



State of Arizona Office of the Auditor General

PERFORMANCE AUDIT

VETERINARY MEDICAL EXAMINING BOARD

**Report to the Arizona Legislature
By Douglas R. Norton
Auditor General
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Report No. 97-7**



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April 25, 1997

Members of the Arizona Legislature

The Honorable Fife Symington, Governor

Dr. Robert L. Hatch, Board Chairman
Veterinary Medical Examining Board

Transmitted herewith is a report of the Auditor General, A Performance Audit of the Veterinary Medical Examining Board. This report is in response to a May 29, 1995, resolution of the Joint Legislative Audit Committee. The performance audit was conducted as part of the Sunset review set forth in A.R.S. §§41-2951 through 41-2957.

The report addresses the need for the Board to appropriately discipline veterinarians when warranted. Veterinarian consultants retained by the Auditor General found as many as one out of every six complaints dismissed by the Board in fiscal year 1996 should have resulted in some discipline. The report also addressed the need for the Board to improve its complaint investigation process by interviewing all complainants and allowing the Board investigators to thoroughly and independently investigate complaints. We identify several areas to improve the public's access to information, and recommend that the Legislature consider increasing public membership on the Board to 50 percent. Finally, the report addresses the need for the Board to conduct more inspections of veterinary premises.

My staff and I will be pleased to discuss or clarify items in the report.

This report will be released to the public on April 28, 1997.

Sincerely,

Douglas R. Norton
Auditor General

Enclosure

SUMMARY

The Office of the Auditor General has conducted a performance audit and Sunset review of the Veterinary Medical Examining Board, pursuant to a May 29, 1995, resolution of the Joint Legislative Audit Committee. This audit was conducted as part of the Sunset review set forth in Arizona Revised Statutes (A.R.S.) §§41-2951 through 41-2957.

According to A.R.S. Title 32, Chapter 21 (A.R.S. §32-2201 et seq), the Board is responsible for licensing and regulation of veterinarians and veterinary facilities and certification and regulation of veterinary technicians. The Board is comprised of 8 members, including 5 veterinarians and 3 public members, one of whom must represent the livestock industry. As of June 1996, the Board licensed 1,375 veterinarians and certified 222 technicians, and licensed 520 veterinary facilities. In fiscal year 1996, the Board resolved 102 medically related complaints. The Board employs an executive director, one full-time investigator, one part-time investigator as of September 1996, and a secretary, and is mainly funded by license renewal fees.

Board Often Does Not Discipline When Warranted (See pages 5 through 10)

The Veterinary Board does not adequately discipline veterinarians. Without the Board taking appropriate disciplinary action, the public will not be protected. In three of the past four fiscal years, the Board dismissed more than 90 percent of consumer complaints. Veterinary consultants retained by the Auditor General reviewed complaints from fiscal year 1996 and found that as many as one out of every six complaints dismissed should have resulted in some discipline. The consultants also reviewed the following two dismissed complaints from fiscal years 1994 and 1995 and concluded that both veterinarians should have been disciplined.

- The Board dismissed a complaint against a veterinarian who inserted a feeding tube into a cat's lungs instead of its stomach. The cat died when food was injected through the tube.
- The Board dismissed a complaint against a veterinarian who euthanized a dog without the proper consent. In a Board meeting, even though the veterinarian admitted making the error, the Board still dismissed the complaint.

The Board needs to overcome its apparent reluctance to discipline veterinarians and commit to carrying out its enforcement duties. In addition, other changes could also augment enforcement. These include adopting minimum standards of practice, disciplinary guidelines, and a cite-and-fine option in which a veterinarian could accept the Board's decision and pay the required fine without admitting guilt.

Board Does Not Adequately Investigate Most Complaints (See pages 11 through 15)

The Veterinary Board's record of weak disciplinary actions may be partly attributable to its failure to adequately investigate most consumer complaints. In fiscal year 1996, the Board investigated only 22 of the 102 consumer complaints it resolved. When a complaint is received, the Board routinely requests the medical records and a response from the veterinarian involved. However, despite having 1.5 full-time investigators, basic investigative steps such as interviewing the complainant and other involved parties, such as the doctor's staff, are generally not performed. In fact, a complainant was interviewed in only 3 of the 102 cases.

Another problem with the Board's complaint process is that the Board inappropriately limits the extent of the investigation performed on each complaint. Rather than allowing the Board's investigators to fully pursue each complaint and present the findings to the Board for adjudication, the Board hears each complaint in a public meeting and sets limits on what the investigator should do. A review of the 22 complaints in fiscal year 1996 in which the Board directed the investigation found that the Board, on average, gave the investigator 2 directives per complaint. These directives involved limited actions, such as obtaining the names of the veterinarians who worked on a given day, or photographing a veterinary facility's sign.

Further, Board staff need to forward all potential violations to the Board. While investigating one complaint, the Board investigator also uncovered information that the veterinarian in question was euthanizing animals with household bleach and other cleaning chemicals, and disposing of the animals in plastic bags while they were still alive. Although the investigator submitted a report regarding these allegations in December 1995, Board members were not made aware of this situation until it was brought to their attention by auditors in November 1996. According to the Board, this is an active investigation case. However, a review of the investigation file in April 1997 found no evidence of investigative activity since December 1995.

To address complaint investigation problems, the Board needs to develop written policies specifying an appropriate investigation process and provide training for its investigators.

The Veterinary Board Needs to Improve Public Access to Information **(See pages 17 through 21)**

The Board needs to do more to help ensure that the public has access to veterinarian licensing and complaint information. The public needs this information to make informed decisions when choosing medical care for their animals. Although the Board revised its public information policy in June 1996, it needs to ensure that the policy is carried out. Auditors acting as pet owners telephoned the Board on five occasions to test whether Board staff would provide information. In four of the phone calls, Board staff failed to provide complete information about complaints and previous disciplinary actions, including a license revocation.

Other recommendations include retaining complaint files longer than four years to maintain more complete veterinarian histories, and ensuring that a complaint is logged against the appropriate veterinarian. Currently, Board staff log the complaint against the name the complainant writes on the complaint form; however, complainants may use only the clinic's name or specify the wrong veterinarian.

Other Findings **(See pages 23 through 25)**

This report also presents findings recommending that the Board increase inspections of veterinary facilities, and that the Legislature increase public membership on the Board from three to four members. Performing routine inspections would help ensure a minimum standard of care at veterinary facilities. Changing a veterinarian position on the Board to a public member position would result in 50 percent public representation as recommended in the Auditor General's 1995 Special Study of Arizona's Health Regulatory System.

Sunset Factors **(See pages 27 through 31)**

This audit report also contains responses to the 12 Sunset Factor questions in accordance with A.R.S. §41-2954. In response to the question addressing the Board's continuation, this Office recommends that the Legislature consider continuing the Board for a period of five years. This will provide the Board sufficient opportunity to address the recommendations made in this report, and provide sufficient time to assess the impact of the changes made. Because the problems found during this audit relate directly to problems identified previously in the 1994 Sunset review of the Board, a timely follow-up review is needed to determine if the Board has rectified the deficiencies reported in this audit.

If the Board has not rectified these problems after the five-year time period, the Legislature should consider other alternatives to ensure that the State's regulatory responsibilities are carried out and that the public is protected. The Legislature may wish to fundamentally change the nature of the Board by making all, or a majority of, Board members "public members." Another option would be to eliminate Board oversight and place this regulatory function in another agency.

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INTRODUCTION AND BACKGROUND

The Office of the Auditor General has conducted a performance audit and Sunset review of the Veterinary Medical Examining Board, pursuant to a May 29, 1995, resolution of the Joint Legislative Audit Committee. This audit was conducted as part of the Sunset review set forth in Arizona Revised Statutes (A.R.S.) §§41-2951 through 41-2957.

Board Responsibilities

The purpose of the Arizona State Veterinary Medical Examining Board is to:

“Provide for the licensure, certification and regulation of veterinarians and veterinary technicians to protect and promote the public health, safety and welfare and to enhance the veterinary medical profession.”¹

The Board fulfills these responsibilities by examining and licensing veterinarians, certifying veterinary technicians, licensing veterinary premises, and investigating and adjudicating complaints filed against licensees. As of June 30, 1996, the Board reported 1,375 licensed veterinarians, 222 certified technicians, and 520 licensed premises. In fiscal year 1996, the Board resolved 102 of the 112 complaints it received relating to medical procedures performed by veterinarians. It dismissed 96 of them and found violations in the remaining 6 complaints.

Staffing and Budget

The Board is comprised of 8 members 5 veterinarians and 3 public members appointed by the Governor for 5-year terms. One public member must represent the livestock industry. For fiscal year 1997, the Board was authorized 3.5 full-time equivalent (FTE) employees an executive director who oversees agency operations, 1.5 investigators, and a secretary.

