PUBLIC CITIZEN
HEALTH RESEARCH GROUP

STATE MEDICAL LICENSING BOARD
DOCTOR DISCIPLINARY ACTIONS IN 1988
(Latest Data Available)

JULY 1990

Ingrid VanTuinen
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PUBLIC CITIZEN HEALTH RESEARCH GROUP REPORT:
STATE MEDICAL BOARD DOCTOR DISCIPLINARY ACTIONS
1988 RANKING OF STATES

We have just received new information from the Federation of State Medical Boards regarding doctor disciplinary rates for 1988, the most recent period available. According to this June 1990 report, 1988 was the first time in five years in which the rate of serious doctor disciplinary actions did not increase. The number of serious disciplinary actions (medical license revocations, suspensions, and probations) remained at 1,489 for 1988[1], as it had been for 1987, the equivalent of 2.77 disciplinary actions for every 1,000 U.S. doctors. In 1988 25 states increased their serious doctor disciplinary rate, 22 decreased that rate, and 4 states maintained the same rate.

This information was not available to us for our June, 1990 report on doctor discipline, 6,892 Questionable Doctors Disciplined by States or the Federal Government. In that book we noted that state medical boards had increased the number of serious disciplinary actions they levied against physicians in 1987, the fourth year of increase in a row, but predicted no significant increase in this rate after 1987.[2]

Public Citizen believes that the 1988 disciplinary rates aren't high enough. A physician could still operate drunk, commit a gross act of negligence, or sexually assault a patient and receive a mere slap on the wrist from his or her state's medical board in most states.

We estimate that well over 100,000 Americans are injured or killed each year as a result of doctors' negligence. The absence in most states of the maximum effort to discipline these doctors is one of the most serious threats to the health of American patients.

American patients would be much more protected if every state would discipline as many doctors as Georgia, the top state in our rankings for 1988. Georgia had a disciplinary rate of 8.55 serious actions per 1,000 physicians, over 21 times more doctor disciplinary actions than Rhode Island, which took only .40 actions per 1,000 physicians. If all states had a rate of serious doctor disciplinary action equalling Georgia's, the total number of M.D.'s seriously sanctioned in 1988 would have been 4,600, over 3 times the number actually subject to those actions that year. This would mean that an additional 3,111 American physicians would have been subjected to serious disciplinary actions in 1988, significantly increasing the amount of patient protection against incompetent or otherwise poorly-practicing physicians.

One bright note: during 1987 and 1988, 44 state legislatures, including those in Florida, Maryland, and Illinois, enacted legislation to strengthen state oversight of physician

behavior.[3] It remains to be seen whether those laws will provide a further push to state medical boards to take incompetent doctors' scalpels and other means of practice away.

OVERALL U.S. TRENDS

For the fifth time in the last six years, Public Citizen Health Research Group has analyzed the most recent (1988) data which state medical licensing boards give to their national organization, the Federation of State Medical Boards. The three types of serious disciplinary actions which we use as the basis for ranking the states are revocation of license, suspension of license, and probation. A fourth category of disciplinary actions, which includes reprimands, voluntary surrender of license and a variety of other actions, is not included because the Federation does not release the details as to what proportion are really serious and how many are not.

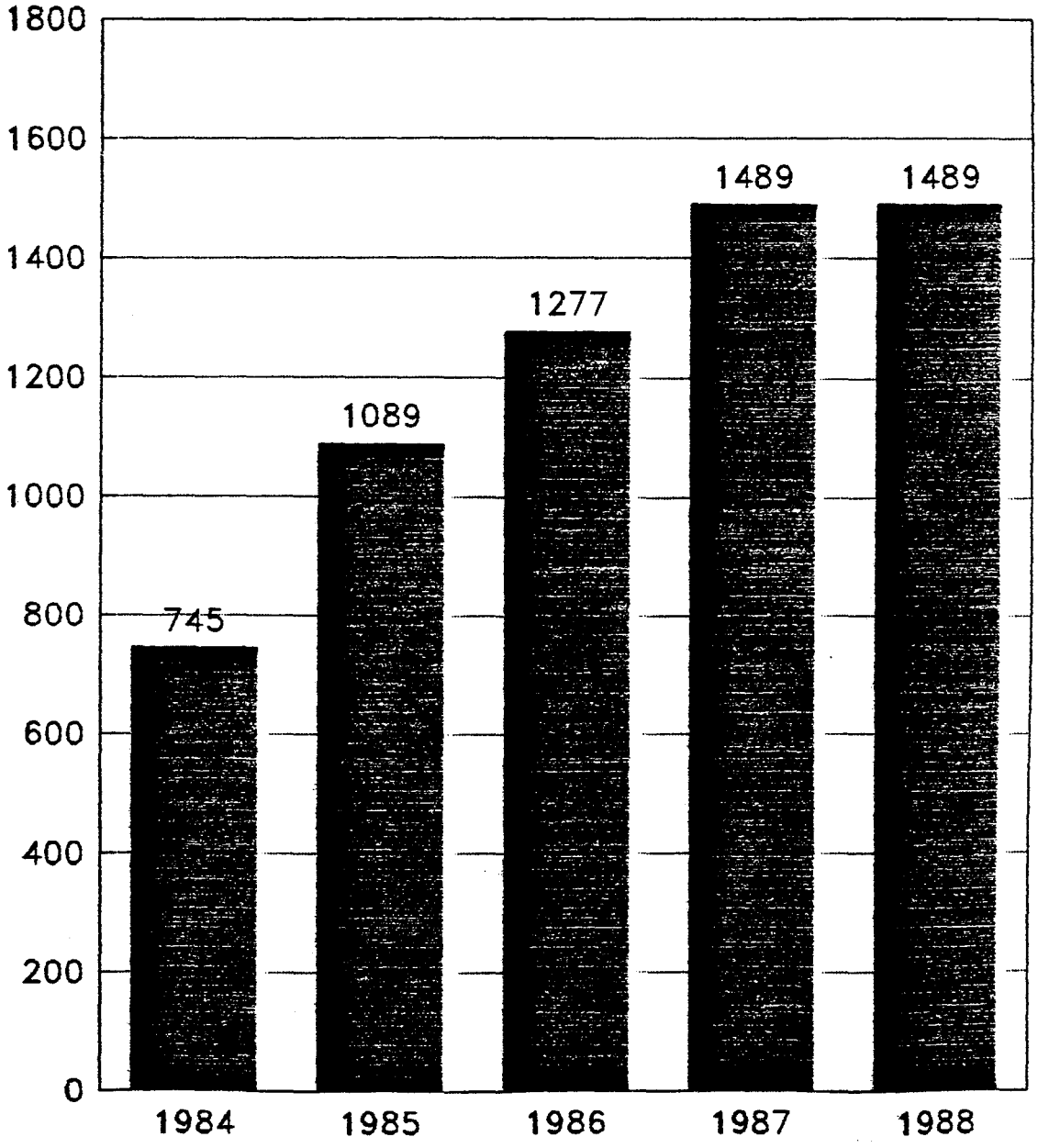
As can be seen in Table 1 below, in 1988 state licensing boards took 1,489 serious disciplinary actions against U.S. physicians (M.D.'s), exactly the same number as were disciplined in 1987. While the number of actions taken by such boards rose steadily from 1984 through 1987, 1988 is the first year in which the number of actions has not risen from the previous year. From 1984 to 1985, the number of actions taken jumped by 344, an increase of 46%. The periods between 1985 and 1986, and between 1986 and 1987, each saw a 17% increase in the rate of discipline. This upward trend seems to have come to a complete stop, and the rates of discipline may even turn downward, leaving health care consumers even less protected than before. This has already occurred in many states, including, for example, New York, Wisconsin, Delaware, and Texas.

