



**Senate Consumer Protection and Professional
Licensure Committee Public Hearing
10 a.m., March 1, 2011
Room 156 Main Capitol**

**Testimony of Chief Counsel Steven V. Turner
Pennsylvania Department of State**

Health Care Licensing in the Department of State

Chair Tomlinson, Chair Boscola and members of the Senate Consumer Protection and Professional Licensure Committee:

Good morning. Thank you for your invitation to appear before the Committee to discuss health care licensing in the Department of State.

The Department of State is tasked with various areas of responsibility ranging from the administration of elections to the regulation of mixed martial arts. Professional licensure is a key element of the Department's duties. To control the quality of practitioners, the Department regulates education, requires experience and a degree of technical expertise and has implemented a process of written examinations and/or demonstrated practical ability. Requirements for continuing education also serve as a means of meeting the constantly changing developments in the various professions and occupations.

A vitally important part of the Department of State's mission is to protect the health, safety and welfare of the public from unethical conduct and unlicensed or unsafe practices through professional licensing. To accomplish this, twenty-nine (29) boards of the Bureau of Professional and Occupational Affairs utilize licensing, enforcement and administrative authority to regulate and service the various professions. The Department investigates complaints against licensees for legal or ethical violations that may result in disciplinary action by the boards.

On Governor Corbett's first full day in office, a Philadelphia County grand jury report was released to the public detailing the horrors that occurred at the Women's Medical Society, a clinic run by Dr. Kermit Gosnell. Gosnell and several employees have been charged with murder and numerous other offenses in the case. The grand jury also documented numerous unsafe and unsanitary conditions.

As your committee heard directly from the authors of the report, I will not focus my remarks on its horrific content and the obvious failures by State and Health in regulating the Women's Medical Society. Instead, I will discuss the Corbett Administration's plan of action to correct administrative deficiencies.

Gov. Corbett ordered his nominees for Secretary of Health, Dr. Eli Avila, and Secretary of State, Carol Aichele, to review the grand jury's recommendation, identify the problems and come up with a plan of action to change the system.

Gov. Corbett also ensured that the people responsible for the lack of oversight be held accountable.

Seven individuals - employees from the Department of Health, as well as the Bureau of Professional and Occupational Affairs - are no longer employed by the state, having either resigned or been terminated since the Gosnell situation came to light. Four other former employees named in the grand jury investigation had previously resigned.

Department of State Plan of Action

The Executive Staff of the Department of State met to develop an action plan to change the way it manages investigations and approaches licensure cases.

First, all complaints concerning a person or facility should be assigned to the same attorney. This common-sense approach will ensure proper management of each specific case, and has already been implemented by our legal staff.

Second, prosecuting attorneys will cross check all files, opened or closed, with other staff attorneys to ensure that any patterns of misconduct do not go unnoticed. For a prosecutor, pattern identification is a key component in demonstrating consistent wrongdoing. Often, proving a pattern of misconduct provides sufficient evidence for prosecutors to present to the Board, which can then take appropriate action to protect the public.

The Department is developing a checklist, which includes the file cross checks, to ensure all steps are taken in a timely manner. In addition to the cross checks, appropriate data collection and history review will be included to ensure reports are complete. This checklist will help to achieve the third change: reports will be more detailed, including history of any prior complaints or violations.

The fourth improvement that the Department is implementing is that attorneys and investigators will receive formal training on investigative procedures and instruction on rules and regulations, including investigating and prosecuting complaints.

Departments of State and Health Joint Efforts

The Departments of State and Health have established an interagency project team to strengthen communication and complement administrative and regulatory efforts. The team will help to achieve several changes.

First, the team has established a mechanism for sharing monthly data between agencies, including complaints, serious events, complications, deaths and investigations. Each agency now has identified a point of contact to avoid confusion and ensure institutional continuity. Health now forwards reports directly to State, and the agencies periodically review the reporting processes to ensure the efficiency of the processes.

Several types of reports and data are being shared, including:

- Induced Terminations of Pregnancy (ITOP) Reports, which will be provided on a monthly basis.
- Reports of complication from physicians called upon to provide medical care to a woman because of a complication arising from an abortion or attempted abortion will be provided on a monthly basis.
- Report of Maternal Death, which, when received, will be promptly shared with the Department of State.
- If a pathological examination report is received, Health will promptly share a copy with State.
- Medical Care and Availability and Reduction of Error Act (MCARE) serious event reports, which applies to freestanding (non-hospital) facilities that annually perform more than 100 abortion procedures. Pursuant to Section 311(f)(2) of MCARE, State is permitted access to serious events reported to Health, for the purpose of licensure or disciplinary action against a health care worker. Health is providing State on a monthly basis copies of serious event reports.
- If Health identifies physicians who fail to report under the Abortion Control Act or MCARE as required, this failure to report will be shared with State for appropriate investigation and prosecution. In addition, if Health identifies other health care workers who fail to report under MCARE as required, this failure to report will be shared with State.
- Quarterly reports filed by facilities are available to State upon request.

The interagency project team will also establish a process for joint investigations by agencies.

For example, the Department of State receives complaints or information concerning healthcare facilities. State has no jurisdiction over these facilities, and often refers the complainant, or sends the information to Health. Historically, this referral has been done on an ad hoc basis, and consistency may have been lacking.

State will now establish a standard operating procedure for the formal reporting of these complaints or information with an established point of contact at Health. Within the Department of State, one person, named by position, will assume responsibility for establishing and enforcing these procedures.

In terms of investigations, both agencies will work in a coordinated manner. During the course of an investigation conducted by Health or State that involves a facility providing abortions, it is the practice of each agency to notify or otherwise involve the other agency. The appropriateness and timing of this coordination is determined on a case-by-case basis.

In conclusion, the tragic circumstances of the Gosnell case presented a call to action for state government. The Corbett Administration has taken several steps to change the way it approaches protecting the public through professional licensure, and the Administration will continue to monitor the situation to decide whether additional action, either regulatory or legislative, is necessary.

Thank you again for the opportunity to appear before you today. I will address your questions at this time.