RANKING OF THE RATE OF STATE MEDICAL BOARDS' SERIOUS DISCIPLINARY ACTIONS, 2019-2021

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August 16, 2023

ACKNOWLEDGMENTS

This report was written by Sidney Wolfe, M.D., Founder and Senior Advisor of Public Citizen's Health Research Group and Robert E. Oshel, Ph.D., former Associate Director for Research of the National Practitioner Data Bank and Advisor to Public Citizen's Health Research Group. The report was copyedited by Fiona Lynn, Managing Editor of Public Citizen's Health Research Group. Robert Steinbrook, M.D. is the Director of Public Citizen's Health Research Group.

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INTRODUCTION

The system of licensing medical practitioners was designed to protect the public from physicians who are inadequately trained or incompetent or whose conduct is illegal or abusive towards patients. Medical practice laws in all states mandate that medical boards, as a part of their important function of responsibly licensing physicians, have the legal obligation to take necessary, appropriate disciplinary actions against licensees known to have injured, endangered, or behaved inappropriately or illegally towards patients.

There is abundant evidence that many patients are negligently injured while being treated. A 2010 study by the Department of Health and Human Services Office of Inspector General analyzing the records of a nationally representative sample of Medicare patients hospitalized during October 2008 found that 13.5% of patients experienced adverse events during their hospital stays.[1] Projected nationally, the researchers estimated that 134,000 Medicare beneficiaries experienced at least one adverse event in hospitals during that month. Further analysis found that 44% of these adverse events, 59,000 a month, were preventable. Nearly half of the preventable events involved substandard care, most frequently because of a delay in diagnosis or treatment.

The purpose of this report is to examine the extent to which medical-licensing boards are taking actions to protect the public from licensed physicians who injure patients or behave inappropriately or illegally. Because, to date, no objective standards have been developed to measure board performance in the abstract, we compare the performance of the state medical boards based on the annual average number of serious disciplinary actions taken by the boards per 1,000 licensees. There is no reason to believe that physicians in any one state are more or less likely to be incompetent or miscreant than the physicians in any other state. Therefore, we believe all observed differences between the boards reflect variations in board performance rather than in physician behavior across different states.

[1] Department of Health and Human Services, Office of Inspector General. Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries. November 2010 OEI-06-09-00090. https://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf. Accessed March 16, 2021.

BACKGROUND: THE NATIONAL PRACTITIONER DATA BANK

All data on licensing-board disciplinary actions used in this report come from the National Practitioner Data Bank (NPDB). Since September 1990, state licensing boards, hospitals, and other health care entities, including professional societies, have been required to report to the NPDB certain adverse licensing and disciplinary actions taken against individual practitioners. Malpractice insurers and other payers are required to report all malpractice payments made on behalf of individual practitioners.

This physician-specific information is only made available from the NPDB in response to inquiries from licensing boards and credentialing authorities. Hospitals are required to query the NPDB concerning all new staff appointments of physicians, dentists, and other practitioners and to query concerning their entire medical staff at least once every two years. Other health care entities, such as health-maintenance organizations or medical or dental group practices, may query the NPDB if they have adopted a formal peer-review process. State medical and dental boards also may query the NPDB and thereby determine whether licensees have been disciplined in other states, have had adverse actions by hospitals or other entities, or have had malpractice-payment reports. However, the public, including physicians, is denied access to any physician-specific information.[2]

METHODOLOGY

Public Citizen's Health Research Group calculated the rate of serious disciplinary actions per 1,000 physicians in each state with either M.D. (Doctor of Allopathic Medicine) only or combined M.D./D.O. (Doctor of Osteopathic Medicine) medical boards. We used state-level data on serious disciplinary actions from the NPDB's Public Use Data File for licensing reports received through March 31, 2022, limited to those serious disciplinary actions actually taken against physicians during 2019, 2020, and 2021, not the year the report was submitted to the NPDB.

We defined "serious disciplinary actions" as those that had a clear impact on a physician's ability to practice. We used the NPDB's reporting categories of license revocations, suspensions, summary restrictions, summary suspensions, voluntary surrenders while under investigation, voluntary limitations while under investigation, limitations or restrictions, denials of renewal, and voluntary agreements to refrain or suspend pending completion of

[2] Physicians can only obtain their own record from the NPDB.

investigation.[3] Probation was not considered to be a "serious disciplinary action" because even if conditions are imposed with probations, most of the conditions of probation, such as a requirement for a nurse to be present during a pelvic exam, are unenforceable and do not seriously impact a physician's practice. The NPDB allows reporters to report up to five actions taken simultaneously on a single report. We therefore included a licensing report in our count only if one or more of the reported actions met our criteria for serious disciplinary actions. Regardless of the number of other serious actions specified in a single report, each report was counted only once.

