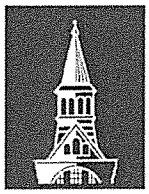

The UNIVERSITY of VERMONT

*The Center for Health and Wellbeing*

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Attorney General, State of Vermont
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Dear Dr. Chen and Mr. Sorrell,

I wish to share with you a number of concerns which have arisen for me out of my opportunity to observe the work of the Vermont Board of Medical Practice (BMP) and the Vermont Attorney General's (AG) office at close range during the last three years.

As you have access to all records pertinent to my case before the BMP, I will provide only a brief summary: I came upon information that Peter Nobes, a physician assistant I supervised and who was employed by the University of Vermont, was prescribing controlled substances in an unprofessional manner. I immediately restricted his prescribing privileges, completed an investigation in a timely manner, sought consultation about my findings from a pain management expert at Dartmouth Hitchcock Medical Center who confirmed my concerns, and consulted with my supervisors and with University Counsel. P.A. Nobes was separated from employment at the University of Vermont, and I reported him to the Board of Medical Practice. He eventually stipulated before the Board to a charge of unprofessional conduct in this matter. I was subsequently charged with unprofessional conduct, the thrust of these charges relating to improper supervision of the P.A. and to a novel theory of strict physician liability for the unprofessional acts of a physician assistant.

My concerns follow.

## I. Quality of the Board's Investigation

The investigator in this case, Paula Nenninger, acknowledged under oath that her investigation included a conversation of approximately one hour with P.A. Nobes and a phone conversation of approximately ten minutes with the former medical director in my practice. She did not interview me. She did not interview other physicians or physician assistants on my staff. She did not speak with the physician expert from Dartmouth I retained to review P.A. Nobes' charts, and she did not seek out an expert who could have informed her about appropriate standards of supervision in Vermont and nationally.

## II. Focus of the Board's Investigator

Upon completing my investigation into the unprofessional behavior of P.A. Nobes, I separated him from affiliation with my license and from his employment in this practice. I had simply lost confidence in his ability to practice medicine with the interests of the patient and the student population for which he was responsible foremost in his mind.

During Ms. Nenninger's conversation with P.A. Nobes, he provided her with a copy of an *anonymous* document expressing anger about my reorganization of clinical services at UVM's Center for Health and Wellbeing - an undertaking familiar to all administrators and necessary in this instance to insure that we were making the most efficient use of our financial resources. Ms. Nenninger apparently found this anonymous complaint relevant to the Board's interests and featured it prominently in her report to the Committee. The title of Ms. Nenninger's report to the Committee, P.A. Termination, would seem to be more appropriate for a human resource review than for an inquiry into the delivery of quality medical care for residents of Vermont – the presumed mission of the BMP.

## III. Focus of the South Committee

The South Committee followed Ms. Nenninger's lead and focused its attention on my decision to separate Mr. Nobes from employment at this office. To reiterate: my decision in this regard was made on the basis of what I considered the best course of action for our patients and the health of our community.

Legal counsel and I met with the South Committee on two occasions. In the first meeting it was immediately clear that few if any Committee members had read the nine page document I submitted outlining our procedures for supervising physician assistants. There was little interest in this topic or on my actual supervision of P.A. Nobes, and instead the Committee focused its attention on trying to discern whether P.A Nobes had resigned or had been fired. Our second meeting with the Committee was identical in theme – it remained fixed on the nature and fairness of the circumstances surrounding P.A. Nobes' separation from his employment. Margaret Martin, lay Board member, inquired whether I had considered any other way of dealing with Mr. Nobes transgressions other than firing him (a characterization which was inaccurate). William Hoser, vice chair of the Board of Medical Practice, requested that I produce Mr. Nobes' letter of resignation.

By all appearances the Committee felt it appropriate to insert itself into a concern related to UVM's personnel policy, an area in which I am legally bound to maintain confidentiality and which at any rate had nothing to do with the Committee's presumed mission of insuring the quality of medical care

for our patients – in this instance determining whether my supervision of P.A Nobes met professional standards.

