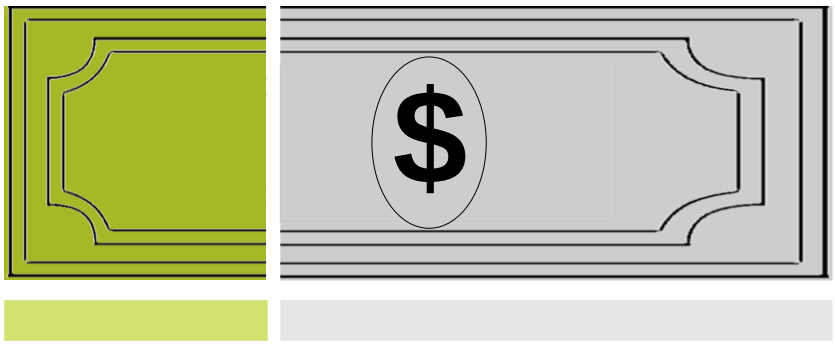
[4] Some states have separate boards for osteopathic medicine and allopathic medicine.

[5] Certain administrative fees are retained by the board.

In fiscal year 2019, fee revenue remitted to the state treasury totaled approximately $6.7 million, more than triple GCMB's state appropriation of $2.1 million the following year. This ratio of fee revenue to budget has remained consistent over the past three fiscal years, during which time the board has requested additional funding.

Exhibit 6
GCMB Fee Revenue Significantly Exceeded State Appropriations
Fiscal Years 2019-2020

For every dollar GCMB remits in fee revenue[1]



$.31 is appropriated to GCMB

$.69 is redirected for other purposes

[1]Based on fiscal year 2019 fee remittances and fiscal year 2020 state appropriations

Source: PeopleSoft financial data and Georgia Revenue and Reserves Report

Because its fee revenue is redirected, GCMB is unable to fully comply with FSMB's recommendation that boards determine staffing needs. For example, in fiscal year 2020, GCMB identified a need for an in-house medical director to review quality of care complaints, but the position was not funded. Fiscal year 2021 budget reductions then forced staff layoffs and unfilled vacancies, including the operations director, the legal services officer, and one of the six investigators.

According to GCMB management, the staffing constraints and general lack of resources have impacted processes related to public outreach, investigations, and discipline. Furthermore, some of the recommendations in this report (licensure background checks, additional mandatory reporters, data system improvements, etc.) will likely require additional resources to implement.

Public Reporting

In accordance with FSMB recommendations, GCMB publishes an annual report and maintains physician profiles. However, we identified deficiencies in both that limit their value to the public.

GCMB's annual report does not include the recommended components needed to ensure transparency, including the board's strategic plan, goals, and objectives. Additionally, while FSMB recommends detailed licensing and disciplinary data, GCMB's report only includes basic statistics such as the number of complaints and

the number of disciplinary actions taken. These statistics vary from year to year, making it difficult to track trends. Other states have more robust reports. North Carolina, for example, provides detailed demographic statistics on current licensees, along with a clear breakdown of the types of disciplinary actions taken by allegation (impairment, quality of care, etc.).

FSMB also recommends that boards maintain online physician profiles with fields that include criminal convictions, malpractice history, and disciplinary history. GCMB's physician profile includes these types of fields, but the profiles are often missing information, such as violation descriptions, that would make it a useful consumer protection tool. This is further discussed on page 31.

RECOMMENDATIONS

1. The General Assembly should consider requiring additional public members as part of the Composite Medical Board.

2. The General Assembly should consider directing all fee revenue to purposes related to licensure, discipline, and board administration.

3. GCMB should establish a formal conflict of interest policy.

4. GCMB should improve its annual report by including additional activity data and a description of goals and objectives. Additional reporting recommendations related to online physician profiles are provided on page 34.

Agency Response: *GCMB generally agreed with recommendations, while noting current practices in place and the need for additional resources:*

- *Funding and staff - GCMB indicated that it would need additional funding to be more proactive in its licensure and investigative processes and improve reporting. According to GCMB, other state boards have dedicated staff to manage press releases and reporting.*

- *Public reporting - GCMB indicated that it will provide additional information concerning disciplinary actions in its public reporting. GCMB also emphasized that it currently publishes a list of monthly public board orders documenting disciplinary actions and reports disciplinary actions on the board's verification site.*

- *Conflict of interest - GCMB plans to establish a conflict of interest policy. As discussed in the finding, GCMB re-stated that the board receives updates from the Office of the Attorney General and board members often recuse on items that may appear to be in conflict.*

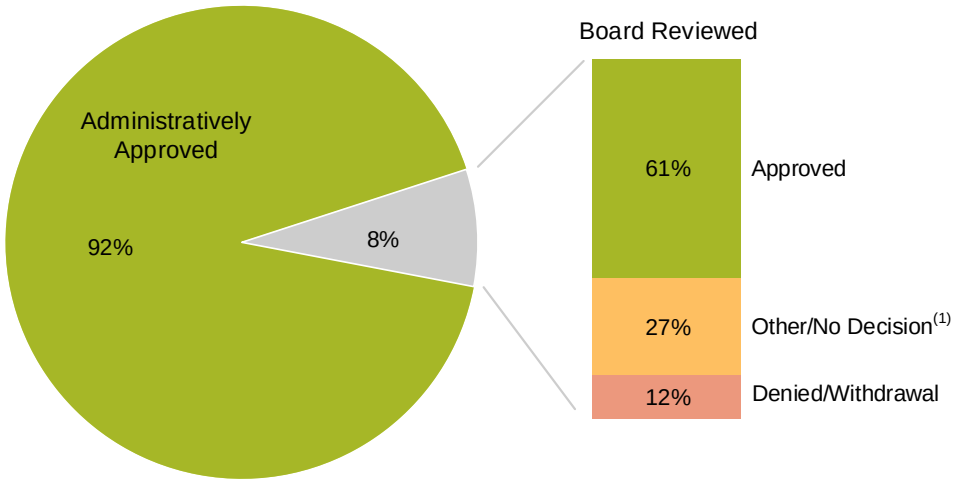
GCMB noted that board composition is determined by the legislature and an additional consumer member was added in 2017.

Finding 2: GCMB's licensing requirements and application review process are similar to other states and best practices, with the exception of criminal background checks and post-graduate training requirements.

GCMB's licensure requirements and application review process are largely consistent with FSMB recommendations or other states' licensing boards. However, GCMB will provide a license to an international medical school graduate with fewer years of post-graduate training, or graduate medical education (GME), than most states, and it has not yet implemented criminal background checks.

GCMB's application review process is similar to other states, with staff reviewing application materials and then submitting only applications with specific concerns for board review. Between January and June 2020, 1,438 of the 1,556 (92%) applications reviewed were administratively approved by staff (see **Exhibit 7**). The other 118 (8%) applications were submitted for board review, most commonly for issues such as malpractice, discipline in other states, and reported concerns from residency training programs or other references. Of the 118 board-reviewed applications, 72 (61%) were approved. The applicants approved following board review typically had active licenses in other states, which provides assurance that other boards have deemed the physician qualified for a license.

Exhibit 7
GCMB Approved Most Applications between January 2020 and June 2020



(1) Includes applications that were tabled and/or additional information requested (e.g., interviews or evaluations), as well as applications in which the Board recommended a more limited license, such as an administrative or volunteer license.

Source: Agency documents

Prior to licensure approval, applicants must demonstrate that they meet GCMB's requirements, which are mostly aligned with FSMB guidance. FSMB recommends that applicants have graduated from medical school, completed postgraduate training, passed comprehensive licensing examinations, passed criminal background checks, and submitted various types of documentation (e.g., proof of citizenship). GCMB aligns with many of these recommendations but requires fewer years of postgraduate training and does not conduct criminal background checks.

- **Post-graduate training** – Georgia requires fewer years of postgraduate training for graduates of approved international medical schools compared to best practices and other states. FSMB recommends that all applicants complete three years of GME. Most states instead require only one year of GME for U.S. medical school graduates, but they do require additional years for graduates of international medical schools. GCMB only requires one year of GME for graduates of both U.S. and board-approved international medical schools.

  The impact of requiring fewer years of GME is unknown. GCMB does not track the number of applicants with only one year of GME.

- **Criminal background checks** – GCMB has not yet implemented criminal background checks despite the best practice recommendation and a Georgia statutory requirement. To ensure that boards do not unknowingly provide a license to an individual with a criminal history, background checks are recommended by FSMB and required by all six states[6] interviewed, as well as the Georgia Board of Nursing.[7] Despite a 2019 state law requiring background checks, GCMB still relies on applicants to self-report criminal history.

  When criminal background check legislation became law in 2019, GCMB intended to begin the checks as part of its membership in the Interstate Medical Licensure Compact.[8] However, the law required background checks for general licensure applicants only but did not permit checks for those seeking licensure through the compact. Because GCMB was initially focused on background checks for membership in the compact, it has been slow to implement criminal background checks for other applicants. Legislation passed during the 2020 legislation session authorizes background checks for compact applicants. According to GCMB, the new legislation is still under review by the FBI, which must approve the background checks for all applicants.

RECOMMENDATIONS

1. GCMB should monitor the years of GME completed and re-evaluate the requirements and potential risks.

2. GCMB should implement criminal background checks for general applicants.

Agency Response: *GCMB indicated that the board previously required international graduates to have three years and US graduates to have one year of training. According to GCMB, a good number of international graduates were US citizens that trained in an offshore school and issues were raised by some program directors and medical students. After discussion, the board agreed to allow any graduate with an approved school from the California List of Approved Medical Schools to only require one year of training.*

[6] Virginia only requires certain applicants to complete criminal background checks.