The Board receives its legislative appropriation from the Board of Veterinary Medical Examiner’s Fund. This Fund contains revenues derived from the collection of license application and renewal fees, examination fees, late renewal fees assessed against licensees, and other fees. Ninety percent of the Board’s revenues are deposited into this Fund and the remaining 10 percent into the General Fund. All civil penalties assessed

¹ Laws 1995, Chapter 156, §4.

against licensees are deposited in the General Fund. The Board's revenues and expenditures are shown in Table 1 (see page 2).

Table 1

**Veterinary Medical Examining Board
Statement of Revenues, Expenditures,
and Changes in Fund Balances
Years Ended or Ending June 30, 1994 through 1997
(Unaudited)**

	1994	1995	1996	1997
	(Actual)	(Actual)	(Actual)	(Estimated)
Revenues ¹ (90% of gross revenues) ²	<u>\$ 52,848</u>	<u>\$308,144</u>	<u>\$ 73,066</u>	<u>\$353,200</u>
Expenditures				
Personal services	93,409	101,451	104,137	125,300
Employee related	17,992	22,296	24,366	26,200
Professional and outside services	20,194	36,853	38,645	39,600
Travel, in-state	8,316	6,301	4,773	11,100
Travel, out-of-state	941	2,544	2,491	2,600
Equipment	3,306	3,686	1,046	
Other operating	<u>10,091</u>	<u>14,759</u>	<u>11,343</u>	<u>12,300</u>
Total Expenditures	<u>154,249</u>	<u>187,890</u>	<u>186,801</u>	<u>217,100</u>
Excess of revenues over (under) expenditures	(101,401)	120,254	(113,735)	136,100
Fund balance, beginning of year	<u>181,959</u>	<u>80,558</u>	<u>200,812</u>	<u>87,077</u>
Fund balance, end of year	<u>\$ 80,558</u>	<u>\$200,812</u>	<u>\$ 87,077</u>	<u>\$223,177</u>

¹ The disparity of annual revenue amounts is due to biennial license renewal.

² As a 90/10 agency, the Veterinary Medical Examining Board remits 10 percent of its gross revenues to the General Fund.

Source: The Uniform Statewide Accounting System *Revenues and Expenditures by Fund, Program, Organization, and Object* reports for the years ended June 30, 1994 through 1996 and the *State of Arizona Appropriations Report* for the year ending June 30, 1997.

Several 1994 Sunset Review Concerns Continue

Although the Board has addressed some problems identified during the 1994 legislative Sunset review of the Veterinary Board, serious concerns with complaint investigations and Board discipline of veterinarians have not been addressed.

Legislative staff under the Committee of Reference's guidance conducted a Sunset review in 1994. That review disclosed the public's concerns that the Board did not investigate complaints, dismissed too many complaints, made it difficult to get information about veterinarians, and other concerns. Because of these concerns, the Legislature continued the Agency for only two years and directed the Auditor General to conduct another Sunset review within that time frame.

The Board has addressed some problems since 1994. The Board has improved some aspects of public access to information, including revising its public information policy in June 1996. The Board has also hired a part-time investigator to assist in complaint investigations and other duties. Further, an Auditor General review of statistics contained in the Board's annual reports found that discrepancies were related to misunderstandings about correct reporting procedures. Finally, the Legislature increased public membership on the Board from two to three public members.

However, this current performance audit and Sunset review found that several problems raised in the previous review still continue. Audit findings in this report address the Board's reluctance to discipline veterinarians, incomplete investigation of complaints, continued problems with disclosing public information, the need for more inspections of veterinary facilities, and the need for an additional public member on the Board.

Audit Scope and Methodology

This performance audit report presents findings and recommendations in five areas:

- The need for the Board to take disciplinary action when warranted;
- The need for the Board to properly and adequately investigate complaints;
- The need for the Board to improve disclosure of public information about veterinarians;
- The need for the Board to conduct more inspections of veterinary premises; and
- The need for an additional public member on the Board.

Information was obtained and analyzed from a variety of sources, including interviews of Board members, the Executive Director, and staff. To evaluate the Board's compliance with open meeting requirements and the complaint-handling process, 7 board meetings were attended, and minutes and associated documentation from meetings since 1991 were reviewed. Four hundred thirty complaints the Board resolved from fiscal year 1993 through fiscal year 1996 were reviewed to determine the types and disposition of these complaints. A more detailed review of 81 of these complaints was conducted with the help of two veterinarian consultants who were employed because of the medical complexity of some complaints.¹ Information was also gathered from 8 states identified by several national veterinary experts as having innovative regulatory programs.² Information was gathered regarding complaint and investigatory processes, and public information policies. However, since each state defines disciplinary action differently, a meaningful comparison of disciplinary rates among states was not possible.

This audit was conducted in accordance with government auditing standards.

The Auditor General and staff express appreciation to the Board Chairman, Board members, Executive Director, and staff of the Veterinary Medical Examining Board for their cooperation and assistance throughout the audit.

¹ Both consultants are veterinarians and have served on their states' Veterinary Boards. Dr. James Dalley has taught veterinary medicine at Michigan State University for the past 37 years and served 2 terms on the Michigan Board of Veterinary Medicine. He is currently national president of the American Association of Veterinary State Boards. Dr. Arthur Hazarabedian has practiced veterinary medicine for 35 years and served 2 terms on the California Board of Examiners in Veterinary Medicine. He was president of the American Association of Veterinary State Boards for 2 years and served as the chairperson of the California Veterinary Board's Enforcement Committee for 8 years.

² The states contacted were Alabama, California, Georgia, Massachusetts, Michigan, Montana, Texas, and Washington.

FINDING I

BOARD OFTEN DOES NOT DISCIPLINE WHEN WARRANTED

The Veterinary Board dismisses most complaints, even though as many as one out of every six complaints appears to warrant disciplinary action. The Veterinary Board appears reluctant to discipline veterinarians for various reasons; however, it must overcome this reluctance. The Board could also augment discipline by establishing additional guidelines and disciplinary options.

A common concern voiced about industry-dominated regulatory boards is that protecting the profession may play a bigger role in decisions than protecting the public. For example, in a 1995 report on regulation of the health care professions across the nation, the Pew Health Professions Commission reported that the autonomy and independence associated with industry regulation of a profession prompts the public's concern that professional self-interest takes priority over protection of the public. This perception has been evident in past reviews of the Veterinary Board. At the Sunset hearing in 1994, many consumers voiced concerns about the Board. Several said they believe the Veterinary Board dismisses complaints that should not be dismissed, while others voiced their belief that the Board protects incompetent veterinarians.

Board Does Not Take Disciplinary Action As Often As Is Warranted

The Board does not take disciplinary action as frequently as it should. The Board dismisses most complaints with no disciplinary action. However, a review of complaints adjudicated in fiscal year 1996 revealed that approximately 17 percent of the complaints were dismissed inappropriately. Further, observations of Board meetings showed the Board dismisses some complaints even after discussion that a violation has occurred.

Few complaints result in disciplinary action The Board seldom takes disciplinary action against veterinarians. The Board took disciplinary action in only 6 of 102 complaints filed in fiscal year 1996, dismissing the remaining 96. This pattern is typical, in that the Board has dismissed more than 90 percent of the complaints it has adjudicated in three of the last four fiscal years. The one year that disciplinary actions significantly increased (fiscal year

1995) was the same year that the Legislature conducted a Sunset hearing of the Veterinary Board (see Table 2).

Table 2

**Veterinary Medical Examining Board
Disposition of Medical Complaints Resolved
Years Ended June 30, 1993 through 1996**

Year	Number of Complaints Resolved	Percentage Dismissed	Percentage Disciplined
1993	86	93%	7%
1994	81	93%	7%
1995	69	80%	20%
1996	102	94%	6%

Source: Office of the Auditor General review of complaint files for fiscal years 1993 through 1996.

Additional disciplinary action warranted While there may be legitimate reasons to dismiss complaints, a review of complaints resolved in fiscal years 1993-1996 revealed that some were dismissed inappropriately. At the request of the Office of the Auditor General, 2 veterinary consultants reviewed 79 complaints resolved in fiscal year 1996 to determine if the Board took appropriate disciplinary action against veterinarians.¹ The consultants concluded that the Board did not take sufficient action in approximately 17 percent of the cases they reviewed. One consultant reviewed 34 complaints and believed that the Board inappropriately dismissed 5 of them; the other consultant reviewed 45 additional complaints and believed that the Board inappropriately dismissed 9. Following is an example of a complaint the Board dismissed that the consultant concluded would have warranted disciplinary action.

¹ The veterinary consultants randomly selected complaints from the 102 complaints resolved in fiscal year 1996, and reviewed as many as possible in the time allotted.

- A puppy was apparently attacked by dogs and taken to a veterinarian for examination, during which the veterinarian noted various injuries, including breathing difficulties. Without performing any diagnostic tests or treating the breathing difficulty, the veterinarian sent the puppy home. The puppy died later that day. An autopsy revealed that the puppy died from severe internal injuries that diagnostic tests could have detected. The Board dismissed the complaint. The consultant who reviewed this case said that the veterinarian's failure to use essential diagnostic tests was negligent and should have resulted in the suspension or revocation of this veterinarian's license.