To obtain the numerator for our calculation of serious disciplinary actions per 1,000 physicians, we added the number of serious disciplinary actions taken in each state for 2019, 2020, and 2021 and then divided this total by three to obtain the average number of serious disciplinary actions for each state per year during the entire three-year period.

Serious disciplinary actions against all licensed physicians were included in states which have either an M.D.-only or a combined licensing board for both allopaths (M.D.s) and osteopaths (D.O.s); serious disciplinary actions against osteopaths were excluded only for the 13 states with separate allopathic and osteopathic licensing boards.[4] We therefore subtracted the number of osteopaths from the total number of physicians in those states with separate osteopathic boards so the rate would be limited to serious actions for M.D.s per 1,000 M.D.s in these states.

The source of the number of physicians licensed by each state board in 2020 was an interactive map on the Federation of State Medical Boards (FSMB) website (fsmb.org/physician census)[5]. The physician count for each state includes both M.D.s and D.O.s if a board licenses both. If a board licenses only M.D.s, we used only the count for M.D.s for that state. 2020 was the median year of our study period. Because some small states do not have many physicians, an increase or decrease of one or two serious actions in a year will have a much greater effect on the rate of discipline in such states (and, therefore, their rankings) than it would in states with larger numbers of physicians. To minimize such fluctuations, we calculated the average annual rate of serious disciplinary actions for all states over a three-year period. Thus, the ranking is based on the average annual rate of serious actions taken in 2019, 2020, and 2021.

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[3] Additional serious actions involving multiple states include multi-state license-privilege revocations, multi-state license-privilege suspensions, multi-state license-privilege summary restrictions, multi-state license-privilege summary suspensions, multi-state license-privilege voluntary surrenders, multi-state license-privilege voluntary limitations, and multi-state license-privilege limitations or restrictions. Further, to avoid an additional potential source of double counting, we included only "initial" and "correction" reports (which replace the "initial" report being corrected in the NPDB). We excluded "revision to action" and "correction to revision to action" reports, which are separate reports that modify an action reported in a previous report but do not replace the related "initial" or "correction" report or any previous "revision to action" or "correction to revision to action" report. This could result in a minor undercount of serious actions in those rare cases in which a board revised a previously non-serious action to become a serious action. Similarly, however, our exclusion of actions revised from serious to nonserious could result in an overcount of serious actions. We believe these two counteracting effects do not materially affect the rankings.

[4]The New Mexico Osteopathic Board was merged with the New Mexico Medical Board on July 1, 2021, reducing the number of Osteopathic boards to 13.

[5]As of the date of this publication, the interactive map with 2020 data is no longer availabale on the FSMB website; the current interactive map shows 2022 data.

RESULTS

Table 1 below provides our ranking of states based on the 2019-2021 annual average rate of serious disciplinary actions per 1,000 physicians. Michigan had the highest rate in the country with an average of 1.74 serious disciplinary actions per 1,000 physicians per year. The District of Columbia had the lowest rate with only 0.19 serious disciplinary actions per 1,000 physicians per year. Thus, the rate of serious disciplinary actions per 1,000 physicians per year in Michigan was slightly more than nine times higher than in the District of Columbia (1.74 divided by 0.19). The average total number of serious disciplinary actions taken per year (2019-2021) by all states was 1,281, which is 165 serious actions per year lower than the average of 1,446 we found in our last report for the years 2017-2019. The new report could not account for the effects, if any, of the COVID-19 pandemic on serious disciplinary actions in 2020 and 2021.

The state of New York, which ranks behind only California in total number of licensed physicians, though it had the seventh highest rate in the country —1.25 serious disciplinary actions per 1,000 physicians per year — was still considerably (28%) lower than Michigan's rate of 1.74. If New York had seriously disciplined physicians at the same rate as Michigan, an additional 0.48 serious actions per 1,000 physicians would have occurred each year in that state. Since there were 102,361 licensed physicians in New York in 2020, a total of 49 (102.361 X 0.49) more serious disciplinary actions a year would have been taken by the New York Medical Board if it had taken such actions at the same rate as the Michigan board.

California, the state with the largest number of physicians, continued to have a much lower rate of serious actions, ranking 27th in the United States. The California rate of 0.83 serious actions per 1,000 physicians was 0.91 lower (1.74 minus 0.83) than Michigan's rate. With 152,450 licensed physicians in California in 2020, a total of 139 (152.45 X 0.91) more serious disciplinary actions a year would have been taken by the California Medical Board were its rate as high as that of Michigan.