TABLE 1
SERIOUS DISCIPLINARY ACTIONS
AGAINST U.S. PHYSICIANS (M.D.s)
1984-1988

YEAR	1984	1985	1986	1987	1988
SERIOUS ACTIONS	745	1089	1277	1489	1489
CHANGE FROM PREVIOUS YEAR	--	+344	+188	+212	+0
PERCENT	--	+46%	+17%	+17%	+0%

With a total of 538,008 non-federal M.D.'s in the U.S. as of December 31, 1986 (the latest available figure)[4], the average rate of doctor discipline for the country is only 2.77 serious

SERIOUS DISCIPLINARY ACTIONS
1984 THROUGH 1988



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disciplinary actions (revocations, suspensions, or probations) per 1,000 M.D.'s.

STATE BY STATE RANKING

The number and rate per 1,000 M.D.'s of serious disciplinary actions for each state and the District of Columbia in 1988, compared to 1987, can be seen in Table 2 on the following page. These rates are calculated by dividing the number of serious disciplinary actions (reported by each state to the Federation of State Medical Boards) by the number of non-Federal M.D.'s in each state.

Better News

Eight of the top 10 states in 1987 remained in the top 10 in 1988. These included **Georgia, Iowa, Oklahoma, Nevada, Mississippi, West Virginia, Hawaii, and South Dakota.** Even better, the other 2 states in the top 10 of 1988 - **Missouri** and **Colorado** - had risen into the top ten since 1987, when Missouri was 11th and Colorado 18th.

Other states showing sizeable increases in the number of serious disciplinary actions from 1987 to 1988 included **Illinois** (up from 25th to 11th), **Minnesota** (up from 24th to 12th), **New Mexico** (up from 39th to 19th), **Ohio** (up from 35th to 21st), **Kansas** (up from 51st to 24th), **Arkansas** (up from 48th to 26th), and **Alabama** (up from 44th to 27th).

Illinois, the state with the largest number of disciplinary actions in 1988 (though only the 11th highest rate) has almost succeeded in doubling its disciplinary action rate (from 67 in 1987 to 126 in 1988). It should be noted, however, that fully 30% of the 1988 actions were based on practicing without a valid license. These figures were inflated by Illinois' crackdown on physician trainees who began their residencies without a proper license, and on doctors who have failed to renew their licenses.

It should also be noted that **Georgia, Iowa,** and **Oklahoma** have been in the top 10 states for doctor disciplinary rates for four straight years, and **West Virginia** has been in the top 10 for three straight years.