In addition, the consultants reviewed two dismissed complaints from fiscal years 1994 and 1995 and concluded that both would have warranted disciplinary action.

- A veterinarian who was treating a cat for lack of balance and inability to eat attempted to insert a tube through the cat's mouth into its stomach for feeding purposes. Unfortunately, the veterinarian inserted the tube into the cat's lungs, and the animal died when the veterinarian subsequently injected food into the tube. The Board dismissed the complaint. The consultant who reviewed this case said that although the improper placement of the feeding tube appeared to be unintentional, it was a violation and would justify a finding of negligence or incompetence.
- The Board received anonymous information that a veterinarian had allowed unlicensed employees to unlawfully practice veterinary medicine and had provided the employees with unsupervised access to drugs for euthanizing animals. The Board investigated the allegations and confirmed that the veterinarian's employees had access to euthanasia drugs, and had euthanized a dog while the veterinarian was out of state. The Board dismissed the complaint. The consultant who reviewed this complaint said the evidence appeared serious enough to warrant revoking the veterinarian's license.

Board members dismiss complaints after stating that a violation occurred In five cases, auditors observed Board members state their belief that a violation had been committed and then dismiss the complaint with no violation. In the following case, the Board dismissed the complaint even though the veterinarian admitted negligence in euthanizing a dog without the owner's consent.

- Two unrelated families took their dogs, one two years old and the other four months old, into an emergency animal hospital at approximately the same time. Hospital staff took both dogs to an examination area while the dogs' owners remained in the waiting room. After examining the two-year-old dog, the veterinarian spoke with the people she believed were that dog's owners, although they were actually the owners of the four-month-old dog. These people, thinking the veterinarian was talking about their four-month-old dog, requested that the dog be euthanized due to the cost of treatment.

The veterinarian, without asking them to confirm the description or identity of their dog, euthanized the two-year-old dog instead. The veterinarian admitted to the Board that she euthanized the dog without speaking to the owners or obtaining their authorization. During the original discussion of the complaint, Board members stated that the veterinarian's failure to correctly identify the owner was "very egregious," "negligent," and "a violation." Following an informal interview at which the veterinarian expressed remorse for her actions, Board members commended the veterinarian for her honesty and, with one member opposed, dismissed the complaint. The consultant who reviewed this case said that euthanizing the dog without the owner's consent was negligent and the veterinarian should have been disciplined.

Reluctance To Discipline Must Be Overcome

The Veterinary Board must overcome its reluctance to discipline veterinarians. Board members appear hesitant to impose discipline for either serious violations or minor offenses. Although the Board's statutory duty is in part to "protect and promote the public health, safety and welfare," two of the eight Board members indicated that they were hesitant to revoke or suspend the license of small community veterinarians because consumers would be left without a nearby veterinarian. In addition, these same two Board members indicated they are hesitant to strongly discipline veterinarians because of the impact the discipline may have on the veterinarian's ability to practice and make a living.

Additional Disciplinary Guidelines and Options Are Also Needed

The Board could also improve discipline by establishing additional guidelines and disciplinary options. To ensure that veterinarians are disciplined appropriately, the Board needs to establish minimum standards of practice. Additionally, the Board should establish disciplinary guidelines that include consideration of past violations. Finally, the Board should establish a cite-and-fine provision to address minor offenses, and should issue letters of concern more frequently.

Minimum practice standards are needed To ensure that veterinarians are disciplined appropriately, the Board needs to establish minimum standards of practice. Arizona does not have a set of minimum practice standards, a deficiency that appears to hinder the Board's ability to discipline veterinarians. For example:

- At one Board meeting, members discussed a complaint that involved the death of a young dog while under anesthesia for teeth cleaning. A Board member noted that the medical records contained no indication that the dog's vital signs, including heart rate

and breathing, had been monitored. He stated that the Board should consider changing its rules to establish minimum standards of practice, since currently there is no requirement that veterinarians monitor anesthetized patients. The Board dismissed the complaint with no violation.

California has minimum practice standards addressed in its rules and regulations. California's standards include that 1) veterinarians must examine all animals within 12 hours prior to surgery, and must provide continuous monitoring for all animals that are under general anesthesia; 2) surgical packs must include drapes, gloves, sponges, and proper instrumentation; and 3) a separate sterile surgical pack must be used for each animal, and sterile gloves must be worn during surgical procedures.

The Board needs to establish disciplinary guidelines and consider past violations The Board currently does not have or use guidelines to determine what type of discipline to impose for various violations. Washington and California use disciplinary guidelines that consider the violation severity and the veterinarian's disciplinary history. In addition, California's disciplinary guidelines establish minimum and maximum penalties for different types of violations.

In addition, the Board needs to routinely consider prior violations when imposing discipline after a violation has been found. The Board has occasionally considered past violations when making disciplinary decisions in some serious cases. However, the Board has not routinely consider past violations for all cases, despite advice to do so from its Attorney General representative. Veterinarians who continue to commit violations should receive progressively stronger disciplinary measures until problems are either resolved or the veterinarian's license is suspended or revoked to protect the public. Our consultants also stressed the importance of the Board taking past violations into account, including disciplinary actions that may have occurred in other states, when making disciplinary decisions.

Additional options needed for minor offenses The Board needs a cite-and-fine disciplinary option and needs to more frequently use its "letter of concern" option when addressing less-serious situations. To provide meaningful discipline for minor violations, both consultants recommended that the Board increase its use of civil penalties by instituting a cite-and-fine provision. A veterinarian who is cited for a violation under such a provision can accept the Board's decision and pay the required fine without admitting guilt. However, the citation documents the violation and can be considered in the future if further disciplinary action becomes necessary. One consultant said the cite-and-fine process is "speedy, admits no guilt, but straightens out many minor violators before the violator becomes more of a problem." To do this, the Board should promulgate rules to establish a cite-and-fine disciplinary option.

Both consultants also recommended that the Board make greater use of letters of concern as another option to address specific problems and prevent them from worsening.

Although letters of concern are not disciplinary actions, they do allow the Board to document its concerns about the activities that led to the complaint. A letter of concern further notifies the veterinarian that while there is not sufficient evidence to support disciplinary action, continuing the activities that led to the complaint being submitted may result in action against the veterinarian's license.

Recommendations

1. The Veterinary Board should take disciplinary action each time it is warranted.
2. The Veterinary Board should promulgate administrative rules to implement a cite-and-fine program to sanction veterinarians who commit minor violations.
3. The Veterinary Board should establish minimum standards of practice for veterinarians to follow.
4. The Veterinary Board should establish disciplinary guidelines that include consideration of past violations, severity of violations, mitigating and aggravating factors, and minimum and maximum penalties for different violations to ensure appropriate discipline for each violation.
5. The Veterinary Board should make greater use of letters of concern to address specific problems and prevent them from worsening.

FINDING II

BOARD DOES NOT ADEQUATELY INVESTIGATE MOST COMPLAINTS

The Veterinary Board's record of weak disciplinary actions may be partly attributable to its failure to adequately investigate most consumer complaints. Although the Board employs one full-time and one part-time investigator, basic investigative steps are not performed. Further, the Board is unnecessarily directing and participating in investigations. This puts the Board in the position of acting both as investigator and adjudicator—a confusion of roles that the Attorney General's *Arizona Agency Handbook* recommends against. The Board needs to develop policies to address these concerns.

Problems with Investigations

The audit identified three concerns with complaint investigations: complaints are not adequately investigated; additional potential violations are not followed up; and other violations identified are not always provided to the Board.

Complaints not adequately investigated Overall, the Board investigated few complaints. In fiscal year 1996, only 22 of the 102 complaints closed were investigated. In addition, the investigator rarely interviewed complainants and other involved parties as part of the investigation. The Board directed the investigator to interview the complainant in only 3 of the 102 complaints.¹ Interviewing the complainant is a fundamental step that should occur early in the investigation.

In addition, the Board has inappropriately restricted the thoroughness of complaint investigations. Rather than allow the Board investigators to fully investigate complaints, the Board screens all complaints and provides “directives” or instructions to investigators in the form of specific questions to which the investigators seek answers. Of the 22 complaints on which investigations were ordered in fiscal year 1996, the Board provided an average of 2 directives per complaint. Examples of these directives include obtaining

¹ The Board also interviewed 11 complainants. However, as discussed on page 14, the Attorney General recommends that Boards be removed from the investigative process due to concerns that it may impact the impartiality of Boards when adjudicating complaints.

records and narrative from the veterinarian, obtaining the names of the veterinarians who worked on certain days, and photographing the veterinary facility's sign. In contrast, an investigator working without constraints could perform other investigatory activities, such as interviewing witnesses or reviewing previous complaints against the veterinarian in question.

Further, one of the veterinary consultants retained for the audit to review fiscal year 1996 complaints noted the following case example as an instance in which the investigation appeared deficient.