[7] We interviewed officials with licensing boards in Florida, Maryland, North Carolina, Ohio, Tennessee, and Virginia. The selection of states was primarily based on their reported practices in the areas covered by this report. For more information, see the objectives, scope, and methodology on page 37.

[8] The Interstate Medical Licensure Compact allows licensees in a member state to receive expedited licenses in other member states. This Compact requires member states to conduct criminal background checks for interstate licensure.

GCMB also stated that the board recently had legislation passed that would allow the board to do background checks through the Federal Bureau of Investigation and Georgia Bureau of Investigation. GCMB is currently waiting on authorization to conduct these checks and hopes to start in a few months. GCMB believes this will require the board to hire additional staff to monitor and maintain these checks. GCMB also noted that the board conducts background checks on owners and operators of Pain Management Clinics.

> ***DOAA Response:*** *Following the 2019 law, the FBI approved background checks for general licensure applicants but not for the interstate medical licensure compact applicants. GCMB is waiting on approval for interstate medical licensure compact applicants before moving forward with background check requirements for any applicant for physician licensure.*

Finding 3: Georgia's Medical Practice Act does not require informed sources such as hospitals and peer licensees to report potential violations to GCMB.

According to FSMB, a board's effectiveness requires valid information from reliable sources to inform its disciplinary process. While FSMB recommends reporting requirements for healthcare providers and other entities in positions to identify potential violations, GCMB's reporting requirements only pertain to liability insurance organizations and physician self-reporting.

As shown in **Exhibit 8** on the next page, Georgia requires reporting from only two of the 12 entities recommended by FSMB.[9] According to FSMB, required reporting entities should include hospitals, healthcare professionals, state and federal agencies, law enforcement, courts, and medical associations. Georgia law, by contrast, only requires liability insurance organizations and the individual physicians to report malpractice settlements and judgments. Physicians are also statutorily required to self-report felony convictions, and GCMB asks them to disclose issues such as impairment, loss of hospital privileges, and any convictions upon license renewal.

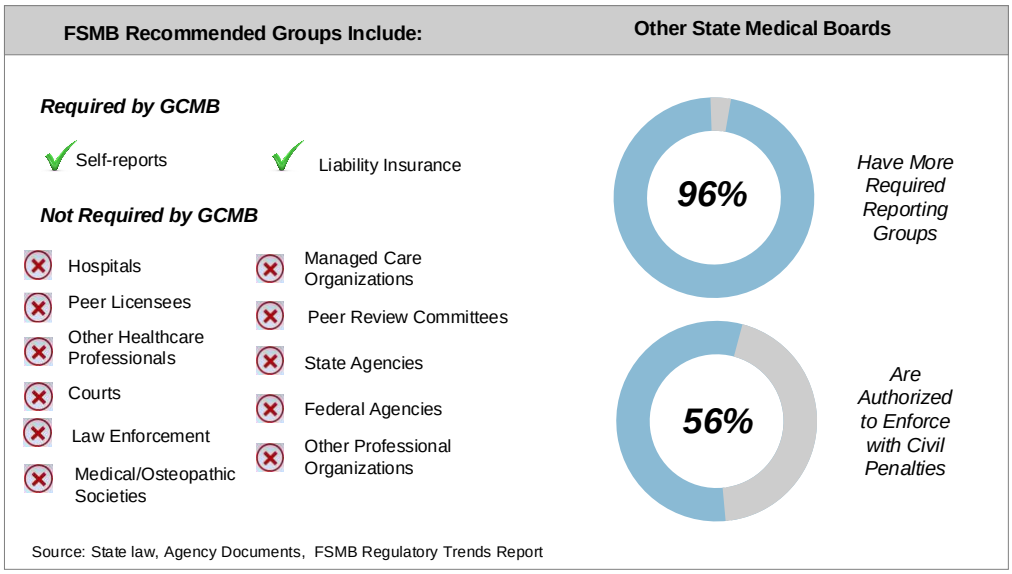
Georgia Board of Nursing advocated for reporting requirements due to cases of nurses being terminated for egregious violations and obtaining employment elsewhere without the Board having knowledge.

GCMB also requires fewer mandatory reporters compared to other state medical boards and the Georgia Board of Nursing. Of the 68 other state medical boards, 65 (96%) require more entities to report than Georgia—most commonly hospitals (96%) and peer licensees (72%). The Georgia Board of Nursing also requires additional mandatory reporters, including peer licensees, hospitals and other employers, and state agencies that certify or survey healthcare facilities.

GCMB also has less authority to enforce reporting requirements compared to FSMB guidance and other state medical boards. FSMB recommends using civil penalties (e.g., fines) to enforce reporting requirements, which 38 of the 68 (56%) other medical boards are authorized to do. Georgia statute does not authorize GCMB to impose civil penalties for failure to report.

[9] This discussion relates to reporting requirements for the general physician population; GCMB has additional reporting requirements specific to institutional licensees and temporary training licensees.

Exhibit 8
Georgia Requires Reporting from Fewer Groups Compared to FSMB Recommendations and Other State Medical Boards



Without statutory requirements, healthcare organizations and professionals may not report violations despite possessing credible information about problem practitioners. For example, board members expressed frustration with a hospital system for not reporting known sexual misconduct, which they were eventually informed of by other means. It is unknown how many cases related to major violations such as this that a hospital or peer licensee may choose not to report. Without access to such information, GCMB is unable to take action to protect patient safety.

While additional mandatory reporters would enhance the board's effectiveness, the increase in complaints may also require additional resources for investigation. The criteria for reporting violations should be explicitly outlined to control the volume and relevance of additional complaints. Several states we interviewed reported receiving a high volume of complaints that did not warrant investigation because reporting requirements were vague. This included hospitals submitting reports related to personnel issues such as habitual tardiness.

RECOMMENDATIONS

1. The General Assembly should consider requiring violation reporting from additional groups such as hospitals, health care organizations, and peer licensees.

2. The General Assembly should consider establishing civil penalties for failure to report.

3. To ensure that expanded reporting requirements do not result in unnecessary reporting, GCMB should clearly indicate in its rules and on its website the types of issues that should and should not be reported.

Agency Response: *GCMB stated that it will update the website to reflect the types of complaints the board handles.*

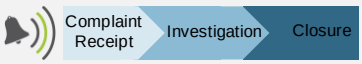
Finding 4: GCMB could take additional steps to improve its outreach and communication to both the public and complainants.

Due to the state's limited reporting requirement for healthcare entities, GCMB largely relies on reporting by patients and their families to identify problematic physicians. However, the agency has not taken sufficient steps to ensure the public is informed of GCMB's role in accepting and investigating complaints. And while GCMB recently began accepting online submissions, more improvements are needed to increase accessibility and improve communication with complainants.

Research indicates that patients may not report concerns about problematic physicians for several reasons including: a lack of awareness of the medical board's role and how to file a complaint; uncertainty if what transpired is a violation; and distrust in the medical board's ability or willingness to take action. These barriers can impact GCMB's effectiveness because the board cannot take action to protect patient safety if a physician is never reported.

To address these barriers and promote confidence and transparency in complaint processing, FSMB and other best practices emphasize the importance of public outreach, a variety of methods to accept complaints, and clear communication with complainants. As shown in **Exhibit 9**, other states have developed more strategies than Georgia to this end.

Exhibit 9
GCMB Can Improve Outreach, Accessibility, and Communication

	Best Practices/ Other States	*Georgia*
Public Outreach 	*Raise public awareness through social media, press releases, newsletters and email alerts.*	*Limited outreach efforts; primarily relying on website to inform the public.*
Accessibility for Reporting 	*Variety of reporting options and clear guidance on the process.*	*Provides options for complaint reporting but additional guidance could be provided.*
Communication with Complainants 	*Notification of complaint receipt and closure (all cases), with limited status updates.*	*Notification of complaint receipt and closure, except when discipline is taken. No status updates.*

Source: FSMB documents and interviews with GCMB and other state medical boards

Public Outreach

Public outreach is also important so consumers will know how to find out whether a physician has been disciplined. FSMB's survey found that 73% of respondents did not know how to find out this information, which is typically reported on medical boards' websites.

Public awareness of the state medical board's role is critical so consumers will know where to file a complaint against a physician. A 2019 FSMB survey, however, found that 69% of respondents nationally did not know that a state medical board is the best resource to contact regarding physician complaints. In addition, 18% of those surveyed had an interaction with a physician who they believed to be providing substandard care or acting unethically or unprofessionally, but only 11% of those filed a complaint with the state medical board.

To address this lack of awareness and promote reporting, state medical boards can engage in public outreach efforts. According to FSMB, boards should implement educational programs to facilitate public awareness of the board's role and function. All six states reviewed utilize strategies for raising public awareness, including press releases, email alerts, and newsletters. In addition, three of the six states utilize social media accounts.

Compared to other states reviewed, GCMB's public outreach is more limited. GCMB primarily relies on its website to inform the public of the board's role. Additionally, while state law does require health care providers to post information about GCMB in their offices, GCMB management indicated that compliance with this public outreach requirement is questionable. It should be noted that the board has a public outreach committee that is exploring strategies for taking a more proactive approach.

Ease & Accessibility of Complaint Reporting

Best practices emphasize the importance of allowing multiple methods for complaint reporting and providing sufficient guidance regarding the reporting process. Otherwise, the public may be less likely to report complaints or may not understand what types of complaints can be investigated or how complaints are handled. While GCMB generally aligns with these best practices, additional steps can be taken to improve guidance.

- **Reporting Methods** – GCMB has expanded complaint reporting options, which are now similar to other states reviewed. GCMB implemented online complaint reporting and has begun to accept anonymous complaints without restrictions. GCMB also accepts complaints via mail and email but not typically over the phone.