In Table 2 below, Michigan — the state with the highest rate of serious disciplinary actions — is used as a basis of comparison for all other states to calculate the number of additional serious actions per 1,000 physicians per year that would have been needed to be taken for each of the other states to match the rate seen in Michigan, as has already been described above for New York and California.

Of note, Michigan is in the upper range of states in terms of the size of its physician population, having 35,506 physicians and ranking 13th in number of physicians. Alabama, which had 18,629 physicians and ranked 26th in number of physicians in 2020 is the state with the median number of physicians.

Based on the 2019-2021 data, if all states had increased their annual rate of serious disciplinary actions to match Michigan's rate of 1.74 serious actions per 1,000 physicians per year for 2019 through 2021, there would have been a total of 1,133 more serious disciplinary actions taken per year against physicians throughout the United States. This would have almost doubled the average annual number of serious state disciplinary actions nationally, from 1,281 to 2,414.

It should be noted that although Michigan currently has the highest rate of serious disciplinary actions, with increased attention to improving the rate of appropriate and necessary serious actions, Michigan or another state could set an even higher standard, further increasing the number of predicted new serious disciplinary actions for all states. In fact, the highest rate of serious board actions in this report is 0.55 serious actions per 1,000 physicians lower than the highest rate in our 2017-2019 report. Indeed, Michigan's rate, the best in this report, is lower than the highest three rates in the 2017-2019 report. Clearly, there is no reason to believe that even the highest rate currently observed is the best that can be achieved, let alone adequate for protecting the public from dangerous physicians.

Table 1: Ranking of State Medical Boards by Annual Average Number of Serious Disciplinary Actions per 1,000 Physicians, 2019-2021

State	2019 - 2021 Ranking	Rate of Serious Actions per 1,000 Physicians*	Average Annual Serious Actions*	Licensed Physicians, 2020	2017-2019 Ranking	Change in Ranking
MI Michigan	1	1.74	61.67	35,506	4	3
OH Ohio	2	1.61	84.67	52,720	13	11
ND North Dakota	3	1.60	8.00	5,005	17	14
CO Colorado	4	1.55	43.00	27,681	14	10
AZ Arizona	5	1.53	40.33	26,397	2	-3
KY Kentucky	6	1.50	30.33	20,156	1	-5
NY New York	7	1.25	128.33	102,361	6	-1
WI Wisconsin	8	1.23	35.67	29,110	24	16
VT Vermont	9	1.20	4.33	3,609	8	-1
IL Illinois	10	1.17	56.00	47,846	10	0
WV West Virginia	11	1.15	8.33	7,219	7	-4
TX Texas	12	1.14	101.00	88,747	11	-1
RI Rhode Island	13	1.08	6.33	5,838	26	13
AL Alabama	14	1.07	20.00	18,629	22	8
KS Kansas	15	1.06	11.67	10,967	15	0
MA Massachusetts	16	1.05	38.33	36,591	25	9
WA Washington	17	1.04	30.00	28,722	29	12
AR Arkansas	18	1.04	12.00	11,565	16	-2
VA Virginia	19	1.02	42.33	41,588	19	0
FL Florida	20	1.00	76.67	76,395	21	1
OR Oregon	21	1.00	17.33	17,321	28	7
MS Mississippi	22	0.99	11.67	11,742	23	1
ME Maine	23	0.91	6.00	6,601	9	-14
AK Alaska	24	0.90	4.33	4,791	5	-19
MD Maryland	25	0.89	28.33	31,841	27	2
PA Pennsylvania	26	0.89	48.00	54,136	3	-23
CA California	27	0.83	126.00	152,450	33	6
NM New Mexico	28	0.81	8.33	10,277	12	-16
IA Iowa	29	0.76	10.33	13,530	18	-11
LA Louisiana	30	0.70	12.67	18,052	41	11
ID Idaho	31	0.65	5.00	7,667	42	11
NC North Carolina	32	0.59	26.00	44,015	38	6
MO Missouri	33	0.57	16.67	29,477	20	-13
WY Wyoming	34	0.56	2.67	4,747	34	0
MN Minnesota	35	0.55	14.67	26,574	47	12
DE Delaware	36	0.55	3.33	6,102	30	-6
TN Tennessee	37	0.54	13.00	23,872	35	-2
SD South Dakota	38	0.54	3.00	5,588	48	10
HI Hawaii	39	0.51	5.33	10,515	43	4
OK Oklahoma	40	0.48	6.33	13,250	36	-4
NJ New Jersey	41	0.45	19.67	43,563	31	-10
CT Connecticut	42	0.42	8.67	20,817	37	-5
MT Montana	43	0.38	2.67	6,973	39	-4
UT Utah	44	0.38	4.33	11,477	44	0
SC South Carolina	45	0.34	7.67	22,307	32	-13
NE Nebraska	46	0.32	4.00	12,376	46	0
IN Indiana	47	0.28	8.67	30,649	40	-7
GA Georgia	48	0.27	10.33	38,367	49	1
NH New Hampshire	49	0.25	2.00	8,019	50	1
NV Nevada	50	0.24	2.33	9,898	45	-5
DC District of Columbia	51	0.19	2.67	13,714	51	0