Worse News

At the other end of the scale, 14 of the bottom 20 states for doctor disciplinary rates in 1987 remained there in 1988. Of these 14 states, 4 showed increases in disciplinary rates (**Maine, Tennessee, Connecticut,** and **Pennsylvania**), 3 maintained a steady rate (**Maryland, Nebraska,** and **Wyoming**), and 7 actually declined (**New Hampshire, Vermont, California, Texas, Arizona, Rhode Island,** and **Montana**). California is particularly noteworthy in this regard because: 1) it sunk even lower in its serious disciplinary rate (from 42nd to 44th); 2) just as importantly,

TABLE 2

SERIOUS DISCIPLINARY ACTIONS AGAINST M.D.S (REVOCATIONS, SUSPENSIONS AND PROBATIONS) BY STATE LICENSING BOARDS 1987

RANK 1988	RANK 1987	STATE	1988	1987	SERIOUS ACTIONS PER 1000 MDS	NUMBER OF DOCTORS
1	8	GEORGIA	90	58	8.55	10,524
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5	9	NEVADA	12	9	7.16	1,676
6	4	MISSISSIPPI	24	20	7.03	3,416
7	18	COLORADO	42	26	5.98	7,028
8	1	WEST VIRGINIA	19	29	5.62	3,381
9	5	HAWAII	13	15	5.19	2,506
10	6	SOUTH DAKOTA	5	6	4.98	1,004
11	25	ILLINOIS	126	67	4.93	25,537
12	24	MINNESOTA	43	28	4.51	9,535
13	3	KENTUCKY	27	41	4.36	6,188
14	14	FLORIDA	116	129	4.17	27,851
15	2	ALASKA	3	5	4.14	724
16	23	NEW JERSEY	74	59	3.92	18,883
17	21	INDIANA	34	30	3.89	8,731
18	19	NORTH DAKOTA	4	4	3.52	1,136
19	39	NEW MEXICO	9	4	3.29	2,735
20	21	SOUTH CAROLINA	18	19	3.26	5,522
21	16	UTAH	10	13	3.20	3,128
21	35	OHIO	68	38	3.13	21,744
23	27	VIRGINIA	36	29	2.92	12,311
24	51	KANSAS	12	2	2.69	4,460
25	26	LOUISIANA	21	22	2.48	8,453
26	48	ARKANSAS	9	3	2.46	3,664
27	20	MASSACHUSETTS	47	67	2.38	19,766
27	44	ALABAMA	15	8	2.37	6,323
29	33	MICHIGAN	40	34	2.28	17,549
30	17	OREGON	13	23	2.21	5,877
31	32	NORTH CAROLINA	26	22	2.21	11,783
32	43	MAINE	5	3	2.17	2,306
33	47	TENNESSEE	20	8	2.15	9,285
34	27	D.C.	8	9	2.09	3,819
35	15	NEW YORK	98	259	1.70	57,779
36	36	MARYLAND	25	26	1.67	15,000
37	50	CONNECTICUT	15	7	1.53	9,833
38	46	PENNSYLVANIA	43	27	1.51	28,476
39	30	IDAHO	2	3	1.49	1,341
40	40	NEBRASKA	4	5	1.45	2,762
41	41	WYOMING	1	1	1.42	706
42	34	NEW HAMPSHIRE	3	4	1.40	2,149
43	31	VERMONT	2	3	1.36	1,469
44	42	CALIFORNIA	93	94	1.30	71,349
45	38	TEXAS	35	43	1.20	29,207
46	29	WASHINGTON	11	23	1.09	10,079
47	12	WISCONSIN	8	45	0.87	9,234
48	13	DELAWARE	1	6	0.78	1,290
49	45	ARIZONA	4	9	0.55	7,303
50	37	RHODE ISLAND	1	4	0.40	2,489
51	49	MONTANA	0	0	0.00	1,323
						538008

the actions of the Medical Board of California are automatically stayed pending appeal, which means the offending physician can continue to practice and potentially cause even more unnecessary deaths.

Three other states, in the bottom 20 for the first time, showed enormous declines in their disciplinary rates. **Wisconsin** fell from 12th to 47th, and **Delaware** also fell 35 places, plummeting from 13th to 48th. Sadly, **New York**, which took the largest number of disciplinary actions in 1987 (259), took less than half that number in 1988 (98), taking it from 15th to 35th place. This put an end to its steady improvement from 1985 through 1987. Both New York's Health Commissioner, David Axelrod, and Governor Mario Cuomo have proposed legislation that would improve New York's disciplinary machinery. Axelrod openly admits that "The current system for handling professional misconduct by physicians in New York State does not efficiently protect the public from medical negligence, incompetence or illegal and unethical practices."[5]

Other declines were seen for **Alaska** and **Kentucky** (both dropping out of the top 10), and for **Oregon**, which dropped from 17th to 30th. Washington state also fell 17 places, from 29th to 46th. **Montana** retains the distinction of having the worst disciplinary rate for 1988 with no serious disciplinary actions in that year.

IMPLICATIONS

The implications for all states, especially those with low doctor disciplinary rates, are quite serious. Public Citizen estimates that at least 100,000 Americans are injured or killed each year by doctor negligence, a number based on three studies:

Harvard researchers recently found that 1 percent of a representative sample of patients treated in New York state hospitals in 1984 were injured, and one quarter of those died, because of medical negligence.[6] Nationwide, that translates into 234,000 injuries and 80,000 deaths in 1988 from negligence in American hospitals.

A similar study conducted in California in 1974 found that 0.8 percent of hospital patients had either been injured by negligence in the hospital or had been hospitalized because of negligent care. Extrapolation of those findings yields an estimate of 249,000 injuries and deaths from malpractice in 1988.

In 1976 the HEW Malpractice Commission estimated that one-half of one percent of all patients entering hospitals are injured there due to negligence.[7] That estimate would indicate 156,000 such injuries and deaths resulted from doctor negligence in 1988.