- **Guidance/Information Provided** – GCMB's complaint reporting page provides basic information on the investigative process; however, several other states reviewed provided more informative guidance on their websites. For example, North Carolina's complaint reporting page provides tips on submitting a complaint and a short video tutorial that describes the types of complaints investigated and not investigated (e.g., rudeness or fee disputes), the length of the complaint review process, and the percentage of cases that result in the possible outcomes.

Communication with Complainants

GCMB provides limited communication to complainants regarding the case status or outcomes, even as cases can take months or years to investigate. The non-transparent process may create a perception that GCMB does not treat complaints seriously.

- **Complaint Acknowledgement** – GCMB's notification process is designed to comply with state law and best practices, but there is not always documentation to show that the process is followed. State law requires GCMB to respond in writing to every complaint, which aligns with other states' practices and FSMB recommendations. Our file review found that copies of complaint acknowledgement letters were missing for 13 of 40 (33%) cases.[10] The letters could have been missing because they were never sent or because a copy was not retained in the file.

- **Investigation Updates** – Unlike other states reviewed, GCMB does not provide the complainant any updates during the investigation. Five of the six states reviewed provide investigation status updates, either at major milestones or upon request from the complainant. In contrast, GCMB will not provide the complainant updates during the investigation, even when requested, due to management's concerns regarding confidentiality.

- **Closure Letters** – We identified deficiencies both in GCMB's process for notifying complainants of case outcomes and documentation. GCMB has not been notifying complainants when a case is closed with discipline, which conflicts with FSMB guidance and the practices of all six states reviewed. Though GCMB intends to send letters when cases are closed without discipline, documentation was missing for 14 of 40 (35%) cases reviewed. The letters could have been missing because they were never sent or because a copy was not retained in the file, similar to acknowledgement letters.

RECOMMENDATION

1. GCMB should consider implementing low-cost public outreach initiatives, such as issuing monthly press releases on disciplinary actions and utilizing social media accounts. GCMB should also consider providing licensees a copy of the flier that is required to be posted in provider offices.

2. GCMB should provide additional information on its complaint reporting page, such as a description of the types of complaints investigated, complainant notification procedures, and a general timeline of the process.

3. GCMB should notify complainants when cases are closed with disciplinary action. In addition, GCMB should better ensure that all required notifications are sent.

4. GCMB should consider strategies for providing complainants more information regarding the investigation status while maintaining an appropriate level of confidentiality.

Agency Response: *GCMB indicated that it has identified areas to improve guidance for complainants and has recently updated the complaint form and added a survey seeking other ways to*

[10] The file review included a non-random sample of 100 cases closed in fiscal year 2020; however, the review of notifications focused on the 40 complaints that were submitted by patients, patient family members, and other individuals. The other 60 complaints included notifications from insurance agencies, FSMB, and other government agencies. Sample results cannot be extrapolated to the all 1,291 cases closed in fiscal year 2020.

improve. In addition, GCMB plans to implement a policy to provide updates, when requested, to the original complainant by mail.

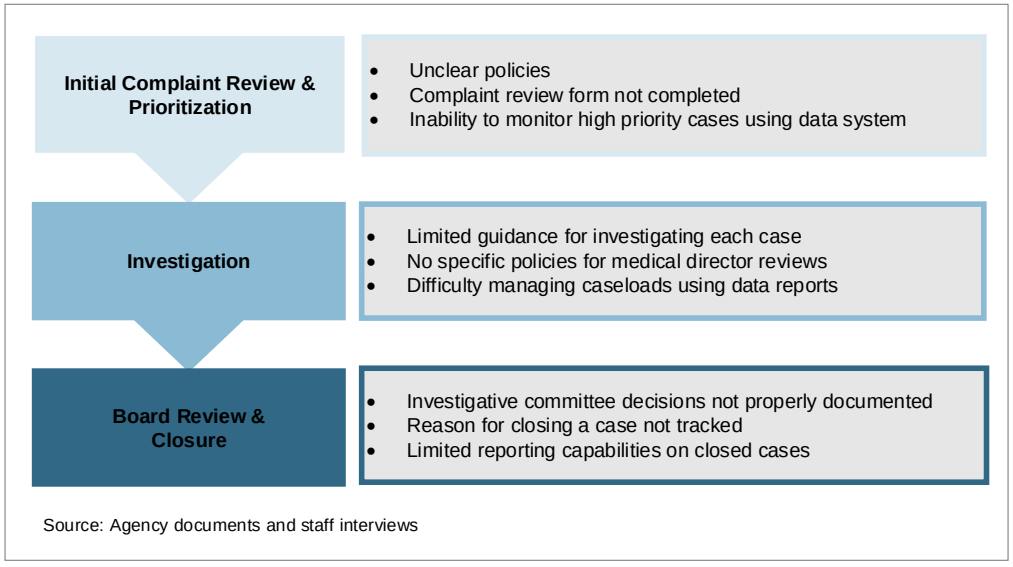
GCMB also noted that it has published in its newsletter a sample of the flier that is to be displayed in the physician's office regarding complaints and the rules.

Finding 5: GCMB could better ensure sufficient complaint investigations through more consistent prioritization, clearly outlined investigative steps, and more in-depth medical reviews.

While GCMB's overall investigative process is similar to other states, GCMB could ensure greater consistency and thoroughness through better complaint prioritization, formal investigative plans and checklists, and more in-depth medical reviews prior to board review of the case. Additionally, improvements to GCMB's data system are needed to more effectively monitor investigations and track case outcomes.

Similar to other states, GCMB's complaint handling process involves an initial intake review and case prioritization, an investigation and/or medical director review of patient records, and a board review to determine whether to close the case or pursue discipline. However, within each phase we identified policies and processes that could be further refined, as shown in **Exhibit 10** and described below. Given that GCMB completes more than 1,000 investigations each year, all necessary steps should be taken to ensure that cases are handled appropriately from intake to closure.

Exhibit 10
Opportunities for Improvement Exist in the Investigative Process



Source: Agency documents and staff interviews

Complaint Intake and Prioritization

GCMB does not use a consistent complaint prioritization method due to differences among the policy manual, forms, and data system. Without clear guidance and proper implementation, cases presenting potential harm may not be designated and monitored accordingly.

- **Policy Manual** – GCMB's manual indicates that cases receive one of two designations—high priority or not high priority. The manual states that impairment and sexual misconduct cases are always high priority, and that other cases may be considered high priority depending on circumstances. The manual does not define the circumstances that would lead other cases to be deemed high priority.

Policy Manual indicates that sexual misconduct complaints are always high priority.

By comparison, the priority levels for sexual misconduct on the initial intake form ranges from 1 (immediate public safety threat) to 3 (minimal public safety threat) without a clear basis for the variation.

- **Initial Complaint Review Form** – The form's priority level designation is not consistent with the policy manual. Instead of simply listing whether a case is high priority, the form designates priority on a scale of 1 to 4.[11] This rating is based on a public safety threat ranging from immediate threat to no threat.

  Additionally, the form is not completed for many cases. Of 100 files reviewed, 84% were either missing the form (25 cases) or included the form but did not designate a priority (59 cases). GCMB management indicated they have started completing these forms on every case; however, as described below, the information also needs to be captured and monitored in the data system to be most useful.

- **Data System** – GCMB's data system has a priority field with a simple yes/no designation, which appears to correspond with the policy but not the initial complaint review form. In addition, there have been no standard reports to identify the open, high priority complaints that may need more immediate attention so management can monitor accordingly.

Most other states reviewed reported processes to ensure that all complaints are consistently prioritized and that the most urgent cases are closely monitored. Of the six states reviewed, five have prioritization systems that are based on case type and/or potential harm. Several states tie the priority level to timeliness benchmarks to ensure high priority cases are fast-tracked. For example, Florida prioritizes complaints on a 1 to 5 scale with each designation having a specified investigation timeline. Reports are reviewed daily to track status and identify which complaints need to be expedited.

Investigations/Medical Director Reviews

GCMB lacks specific guidance regarding investigations and does not systematically monitor the process.[12] In addition, the medical review of cases is more limited compared to other states, which generally have more extensive resources available for these reviews.

- **Investigations** – GCMB's guidance to staff and monitoring of progress are limited, which may be impacting the quality of investigations. GCMB's policy manual provides general guidance on investigations but not detailed procedures. In addition, management cannot easily track the progress of investigations due to data system limitations. For example, management cannot run reports showing open complaints by investigator, requiring management to meet with staff to review investigations on a case-by-case

[11] GCMB's scale goes to five, but this is for complaints that are out-of-jurisdiction and not investigated.

[12] Investigations include both matters under inquiry (MUIs) and formal investigations.

basis. It should be noted that GCMB is working with the data system vendor to expand reporting capabilities.

The limited guidance and monitoring can result in incomplete investigations. Of 100 cases reviewed, we identified at least 15 where additional information was requested by the medical director and/or board, and these requests can lead to significant delays. For example, GCMB received a prescribing complaint in November 2017 and completed the initial investigation in April 2018. Additional investigative work was requested by both the medical director and the board before the case was eventually closed in December 2019, more than two years after the complaint was received.

While the range of case circumstances may hinder the use of a detailed list of investigative steps for all cases, other states have implemented strategies for providing additional guidance and accountability, as well as systematic monitoring. For example, Tennessee and Maryland established a clear course of action at complaint intake by developing investigative plans and compiling an inventory of evidence to obtain. Virginia has established quality control metrics for investigators, including the number of investigations with complete versus missing information. Virginia's detailed sanctioning criteria also helps ensure thorough investigations because all factors (e.g., patient harm) must be identified and documented (see page 29). Furthermore, all six states interviewed monitor the progress of investigations through routine data reports.