## IV. Objectivity of the South Committee

The South Committee's hostile tone in all of our interactions was striking. Taken together with the unusual focus of the questioning it pursued in our meetings, Counsel and I felt compelled after our second meeting to write a letter to Harvey Reich (South Committee Chair) expressing our concern about the ability of the South Committee to adopt an open, unbiased approach in this instance. We received no response. Our concern was in due course reinforced by the sworn testimony of P.A. Nobes that William Hoser (vice chair of BPM and a Physician Assistant) had contacted him in 2010 for the purpose of keeping him current on the Committee's progress toward specifying charges in my case – "a P.A. to P.A. thing" in the words of Mr. Nobes in his testimony. Communication of this nature from a member of the Board would, of course, represent a serious violation of the Board's rules regarding the confidentiality of its proceedings prior to specification of charges - not to mention demonstrating a bias in his approach to my case before the Board. In his deposition, Mr. Hoser was unable to recall such contact with Mr. Nobes – leaving unanswered the question of why P.A. Nobes would fabricate such a story.

## V. Propriety and Objectivity of the Hearing Panel Process

Participating in the three days of the panel hearing – where my license, livelihood, and reputation were at stake – left the distinct impression that this proceeding was not in any sense objective.

On the opening day of the hearing, two of the panel members (former members of the Board of Medical Practice) enthusiastically greeted many of the staff members from the attorney general's office and the Board of Medical Practice. Panel member Russell D'Avignon, MD embraced Ms. Nenninger (a witness for the State) in greeting. On the following day, panel member Janice Ryan greeted assistant attorney general Susanne Young in similar fashion. Members of the Panel openly perused the current edition of the Burlington Free Press each morning and left the newspaper open to the coverage of this case. Dr. D'Avignon's outburst on the first day of the proceeding regarding his particular interpretation of a defense exhibit was seriously disruptive, clearly directed at the defense, and poorly handled by the Hearing Officer. With a number of assistant attorneys general present in the hearing room, Board Executive Director David Herlihy spent lengthy periods of time at the prosecution table with the lead prosecuting attorney, apparently trying to assist him with his line of questioning. Finally, the release of P.A. Nobes from standing Board sanctions just nineteen days prior to his testimony at my hearing raises the question as to whether Mr. Nobes received special consideration from the attorney general's office in response for his testimony. If such was the case, this would certainly have informed the approach of Defense Counsel to the testimony of this witness.

## VI. Supervision of the Prosecuting Assistant Attorney General

The office of the Attorney General specified charges and continued to a contested hearing on counts alleging inadequate P.A. supervision *without* obtaining an expert witness who could testify to the legitimacy of its allegations. Lacking any proper evidence to support its case, the Attorney General's

office persisted in its attempt to make the *anonymous* document referred to above a central feature of its case. Although the Hearing Officer had properly excluded the document from evidence months previously, the Assistant Attorney General managed to read portions of it before the hearing panel – apparently in an attempt to sway panel members. Based on the lengthy roster of AG staff present at each step of this prosecution, I assume that the tactical direction the state adopted in this case was known and received approval at high levels of the Attorney General's office.

## VII. Decision to Appeal BMP Finding to the Vermont Supreme Court

In its finding dated 1/4/12, the BMP wrote:

> ***...the Board finds that it is not required by law to find that Dr. Porter is guilty of unprofessional conduct for improperly prescribing "schedule drugs" based solely on the fact the [sic] PA Nobes, who Dr. Porter was supervising, engaged in this conduct. The Board finds that where, as here, the supervising physician did not engage in the improper conduct, was not aware of this improper conduct and could not reasonably be expected to be aware of this improper conduct, the law does not require the Board find the physician guilty of unprofessional conduct for the acts of his PA "agent."***

Despite the Board's expressed stance in this matter – that it was not compelled to hold physicians to a strict liability standard in their supervision of physician assistants - the Attorney General appealed to the Supreme Court asking that such a standard prevail. The Attorney General made this decision in spite of expert input at each step of this process that such a standard would not improve the quality of care for Vermonters. In fact, the AG was informed and repeatedly reminded that physicians would not be willing to assume the burden of responsibility such a standard would impose upon them. The consequence of this action would be the loss of physician assistants as resources providing care in Vermont and reduced health services for our citizens. Because the statutory language pertaining to the supervision of physician assistants is essentially identical to the language defining physician responsibility for the supervision of physicians in training, they would likewise be unemployable in this state. In our current context of already-strained medical resources, when the AG has *never* before sought to establish this standard in Vermont and there is no record of it having been attempted in any other state, the legal and/or policy considerations underlying the Attorney General's action are extraordinarily difficult to fathom.