Since there is no evidence that doctors settle in certain

states depending on how competent they are, differences in the rate of doctor discipline reflect differences in how serious states are about disciplining doctors. The disparity between states with higher rates of doctor discipline and states with only a fraction of these higher rates is cause for alarm by the residents of the low-discipline states. People in these states are much more likely than people in states with high doctor disciplinary rates to be injured or killed by doctors still on the loose because they haven't been "caught". What might be unacceptable medical practice in one state just goes by the state licensing boards without notice in another state.

Even though the 1988 total of 1,489 serious doctor disciplinary actions has not declined from its highest level in 1987, it falls very short of catching most of the incompetent doctors in this country. In most states, more disciplinary actions are for drug and alcohol problems (9.2%) than for medical negligence or incompetence (8.9%).[8] Boards say proving incompetence is difficult, and investigations of substandard care soak up resources like a sponge. Instead, they use prescription violations and fraud convictions, offenses that are easier to document because they leave a paper trail, as potential indicators of more serious violations.

A further indication that the rate of doctor discipline by most state medical boards is too low comes from a 1989 Tufts University study.[9] Those researchers found that physician-owned insurance companies terminated coverage of 6.6 out of every 1,000 policyholders in 1985 because of negligence-prone behavior. In addition, they restricted the practice or imposed other medical sanctions on an additional 7 of every 1,000 policyholders, whose performance was viewed as substandard. Thus, if the combined rates of malpractice insurance termination and other sanctions by physician-owned insurance companies (13.6 per 1,000 physicians) were applied to all physicians in the U.S., this rate would be almost 5 times higher than the actual average rate of serious doctor disciplinary actions by state licensing boards and would affect 7,317 physicians.

DOCTOR DISCIPLINE AND MEDICAL MALPRACTICE

Until the rate of doctor discipline in this country significantly increases, there is no realistic possibility of a major decrease in the amount of medical malpractice or medical malpractice litigation. At the heart of the so-called medical malpractice litigation crisis, other than the manipulative efforts of the insurance industry, is actual malpractice, patients being injured or killed by negligent physician behavior.

WHY IS GEORGIA NUMBER ONE IN DOCTOR DISCIPLINE?

The Georgia Composite State Board of Medical Examiners is one of the best medical disciplinary boards in the country. The board has proven its excellence by achieving the highest

disciplinary rate on our 1988 list, and by maintaining a position in the top 10 states for the last four years.

This board sees its primary role as protecting the public, not the doctors it examines. According to board executive director Andrew Watry, "We feel we can't really do a good job protecting the consumer if we have to be concerned about the doctor's right to earn a living. We have to be concerned about the patient." Thus the board's investigators don't just respond to complaints, they take an active role in seeking out bad doctors before a formal complaint may have been registered.

Despite the board's commendable performance, Watry is concerned that the board may be backsliding. The legislature has cut his budget, forcing him to leave a staff position vacant for the last two and a half years. In one of several damaging court decisions, the Georgia Supreme Court handed down a decision last year that may jeopardize the precious confidentiality of those reporting violations to the board.

RECOMMENDATIONS FOR STATES

1. **Strengthen the statutes.** States that have not already done should adopt a modified version of the Model Medical Practice Act developed by the Federation of State Medical Boards.[10]
2. **Restructure the board.** States should sever any remaining formal links between state licensing boards and state medical societies. Members of medical boards (and separate disciplinary boards, where present) should be appointed by the governor, and the governor's choice of appointees should be unconstrained, not limited to a medical society's nominees.

At least 30 percent of the members of each medical board and disciplinary board should be public members who have no ties to health care providers.

The governor should appoint medical board members to the Medical Board whose top priority is not providing assistance to physicians, but protecting the public's health.

3. **Inform the public.** Each state's Open Records Law and its Medical Practice Act should state that all formal disciplinary actions against licensed professionals are fully public records.

Each Legislature should require widespread dissemination of final disciplinary orders. Lists of those disciplined and full disciplinary orders should be promptly available to all who ask, through the mail.

Notices of disciplinary actions should be sent to the news media and to all hospitals, HMOs, and other health care providers in the state, as well as to other state agencies, the federal Department of Health and Human Services, and the

federal Drug Enforcement Administration.

4. **Strengthen board authority.** Every medical board should have the authority to impose emergency suspensions pending formal hearing where there is a potential danger to the public health. Boards should aggressively use this authority when they learn of a potentially dangerous doctor.

Every medical board should have the authority to impose civil fines of up to $100,000 for violations. Boards should aggressively use this authority to enforce the requirements for all health care providers to report violations.

Medical boards should have the authority to accept the findings of other state boards and of the federal Department of Health and Human Services and the Drug Enforcement Administration. If a physician has been disciplined by another state, the second state's medical board should be required to impose sanctions at least as stringent as those imposed by the first state.

States should require already-licensed physicians to submit affidavits that they are not under investigation elsewhere before resuming practice in the state. Physicians who are under investigation should not be permitted to return.

Each legislature should provide the Board with authority to examine physicians for physical, mental and professional competence and to test them for alcohol and drug use.

5. **Encourage complaints.** Each legislature should provide the protection of confidentiality and immunity to those who report violations of the Medical Practice Act to the Board and to board members, staff and consultants.

Each legislature should require all licensed health care practitioners to report Medical Practice Act violations by other practitioners to the medical board, with large civil penalties for failure to do so. It should require hospitals to report all revocations, restrictions, or voluntary surrenders of privileges.

It should require courts to report all indictments and convictions of physicians to the medical disciplinary board. It should require liability insurers to report all claims, payments, and policy cancellations. It should require reports from other state agencies, Medicare, the DEA and other federal agencies. It should require impaired physicians' programs to report the names of doctors who fail to successfully complete the program.