- **Medical Director Reviews** – While GCMB's policy manual lacks guidance regarding the medical director review, management indicated that the review serves as a basic triaging before board members assess complaints in greater detail. We found this to be the case in our file review, as most of the medical director summaries restated the complaint or pointed to particular concerns without presenting conclusions regarding the quality of care provided. A more in-depth assessment may not be feasible given that GCMB only contracts with one medical director and one assistant medical director. However, there is a risk that more complex cases may not be adequately assessed, especially given the volume of cases that board members must review each month.

  Other states have a more in-depth medical review process to determine whether the medical care provided met standards before a case is presented to the board. All six states reviewed have a pool of medical consultants who review cases when in-house staff or board members lack expertise in a specialty. For example, each year North Carolina submits approximately 150 cases for an expert reviewer to determine whether, and to what extent, a physician has breached the standards of care. North Carolina's manual provides guidance regarding the information that should be documented in reports, including references supporting the conclusions (e.g., peer-reviewed journal articles or other medical literature).

Board Review and Closure

Investigative reports and medical director reviews are submitted to the board's investigative committee to determine the next step, which could be to close, close with a letter of concern, request an interview or peer review, or send to the Attorney

General's office for discipline. As discussed below, there is limited documentation of these decisions or the supporting rationale and minimal tracking of case outcomes.

The investigative committee's decision for each case should be reported on a case review form, but the form is frequently not completed by board members. GCMB implemented the review form to provide an official record of the committee's recommendation and to stipulate the specific language to be used in a letter of concern when necessary. However, the form was missing for half of the case files reviewed (50 of 100) because board members have not followed procedures. Without the forms, there is no documentation of the committee's decision aside from any notes taken by GCMB management during the meeting.

For cases closed without action, there is no documentation of the rationale, either on the forms or in the data system. Cases can be closed for a variety of reasons: there was no or insufficient evidence that a violation occurred; the violation occurred but there is low risk of the physician re-offending; or the physician's license lapsed, preventing the board from acting. The reason for closing a case would be useful when reviewing future complaints involving the same physician and general monitoring purposes.

Monitoring of board decisions is also hindered by the lack of data system reporting capabilities. GCMB's data reports categorize case disposition as "closed" or "closed with board action." The closed complaints include closed, closed with letter of concern, and complaints outside of GCMB's jurisdiction. The complaints closed with board action include all cases resulting in discipline without distinguishing between license revocations, suspensions, probation, or reprimands. Consequently, GCMB cannot easily access and track basic case outcome data.

RECOMMENDATIONS

1. GCMB should establish clear intake policies for assessing complaints and assigning a priority level, whether based on case type, level of threat, or both.

2. GCMB should modify the initial complaint review form and/or the prioritization field in the database to make these consistent and reflective of established policies. Management should continue efforts to ensure the forms and the data fields are completed.

3. GCMB should consider establishing comprehensive checklists for more routine case reviews and investigative plans for more complex investigations.

4. GCMB should establish more specific policies regarding medical director reviews and should consider whether additional resources are necessary to adequately assess the standard of care.

5. GCMB should ensure that board members properly document decisions on the investigative committee review forms.

6. GCMB should consider documenting the reason for closing cases without discipline for internal purposes.

7. GCMB should continue to expand data system reporting capabilities for monitoring purposes.

Agency Response: *The board acknowledged that an updated policy manual should be implemented. The board also indicated that it is working with its vendor to make improvements in the licensure/complaint system for better monitoring.*

Finding 6: GCMB should establish timeliness goals for major milestones and should monitor to ensure cases progress in a timely manner.

While GCMB closes many cases within a reasonable timeframe, some investigations take significantly longer, especially cases that result in discipline. When GCMB takes a long time to impose discipline, a physician may continue to treat patients without restrictions, creating a public safety risk. Although some cases are delayed by external factors, timeliness standards, monitoring, and follow-up would likely reduce the average time to close a case.

Unlike GCMB, most states reviewed have established formal timeliness goals for the overall process and/or major milestones. For example, Tennessee sets investigation goals based on complaint prioritization, while Maryland expects all cases to be closed within 12 months. GCMB has no formal timeliness goals and has only informal goals to investigate sexual misconduct and impairment cases within 30 days and other cases within six months. There are no goals for overall timeliness, which includes board review, investigative committee interviews and peer reviews if needed, or the imposition of discipline.

As part of their timeliness goals, other states have methods of monitoring the progress of cases to ensure timely completion that GCMB lacks. The methods are typically associated with the agency's data system. For example, Tennessee has due date alerts for each case in the data system, routinely runs statistical reports, and tracks timeliness measures on a dashboard. GCMB management indicated that they cannot easily monitor the time it takes to complete investigations or reach other milestones due to data system limitations.

While GCMB does not track the timeliness of cases, we reviewed a sample of high priority complaints and found that investigations are not always completed within the expected 30 days. We also found that many cases are closed within a reasonable timeframe, though some cases are delayed.

- **Time to investigate** – We found that GCMB rarely met its informal target of 30 days for high priority cases. Of the 21 impairment and sexual misconduct cases closed in fiscal year 2020, only five were investigated within 30 days of complaint receipt. The investigation time for the remaining 16 cases ranged from 35 days to 9 months.

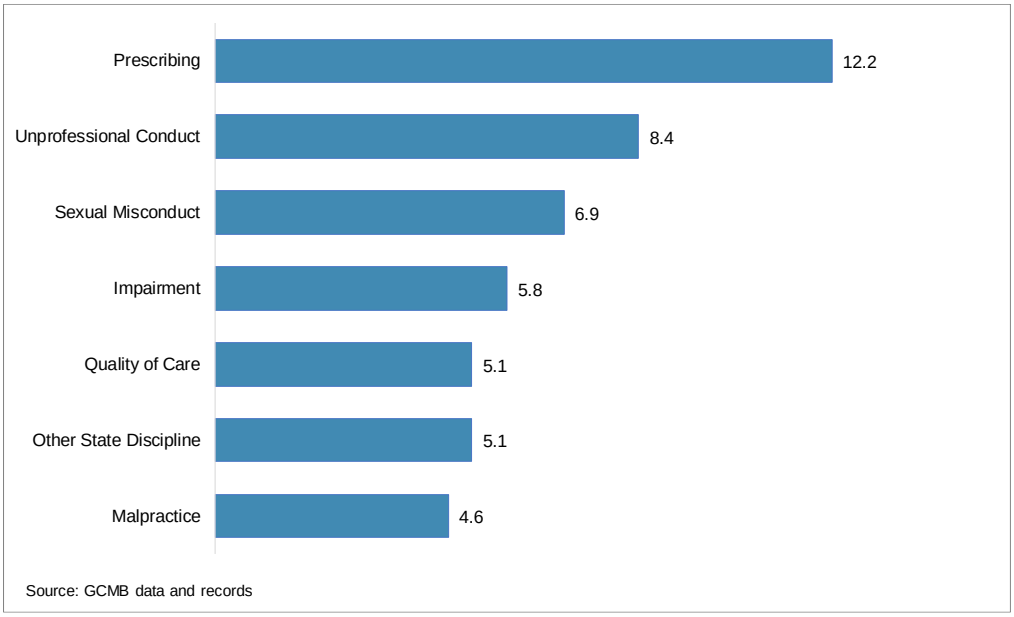
- **Time to close a case** – We analyzed complaint data for approximately 1,050 complaints[13] closed in fiscal year 2020 and found that overall time from complaint receipt to closure varies. Cases that did not result in formal discipline took a median of 5.6 months to close; however, approximately 21%

[13] Includes cases closed with a letter of concern or cases closed with no action but does not include cases deemed outside of GCMB's jurisdiction.

(215 cases) were open for more than a year. In addition, 10 of the 18 cases with public disciplinary action took more than a year to close.

As shown in **Exhibit 11**, timeliness also varied by complaint type. The overall time to close prescribing complaints, which typically involve more complex investigations, ranged from one month to eight years with a median of 12.2 months. In contrast, the time to close malpractice cases ranged from one month to 15 months with a median of 4.6 months.

Exhibit 11
Median Number of Months to Close Cases Varies by Complaint Type
Fiscal Year 2020



Based on a review of case files for 71 complaints that took more than six months to close, we found that delays were caused by both internal and external factors. Most often, delays occurred when physicians failed to provide responses and patient records quickly or when external agencies such as law enforcement were involved. Other cases were prolonged when the board requested supplemental information or additional steps (such as peer review) were needed. We also found cases in which GCMB was slow to initiate the investigation or request necessary information such as patient records.

Regardless of the reason, delays in resolving complaints can pose risks for the public. Below are examples of cases in which delays allowed physicians to continue practicing for extended periods after a complaint was filed.

- An investigation was opened in 2016 for a physician who had been disciplined in 2012 for improperly prescribing narcotics but had never completed the related requirements. The physician declined an interview with the board in 2016 and failed to appear at a hearing in 2018 before his license was indefinitely suspended in March 2019.

- In September 2016, a sexual misconduct complaint was reported against a physician with a history of complaints and prior disciplinary action. The physician maintained an unrestricted license for almost a year before an examination deemed the physician a significant safety threat and the board issued a summary license suspension[14] in August 2017. The final order for indefinite license suspension was issued in January 2019.

- In early 2016, a sexual misconduct complaint was filed against a physician with a prior license suspension and probation violation. In May 2017, the board referred the physician for an evaluation that found he was not an imminent risk but needed treatment and safeguards. The board issued an initial decision for license suspension in January 2019 (nearly three years after the complaint), followed by a final order in August 2019.

In addition to immediate risks, delays can also prevent the board from ever imposing discipline, allowing a physician's record to remain clear if they practice in another state. GCMB has no authority to apply sanctions to a physician whose license has lapsed.[15] With a two-year license period and lengthy investigations, it is not uncommon for physicians to have the opportunity to allow a license to lapse. For example, in January 2019, GCMB received a report that a physician's license was revoked in one state for incompetence and gross negligence. Based on this report, a second state suspended the physicians' license almost immediately. By contrast, GCMB began requesting documents in February and recommended disciplinary action in June 2019. No action was taken before the physician's license lapsed, and the case was officially closed in December 2019.

