Medicolegal Sidebar

Medicolegal Sidebar: State Medical Boards and Physician Disciplinary Actions

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Introduction

Orthopaedic surgeons face a number of regulations and professional mandates under the umbrella of improved patient safety and high-quality medical care. Examples of these regulatory interventions include the familiar timeout procedure before surgery, the use of electronic medical records with specific documentation requirements, and so-called “never events.”

In addition to regulatory mandates, monitoring of physician conduct by state medical boards is another source

of oversight. State medical boards were created at the behest of private medical associations who encouraged state legislators to regulate clinical medicine [1]. The goal of state medical boards is to ensure medical quality by disciplining delinquent physicians, and ensuring public protection [12]. Medical licensure mandates that the prospective physician show requisite qualifications and training, good moral character, and a clear criminal record, among other requirements.

Medical boards reprimand less than one-half of one percent of physicians

annually [10]. However, medical boards are increasingly wielding their authority on matters that relate to physician character, rather than clinical practice. Physicians have been disciplined by various state medical boards for behaviors such as driving while intoxicated, drug possession, illicit sex, and other conduct that may reflect poorly on the profession.

The purpose of this article is to examine the nature of state medical board disciplinary power — especially as it relates to character-based actions — rather than acts that directly impact clinical care, patient safety, or medical quality. We will also examine the judicial reasoning that supports the exercise of medical board discretion in this manner.

Authority

In the 1889 legal case of *Dent v West Virginia* [2], the United States Supreme Court was asked to decide whether state law could require doctors to possess a recognized medical degree, pass an examination, and prove practice in the state for a certain number of years.

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Frank Dent had graduated from a non-traditional medical school, and had been in practice for 6 years in West Virginia when he was convicted under the law. A unanimous US Supreme Court confirmed that states can regulate medicine, and other professions, via professional licensing boards [2].

A subsequent legal case addressed whether states could add new qualification requirements applicable to physicians who were already in practice, and whether character was a relevant qualification for obtaining a medical license. After serving time for a felony conviction related to performing an illegal abortion, Dr. Benjamin Hawker had resumed his medical practice [9]. Some years later, the New York legislature passed a law barring convicted felons from practicing medicine. Hawker challenged the law, citing protection from *ex post facto* laws in Section 10 of Article One of the US Constitution. The US Supreme Court disagreed; in *Hawker v New York* [9], the Court clarified that states can add new qualifications for practicing medicine, and that those qualifications can apply to those already in practice. The Court also said that states have the authority to revoke professional licensure based on a prior conviction where that conviction is reasonable evidence of insufficient good character [9].

Exerting Disciplinary Power

Today, most state medical boards exercise their power in a reactive manner. The disciplinary process is usually triggered by a complaint filed against a physician, by the board learning of criminal charges involving a physician, or by a serious disciplinary action taken by a hospital against a physician staff member. A medical board can choose to investigate further, and if necessary, recommend discipline ranging from a reprimand to license revocation. Common grounds for physician discipline by state medical boards include impairment, drug or alcohol use, practicing without a valid license, and a general category of actions labeled “unprofessional conduct.” These actions include criminal acts and other behaviors that bring dishonor and disrepute to the profession [3, 10].

Licensure seeks to establish a minimal level of physician competence, and to assure public protection [12]. In return, under US law, a medical license affords a measure of professional exclusivity and certain procedural due process protections. Consumer rights advocates suggest that these protections for professionals result in insufficient protection of the public, and cite the high frequency of medical malpractice lawsuits as evidence that professional oversight is insufficient. [12]. However,

the Federation of State Medical Boards has indicated that medical professionals face serious discipline at the same rate as other professions [10].

Medical board disciplinary proceedings are guided and limited by the constitutional principle of substantive due process. As the Supreme Court explained in *Dent* [2], when arguing against an applicant’s ability to practice medicine, the board’s disciplinary actions must be clear and detailed, while showing common sense rationality. As existing case law shows, on appeal, courts will usually defer to the judgment of medical boards, and uphold the disciplinary action in question [2, 5, 6, 9, 11].

Professional Discipline

State medical boards must use a system of triage in disciplinary matters because of limited budgets and other constraints. Disciplinary actions related to unprofessional or criminal misconduct are relatively easy and inexpensive to pursue when compared to complaints dealing with clinical competency. The court automatically reports a licensed physician’s criminal conviction to the state board of medicine. These cases require few resources, as adequate documentation exists at the hospital level. Conversely, physician errors related to gross

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negligence or incompetence require considerable amounts of discovery and investigation, similar to civil malpractice suits [4].

Partly because of these practical considerations, disciplinary sanctions against physicians often target misconduct that may not necessarily be associated with patient safety or public health. Data from the Office of the Inspector General (OIG) in the 1980s and 1990s [3] showed that few medical board disciplinary actions against physicians were related to quality of care. Instead, state board disciplinary actions were distributed among three general categories: 1) abusing drugs and alcohol, 2) criminal convictions, and 3) unethical conduct. Approximately one-third of disciplinary cases were related to unethical conduct, which encompasses various character-related actions from income tax fraud to marijuana possession [3]. There are no more current data that suggest that these patterns of disciplinary actions targeting the social behavior of physicians have changed since the OIG reviews [13].