Medical boards should conduct random audits of institutions to check compliance with these reporting requirements, and should fine those who fail to comply. After a doctor is disciplined, a board should fine any other practitioners who knew of that doctor's offense, but failed to report it.

6. **Keep the courts in check.** Each Legislature should instruct its state's courts to give deference to disciplinary decisions by the board. Stays should be prohibited; medical board actions should always take effect pending appeal.

Each legislature should adopt the 'Preponderance of the Evidence' standard of proof in medical disciplinary cases, replacing the tougher-to-meet 'Clear and Convincing Evidence' standard now in effect in most states.

7. **Beef up funding and staffing.** Each legislature should permit the medical board to set its own fees and spend all the resulting revenue, rather than being forced to give part to the state Treasury. The medical boards should raise their fees to $500 a year.

All boards could benefit from hiring new investigators and legal staff. Boards should ensure adequate staff to process and investigate all complaints within 30 days, to review all malpractice claims filed with the board, to monitor and regularly visit doctors who have been disciplined to ensure their compliance and to ensure compliance with reporting requirements.

They should hire investigators to seek out errant doctors, through review of pharmacy records, speaking with medical examiners, and targeted office audits of those doctors practicing alone and suspected of poor care. "Physicians who have problems," comments Department of Health and Human Services Inspector General Richard Kusserow, "have retreated to areas where they cannot be observed."

8. **Require risk management.** States should adopt a law, similar to one in Massachusetts, that requires all hospitals and other health care providers to have a meaningful, functioning risk management program designed to prevent injury to patients. Massachusetts also requires all adverse incidents occurring in these institutions or in doctors' offices to be reported to the medical board.

9. **Require periodic recertification** of doctors based on a written exam and audit of their medical care records.

RECOMMENDATIONS TO PATIENTS

1. **Complain.** File your complaints about poor medical care or medical misconduct with your state medical board and with the federal Department of Health and Human Services. If the offense occurred in a hospital, also file a complaint with the hospital peer review committee.

Your complaints are needed to protect others!

2. **Organize.** Form citizens' action or victims' rights groups to improve medical quality assurance in your area. The

American Association of Retired Persons publishes a guide that can help you mobilize a group for reform.[1]1 Try to get a representative of your group appointed to the state medical board or the Medicare Peer Review Organization for your state.

Notes

1. Winn, James R. and Breaden, Dale G. "Official 1988 Federation Summary of Reported Disciplinary Actions." Federation Bulletin June, 1990.

2. Public Citizen Health Research Group. 6,892 Questionable Doctors Disciplined by States or the Federal Government. June, 1990, p. xiv.

3. Intergovernmental Health Policy Project, State Oversight and Regulation of Physicians, George Washington University, September, 1988.

4. Physician Characteristics and Distribution in the U.S., 1987. Chicago: American Medical Association, 1987.

5. Governor's Program Bill, #182, 1990, Memorandum.

6. Harvard Medical Practice Study Group, "Patients, Doctors and Lawyers: Medical Injury, Malpractice, Litigation and Patient Compensation in New York," 1990.

7. Journal of Legal Medicine February, 1976.

8. Public Citizen Health Research Group. 6,892 Questionable Doctors, op. cit. p. xxii, Table 3.

9. Schwartz, William B. and Mendelson, Daniel N. "The Role of Physician-Owned Insurance Companies in the Detection and Deterrence of Negligence", Journal of the American Medical Association 1989, vol. 260, no. 10, pp. 1342-1346.

10. Federation of State Medical Boards, Elements of a Modern State Medical Board: A Proposal, August, 1989.

11. American Association of Retired Persons, "Effective Physician Oversight: Prescription for Medical Licensing Board Reform", 1987.