- The Board dismissed, without ever interviewing the veterinarian involved, a complaint regarding failure to correctly diagnose a dog's condition. The veterinarian examined the dog and prescribed antibiotics based on the diagnosis of a respiratory infection. The dog's condition subsequently worsened and the owner had the animal examined by another veterinarian, who diagnosed it with heartworm infestation. The Veterinary Board found that the first veterinarian's failure to correctly diagnosis the dog was not a violation and dismissed the case; however, the medical records indicated that this veterinarian had not performed heartworm testing. The consultant concluded that the first veterinarian should have been interviewed to determine why he had failed to recognize the symptoms of heartworm disease in his diagnosis.

Investigator did not follow up on potential violations Auditors accompanying the investigator on four clinic inspections identified potential violations that merited further review at two of the clinics. However, the investigator did not recognize the potential violation in either case. These instances suggest that further investigator training is needed.

- In a July 1996 inspection an investigator noted six violations regarding maintaining and dispensing controlled substances. The investigator also saw that the veterinarian had written numerous pages of prescriptions for Percodan, a narcotic. Upon questioning by an auditor, a Board member stated that the number of prescriptions written for that particular narcotic was highly unusual and should warrant further investigation. Although Board members stated that an investigation later found no violation, the investigator did not inform the Board about this potential violation until February 1997.
- During another July 1996 inspection, an auditor noticed that a cat in a cage that was marked as having a contagious, incurable disease was touching a noninfected cat in an adjacent cage. However, the investigator was unaware that this disease was contagious, and therefore this cat should not be housed with other animals.

Training could help investigators become more familiar with all aspects of the Board's statutes, and obtain knowledge of veterinary medical practice and knowledge of appropriate investigative techniques. To date, the Board's investigators have not received any investigative training. One option for investigator training is the International Council on Licensure, Enforcement, and Regulation (CLEAR), which provides investigators/inspectors training specifically for licensing and regulatory boards. This training is used by other Arizona health regulatory agencies and other states' veterinary boards. CLEAR's National Certified Investigator/Inspector Training curriculum offers training in interviewing techniques, evidence development, administrative law, and report writing.

In addition, in one instance Board staff did not forward a potential violation to the Board for their consideration. Most investigations involve the investigator obtaining answers to the Board's specific investigation questions. However, in some cases the investigator may discover new information that could warrant additional sanctions against the veterinarian in question, as illustrated by the following case example.

- In June 1995, the Board received a complaint alleging that a veterinarian was allowing nonveterinary employees to practice veterinary medicine using her name. While investigating these allegations, the investigator also discovered additional allegations from five former employees and a veterinarian. According to the former employees and the veterinarian, the veterinarian in question euthanized animals with bleach and floor cleaning solutions and placed animals in plastic bags while they were still alive, all of which contradicts proper veterinary practice. In December 1995, the investigator wrote a report concerning the additional allegations. However, the Board was apparently unaware of these additional circumstances until notified by auditors in November 1996. The Board states that this situation is now an ongoing investigation. However, a review of the investigation file found no evidence of investigative activity since December 1995.

Board's Extensive Involvement in Directing Investigations Impairs Its Role As Complaint Adjudicator

The Board needs to extricate itself from complaint investigations. It currently provides very specific direction as to which complaints are to be investigated and how the investigations are to be conducted, and through informal interviews, it also becomes involved in the evidence-gathering process. Such a role can raise questions about the Board's ability to act as an impartial adjudicator.

Board is heavily involved in deciding which complaints to investigate and what questions to ask The Board is extensively involved in screening complaints for further investigation. When a complaint is received, it is initially assigned to a Board member, who

reviews the written complaint and the medical records that are requested from the veterinarian against whom the complaint was filed. The Board member then presents his or her recommendation to the Board, which has also received copies of the written complaint and medical records. The Board dismisses the complaint, or provides specific direction as to what further investigation staff should conduct, or it may also schedule an informal interview without further investigation. Most complaints are dismissed without further investigation.

Further, the Board at times becomes involved in the evidence-gathering process itself, through informal interviews. These interviews are held with the veterinarian against whom the complaint was filed and may also involve the complainant. Board members use the interview to gather information and evidence, and as part of the interview they then determine whether, on the basis of the information they have gathered, a violation occurred. The Board, however, conducts informal interviews prior to obtaining a thorough investigation, and instead uses the informal interview for both investigation and adjudication purposes. This mixture of investigation and adjudication inhibits the Board's ability to objectively adjudicate complaints as discussed below. To improve the process, the Board should allow its investigators to complete the investigation before proceeding with an informal interview.

Extensive involvement blurs investigative and adjudicative functions Many other regulatory boards do not involve the entire board in the investigative process. Instead, they rely on the investigator and a board member to determine the nature and extent of complaint investigations. This approach is consistent with advice provided to state agencies by the Attorney General in the Attorney General's *Arizona Agency Handbook*:

"Do not permit the hearing officer or decision-maker [the Board] to participate directly in the investigation of a charge [complaint]. Normally, the investigation can be accomplished by the agency's staff. Once the investigation is completed, the decision-maker may decide, or participate in the decision, whether the results of the investigation warrant a formal hearing."
[Parenthetical comments added]

Separating the investigation and adjudication processes helps ensure that adjudicators have a clear and objective mind when considering the facts of a case.

Board Needs To Develop Written Investigation Policies

The Board needs to develop written policies specifying an appropriate investigation process. At present, the Board's policies do not address the investigation process. Incorporating the complaint investigation process into the Board's written policies could

help ensure that criteria exist for proper investigation and that consumers' concerns are addressed.

A revised investigative process addressing the concerns raised in this finding should work as follows. When complaints are received, the Executive Director should assign complaints to the investigator and an individual Board member who can provide medically related guidance. Working together, these two should determine the investigatory steps needed, eliminating the need for the Board to gather evidence through informal interviews. The investigator should also be free to pursue any other allegations that surface as a result of investigating a complaint. When the investigation is completed, an investigation report containing a summary of the potential violations should be provided to the Board for adjudication. These procedures reflect common investigatory practices at other regulatory agencies.

Recommendations

1. The Veterinary Board should develop and establish in its policies a complaint investigation process that:
 - a. Allows the Board investigator to perform comprehensive complaint investigations and pursue all allegations uncovered during the investigation;
 - b. Removes the Board from the complaint investigation process;
 - c. Requires that all complaint-related information discovered during an investigation is presented to the Board;
 - d. Requires that each complaint be investigated prior to resolution, including interviewing the complainant in every case;
 - e. Requires an investigation report containing potential violations be prepared and provided to the Board; and
 - f. Allows the Board to conduct informal interviews only after it has received the investigative report.
2. The Veterinary Board should send its investigators to investigative training, such as the course offered by the International Council on Licensure, Enforcement, and Regulation.

FINDING III

THE VETERINARY BOARD NEEDS TO IMPROVE PUBLIC ACCESS TO INFORMATION

The Veterinary Board can take a number of steps to improve public access to information. Although the Board recently revised its public information policy to make information about complaint histories more readily available, the information Board personnel provided during four of five test phone calls was incorrect or incomplete. Additionally, the Board does not ensure that complaints are logged against the correct veterinarian, and it retains most complaint files for only four years. In addition to resolving these problems, the Board can further improve public information by distributing a list of disciplinary actions taken against veterinarians.

The Veterinary Board Needs To Ensure Adherence to Its Public Information Policy

Until recently, Board policies created considerable obstacles for consumers requesting information about veterinarians. The Board has revised the policy in ways that should make such information more obtainable; however, initial attempts to obtain information resulted in Board staff giving incorrect or incomplete responses.

The Veterinary Board recently improved its public information policy In June 1996, the Board developed a new policy addressing concerns raised in the Auditor General's 1995 report, *A Special Study of the Health Regulatory System* (Report 95-13). That report found that the State's 23 health regulatory boards, including the Veterinary Board, limited the public's ability to obtain information about licensees' disciplinary history. The report also found that regulatory boards created barriers to obtaining the information that was available, and that the Veterinary Board was among the 5 most restrictive of the 23 Boards studied. At the time of the Special Study, the Veterinary Board's public information policy created obstacles for consumers requesting information, such as requiring consumers to submit a notarized information request form before providing any complaint information, which it retained in the veterinarian's licensing file. Additionally, the Board required consumers to schedule an appointment to review files. It also provided only the number and general nature of disciplinary actions or letters of concern to callers requesting information, and did not provide any information regarding dismissed or pending complaints.

In response to the Health Regulatory System report, the Board adopted a public information policy to provide consumers, either in person or over the phone, with the following information:

Status of the veterinarian's license;

Disciplinary action taken by the Board against the veterinarian;

Number of complaints filed against the veterinarian;

Nature of the complaint allegations; and

Disposition of each complaint.

Additionally, the Board's policy provides that staff will mail information to consumers, or allow them to personally review complaint files, if consumers request further information. The Board also developed a public information brochure to inform the public of the Board's function and how to file a complaint. The Board supplies the brochures to veterinarians for distribution at their clinics. In addition, the Board mails brochures to consumers who request complaint forms, and also has the brochure available at the Board office.