## VIII. Taxpayer Resources Expended on This Prosecution

This case has just been concluded after over three years of legal activity. It originated in *my* report to the Board of a physician assistant's unprofessional behavior. My confidence in the manner in which physician assistants are supervised in my practice precluded acquiescence to the state's charges, and yet I wished to avoid the expense of a trial. At each juncture I expressed to BMP and the AG my genuine interest in collaborating with BMP to establish appropriate state-wide standards of P.A. supervision in an effort to optimize the quality of care Vermonters receive. At each juncture this offer was declined in favor of specification of charges and a contested hearing.

The costs involved in defending against this prosecution have been tremendous. I have no way to estimate how much the Board of Medical Practice and Attorney General's office together spent on this endeavor. My observation that there were often no fewer than four assistant attorneys general in

attendance at each day of the panel hearing and at the recent Supreme Court hearing leads me to conclude that tremendous resources were, in fact, expended by the state in this prosecution.

Based on these eight areas of concern, I seek your response to the following questions:

1. **What training do BMP investigators receive regarding the proper conduct of investigations?**

2. **What standards exist to insure that BMP investigations are of high quality? Are such standards internal to the Board? Are there national standards outlining appropriate quality standards for BMP investigations?**

3. **In light of such standards, who holds final accountability for the rigor and quality of investigations carried out by BMP?**

4. **With regard to the emphasis of the investigator and the South Committee in the circumstances surrounding P.A. Nobes' separation from my license and his employment: What indeed is the mission of the BMP? Are the focus of the investigator and the South Committee on Mr. Nobes removal from employment in line with this mission? How is this mission promulgated to the organization? To professional and lay members of the Board?**

5. **Regarding the spectrum of ethical issues encountered by those who serve involved on the BMP, and with particular attention to the issue of confidentiality regarding its proceedings, what ethical training or guidance do BMP members receive? How often is it conducted? What are the consequences for behavior outside of these guidelines? Does the BMP have a conflict of interest protocol requiring recusal if a member has (or appears to have) a conflict of interest in a proceeding?**

6. **What training does the leadership of the Board and its Committees receive about how to effectively conduct the business of the Board? With what frequency is it carried out?**

7. **How is the quality of Committee and Board work assessed? At what intervals? Are there national standards outlining best practices for the Board and its Committees?**

8. **Who holds final accountability for the performance of the Committees and the entire Board?**

9. **With regard to the presence of the BMP Executive Director at the prosecution table in the panel hearing: What is the Executive Director's role in the investigation and prosecution of cases? What is the Executive Director's relationship to the Attorney General's office? With regard to both organizational structure and functional duties, to whom does he report?**

10. **How many hours of attorney and staff time did the Attorney General's office expend on the prosecution of this case over the last three years?**

11. **Is there regular coordination and collaboration between the Health Commissioner and the Attorney General in the prosecution and disposition of cases before BMP? In what situations can the Attorney General 'overrule' the action of the BMP? In this instance, were the Health Commissioner and the Attorney General in agreement that the public health was best served by the conduct of the prosecution and its subsequent decision to appeal the Board's finding?**

I believe the concerns and questions outlined above have merit which transcends the outcome of my particular case. The manner in which the Board and the Attorney General utilize resources and carry out their respective missions and the Attorney General's use in this instance of his prosecutorial powers to potentially restructure the state's health care delivery system in dramatic fashion are tremendously important issues. They deserve an airing within and between your respective offices - with public input as appropriate - so that thoughtful resolution in the form of policy and procedural change can take place. I appreciate your review of these concerns and look forward to hearing from you.

Sincerely,

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