**Calculations were performed with greater precision than shown in the table.*

Table 2: Calculated Increase in Annual Numbers of Serious Disciplinary Actions Each State Would Have Needed to Take to Have Matched the Rate for Michigan, 2019-2021

State	Average Annual Serious Actions	Calculated Additional Serious Actions per Year Needed to Have Matched the Rate in Michigan	Calculated Percent Increase in Average Number of Serious Actions Needed to Have Matched Michigan's Rate	2019 - 2021 Ranking
MI Michigan	61.67	N/A	N/A	1
OH Ohio	84.67	6.90	8.15	2
ND North Dakota	8.00	0.69	8.66	3
CO Colorado	43.00	5.08	11.81	4
AZ Arizona	40.33	5.51	13.67	5
KY Kentucky	30.33	4.67	15.41	6
NY New York	128.33	49.45	38.53	7
WI Wisconsin	35.67	14.89	41.75	8
VT Vermont	4.33	1.93	44.65	9
IL Illinois	56.00	27.10	48.39	10
WV West Virginia	8.33	4.20	50.46	11
TX Texas	101.00	53.14	52.61	12
RI Rhode Island	6.33	3.81	60.10	13
AL Alabama	20.00	12.35	61.77	14
KS Kansas	11.67	7.38	63.26	15
MA Massachusetts	38.33	25.22	65.79	16
WA Washington	30.00	19.88	66.28	17
AR Arkansas	12.00	8.09	67.38	18
VA Virginia	42.33	29.90	70.62	19
FL Florida	76.67	56.02	73.06	20
OR Oregon	17.33	12.75	73.56	21
MS Mississippi	11.67	8.73	74.80	22
ME Maine	6.00	5.46	91.08	23
AK Alaska	4.33	3.99	92.02	24
MD Maryland	28.33	26.97	95.18	25
PA Pennsylvania	48.00	46.02	95.88	26
CA California	126.00	138.77	110.14	27
NM New Mexico	8.33	9.52	114.19	28
IA Iowa	10.33	13.17	127.41	29
LA Louisiana	12.67	18.69	147.52	30
ID Idaho	5.00	8.32	166.32	31
NC North Carolina	26.00	50.45	194.02	32
MO Missouri	16.67	34.53	207.17	33
WY Wyoming	2.67	5.58	209.17	34
MN Minnesota	14.67	31.49	214.68	35
DE Delaware	3.33	7.26	217.94	36
TN Tennessee	13.00	28.46	218.93	37
SD South Dakota	3.00	6.71	223.51	38
HI Hawaii	5.33	12.93	242.42	39
OK Oklahoma	6.33	16.68	263.36	40
NJ New Jersey	19.67	55.99	284.71	41
CT Connecticut	8.67	27.49	317.17	42
MT Montana	2.67	9.44	354.15	43
UT Utah	4.33	15.60	360.00	44
SC South Carolina	7.67	31.08	405.34	45
NE Nebraska	4.00	17.49	437.36	46
IN Indiana	8.67	44.56	514.20	47
GA Georgia	10.33	56.30	544.86	48
NH New Hampshire	2.00	11.93	596.37	49
NV Nevada	2.33	14.86	636.75	50
DC District of Columbia	2.67	21.15	793.19	51

DISCUSSION: WHAT COULD IMPROVE MEDICAL BOARDS' PERFORMANCE?

Given the observed wide variation in serious disciplinary actions taken per 1,000 physicians across states and the District of Columbia, many if not most, state medical boards are doing a dangerously lax job in enforcing their states' medical practice acts. Low rates of serious disciplinary actions suggest that medical boards are not adequately taking actions to discipline physicians responsible for negligent medical care or whose behavior is unacceptably dangerous to patients.