Veterinary Board staff does not adequately follow Board policy Although the Veterinary Board adopted an improved public information policy, Board staff does not adequately follow the policy. Auditor General staff posing as members of the public made three phone calls to the Board office requesting information about various veterinarians, and Board staff provided incorrect information in two of the phone calls and incomplete information in the third.

- In 1 phone call, a Board staff member was asked for information regarding a veterinarian who had 24 complaints, had been disciplined 3 times, and recently had his license revoked. The staff member, however, responded that the Board did not have a current listing for the veterinarian, and did not inform the caller that the Board had revoked the veterinarian's license.
- Another call was placed requesting information about a veterinarian with three complaints and one disciplinary action. Board staff informed the caller that the veterinarian's license was active and in good standing. The staff member further informed the caller that the veterinarian had not received any complaints, and had never been disciplined by the Board.

- During a third phone call, Board staff correctly informed the caller about 11 complaints filed against a veterinarian, as well as a letter of concern the Board issued. However, the staff member provided information for the past 4 years only, and did not inform the caller about a complaint that was filed prior to that time.

After being informed of the test results, the Board's Chair and Executive Director requested that they be allowed three weeks to train staff, and that auditors retest staff at the end of that time. When retested, Board staff once again failed to provide complete and accurate information in one of two calls. In the first call, staff correctly informed the caller about the complaints and disciplinary actions against the veterinarian; however, in the second phone call, the staff member refused to answer the caller's question regarding what type of information the Board maintained on veterinarians. The second caller was informed only that she would have to leave a message for the investigator, who was unavailable at that time.

The Veterinary Board Should Improve Complaint File Processing and Retention

The Veterinary Board should ensure that complaints are logged against the correct veterinarian, and should increase the amount of time it retains complaint files.

The Board fails to ensure that complaints are logged against the correct veterinarian The Board's Executive Director stated that it is the Board's unwritten rule to log a complaint under the name the consumer provided. If a consumer names only the veterinary clinic on the complaint form, Board staff log the complaint under the name of the responsible veterinarian for that clinic.¹ If a consumer names a specific veterinarian on the complaint form, Board staff log the complaint under that veterinarian's name. In either case, the veterinarian under whose name the complaint is logged might not be accountable for the treatment or policy that prompted the complaint. This policy of not ensuring that complaints are logged under the correct veterinarian's name prevents consumers from obtaining complete information on each veterinarian and further prevents them from making fully informed decisions regarding their animals' care. For example:

- A consumer filed a complaint due to a payment policy established by Dr. A, a clinic's responsible veterinarian. On the complaint form, however, the consumer named Dr. B, a veterinarian employed by Dr. A's clinic. Staff logged the complaint under Dr. B's name, not Dr. A's name, even though the complaint involved a policy issue for which

¹ A "responsible veterinarian" is the veterinarian responsible to the Board for the policies of the veterinary facility. (A.R.S. §32-2201[11]).

Dr. A, as responsible veterinarian, was accountable. During the audit, a local news reporter visited the Board office and requested to review this complaint against Dr. A. Staff looked up Dr. A's complaint records, could not locate this complaint because it was logged under Dr. B's name, and informed the news reporter that this complaint involving a payment policy had not been filed. Staff later located the complaint by looking under the complainant's name, and provided the complaint to the reporter.

The Veterinary Board should retain complaint files longer The Board currently retains most complaint files for only four years, which is not a sufficient period to fully document veterinarians' complaint histories. The Board apparently recognized this problem and, at the November 1996 Board meeting, modified its record retention policy to retain certain complaints for a ten-year period. Complaints that resulted in probation, suspension, or revocation will be retained for a ten-year period, whereas complaints that were dismissed with no violation, or that resulted in a consent agreement or civil penalty, will be retained for four years. While the modified policy's increased retention time is an improvement, other Health Regulatory Boards in Arizona, and veterinary boards in other states, retain complaint files for a longer period. For example, the Arizona Board of Nursing permanently retains all complaint files that result in discipline. Additionally, the Washington Veterinary Board retains complaint files that did not result in discipline for 25 years, and complaint files that did result in discipline for 75 years. To protect consumers, the Board should retain complaint files that result in discipline for a length of time that is sufficient to encompass each veterinarian's career.

The Veterinary Board Should Consider Implementing Additional Procedures To Improve Access to Public Information

The Veterinary Board can further improve access to public information by implementing additional procedures. The Board should distribute a list of disciplinary actions taken against veterinarians. The Board may also want to consider requiring veterinarians to display disciplinary orders at their clinic.

The Veterinary Board should publish disciplinary actions To further improve public information, the Board should publish and distribute at least annually a list of disciplinary actions that includes the disciplined veterinarian's name, the violation, and the discipline imposed. The Board should mail the disciplinary listing to licensed veterinarians, interested consumers, and the media. The Board could additionally distribute the listing at Board meetings and through the Board office. A veterinary board newsletter, as used by some other states, is one option for dispersing disciplinary information.

Displaying disciplinary orders The Board may also wish to require veterinarians to display some disciplinary orders in their clinics. California's Veterinary Board frequently

requires veterinarians to display disciplinary orders. For example, the California Board can require a veterinarian whose license has been suspended or revoked to conspicuously display the disciplinary order in his or her place of business. In Arizona, the Board of Dental Examiners requires dentists whose licenses are revoked to post the orders. Displaying a disciplinary order that restricts such things as the veterinarian's ability to handle controlled substances, perform surgery, or practice without direct supervision could also help to inform consumers of potential problems.

Recommendations

1. The Board should ensure that Board staff have knowledge of and consistently follow its public information policy.
2. The Board should adopt a policy to ensure that complaints are logged under the correct veterinarian's name.
3. The Board should retain complaint files that result in discipline for a length of time sufficient to encompass the veterinarian's career.
4. The Board should produce and distribute at least annually a list of disciplinary actions that contains the disciplined veterinarian's name, the violation, and the discipline imposed.

FINDING IV

VETERINARY FACILITY INSPECTIONS NEEDED

The Board needs to conduct additional inspections of veterinary facilities. These additional inspections can help ensure that veterinary facilities meet standards for sanitation, controlled substances, medical records, and other areas. The Board has sufficient resources to conduct additional facility inspections.

Veterinary Facilities Not Randomly Inspected

Currently, the Veterinary Board does not conduct routine inspections of the 520 veterinary facilities it regulates. The Board has authority to “inspect any site at which a veterinarian offers veterinary services to the public.” Despite this authority, the Board’s staff conducts inspections only when facilities are first established, when there is a major change in the scope of veterinary services offered, or when there is a change in the facility’s ownership or location. In addition, the Board may order a facility inspection in response to a complaint. As a result, according to the Board’s investigator, approximately 50 veterinarian facilities have never been inspected,¹ and about 250 facilities have not been inspected in the last 5 years.

Inspections Needed

While routine annual inspections of all facilities are not possible with the current staffing level, a program of inspecting facilities, chosen at random, would help ensure a minimum standard of care at veterinary facilities. An inspection of a veterinary facility covers many areas: sanitation, medical records, adequate equipment and supplies, proper storage of medications, and proper and sanitary animal housing facilities. In their review of complaint files, our consultants noted that medical records are frequently inadequate. One consultant reported that the records were barely legible, uniformly brief, and lacked evidence of specific diagnostic procedures the animal’s owner had consented to.

¹ In 1980, the Board began requiring inspections of veterinary facilities prior to issuing a premise license. Facilities licensed prior to 1980 were not required to be inspected to maintain a facilities license.

Random inspections can be beneficial. California's random inspection program of veterinary facilities in fiscal year 1996 completed 384 inspections and issued 434 notices of violations to offenders. In California, veterinarians should demonstrate, at a minimum, sufficient knowledge of sanitation, recordkeeping, minimum standards of practice, and the statutes regulating veterinary medicine. Moreover, one of the consultants believes that "Inspections help to create a climate of regulation which is beneficial to licensees and public alike."

Sufficient Resources Available

The Board has sufficient resources to conduct random inspections of veterinary facilities. In fiscal year 1996, the Board conducted 65 statutorily mandated inspections. Based on our observations, an investigator can complete most inspections in approximately 2 hours, including travel time. Currently, the Board has one full-time and one part-time investigator, who was added in fiscal year 1997. This additional investigator would allow the Board to complete approximately 50 additional inspections per year.

Recommendation

1. The Board should randomly inspect Arizona's licensed veterinary facilities.

FINDING V

VETERINARY BOARD NEEDS MORE PUBLIC REPRESENTATION

The Legislature should consider increasing the number of public members on the Veterinary Medical Examiners Board. While current statutes limit public representation on the Board, a recent study cites the importance of increased public membership to consumer protection.

Public Representation Still Below Recommended Standard

The Legislature should consider adding one more public member to the Veterinary Board. The Auditor General's 1995 *Special Study of Arizona's Health Regulatory System* report recommended increasing public membership to 50 percent on all health regulatory boards. This report noted that there is a trend toward increasing public membership. In addition, according to one study, increasing proportions of public members is associated with stronger board disciplinary sanctions. Currently, the Board is composed of five licensed veterinarians and three lay members, two representing the general public and one representing the livestock industry. Converting one of the five licensed veterinary positions to a public member would allow the Board to meet the 50 percent public membership standard.¹

Recommendation

1. The Legislature should consider increasing the number of public members on the Veterinary Medical Examiners Board by converting one licensed veterinarian board member position to a lay person who represents the general public.