RECOMMENDATIONS

1. GCMB should formally establish timeframes for overall complaint resolution, as well as major milestones.

2. GCMB should track the extent to which timeliness standards are met and determine where delays may occur.

3. GCMB should implement specific strategies for addressing common delays. For example, to reduce time waiting for physician responses and records, GCMB could implement automated triggers at designated time intervals and send more strongly worded reminders.

Agency Response: *GCMB plans to update policies to clearly identify case timelines. GCMB has also been working with the system vendor to update/modify reports to allow for better case monitoring.*

[14] A summary license suspension is an emergency action to prevent the licensee from continuing to practice while the legal process continues.

[15] GCMB management indicated that although it cannot apply sanctions in these circumstances, it has begun notifying the National Practitioner Data Bank when a license lapses during an investigation.

Finding 7: GCMB issues fewer public disciplinary actions than other states.

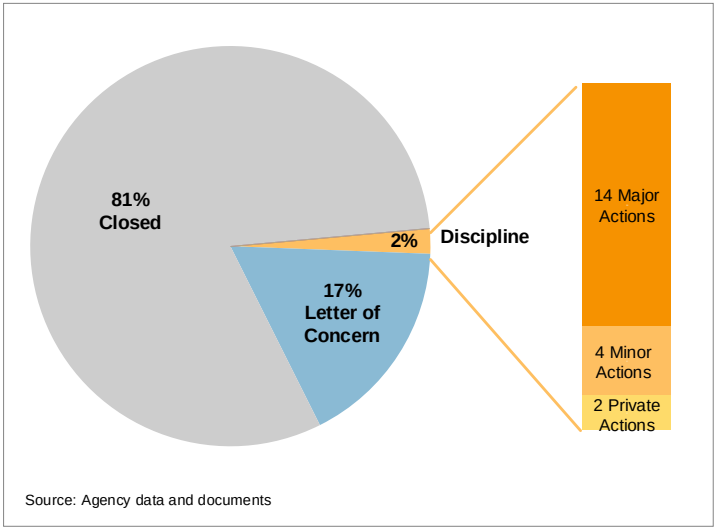
GCMB's complaint investigations rarely result in public disciplinary action. In fiscal year 2020, GCMB issued public board orders for discipline in 18 of the more than 1,000 cases for which it had jurisdiction. Georgia's discipline rate per 1,000 physicians is lower than other states reviewed. We also identified instances in which other states disciplined a physician but GCMB did not do so for the same violation.

O.C.G.A. § 43-34-8 provides GCMB with discretion to apply a range of disciplinary and non-disciplinary actions for many reasons. Grounds for action include items such as a physician's failure to conform to minimum standards, physician impairment, or discipline imposed by another state board. GCMB is authorized to issue sanctions such as public and private reprimands, license suspensions and revocations, license restrictions, fines, and educational requirements, as well as non-disciplinary letters of concern.

The GCMB code section does not impose mandatory discipline for any reason. Due to the absence of this criteria, as well as the complexity of cases, we did not attempt to determine whether GCMB's disciplinary decisions were appropriate. This discussion is limited to a comparison of Georgia's discipline outcomes to other states and an examination of possible reasons for those differences.

As shown in **Exhibit 12**, more than 98% of cases are closed without discipline. In fiscal year 2020, GCMB closed approximately 1,050 cases, but only 18 resulted in public discipline.[16] The 18 public disciplinary actions consisted of 14 major actions (license suspensions/voluntary surrenders) and four board orders with minor actions including fines, reprimands, license restrictions, and educational requirements.[17] These 18 cases involved violations related to prescribing, other state discipline, sexual misconduct, and criminal charges/convictions.

Exhibit 12
Less than 2% of Cases Closed with Formal Discipline
Fiscal Year 2020



Source: Agency data and documents

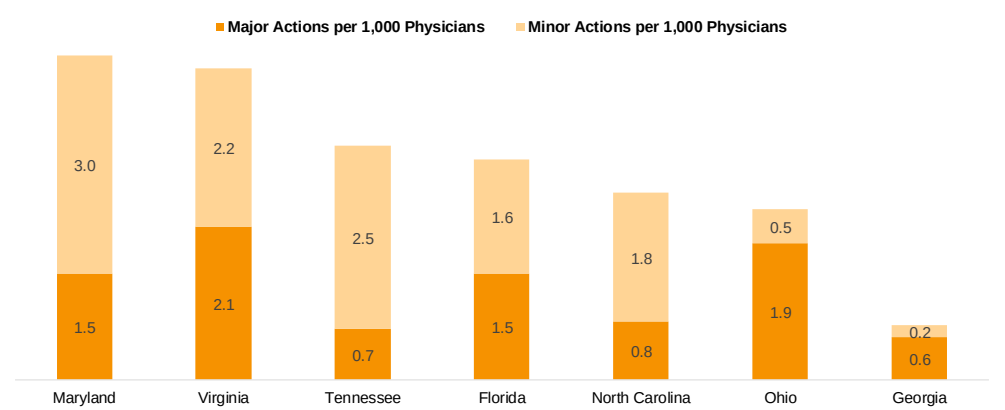
[16] Excludes approximately 260 complaints that were outside of GCMB's jurisdiction.
[17] A board order can include multiple sanctions (e.g., fine and educational requirement).

Disciplinary Actions

When comparing disciplinary rates, we considered disciplinary actions to include public, adverse actions taken against a physician. For example, we included public letters of concern (issued in other states) as discipline but not private letters of concern.

GCMB's disciplinary rate is lower than other states and has been for several years. As shown in **Exhibit 13**, Georgia's rate was lower than the six other states reviewed for both major and minor disciplinary actions in fiscal year 2020. Discipline rates for other states reviewed were three to nearly six times higher than Georgia's. In addition, a 2016 longitudinal study[18] found that 38 of 50 states had higher rates of total discipline than Georgia, and 46 states had higher rates of major discipline.

Exhibit 13
GCMB's Disciplinary Rate is Lower Than Other States
Fiscal Year 2020



Source: Disciplinary reports/board orders from other states' websites; Association of American Medical Colleges' 2019 State Physician Workforce Data Report

There are a number of reasons that may explain Georgia's low discipline rate in relation to other states. These include factors outside the board's purview (differences in mandatory reporting or mandatory discipline laws), as well as those directly related to the board and its staff (culture and investigations). The reasons are described in more detail below.

- **Statutory Requirements** – Compared to Georgia, other states have more stringent requirements regarding mandatory reporting and may have additional circumstances mandating discipline. As discussed on page 13, Georgia does not require reporting from entities such as hospitals and peer licensees, which may have the most reliable information regarding problematic physicians who should be disciplined. Other states may also have laws mandating discipline under a broader range of circumstances than Georgia. For example, Virginia law requires a license suspension if a physician is convicted of a felony or has a license suspended in another state and not reinstated. Georgia requires notification to the board if convicted of a felony, but discipline is only required for licensees convicted of a controlled substance offense.

- **Board Culture** – Medical boards can vary in their philosophy and principles, which impacts how lenient or punitive the board may be in its decision making. According to GCMB leadership, the board's primary role is to protect the public, which may be achieved without formal discipline in some cases. It

[18] Harris, Byhoff. *Variations By State in Physician Disciplinary Actions by US Medical Licensure Boards;* British Medical Journal, 2016. The study analyzed disciplinary data from 2010-2014.

Boards are also dependent on their legal counsel's willingness to aggressively pursue cases. If legal counsel has a relatively high threshold for taking action, the board may have difficulty imposing discipline even when motivated.

should be noted that board culture is partially driven by membership composition, and GCMB has fewer non-physician members than most (see page 8). Culture can also be impacted by the board attorney, who advises when discipline may be warranted or could be successfully defended.

Our file review identified examples in which the board chose not to impose discipline for violations because the physicians had taken actions to address the issue. These included a physician who had enrolled in an addiction treatment program and faced no discipline for prescribing violations and falsifying records to cover them up. In another case, a physician who improperly diagnosed a patient explained the changes implemented to avoid future diagnostic errors. The board opted to issue a private letter of concern rather than formal discipline.

There are also certain types of cases that other boards may address through discipline, but GCMB does not. For example, GCMB received multiple reports of other states' discipline related to administrative issues. such as failure to submit continuing education documentation and chose to close these cases without discipline.

- **Investigations** – A thorough and timely investigation must be conducted so the board has sufficient evidence to impose discipline. If an investigation is not completed quickly, the physician can allow their license to lapse to avoid discipline. For example, GCMB received a report of a physician disciplined by another state for prescribing violations in September 2018. GCMB's medical director recommended that the board mirror the other state's discipline; however, the physician's license was nearly expired when the case was presented to the board in March 2019, forwarded to the Attorney General's Office, then closed before discipline could be imposed. Issues with the investigative process and timeliness are discussed in greater detail on pages 18 and 22, respectively.

Our review also identified several cases where GCMB potentially allowed an unsafe physician to continue practicing. In one case, GCMB was notified of another state board suspending a physician's license following an arrest on prescribing-related charges. GCMB closed the case, allowing the physician to maintain an active license in Georgia while awaiting a trial on drug charges. Another case involved a physician whose license was suspended in another state due to cognitive deficits from severe alcohol use disorder. While the other state determined that public health and safety concerns necessitated emergency action, GCMB allowed the physician to continue practicing in Georgia for years, suspending the physician's license only after receiving additional complaints.