Justification for Character-Based Discipline

In targeting character-based physician transgressions for disciplinary action — rather than substandard professional

conduct — the assumption is that character is a suitable substitute for competent and safe clinical practice. If a physician lacks judgment in not recognizing the hazard in driving after alcohol consumption, for example, perhaps the physician would also be inclined toward dishonest billing practices or false documentation in medical records. This line of logic has been used by courts in upholding the character-based disciplinary actions of state medical boards. In *Haley v Medical Disciplinary Board* [7], the Washington Supreme Court ruled that a physician's conviction for tax fraud indicates a "lack of trustworthiness," increasing a "reasonable apprehension" that he may "abuse the trust inherent in professional status." [7].

A related reason for disciplinary actions targeting character-based acts is based on the trust theory: character-based misconduct — even if unrelated to clinical medicine — weakens the public's trust in the medical profession. Trust is a vital element of the medical relationship [8]. Without trust, patients would be hesitant to seek medical care. Therefore, any physician behavior that reduces public confidence in the medical profession, even if unrelated to clinical practice, should be subject to disciplinary action. In order to practice medicine, doctors agree (whether implicitly or explicitly) to an elevated standard of conduct than the general public.

Judicial View of Medical Board Disciplinary Actions

Historically, court opinions on board actions related to physician discipline and the fitness to practice have been deferential to medical boards. In *Hawker*, even though the US Supreme Court provided little support for its view that personal character is "as important a qualification as knowledge" [9] for professional practice, it upheld a state law prohibiting the practice of medicine by convicted felons. The Supreme Court explained that "the physician is one whose relations to life and health are of the most intimate character. It is fitting, not merely that he should possess knowledge of diseases and their remedies, but also that he should be one who may safely be trusted to apply those remedies." [9]. Other state court decisions in medical board disciplinary matters have echoed this view [5, 6, 11].

Conclusions

Surgeons are familiar with regulations that guide clinical practice: they take timeouts before making an incision, they provide appropriate documentation in patients' electronic medical records, and they report complications to peer forums. Although not always grounded by evidence of efficacy,

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these rules have a direct relationship to the desire to increase patient safety and enhance the quality of medical care. Similarly, compliance with certain medical board requirements — such as monitoring narcotic prescriptions, updating licensure requirements, and compliance with institutional staff bylaws — are directly connected to clinical practice.

In contrast, disciplinary actions imposed by state medical boards for misconduct that arises from physician character flaws may appear to be arbitrary. Nonetheless, these boards apply sanctions for precisely those kinds of misconduct on a routine basis, even when the misdeeds appear unrelated to patient care, safety, and medical quality. Importantly, when those sanctions have been challenged in court, the legal system has supported them.

Physicians should be aware that the legal system views medical licensure as an exclusive privilege. As such, physicians are held to a higher standard of moral and personal conduct than the general population. Thus, personal actions that reflect poor judgment, flawed character, and substandard decision-making may trigger state medical board sanctions. While a

physician could argue that such variables have little or no relationship to the delivery of medical care, they are not in the same professional circumstance as nonphysicians who may have their similar misdeeds excused.

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References

1. Akers RL. The professional association and the legal regulation of practice. *Law & Society Review*. 1968;3:463–482.
2. Dent v West Virginia, 129 U.S. 114, 122 (1889).
3. Department of Health and Human Services Office of Inspector General. State medical boards and medical discipline. OEI-01-89-00560. Available at: <http://oig.hhs.gov/oei/reports/oei-01-89-00560.pdf>. Accessed Sept. 25, 2013.
4. Department of Health and Human Services Office of Inspector General. State medical boards and quality-of-care cases. OEI-01-92-0000. Available at: <http://oig.hhs.gov/oei/reports/oei-01-92-00050.pdf>. Accessed Sept. 25, 2013.
5. Dittman v California, 191 F3d 1020, 1032 (9th Cir 1999).
6. Foster v. Board of Medical Quality Assurance, 227 Cal. App. 3d 1606, 1610 (1991) (aff'd), 278 Cal Rptr. 117.
7. Haley v. Medical Disciplinary Board, 818 P2d 1062, 1069 (Wash: Supreme Court 1991).
8. Hall MA. Law, medicine, and trust. *J Nurs Law*. 2003;9:33–84.
9. Hawker v New York, 170 U.S. 189 (1898).
10. Public Citizen Health Research Group. Ranking of the rate of state medical boards' serious disciplinary actions, 2005–2007 (HRG Publication #1837). Available at: <http://www.citizen.org/documents/medicalboardtable.pdf>. Accessed Sept. 25, 2013.
11. Raymond v Board of Registration in Medicine, 443 NE2d 391, 395 (1982).
12. Sawicki NN. Character, competence, and the principles of medical discipline. *J Health Care Law Policy*. 2010;13:285–323.
13. Thompson JN, Robin LA. State medical boards. Future challenges for regulation and quality enhancement of medical care. *J Leg Med*. 2012;33:93–114.