¹ In 1995, the Legislature increased the Board's public membership from two to three by adding an additional Board member. According to the minutes from the Senate Committee on Professions and Employment, this action was taken as a result of numerous consumer concerns voiced at the Board's 1994 Sunset Hearing.

SUNSET FACTORS

In accordance with A.R.S. §41-2954, the Legislature should consider the following 12 factors in determining whether the Arizona State Veterinary Medical Examining Board should be continued or terminated.

1. The objective and purpose in establishing the Board.

Laws 1995, Chapter 156, §4, states that the purpose of the Veterinary Medical Examining Board is to provide for licensing and regulation of veterinarians and veterinary medical premises and certification and regulation of veterinary technicians in order to protect and promote the public health, safety, and welfare and to enhance the veterinary medical profession.

Arizona law establishes the objective of assuring competence and quality in the veterinary profession by authorizing the Board to:

- Examine, license, require continuing education of, and discipline veterinarians;
- Examine and certify veterinary technicians;
- License veterinary medical premises and take action against the licenses of the premises or the licenses of responsible parties;
- Take action against unlicensed practitioners; and
- Regulate the dispensing of drugs and devices.

2. The effectiveness with which the Board has met its objective and purpose and the efficiency with which the Board has operated.

The Board can improve its effectiveness and efficiency in fulfilling its statutory responsibility to protect public health, safety, and welfare. The audit found that the Board often does not impose discipline when warranted and must overcome its reluctance to discipline veterinarians (see Finding I, pages 5 through 10). The Board's record of weak disciplinary actions may be partly attributable to its failure to adequately investigate most consumer complaints (see Finding II, pages 11 through 15).

In addition, the Board should conduct random inspections of licensed veterinary facilities (see Finding IV, pages 23 through 24). The Board could improve its efforts to better inform the public by distributing a listing of disciplinary actions and by providing more thorough information concerning the nature and disposition of complaints (see Finding III, pages 17 through 21).

The Board should consider studying whether staggering the renewal dates of biennial licenses and certificates could improve operational efficiency. Currently, all veterinarians, veterinary technicians, and veterinary facilities renew their biennial licenses and certificates on the same day. The volume of work in the renewal period is very large and requires a temporary employee to assist in processing renewals. To reduce the need for temporary help, the Board could renew licenses biennially according to the licensee's date of birth. Under the staggered system used in some other state agencies, such as the Board of Nursing, and in other states, licensees renew during their birth month, and licensees born in even-numbered years renew in even-numbered years. Changing to this system would allow staff to handle approximately 2,000 renewals over a 24-month period rather than encountering year-end peaks. Further, the reduced need for temporary help may allow the Board to implement the new system at little or no cost increase.

3. The extent to which the Board has operated within the public interest.

Although the Board operates in the public interest by ensuring practicing veterinarians in Arizona meet minimum licensing standards, it fails to take adequate enforcement actions to properly protect the public from incompetent and potentially dangerous veterinarians. In addition, inappropriately allowing some veterinarians to continue their current practice may place the public at risk. Furthermore, the Board could do more to make disciplinary information about veterinarians available to the public. The Board has adopted a public information policy; however, as of December 1996, the policy was not being followed. According to the Board, however, staff will, upon request, provide complainants with recordings of Board meetings in which their complaints are discussed.

4. The extent to which rules adopted by the Board are consistent with the legislative mandate.

Although current rules are consistent with its statutes, the Board plans to draft revisions to update and clarify several of its rules. In addition, our report specifically indicates several changes and additions needed in the Board's rules. The following changes and additions to the Board's rules are needed:

- Establish disciplinary guidelines;

- Adopt minimum standards of practice;
- Adopt a cite and fine program for minor offenses; and
- Conduct random inspections of veterinary facilities.

5. The extent to which the Board has encouraged input from the public before promulgating its rules and regulations and the extent to which it has informed the public as to its actions and their expected impact on the public.

The Board holds monthly meetings to discuss disciplinary and licensing matters. As required by statute, the Board informs the public of its actions by complying with the Open Meeting Law requirements regarding notifying the public of its meetings by placing public hearing notices with the Secretary of State.

According to the Agency, as part of its rule-making process, the Board encourages input from the public as well as the professional associations. The Board indicated that it intends to encourage public input on its upcoming rule revisions.

6. The extent to which the Board has been able to investigate and resolve complaints that are within its jurisdiction.

Statutes and rules provide the Board authority to investigate and resolve complaints concerning licensed practitioners. However, experts noted the Board is inappropriately dismissing some complaints and does not consider complaint histories when imposing discipline (see Finding I, pages 5 through 10). In addition, because of the Board's extensive involvement with the complaint resolution process, investigators are unable to adequately investigate complaints (see Finding II, pages 11 through 15).

7. The extent to which the Attorney General or any other applicable agency of state government has the authority to prosecute actions under the enabling legislation.

A.R.S. §32-2237(B)(2) authorizes the Board to request the County Attorney or Attorney General to file criminal charges against persons violating Board statute. In addition, the Attorney General representative provides counsel to the Board at its meetings and assists in prosecuting violators of Board statutes.

8. The extent to which the Board has addressed its deficiencies in its enabling statutes which prevent it from fulfilling its statutory mandate.

According to Board staff, numerous changes have been made to agency statutes over the years. For example, revisions to statutes in 1991 gave the Board authority to issue cease-and-desist orders to unlicensed practitioners. More recently, in 1994 the statutes were revised to change what licensees perceived to be an unfair category of “unprofessional conduct” for violations such as failing to renew licenses on time or failing to notify the Board of an address change, to now reflect “administrative violations.”

9. The extent to which changes are necessary in the laws of the Board to adequately comply with the factors listed in the sunset review statute.

The Legislature should consider the following statutory change to improve veterinarian regulation:

- Increase the Board’s number of public members to 50 percent.

10. The extent to which the termination of the Board would significantly harm the public health, safety, or welfare.

Terminating state regulation of veterinary medical practice would significantly endanger the public because it would eliminate the testing and licensing of veterinarians, licensure of veterinary premises, and the voluntary certification of veterinary technicians. Without state regulation, the public could be subject to untrained and unskilled veterinary practice that could impact the health and well-being of their pets, livestock, other farm animals, animals in zoos, and wildlife. In addition, human health could suffer from inadequate treatment of sick animals. Further, without regulation, veterinarians could not dispense prescription medicines for animals. No other state in the nation allows unregulated veterinary medical practice.

Although regulation of veterinary medicine is necessary, the Legislature may need to consider placing regulatory responsibilities with another entity if the current Board fails to address problems identified in this audit. We recommend that the Legislature continue the current Board for a period of five years. This will provide the Board sufficient opportunity to develop the recommended standards of practice and disciplinary guidelines, and to promulgate needed rules changes. Five years will also provide sufficient time to assess the impact of these changes once implemented. Although serious concerns were raised at the 1994 Sunset hearing,

no specific recommendations were given to the Board. This audit provides specific recommendations to address problems.

If the Board has not rectified these problems after the five-year period, the Legislature should consider other alternatives to ensure that the State's regulatory responsibilities are carried out and that the public is protected. The Legislature may wish to fundamentally change the nature of the Board by making all, or a majority of, Board members "public members." Another option would be to eliminate Board oversight and place this regulatory function in another agency.

11. The extent to which the level of regulation exercised by the Board is appropriate and whether less or more stringent levels of regulation would be appropriate.

We found the current level of regulation for veterinarians and veterinary technicians to be appropriate. However, the audit found that the Board needs to inspect additional veterinary facilities (see Finding IV, pages 23 through 24).

12. The extent to which the Board has used private contractors in the performance of its duties and how the effective use of private contractors could be accomplished.

The Agency has used private contractors for activities such as hearings, testing, and investigations. Due to the nature of the Agency's functions, the Board's use of private sector contractors appears to be appropriate.

Agency Response

Fife Symington
Governor



Louise Battaglia
Executive Director

ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD

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Phone (602) 542-3095 FAX (602) 542-3093

April 22, 1997

Mr. Douglas R. Norton
Auditor General
2910 N. 44th Street #410
Phoenix, AZ 85018

Dear Mr. Norton:

Enclosed is the Board's Final Response to the Performance Audit that was conducted in response to a May 29, 1995, resolution of the Joint Legislative Audit Committee.

We have reviewed the audit report and have responded accordingly. If the Board Members or Staff may be of any further assistance, we would be pleased to accommodate your staff.

We appreciate the professional meetings we have had with your Performance Managers, and we will be modifying areas that we agreed need to be improved upon.

Sincerely,

A handwritten signature in cursive script, appearing to read "Robert L. Hatch".