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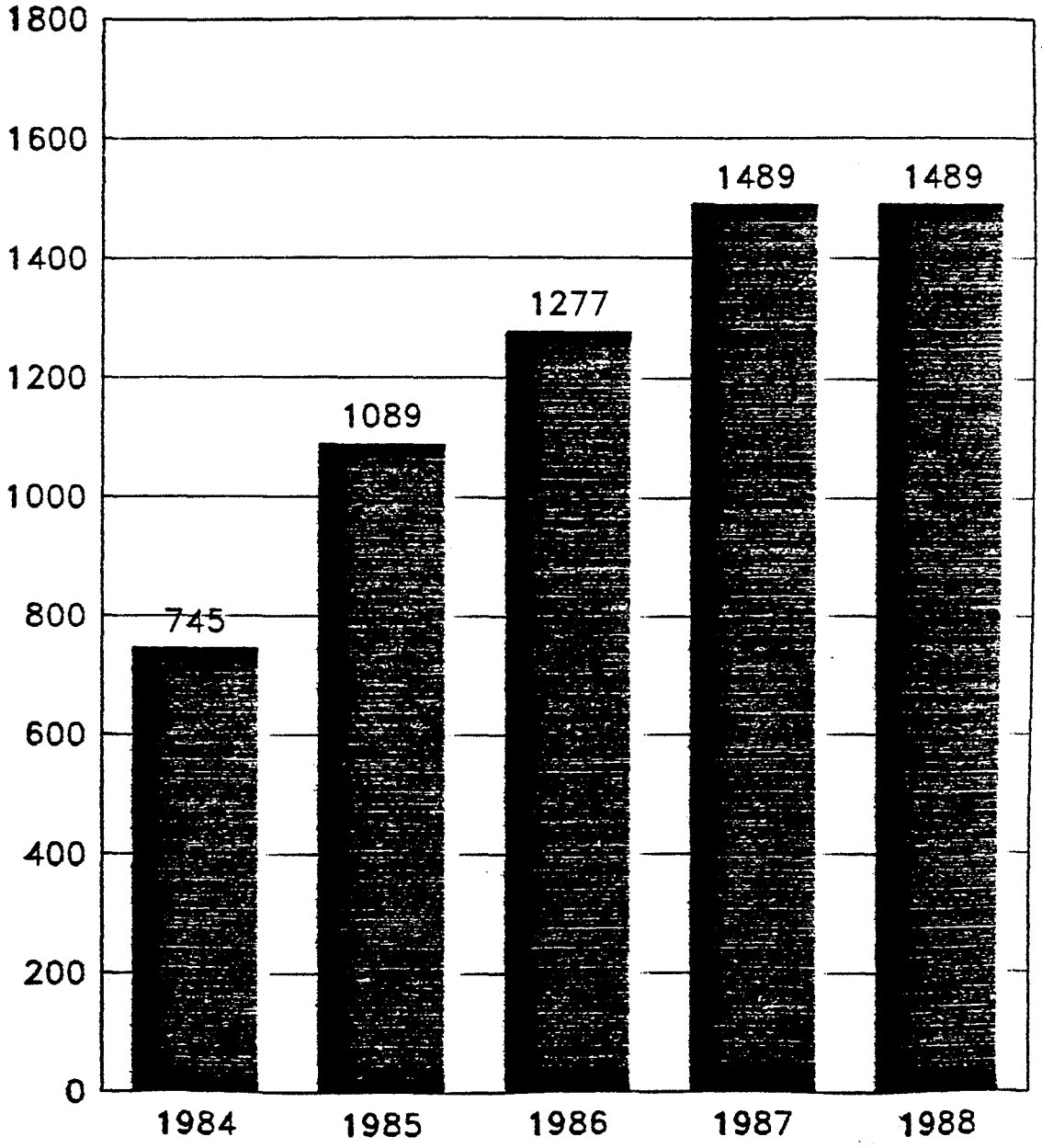

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6	4	MISSISSIPPI	24	20	7.03	3,416
7	18	COLORADO	42	26	5.98	7,028
8	1	WEST VIRGINIA	19	29	5.62	3,381
9	5	HAWAII	13	15	5.19	2,506
10	6	SOUTH DAKOTA	5	6	4.98	1,004
11	25	ILLINOIS	126	67	4.93	25,537
12	24	MINNESOTA	43	28	4.51	9,535
13	3	KENTUCKY	27	41	4.36	6,188
14	14	FLORIDA	116	129	4.17	27,851
15	2	ALASKA	3	5	4.14	724
16	23	NEW JERSEY	74	59	3.92	18,883
17	21	INDIANA	34	30	3.89	8,731
18	19	NORTH DAKOTA	4	4	3.52	1,136
19	39	NEW MEXICO	9	4	3.29	2,735
20	21	SOUTH CAROLINA	18	19	3.26	5,522
21	16	UTAH	10	13	3.20	3,128
21	35	OHIO	68	38	3.13	21,744
23	27	VIRGINIA	36	29	2.92	12,311
24	51	KANSAS	12	2	2.69	4,460
25	26	LOUISIANA	21	22	2.48	8,453
26	48	ARKANSAS	9	3	2.46	3,664
27	20	MASSACHUSETTS	47	67	2.38	19,766
27	44	ALABAMA	15	8	2.37	6,323
29	33	MICHIGAN	40	34	2.28	17,549
30	17	OREGON	13	23	2.21	5,877
31	32	NORTH CAROLINA	26	22	2.21	11,783
32	43	MAINE	5	3	2.17	2,306
33	47	TENNESSEE	20	8	2.15	9,285
34	27	D.C.	8	9	2.09	3,819
35	15	NEW YORK	98	259	1.70	57,779
36	36	MARYLAND	25	26	1.67	15,000
37	50	CONNECTICUT	15	7	1.53	9,833
38	46	PENNSYLVANIA	43	27	1.51	28,476
39	30	IDAHO	2	3	1.49	1,341
40	40	NEBRASKA	4	5	1.45	2,762
41	41	WYOMING	1	1	1.42	706
42	34	NEW HAMPSHIRE	3	4	1.40	2,149
43	31	VERMONT	2	3	1.36	1,469
44	42	CALIFORNIA	93	94	1.30	71,349
45	38	TEXAS	35	43	1.20	29,207
46	29	WASHINGTON	11	23	1.09	10,079
47	12	WISCONSIN	8	45	0.87	9,234
48	13	DELAWARE	1	6	0.78	1,290
49	45	ARIZONA	4	9	0.55	7,303
50	37	RHODE ISLAND	1	4	0.40	2,489
51	49	MONTANA	0	0	0.00	1,323
						538008

the actions of the Medical Board of California are automatically stayed pending appeal, which means the offending physician can continue to practice and potentially cause even more unnecessary deaths.