The potential for allowing an unsafe physician to practice will always present a risk in the disciplinary process. Conversely, there is also a risk that an overly stringent board decision could unnecessarily limit a physician's right to practice and the patients' access to the physician. To help ensure appropriate disciplinary decisions,

GCMB's Role in Enforcing PDMP Registration

Approximately 1,500 physicians have not complied with the statutory requirement to register with the Prescription Drug Monitoring Program (PDMP), a database that tracks the prescribing of controlled substances. GCMB has been slow to enforce this requirement for a number of reasons, including changes in its statutory authority to impose discipline.

PDMP data allows medical professionals to identify concerning prescribing patterns and avoid over-prescribing. O.C.G.A. 16-13-57 required all prescribers with a Drug Enforcement Administration registration number to register with the PDMP by July 1, 2018. The initial legislation also required boards to hold non-compliant licensees accountable, potentially through disciplinary action.

GCMB began initiating disciplinary actions against non-compliant physicians in late 2018; however, these actions were never imposed following a 2019 amendment that limited GCMB's authority to impose discipline. Effective April 2019, board actions against non-compliant licensees were limited to, at most, a non-disciplinary administrative fine. However, in the 18 months since that amendment, GCMB has not issued any administrative fines for the approximately 1,500 non-compliant physicians. GCMB noted that for several of those months it did not have the necessary data from the Department of Public Health, which manages the PDMP.

GCMB received the necessary data and sent warning letters in August 2020 threatening a fine to non-compliant physicians if registration was not completed by October 1, 2020. As of late October, GCMB had not obtained updated physician registration information. It should be noted that monitoring compliance is an ongoing process as additional physicians are licensed by GCMB.

other states have implemented additional strategies that are discussed in the next finding.

Agency Response: *GCMB noted that each state's disciplinary authority is different based on the laws of that state. As discussed in the finding, the GCMB code section does not impose mandatory discipline for any reason. GCMB also indicated that cases are reviewed on a case by case basis considering the facts of the case and any outside information to make a decision along with the guidance of the Office of the Attorney General.*

Finding 8: GCMB should implement additional strategies to ensure consistent and appropriate disciplinary decisions.

Similar to other states, GCMB's disciplinary process allows for board member discretion when determining whether and what type of discipline is warranted. Given GCMB's particularly low discipline rates compared to licensing boards in other states and the confidentiality afforded to the investigation and discipline process, the board should take additional steps to provide greater assurance that its decisions are appropriate and consistent.

While board members typically decide case outcomes, other states have implemented processes and strategies to guide these decisions. Unlike Georgia, several states reviewed formally determine whether a violation occurred before deciding on the appropriate response. Then, to help ensure the response is appropriate and consistent, the states provide disciplinary guidelines and training to board members, who may have limited experience or knowledge of regulating a profession. Lastly, some states use additional layers of review or monitoring to further reduce the risk of inconsistent or inappropriate decisions.

Violation Determination

Other states have a larger pool of medical experts who can assess complex cases and provide support for a violation determination, as discussed on page 19.

Other states reviewed have a more deliberate decision-point for determining whether a violation occurred. For example, in Florida, an in-house medical expert makes a preliminary assessment, but then if the case proceeds, a contracted medical expert provides a detailed report. The report is reviewed by a panel that determines whether there is reasonable basis to suspect the physician has violated the law before the case is presented to the board. To promote transparency, the number of cases where probable cause of a violation was found and not found is publicly reported, along with data on complaints received, investigations completed, and final orders for disciplinary action.

In comparison, while GCMB *may* make a violation determination during the case review, this information is not documented or tracked. Complaint investigations typically result in an investigative report and/or medical director review, but these documents provide general information rather than conclusions that substantiate or refute the allegations. Cases are then forwarded to board members on the investigative committee, who may discuss the case during a monthly meeting but are not required to document violations.

Without documented violations, GCMB cannot monitor trends in the number of violations that do not result in discipline, which could provide a measure of consistency and an indication of whether problems go unaddressed too frequently. Additionally, GCMB is unable to publicly report this information, which could provide insight into why almost all cases are closed without discipline. Lastly, when a complaint is received against a particular physician, GCMB staff cannot easily determine whether any prior complaints involved confirmed violations.

Disciplinary/Sanctioning Guidelines

Virginia's Scoring Criteria:

Patient/Offense Factors: Case type, number of patients harmed, injury level, etc.

Physician Characteristics: Prior violations, past drug problems, likelihood to continue to commit violations, etc.

Disciplinary or sanctioning guidelines are recommended by best practices and utilized by most states reviewed to ensure consistency. These guidelines typically establish the suggested minimum and maximum sanctions by violation type, and some also outline aggravating and mitigating factors. Virginia implemented a more complex sanctioning reference system that scores each case on factors related to the violation and physician characteristics, which then results in a recommended sanction. To promote transparency, the scoring system and completed worksheets are shared with the involved parties.

Several other states also stipulate when their boards may issue a private letter of concern, which consumers are not aware of and thus must be used appropriately. For example, North Carolina's disciplinary guidelines indicate that a private letter of concern may be issued for certain violations (e.g., misdemeanor conviction, inadequate recordkeeping, or failure to file paperwork) but not for more serious offenses such as sexual misconduct.

Unlike other states, GCMB does not have sanctioning guidelines or other formal criteria for ensuring consistent disciplinary decisions. GCMB also does not have written policies regarding the use of letters of concern or other private actions. While the board attorney can provide guidance regarding disciplinary decisions, there are no formalized standards that help ensure consistent decision-making.

Board Member Training

Because board members serve a key role in the disciplinary process, FSMB recommends formal training on their duties, which we found other boards provide. Maryland's board training includes an individual orientation on roles and responsibilities, an annual in-person training event, additional sessions on specific topics (e.g., sexual trauma), and ad-hoc training by staff during board meetings. Georgia's Board of Nursing provides a formal one-day training session and a mentor for each new board member. New members are also not expected to make disciplinary decisions immediately.

GCMB does not have a formal training program despite the significant workload and decision-making responsibilities placed on board members. New investigative committee members receive an introductory document with a general description of the process. They may also have discussions with the director of investigations and board attorney. While board members may be able to assess a case from a clinical perspective, they may lack the regulatory and legal knowledge to determine when an infraction rises to the level of a violation and how various factors should be weighed when recommending disciplinary action or closure.

Additional Reviews & Outcome Monitoring

Several states we interviewed have adopted layers of review and monitoring that GCMB lacks. The North Carolina board's senior staff, with their institutional memory and knowledge of case precedent, review and make a recommendation for each case. Ohio is implementing a risk-based approach that includes an internal review of sexual misconduct cases recommended for closure without action and a review of cases that were closed out due to age. Virginia requires an additional board member review before closing cases with the highest priority designations. Virginia also monitors outcomes by tracking the percentage of disciplinary decisions that fall within, above, and below the recommended sanction.

GCMB does not have any additional layers of review or monitoring of case outcomes that may mitigate the inherent risks the decision-making process. Given that GCMB also lacks sanctioning guidelines and provides minimal board member training, an additional check in the process could help ensure that public is adequately protected.

RECOMMENDATIONS

1. For each complaint investigated, GCMB should determine and document whether there was sufficient evidence that a violation occurred.

2. GCMB should implement a more formal training program for board members.

3. GCMB should establish sanctioning guidelines that outline criteria for determining appropriate disciplinary action. The guidelines should address the use of private actions, including non-disciplinary letters of concern and private reprimands.

4. GCMB should identify areas of greatest risk in the disciplinary process (e.g., certain case types, characteristics, or steps in the process) and evaluate how resources could be used to implement additional reviews and//or monitoring practices.

Agency Response: *GCMB plans to obtain information on disciplinary sanctioning guidelines from other states and consider these strategies. In addition, the board will implement a formal training module for new members.*

Regarding additional reviews and monitoring, GCMB indicated that it lacks staffing. GCMB noted that cases are reviewed by the medical director, a board member, and a board committee prior to any actions being taken. GCMB emphasized the institutional knowledge among staff, with both the medical director and executive director having been with the board for over 15 years and the Attorney General staff being with the board for over 10 years.

Finding 9: GCMB's physician profiles do not provide the public with easy access to important information such as disciplinary history or malpractice insurance coverage.

GCMB's physician profile provides limited value to the public due to missing information, the inclusion of information that likely has little relevance to consumers, and an ineffective layout. Without clear and complete information in the profile, patients may not be able to obtain relevant facts, including whether a particular physician maintains malpractice insurance or has settled or lost a malpractice claim, whether hospital privileges have been revoked, or whether disciplinary action has been taken by GCMB or another medical board.

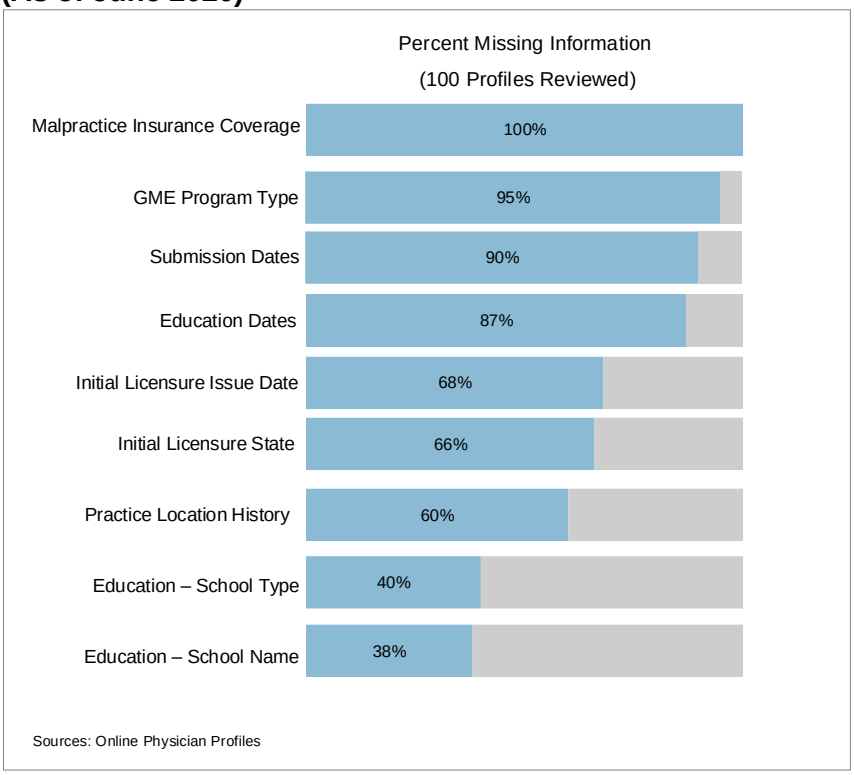
GCMB's physician profiles are required to provide consumers access to comprehensive physician information under the state's Patient Right to Know Act. The law specifies required fields related to license information, malpractice insurance coverage, medical education, postgraduate training, initial licensure and practice location history, and adverse actions (discipline, criminal convictions, etc.). The law also outlines optional fields, including published research, community activities, and awards received. Lastly, the law requires physicians to report any changes within 10 or 30 days depending on the information reported.