Robert L. Hatch, D.V.M.
Board Chairman

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SUMMARY RESPONSE

The Board disagrees with the conclusion that the public is not adequately protected through its actions and believes that the Audit Performance does not reflect many of the changes that the Board has implemented since appearing before the Joint Legislative Committee of Reference in November 1994.

The Board does agree with several of the recommendations, some of which have been in place since March 1996. The Board has demonstrated a proactive approach toward correcting perceived deficiencies and will continue to do so in the future.

The Board participated in the Auditor General's Special Study on Regulatory Reform in 1995 and has instituted changes in those areas where improvement was recommended as is verified by its policies of ten-year retention of complaint files, easier access to public information, distribution of consumer brochures, call to the public to give testimony at public meetings, interviewing complainants, and the addition of one more public member to the Board.

Some of the recommendations presented will require statute and rule changes, and the Board has begun to address the specific area of Standard of Care in its proposed rules.

The Board has proven that it has taken measures to improve in its performance since the 1994 Sunset Review and would welcome a review in five years to report on its progress regarding recommendations made by the Legislature.

1994 Sunset Review Concerns Continue (Page 3)

Since the 1994 Sunset Review, the Board, on its own initiative, has undertaken the following improvements:

- 1) Public access has improved in several areas. (See Finding III)
- 2) An additional Public Member was added to the Board in FY 96. (Legislative Change)
- 3) A part-time investigator was hired in FY 97 to interview complainants.
- 4) Statistics contained in annual reports were audited and found to be in compliance.

- 5) A revised Policy of Public Information was adopted June 1996, which provided for the release of public information via the telephone.
- 6) The requirement of notarized request forms as a prerequisite to review complaint files or licensee files was eliminated.
- 7) The Board has published a "Consumer Guide" for distribution to the public and veterinary premises.
- 8) A policy of 10-year Retention of Complaints with Discipline was adopted January 1997.

Audit Scope and Methodology (Page 4)

The Board has concerns regarding the thoroughness and accuracy of the case assessments performed by two veterinary consultants who reviewed 81 complaints within only 2.5 days. The review included reading the entire complaint file, listening to audio tapes of the informal interviews (approx. 90 min each), and meetings with the audit team. If each veterinary consultant devoted 10 hours a day to review 40 cases, that would allow an average of approximately 37.5 minutes per case. Board members will confirm that it takes, on average, at least two hours to review a case, not including the actual meeting time. The Board feels the audit was deficient in not allowing the consultants to be present to hear a case as it was presented to the Board.

Seven of the eight states named as having innovative regulatory programs actually have programs that are very similar to the program in place in Arizona, with California being an exception because of the use of a Cite and Fine Program. All disciplinary actions are public documents in Arizona and are reported as such in the Board's annual reports.

Finding I

BOARD OFTEN DOES NOT DISCIPLINE WHEN WARRANTED

Board Does Not Take Disciplinary Action As Often As Is Warranted (Page 5, paragraph 1)

The Arizona Board disciplines proportionately more veterinarians more often than veterinary boards of other states that the audit uses as examples of innovative regulatory programs. The Board reviews cases thoroughly; takes testimony from licensees, complainants, and witnesses at Informal Interviews; and when it finds violations, the Board is not reluctant to discipline veterinarians. The Board carries out its responsibilities in administering discipline when violations are found pursuant to the Board's statutes and rules at A.R.S. §32-2201, et seq.

Additional Disciplinary Action Warranted (Pages 6, 7 and 8)

The Board feels the independent veterinary consultants' assessment of cases was not thorough, thereby causing them to arrive at erroneous conclusions:

In the case of the puppy that was "apparently" attacked by dogs, the Board received unsolicited information from a local police officer that the pup's injuries were caused by owner abuse and not a dog attack. This gave cause for the Board to question the validity of the complainant's statements. The complainant further stated in his written narrative that he would offer no further information regarding the case, severely limiting further investigation. Regarding the consultant's statement that appropriate diagnostic testing was not done: This incident occurred in a small, remote, rural community where there is only this one veterinarian whose premise is not equipped to practice modern state of the art diagnostics due to economic constraints of the community. Therefore, the standard of practice could not be held to be the same as for a metropolitan area. The Board stands by its decision in this case.

In the case of the unauthorized euthanasia of the two-year-old dog at an emergency clinic: While it is true that permission for euthanasia was received from the wrong family, the correct dog, a severely debilitated and suffering animal, was euthanized. At the informal interview, during which testimony was received from the complainant and veterinarian, it became apparent that a clerical error was made in which the wrong owners were placed in the exam room for consultation with the veterinarian. The

veterinarian was a recent graduate and employee of the emergency clinic, and she was not responsible for the supervision of lay staff. By the time of the informal interview, the emergency clinic had already instituted procedures that would prevent any future similar incidents. As unfortunate as the situation was, the Board did not find the veterinarian negligent. It is important to note that, after testimony at the informal hearing, the complainant stated that she felt the veterinarian should not be disciplined.

In the case of a veterinarian's employees euthanizing a dog while the veterinarian was out of state: This was another example in which pertinent details were identified during the informal interview that contributed significantly to the Board's decision. This case was initially brought to the Board's attention by a disgruntled employee. The veterinarian in question had gone back east on vacation, and a small staff was maintaining basic housekeeping and administrative functions at the veterinary clinic. An elderly lady in the rural community where the clinic was located had a pet dog that was suffering and dying. She had made numerous unsuccessful attempts to find a veterinarian to go to her house to euthanize her dog. She called the clinic in question pleading for help and stated that she did not desire further medical treatment for her pet but only wanted to have the dog humanely euthanized to end its suffering. She was told the veterinarian was out of town and would not be back for several days. After numerous such calls for help, two staff members, one of whom was a skilled veterinary technician, went to the lady's house and euthanized the dog. They did not receive payment for their services but did it only out of consideration for the lady and her dog. The veterinarian was not notified of the situation at the time, did not condone it, and had no control over it. The Board had no jurisdiction over the staff members that euthanized the dog. Given the extenuating circumstances and the altruistic actions of the veterinarian's employees, the Board found no violation.

The Board feels these cases exemplify several issues addressed in the audit report. First, as these cases show, it was impossible in the time allowed for the expert consultants contracted by the Auditor General to thoroughly evaluate as many cases as they did, primarily because of the length of time it would have taken to completely review the audio tapes of the informal interviews in order to completely understand all aspects of the cases. Second, the fact that informal interviews were ordered underscores the concern the Board had that violations may have been committed. That these particular cases were dismissed is simply verification of the effectiveness of the interview process in uncovering important details. In other cases, one can find instances in which preliminary findings and suspected violations were substantiated during informal interviews and violations were found. Third, if the auditor's case examples as cited were accepted without explanation, one would conclude the Board was "reluctant to impose discipline." But, when conscientiously examined, one can see that the Board is "reluctant" to discipline only when it has thoroughly reviewed a case and has determined there is no violation of the Statutes or Rules.

**Board Members Dismiss Complaints After Stating That a Violation Occurred
(Page 7, paragraph 5)**

While it is true that in the course of the preliminary discussion of a case one or more Board members may voice concern that a violation has occurred, when more evidence has been brought to light through investigation or an informal interview, the member may either validate or dispel those concerns. Ultimately, a majority vote decides the case and one or more members may dissent.

**Reluctance To Discipline Must Be Overcome
(Page 8)**

The audit makes an assumption that Board members are "reluctant to take strong disciplinary action." The Board questions the auditor's ability to evaluate what is in the minds of Board members. The Board would prefer to be judged objectively by its performance. The Board must find violations and discipline based upon written statutes and rules. It cannot be capricious in its decisions. The Board has begun to work toward the development of formalized "minimum standards of care" for introduction into the statutes and rules.

Veterinarians serving on the Board realize that it is in the best interest of the profession to eliminate substandard veterinary practice in Arizona.

*DISCIPLINE COMPARISONS BETWEEN ARIZONA AND FOUR OF THE STATES WITH "INNOVATIVE" REGULATORY PROGRAMS IN FY 96				
	Number of Licensees	Number of Consent Agreements	Number of Board Orders	
California	5,500	56	10	(.18%)
Arizona	1,375	4	6	(.44%)
Michigan	3,276	N/A	11	(.34%)
Arizona	1,375	4	6	(.44%)
Texas	5,593	16	16	(.28%)
Arizona	1,375	4	6	(.44%)
Alabama	1,212	N/A	4	(.33%)
Arizona	1,375	4	6	(.44%)
<p>*Note: Four states in the above table data have been verified. Verification from other four states unavailable. Named states data unavailable. ARIZONA RATE OF DISCIPLINE AS VERIFIED BY NUMBERS OF BOARD ORDERS EXCEEDS "INNOVATIVE" REGULATORY PROGRAMS USED IN COMPARISON STATES</p>				

**Additional Disciplinary Guidelines and Options Are Also Needed
(Page 8)**

The Board agrees to establish guidelines to help ensure minimum standards of practice.