Three other states, in the bottom 20 for the first time, showed enormous declines in their disciplinary rates. **Wisconsin** fell from 12th to 47th, and **Delaware** also fell 35 places, plummeting from 13th to 48th. Sadly, **New York**, which took the largest number of disciplinary actions in 1987 (259), took less than half that number in 1988 (98), taking it from 15th to 35th place. This put an end to its steady improvement from 1985 through 1987. Both New York's Health Commissioner, David Axelrod, and Governor Mario Cuomo have proposed legislation that would improve New York's disciplinary machinery. Axelrod openly admits that "The current system for handling professional misconduct by physicians in New York State does not efficiently protect the public from medical negligence, incompetence or illegal and unethical practices."[5]

Other declines were seen for **Alaska** and **Kentucky** (both dropping out of the top 10), and for **Oregon**, which dropped from 17th to 30th. Washington state also fell 17 places, from 29th to 46th. **Montana** retains the distinction of having the worst disciplinary rate for 1988 with no serious disciplinary actions in that year.

IMPLICATIONS

The implications for all states, especially those with low doctor disciplinary rates, are quite serious. Public Citizen estimates that at least 100,000 Americans are injured or killed each year by doctor negligence, a number based on three studies:

Harvard researchers recently found that 1 percent of a representative sample of patients treated in New York state hospitals in 1984 were injured, and one quarter of those died, because of medical negligence.[6] Nationwide, that translates into 234,000 injuries and 80,000 deaths in 1988 from negligence in American hospitals.

A similar study conducted in California in 1974 found that 0.8 percent of hospital patients had either been injured by negligence in the hospital or had been hospitalized because of negligent care. Extrapolation of those findings yields an estimate of 249,000 injuries and deaths from malpractice in 1988.

In 1976 the HEW Malpractice Commission estimated that one-half of one percent of all patients entering hospitals are injured there due to negligence.[7] That estimate would indicate 156,000 such injuries and deaths resulted from doctor negligence in 1988.

Since there is no evidence that doctors settle in certain

states depending on how competent they are, differences in the rate of doctor discipline reflect differences in how serious states are about disciplining doctors. The disparity between states with higher rates of doctor discipline and states with only a fraction of these higher rates is cause for alarm by the residents of the low-discipline states. People in these states are much more likely than people in states with high doctor disciplinary rates to be injured or killed by doctors still on the loose because they haven't been "caught". What might be unacceptable medical practice in one state just goes by the state licensing boards without notice in another state.

Even though the 1988 total of 1,489 serious doctor disciplinary actions has not declined from its highest level in 1987, it falls very short of catching most of the incompetent doctors in this country. In most states, more disciplinary actions are for drug and alcohol problems (9.2%) than for medical negligence or incompetence (8.9%).[8] Boards say proving incompetence is difficult, and investigations of substandard care soak up resources like a sponge. Instead, they use prescription violations and fraud convictions, offenses that are easier to document because they leave a paper trail, as potential indicators of more serious violations.

A further indication that the rate of doctor discipline by most state medical boards is too low comes from a 1989 Tufts University study.[9] Those researchers found that physician-owned insurance companies terminated coverage of 6.6 out of every 1,000 policyholders in 1985 because of negligence-prone behavior. In addition, they restricted the practice or imposed other medical sanctions on an additional 7 of every 1,000 policyholders, whose performance was viewed as substandard. Thus, if the combined rates of malpractice insurance termination and other sanctions by physician-owned insurance companies (13.6 per 1,000 physicians) were applied to all physicians in the U.S., this rate would be almost 5 times higher than the actual average rate of serious doctor disciplinary actions by state licensing boards and would affect 7,317 physicians.

DOCTOR DISCIPLINE AND MEDICAL MALPRACTICE

Until the rate of doctor discipline in this country significantly increases, there is no realistic possibility of a major decrease in the amount of medical malpractice or medical malpractice litigation. At the heart of the so-called medical malpractice litigation crisis, other than the manipulative efforts of the insurance industry, is actual malpractice, patients being injured or killed by negligent physician behavior.

WHY IS GEORGIA NUMBER ONE IN DOCTOR DISCIPLINE?

The Georgia Composite State Board of Medical Examiners is one of the best medical disciplinary boards in the country. The board has proven its excellence by achieving the highest

disciplinary rate on our 1988 list, and by maintaining a position in the top 10 states for the last four years.

This board sees its primary role as protecting the public, not the doctors it examines. According to board executive director Andrew Watry, "We feel we can't really do a good job protecting the consumer if we have to be concerned about the doctor's right to earn a living. We have to be concerned about the patient." Thus the board's investigators don't just respond to complaints, they take an active role in seeking out bad doctors before a formal complaint may have been registered.

Despite the board's commendable performance, Watry is concerned that the board may be backsliding. The legislature has cut his budget, forcing him to leave a staff position vacant for the last two and a half years. In one of several damaging court decisions, the Georgia Supreme Court handed down a decision last year that may jeopardize the precious confidentiality of those reporting violations to the board.

RECOMMENDATIONS FOR STATES

1. **Strengthen the statutes.** States that have not already done should adopt a modified version of the Model Medical Practice Act developed by the Federation of State Medical Boards.[10]

2. **Restructure the board.** States should sever any remaining formal links between state licensing boards and state medical societies. Members of medical boards (and separate disciplinary boards, where present) should be appointed by the governor, and the governor's choice of appointees should be unconstrained, not limited to a medical society's nominees.

   At least 30 percent of the members of each medical board and disciplinary board should be public members who have no ties to health care providers.

   The governor should appoint medical board members to the Medical Board whose top priority is not providing assistance to physicians, but protecting the public's health.

3. **Inform the public.** Each state's Open Records Law and its Medical Practice Act should state that all formal disciplinary actions against licensed professionals are fully public records.

   Each Legislature should require widespread dissemination of final disciplinary orders. Lists of those disciplined and full disciplinary orders should be promptly available to all who ask, through the mail.