While GCMB's physician profiles include the fields listed in the Patient Right to Know Act, the profiles do not fulfill the Act's purpose of providing consumers with useful information because required fields are frequently blank. Additionally, the amount of content and the layout can make it difficult for consumers to find the most critical information.

- **Profiles Are Incomplete** – Our review of 100 physician profiles found several fields are often incomplete, including those related to malpractice insurance coverage, initial licensure, practice location history, postgraduate training, and education (see **Exhibit 14**). In some cases, it may be unclear to the consumer how the blanks should be interpreted. For example, a blank entry for malpractice insurance coverage could either indicate that the physician is uninsured or that the physician is insured but failed to report the information.

  Although statute requires physicians to submit and update physician profile information, GCMB is not adequately enforcing this requirement. GCMB provides information regarding profile requirements on license renewal forms but does not ensure that profiles are complete and current when physicians renew their license online.

Exhibit 14
Physician Profiles Are Often Missing Information
(As of June 2020)



- **Content and Layout Are Not Consumer-Oriented** – Physician profiles are difficult to read and understand due to the amount of content and layout. Each profile includes more than 50 distinct fields. Some of the information captured in the profile— practice location history, initial licensure, and medical school appointments— are not common in other states' physician profiles and likely offer less value than other fields. With the amount of content provided, the information most critical for consumer protection can be more difficult to locate.

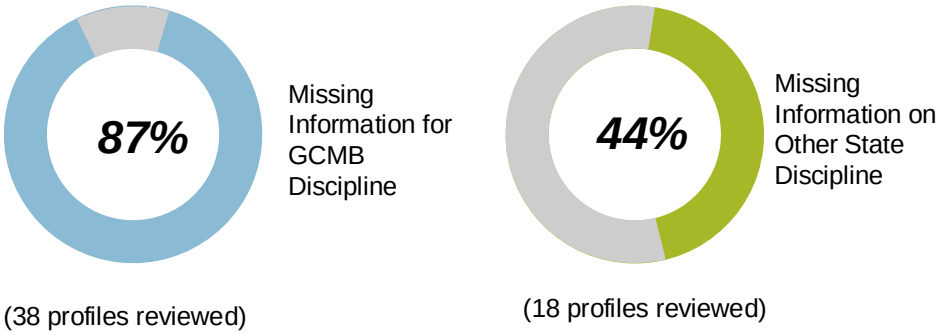
  The large number of fields would be less problematic if the profile's layout allowed patients to easily find information. GCMB's physician profile is a single long page, and more important information (e.g., hospital privilege revocations) is buried among the many other fields. By contrast, other states' physician profiles include tabbed sections and headings, allowing consumers to easily navigate to needed information. For example, Florida's physician profile includes tabs linking to categories such as license information, specialty certification, and proceedings and actions.

Missing and hard-to-find information is particularly significant when it concerns disciplinary actions. We reviewed the profiles for 38 physicians GCMB disciplined in fiscal years 2019 and 2020 and found that only five profiles included a violation description and action description (see **Exhibit 15**).[19] We also found that GCMB does

[19] A board order that includes the discipline is linked in a Public Documents section of the profile; however, a consumer may first note a blank disciplinary action section.

not always report discipline taken by other states. Of 18 Georgia physicians disciplined by other states, eight had profiles lacking this information, even though the action was reported to GCMB. It should be noted that unlike other fields, GCMB can update disciplinary action itself, rather than relying on physicians to self-report.

Exhibit 15
Physician Profiles Are Often Missing Information



Sources: Online Physician Profiles, Agency Documents

Even when GCMB did provide violation information, it was a much briefer description (i.e., three words) than those provided by other states reviewed. As shown in **Exhibit 16**, Florida's board provided significantly more information about a physician disciplined in both states. Florida's narrative description is useful for consumers who may find it difficult to understand lengthy legal documents. Florida also includes a link to the board order next to the narrative. By contrast, the link to Georgia's board order is in an entirely separate section titled "Public Documents."

Exhibit 16
Florida's Physician Profiles Provide A Narrative Description That Is Not Included in GCMB's Profile

GCMB's Disciplinary Action Section Provides Minimal Information on Suspended Physician:

Final Disciplinary Action

Agency Name	Discipline Date	Violation Description	Action Type	Action Description
Georgia Composite Medical Board	06/07/2018		Suspension	

*Copy of board order is linked in separate section under "public documents"

Florida's Disciplinary Action Section for the Same Physician Provides a Narrative Description:

Allegation:

Allegations that on or about June 10, 2013 during one or more appointments, Respondent initiated hugs with several patient. Respondent also inappropriately touched patient's breasts. On several occasions Respondent inappropriately touched patient's buttocks with his hands, attempted to kiss, inserted his tongue into patient's ear and give his phone number and offered to take the patient to lunch. The Respondent has violated the physician-patient relationship through which the physician uses said relationship to induce or attempt to induce the patient to engage or attempt to engage the patient. Florida Administrative Code, provides that sexual contact with a patient is sexual misconduct and is a violation of Florida Statutes.

*Copy of board order is linked in the same section, next to the narrative description link

Source: Online physician profiles

RECOMMENDATIONS

1. GCMB should organize physician profile information into better delineated subsections and consider eliminating some of the optional fields (publications, awards, etc.).

2. GCMB should provide a narrative summary of any violations and disciplinary action. Links to the full board orders should be included in the discipline section.

3. GCMB should enter disciplinary action when it is imposed or when the report of discipline taken by other states is received. Physicians should not have the ability to change this information.

4. GCMB should require physicians to update their profiles during license renewal and provide an entry for every field to eliminate blanks. GCMB should ensure data system controls are used to enforce this requirement.

Agency Response: *GCMB indicated that it has begun to provide a more descriptive summary of the case in the violation description field with a reference to the board order for additional information. GCMB also indicated that it will move the disciplinary action section close to the section for public documents to ensure it is noticed and accessible.*

Appendix A: Table of Recommendations

Finding 1: While GCMB's board structure and responsibilities align with best practices in some respects, changes could be made to improve board composition, funding, and administration. (p. 7)
1. The General Assembly should consider requiring additional public members as part of the Composite Medical Board.
2. The General Assembly should consider directing all fee revenue to purposes related to licensure, discipline, and board administration.
3. GCMB should establish a formal conflict of interest policy.
4. GCMB should improve its annual report by including additional activity data and a description of goals and objectives.
Finding 2: GCMB's licensing requirements and application review process are similar to other states and best practices, with the exception of criminal background checks and post-graduate training requirements. (p. 11)
5. GCMB should monitor the years of GME completed and re-evaluate the requirements and potential risks.
6. GCMB should implement criminal backgrounds checks for general applicants.
Finding 3: Georgia's Medical Practice Act does not require informed sources such as hospitals and peer licensees to report potential violations to GCMB. (p. 13)
7. The General Assembly should consider requiring violation reporting from additional groups such as hospitals, health care organizations, and peer licenses.
8. The General Assembly should consider establishing civil penalties for failure to report.
9. If reporting requirements are expanded, GCMB should clearly indicate in its rules and on its website the types of issues that should and should not be reported.
Finding 4: GCMB could take additional steps to improve its outreach and communication to both the public and complainants. (p. 15)
10. GCMB should consider implementing low-cost public outreach initiatives, such as issuing monthly press releases on disciplinary actions and utilizing social media accounts. GCMB should also consider providing licensees a copy of the flier that is required to be posted in provider offices.
11. GCMB should provide additional information on its complaint reporting page, such as a description of the types of complaints investigated, complainant notification procedures, and a general timeline of the process.
12. GCMB should notify complainants when cases are closed with disciplinary action. In addition, GCMB should better ensure that all required notifications are sent.
13. GCMB should consider strategies for providing complainants more information regarding the investigation status while maintaining an appropriate level of confidentiality.
Finding 5: GCMB could better ensure sufficient complaint investigations through more consistent prioritization, clearly outlined investigative steps, and more in-depth medical reviews. (p. 18)
14. GCMB should establish clear intake policies for assessing complaints and assigning a priority level, whether on the basis of case type, level of threat, or both.
15. GCMB should modify the initial complaint review form and/or the prioritization field in the database to make these consistent and reflective of established policies. Management should continue efforts to ensure the forms and the data fields are completed.
16. GCMB should consider establishing comprehensive checklists for more routine case reviews and investigative plans for more complex investigations.