**The Board Needs to Establish Disciplinary Guidelines
and Consider Past Violations
(Page 9, paragraph 2)**

The Board does consider past violations when determining the need for stronger discipline for repeat violators. However, in the past, the procedure had not been formalized. The Board has now taken steps to incorporate the procedure in its Policy and Procedure manual. There are very few repeat offender licensees, but even stronger discipline has been imposed as evidenced by the Board's record of revoking licenses of chronic violators.

(Page 9, paragraph 5)

"Letters of Concern" - This issue has arisen as to its use throughout the past several years. It is not characterized as a disciplinary tool, but the Board has used this Letter 28 times in 4 years when so deemed appropriate as it can be used in determining degrees of discipline if future violations are found. Note that the status of Letters of Concern is still being reviewed by the Courts and the Board has been advised by the Attorney General to be very cautious in using it, especially if it does not tie into a possible statute violation.

FINDING II

BOARD DOES NOT ADEQUATELY INVESTIGATE MOST COMPLAINTS

Problems with Investigations (Page 11)

As of FY 97, the newly employed .5 investigator's specific duty is to interview complainants before the complaint is processed and logged onto the computer tracking system. The Board did not have staffing in FY 96 to interview all complainants. The Board accepts testimony from complainants and witnesses at monthly public Board meetings. It also accepts comments from any member of the public who wishes to be heard.

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- ◆ Heartworm case study - According to Merck, Inc., there were 128 cases of Heartworm diagnosed in the entire state in 1995, e.g., one case per several thousand dogs. The expert consultants failed to consider the extremely low prevalence of this disease in Arizona and applied their home area standards.
- ◆ July 1996 case study (contagious cat) - The cages were adjacent, but the cats were not housed together. FeLV, similar to HIV, is only transmitted by the exchange of body fluids (saliva) not via airborne means. Refer to Consultations in Feline Internal Medicine (John August, Editor, pp. 572-577).

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- ◆ The information in the report is inaccurate. The allegations were discussed in a Board meeting, and the investigator gave her opinion that the allegations were without merit. The primary person making the allegations was a disgruntled former employee. When the investigator made an appointment to interview her, she did not appear and has not been able to be located since. There were reports that she had left the area permanently. The file remains open, but no other information has been forthcoming.

The Board will request funding for training and development and out-of-state travel for two investigators to attend the recommended International Council on Licensure, Enforcement and Regulation (CLEAR) training. The Board is also pursuing training seminars with the medical investigators of health agencies.

The Board agrees to implement the Cite and Fine Program and will study the program as it is used in the one state cited in the audit report. This program is not widely used across the nation. If the Board is required by statute to implement its use and it is determined at the next audit performance review that the public is not being protected by the Cite and Fine Program, the Board will proceed with informing the Legislature and request it be removed from the statutes.

The Board understands the recommendation of assigning a board member to work with staff to conduct its investigations. If this becomes a requirement, the Board will need to request funding for a .5 staff veterinary medical consultant, and/or contract a veterinary medical consultant, to ensure that more than one opinion of a medical investigator is presented to the Board for its consideration in determining whether or not a violation has occurred. Additionally, in following the audit recommendation to assign cases to one board member, if that board member is a lay member, that member would need the expertise of a medical consultant to present the findings of a medically related case.

The Board is aware that written policies detailing the investigative process need to be developed, and it has begun to take action in this area.

The Board would like to accurately explain the investigative process as it now exists since the Board feels that, given the limited financial resources of the Board, the current method of handling cases is more efficient and cost effective than the proposed changes suggested in the audit report. The Board also feels it is more objective in its deliberations than the audit report would lead one to believe. The method in which the Board investigates cases is not completely described in the audit report.

The current complaint process begins with a complaint being received at the Board office. The complaint is logged, and the complainants are contacted and asked to submit a thorough written narrative. They are informed that they may appear at the Board meeting in which the case is to be reviewed and that they may give testimony if they wish. The veterinarian charged is contacted, and copies of all original pertinent records including radiographs, consultations, etc. are demanded as well as typewritten transcripts of records and a typewritten narrative of events surrounding the case. Consultants may also be contacted for their narratives and pertinent records. When all requested materials have been submitted, they are checked for completeness. If deficiencies are found or more information is needed, the investigator or other staff member will either request or personally obtain such information. A completed packet is then forwarded to each Board member for review at least one week prior to the scheduled Board meeting. At the meeting one assigned Board member is responsible for leading the discussion of the case. After testimony by interested parties has been presented and discussion of the case has concluded, the Board decides whether or not there is any indication of a violation, regardless of how significant the violation may be. If not, the case is dismissed. If so, then an informal interview is scheduled. At the

informal interview the case is again reviewed and extensive questioning of complainant, witnesses and veterinarian is conducted. This is a process that is akin to testimony of witnesses and defendant before an adjudicating body. It is objective and fair. Information derived from informal interviews from these cases would be difficult to derive second hand from an investigative report, especially when all objective data has been previously submitted in the form of medical records and written statements.

FINDING III

THE VETERINARY BOARD NEEDS TO IMPROVE PUBLIC ACCESS TO INFORMATION

(Page 17)

As reflected in the audit report, the Board fully cooperated with the Auditor General's 1995 Special Study of the Health Regulatory System. As a result of that study, the Board proactively implemented a policy of easier public access to information. From March 1996 until March 1997, the Board's performance regarding accessibility to information was made on its own initiative. The Board has shown in many ways that it is a responsive body when requests for information are received from the public.

Examples of policies adopted:

- a) Call to the Public at open meetings
- b) Issuance of tape recordings of complaints discussed at Board meetings
- c) Installation of a new computer complaint tracking system
- d) Adoption of revised public information policy
- e) Adoption of policy to retain disciplined actions for a period of 10 years
- f) Files may be inspected at any time during business hours
- g) Development of Consumer Guide Brochures

1. The audit report states that the Board fails to ensure that complaints are logged against the correct veterinarian. The Board recognized this deficiency and in the Supplemental Budget Cycle of FY 97, it requested funding for a .5 investigator for the specific purpose of interviewing complainants and determining that the facts are correct as stated on the complaint form before it is logged into the computer tracking system.

The Board will seek appropriated funding to program a computer cross-reference file as a measure of easier access to the public in retrieving complaint information.

2. The audit's recommendation to retain files of disciplined veterinarians for 75 years is acceptable to the Board. The Board will request additional storage space at its present location and will need appropriated funds for storage rental. Presently, the Board can accommodate the 10-year retention of disciplined complaint files.

3. If it is deemed to have the Board publish disciplinary actions through an annual newsletter, the Legislature will need to appropriate funds for this purpose. Presently, the Board publishes its actions taken against licensees who have been suspended or revoked in the Arizona Veterinary Medical Association newsletter.

4. The Board has taken corrective measures regarding its deficiency in the release of public information via the telephone.

FINDING IV
VETERINARY FACILITY INSPECTIONS NEEDED
(Page 23)

In enumerating the number of annual premise inspections done by the California Board, the audit team failed to report that California does not inspect premises before the issuance of a license as is done in Arizona. In 1996, California inspected 15 percent of its 2,453 hospitals by using several contract personnel. In 1996, Arizona inspected 12.5 percent of its 520 hospitals using one staff personnel, with inspections being completed before issuance of a license for the purpose of protecting the public.

“Fifty more inspections per year” - There are more than 100 premises outside of the two metropolitan areas. Travel time to some outlying areas, plus inspection time, would require more than two hours, plus overnight stay by investigators. The Board will need to request additional funding for this purpose.

At the present time, the Board's investigator does inspect premises at unannounced times when following up on past or alleged violation.

FINDING V

VETERINARY BOARD NEEDS MORE PUBLIC REPRESENTATION

Public Representation Still Below Recommended Standard (Page 25)

The Board does not agree with the recommendation to increase public membership by decreasing one veterinarian.

This recommendation was proposed in the 1995 Special Study on Regulatory Reform, and the Legislature wisely did not adopt the recommendation. Public Members objected at that time, and the public members presently on the Board object to losing the expertise of a veterinarian.

In 1995, the Legislature increased the Board's public membership by one.

The audit team interviewed the three public members, and ALL members are in agreement that the composition of the Board should remain as it is. They need to have the expertise of the profession to determine medical factors of a case.

The success of 50-50 Boards has yet to be determined since the concept has not been adopted across the nation.

SUNSET FACTORS

The Board rejects the recommendation of issuing renewals based on a licensee's date of birth. The Board's computer renewal system does not contain fields with birth dates. Therefore, the data base would need to be reprogrammed. In order to gather birth dates for all licensees, funds would need to be appropriated to hire temporary personnel to retrieve the data from hard copy files, keystroke data into the newly programmed system, and establish a dedicated staff position for monthly renewals.

The audit team did not include the renewals of premises at the end of each fiscal year. The computer renewal system would need to be reprogrammed to issue licenses alphabetically by name. In doing so, it would cause a split system to be installed, one for premises and one for licensees and technicians.

It would not be cost-effective to change over since the present system was installed in 1995 and is working well with full productivity by 3.5 staff during the renewal cycle period.

Since the Board is on a biennial budget cycle, it carefully monitors its appropriated funds during the non-renewal years.