   Notices of disciplinary actions should be sent to the news media and to all hospitals, HMOs, and other health care providers in the state, as well as to other state agencies, the federal Department of Health and Human Services, and the

federal Drug Enforcement Administration.

4. **Strengthen board authority.** Every medical board should have the authority to impose emergency suspensions pending formal hearing where there is a potential danger to the public health. Boards should aggressively use this authority when they learn of a potentially dangerous doctor.

Every medical board should have the authority to impose civil fines of up to $100,000 for violations. Boards should aggressively use this authority to enforce the requirements for all health care providers to report violations.

Medical boards should have the authority to accept the findings of other state boards and of the federal Department of Health and Human Services and the Drug Enforcement Administration. If a physician has been disciplined by another state, the second state's medical board should be required to impose sanctions at least as stringent as those imposed by the first state.

States should require already-licensed physicians to submit affidavits that they are not under investigation elsewhere before resuming practice in the state. Physicians who are under investigation should not be permitted to return.

Each legislature should provide the Board with authority to examine physicians for physical, mental and professional competence and to test them for alcohol and drug use.

5. **Encourage complaints.** Each legislature should provide the protection of confidentiality and immunity to those who report violations of the Medical Practice Act to the Board and to board members, staff and consultants.

Each legislature should require all licensed health care practitioners to report Medical Practice Act violations by other practitioners to the medical board, with large civil penalties for failure to do so. It should require hospitals to report all revocations, restrictions, or voluntary surrenders of privileges.

It should require courts to report all indictments and convictions of physicians to the medical disciplinary board. It should require liability insurers to report all claims, payments, and policy cancellations. It should require reports from other state agencies, Medicare, the DEA and other federal agencies. It should require impaired physicians' programs to report the names of doctors who fail to successfully complete the program.

Medical boards should conduct random audits of institutions to check compliance with these reporting requirements, and should fine those who fail to comply. After a doctor is disciplined, a board should fine any other practitioners who knew of that doctor's offense, but failed to report it.

6. **Keep the courts in check.** Each Legislature should instruct its state's courts to give deference to disciplinary decisions by the board. Stays should be prohibited; medical board actions should always take effect pending appeal.

Each legislature should adopt the 'Preponderance of the Evidence' standard of proof in medical disciplinary cases, replacing the tougher-to-meet 'Clear and Convincing Evidence' standard now in effect in most states.

7. **Beef up funding and staffing.** Each legislature should permit the medical board to set its own fees and spend all the resulting revenue, rather than being forced to give part to the state Treasury. The medical boards should raise their fees to $500 a year.

All boards could benefit from hiring new investigators and legal staff. Boards should ensure adequate staff to process and investigate all complaints within 30 days, to review all malpractice claims filed with the board, to monitor and regularly visit doctors who have been disciplined to ensure their compliance and to ensure compliance with reporting requirements.

They should hire investigators to seek out errant doctors, through review of pharmacy records, speaking with medical examiners, and targeted office audits of those doctors practicing alone and suspected of poor care. "Physicians who have problems," comments Department of Health and Human Services Inspector General Richard Kusserow, "have retreated to areas where they cannot be observed."

8. **Require risk management.** States should adopt a law, similar to one in Massachusetts, that requires all hospitals and other health care providers to have a meaningful, functioning risk management program designed to prevent injury to patients. Massachusetts also requires all adverse incidents occurring in these institutions or in doctors' offices to be reported to the medical board.

9. **Require periodic recertification** of doctors based on a written exam and audit of their medical care records.

RECOMMENDATIONS TO PATIENTS

1. **Complain.** File your complaints about poor medical care or medical misconduct with your state medical board and with the federal Department of Health and Human Services. If the offense occurred in a hospital, also file a complaint with the hospital peer review committee.

Your complaints are needed to protect others!

2. **Organize.** Form citizens' action or victims' rights groups to improve medical quality assurance in your area. The

American Association of Retired Persons publishes a guide that can help you mobilize a group for reform.[1]1 Try to get a representative of your group appointed to the state medical board or the Medicare Peer Review Organization for your state.

Notes

1. Winn, James R. and Breaden, Dale G. "Official 1988 Federation Summary of Reported Disciplinary Actions." Federation Bulletin June, 1990.

2. Public Citizen Health Research Group. 6,892 Questionable Doctors Disciplined by States or the Federal Government. June, 1990, p. xiv.

3. Intergovernmental Health Policy Project, State Oversight and Regulation of Physicians, George Washington University, September, 1988.

4. Physician Characteristics and Distribution in the U.S., 1987. Chicago: American Medical Association, 1987.

5. Governor's Program Bill, #182, 1990, Memorandum.

6. Harvard Medical Practice Study Group, "Patients, Doctors and Lawyers: Medical Injury, Malpractice, Litigation and Patient Compensation in New York," 1990.

7. Journal of Legal Medicine February, 1976.

8. Public Citizen Health Research Group. 6,892 Questionable Doctors, op. cit. p. xxii, Table 3.

9. Schwartz, William B. and Mendelson, Daniel N. "The Role of Physician-Owned Insurance Companies in the Detection and Deterrence of Negligence", Journal of the American Medical Association 1989, vol. 260, no. 10, pp. 1342-1346.

10. Federation of State Medical Boards, Elements of a Modern State Medical Board: A Proposal, August, 1989.

11. American Association of Retired Persons, "Effective Physician Oversight: Prescription for Medical Licensing Board Reform", 1987.