17. GCMB should establish more specific policies regarding medical director reviews and should consider whether additional resources are necessary to adequately assess the standard of care.
18. GCMB should ensure that board members properly document decisions on the investigative committee review forms.
19. GCMB should consider documenting the reason for closing cases without discipline for internal purposes.
20. GCMB should continue to expand data system reporting capabilities for monitoring purposes.
Finding 6: GCMB should establish timeliness goals for major milestones and should monitor to ensure cases progress in a timely manner. (p. 22)
21. GCMB should formally establish timeframes for overall complaint resolution, as well as major milestones.
22. GCMB should track the extent to which timeliness standards are met and determine where delays may occur.
23. GCMB should implement specific strategies for addressing common delays. For example, to reduce time waiting for physician responses and records, GCMB could implement automated triggers at designated time intervals and send more strongly worded reminders.
Finding 7: GCMB issues fewer public disciplinary actions than other states (p. 25)
N/A
Finding 8: GCMB should implement additional strategies to ensure consistent and appropriate disciplinary decisions. (p. 28)
24. For each complaint investigated, GCMB should determine and document whether there was sufficient evidence that a violation occurred.
25. GCMB should implement a more formal training program for board members.
26. GCMB should establish sanctioning guidelines that outline criteria for determining appropriate disciplinary action. The guidelines should address the use of private actions, including non-disciplinary letters of concern and private reprimands.
27. GCMB should identify areas of greatest risk in the disciplinary process (e.g., certain case types, characteristics, or steps in the process) and evaluate how resources could be used to implement additional reviews and//or monitoring practices.
Finding 9: GCMB's physician profiles do not provide the public with easy access to important information such as disciplinary history or malpractice insurance coverage. (p. 31)
28. GCMB should organize physician profile information into better delineated subsections and consider eliminating some of the optional fields (publications, awards, etc.).
29. GCMB should provide a narrative summary of any violations and disciplinary action. Links to the full board orders should be included in the discipline section.
30. GCMB should enter disciplinary action when it is imposed or when the report of discipline taken by other states is received. Physicians should not have the ability to change this information.
31. GCMB should require physicians to update their profiles during license renewal and provide an entry for every field to eliminate blanks. GCMB should ensure data system controls are used to enforce this requirement.

Appendix B: Objectives, Scope, and Methodology

Objectives

This report examines the Georgia Composite Medical Board (GCMB). Specifically, our audit set out to determine the following:

1. Does Georgia's Medical Practice Act align with best practices for board structure and function as outlined by the Federation of State Medical Boards (FSMB)?
2. Are GCMB license requirements designed to ensure that only qualified candidates are licensed to practice medicine in Georgia?
3. Does GCMB protect the public through an accessible, efficient, and effective complaint process?
4. Does GCMB issue sanctions when necessary?

Scope

This audit generally covered activity related to licensing and investigations decisions that occurred during fiscal year 2020, with consideration of earlier periods when relevant. Information used in this report was obtained by reviewing relevant laws, rules, and regulations, researching best practices, and interviewing GCMB staff and board members. We also reviewed agency reports and data and conducted a file review of licensure applications and investigative files. Lastly, we conducted interviews with officials from six other state medical boards – Maryland, Virginia, North Carolina, Florida, Ohio, and Tennessee. These states were chosen based on general similarity to Georgia (size, geographic location) and/or the use of innovative practices.

Government auditing standards require that we also report the scope of our work on internal control that is significant within the context of the audit objectives. We reviewed internal controls as part of our work related each objective, as described in the methodology section below.

Methodology

To determine the extent to which GCMB aligns with best practices for board structure and function as outlined by Federation of State Medical Boards (FSMB), we compared FSMB best practices to GCMB operations and statutory requirements. We reviewed FSMB's "Guidelines for the Structure and Function of a State Medical and Osteopathic Board" and identified recommendations most relevant to 1) board's overall effectiveness – resources, staffing, membership, and organization; 2) transparency – meeting minutes, annual reporting, and physician profiles; and 3) internal controls - conflict of interest policy.

We compared these best practice recommendations to requirements in Georgia's Medical Practice Act. We also compared the best practices to GCMB operations by interviewing staff and reviewing agency documents including annual reports and financial information. Lastly, we reviewed a non-random sample of 100 physician profiles to determine the completeness of fields related to licensure, education, training, practice information, and experience. The sample included the same

physicians selected in the investigative file review sample described in the next objective.

To determine the extent to which GCMB license requirements were designed to ensure only qualified candidates are licensed, we compared GCMB's licensure requirements and processes to FSMB best practices and other states. We obtained information on licensure requirements in other states from the 2018 FSMB Medical Regulatory Trends survey. In addition, we interviewed six states regarding their licensure processes and requirements. As noted above, these states were chosen based on general similarity to Georgia (size, geographic location) and/or the use of innovative practices. To identify GCMB's process and requirements, we reviewed state laws and regulations, interviewed GCMB staff, and reviewed application materials. As part of this comparison, we evaluated controls, including application verification procedures and levels of review.

To determine the percentage of licensure applications that were approved and denied, we reviewed board meeting minutes from January through June 2020. We also used the meeting minutes to determine the percentage of applications that are board-reviewed due to concerns. To obtain additional information on the board-reviewed applications, we reviewed 86 of the 179 applications that were presented to the board between January 2020 and August 2020. For these 86 applications, we identified the specific reasons prompting board review and determined if the applicants were licensed in other states.

To determine the extent to which GCMB protects the public through an accessible, efficient, and effective complaint process, we compared GCMB's processes to FSMB best practices and other states. We identified GCMB's processes, including controls such as monitoring procedures, through staff interviews and a review of laws, regulations, and policies. To identify FSMB best practices and other states' practices, we reviewed various guidance documents and FSMB's Regulatory Trends report. We also interviewed the six states regarding their complaint reporting and investigative processes and reviewed their websites for information related to public outreach and complaint submission.

To evaluate the execution of GCMB's process, we reviewed a non-random sample of 100 physician cases closed in fiscal year 2020 (of 1,291 total) to assess intake/prioritization, investigative reports and medical director reviews, communication with complainants, documentation, and reasons for delays. The 100 cases included 98 closed or closed with a letter of concern and two cases closed with formal discipline, which is generally reflective of overall case outcomes. The cases were selected based on risk factors, including length of time to close the case, prior complaints against the physician, the type of allegation, and action by other state medical boards. Because the sample was not randomly selected or representative, the results cannot be extrapolated.

To further assess timeliness, we analyzed data on cases closed in fiscal year 2020 to determine the time from complaint receipt to closure. We relied on a data report provided by GCMB to determine when a complaint was received. Based on a comparison of documents obtained as part of the file review above, we determined that the data was reliable for our purposes.

To determine the extent to which GCMB issues sanctions when necessary, we compared Georgia's processes to FSMB best practices and other states. We interviewed the six other states to identify specific controls for ensuring appropriate and consistent disciplinary decision-making and reviewed related documents, such as sanctioning guidelines. To identify GCMB's process we reviewed state laws and regulations, attended investigative committee meetings and interviewed a board member, the board's attorney, and staff regarding disciplinary decision-making.

To determine case outcomes, we analyzed cases closed in fiscal year 2020 to identify cases closed, closed with a letter of concern, and closed with discipline. As part of the file review of closed cases, we reviewed documentation of the board's decisions and any explanations of why cases may be closed without discipline.

For those cases closed with public discipline in fiscal years 2019 and 2020, we reviewed the public board orders to determine the types of allegations and the specific sanctions applied. We then reviewed physician profiles to determine if and what type of information regarding the violations and disciplinary actions was reported.

To compare GCMB's disciplinary rates to other states, we compiled data from the six other states using public board orders and disciplinary reports. The disciplinary actions for each state were categorized by the audit team as major or minor. It should be noted that we broadly included all public, adverse actions in this comparison, even if they may not have technically been considered a disciplinary action by the other state. We also counted the disciplinary actions by physician/violation rather than each sanction applied (e.g., if one complaint investigation resulted in an order with a fine and reprimand, it would be counted once rather than twice). The number of disciplinary actions per 1,000 physicians was then calculated using the Association of American Medical College's 2019 State Physician Workforce Data Report.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix C: Grounds for Board Action and Range of Actions

Grounds for Board Action	
Unprofessional/Harmful Practice	**Criminal Conduct/Violation of Laws**
Failure to meet minimum standards of care	Felony convictions
Sexual Misconduct	Committing crime of moral turpitude
Impairment related to substance abuse or mental/physical conditions	Aiding or abetting a criminal abortion
Mental Incompetence	Violating any laws/regulations related to the practice of medicine
Mistreating/abandoning a patient or their records	Noncompliance with federal laws/standards related to medicine or other health care professions
Other state discipline	
Moral Character	**Other Compliance Issues**
Fraudulent representations and false statements	Failure to respond to board subpoena
Advertised for patients/extravagant claims	Failure to maintain medical records
Acts/omissions indicative of bad moral character	Failure to follow infection control procedures
Cheating on board examinations	Noncompliance with child support orders
Conduct which discredits the profession	Student loan defaults
Knowingly maintaining associations with those in violation of the Act	
Range of Board Actions	
Public Disciplinary Actions	**Other Board Actions**
License Revocation	Private reprimands
License Suspension	Non-disciplinary letters of concern
License Surrender	Requirement for counseling or treatment
License limits or restrictions	Requirement for examinations/evaluations
Probation	Administrative warnings and fines[1]
Medical education requirements	
Reprimands	
Fines and reimbursements	

[1] Authorized under O.C.G.A. §16-13-57 for failure to register with the prescription drug monitoring program

Source: State law (O.C.G.A. §43-34-8)

The Performance Audit Division was established in 1971 to conduct in-depth reviews of state-funded programs. Our reviews determine if programs are meeting goals and objectives; measure program results and effectiveness; identify alternate methods to meet goals; evaluate efficiency of resource allocation; assess compliance with laws and regulations; and provide credible management information to decision makers. For more information, contact us at (404)656-2180 or visit our website at www.audits.ga.gov.