There is no evidence that the observed differences in state disciplinary action rates can be explained by differences in the competence or conduct of the physicians practicing in the various states; therefore, they must be related to differences in how well or poorly the licensing boards adhere to their legal responsibility to protect the public from incompetent or miscreant licensees.

In addition to the variation from state to state in licensure disciplinary action rates by state medical boards, other evidence from NPDB data demonstrating that licensing boards are often lax in taking disciplinary actions includes a recent analysis by one of this report's authors (RO) of data from the NPDB showing that by the end of 2021, 9,286 U.S. physicians have had five or more malpractice-payment reports since the NPDB began collecting such information in 1990. This is a malpractice record worse than 99% or more of all physicians who have practiced since then. Yet, dangerously and unacceptably, three-quarters (75%) of these 9,286 physicians have never had a medical board licensure action of any kind, serious or nonserious.

Additional evidence that state licensing boards are often lax in taking disciplinary action is provided by the fact that of the 16,287 physicians who have been reported to the NPDB for clinical-privileges actions affecting their ability to practice for more than 30 days by hospitals or other organizations that grant privileges to practice in their facilities or organizations, only 51.3% have ever had any action, even a reprimand, reported by a state licensing board. Thus, almost half of physicians deemed worthy of discipline by their peers with whom they practice had no action taken by a licensing board. Even for the 888 physicians who had been judged by their peers to be an immediate threat to health or safety, the percentage who had ever had state board action taken against their license was only marginally higher. Of these "immediate threat" physicians, only 52.1% had ever had any licensure action taken against them. [6]

The following reforms could materially improve the performance of medical boards:

[6] A recent unpublished analysis by Robert Oshel

- **State governors, who typically appoint the members of state medical boards, should appoint members whose credentials include being committed to changing the culture of the boards so that their first priority is to protect the public from incompetent or miscreant physicians, not to protect the livelihood of questionable physicians. This must include a substantial number of nonconflicted public members, also known to have the first priority of protecting the public.**

- **Significantly increase the use of the NPDB by medical boards**

The Health Care Quality Improvement Act of 1986, which created the NPDB, requires all hospitals to make a background query every time a physician seeks admitting privileges and every two years thereafter upon renewal.[7] No such requirement exists for medical boards, even if a complaint about a physician is made to the board by a patient or another physician. If the boards consistently queried the NPDB on all their licensees, they would learn of all adverse actions taken by licensing boards in other states where their licensees may also be licensed, all malpractice payments, and all adverse actions taken by hospitals or other health care entities concerning their licensed physicians. Unless they routinely query the NPDB or enroll all their licensees in the NPDB's continuous query service, there is no guarantee that state medical boards will be informed of all malpractice payments or other adverse actions concerning their licensees.

For $2.50 per physician per year, boards can purchase "continuous query" from the NPDB for each licensee. This means that within 24 hours of the NPDB receiving new information about an action taken by hospitals or other health care entities, another state medical board action, or a malpractice payout made on behalf of any licensee, the information is transmitted from the NPDB to the board. Published data documents how infrequently boards seek data from the NPDB. In 2022 the licensing boards of 29 states had no physicians enrolled in the Data Bank's continuous query service. Another seven state boards only had between one and fifty physicians enrolled. Six state boards had no continuous query enrollments and made no single name queries to the Data Bank. Only the licensing boards of Florida, Massachusetts, Vermont, and Wyoming enrolled substantially all their licensees in continuous query.[8] All of these states except Wyoming -- a low population state for which a relatively few licensure actions could make a relatively large change in ranking position -- were among the twenty highest ranked states. Of note, New Jersey and Texas have recently enacted legislation requiring their licensing

[7] Department of Health and Human Services. Title IV of Public Law 99-660. The Health Care Quality Improvement Act of 1986, as amended 42 USC Sec. 11101 01/26/98. https://www.npdb.hrsa.gov/resources/titleIv.jsp. Accessed March 17, 2021.

[8]Data on 2022 query volume and continuous query enrollments by state licensing boards provided by HRSA on May 12, 2022, in response to Public Citizen's request for this information. Note that osteopathic boards are excluded from our analysis.

boards to query the Data Bank or enroll all licensees in the Data Bank's continuous query service.[9]

Congress should amend the Health Care Quality Improvement Act of 1986 to require state licensing boards to routinely query the NPDB for all applicants for licensure and periodically when they renew their licensees. A requirement that all state licensing boards enroll all their licensees in the NPDB's continuous query service would be even better since boards would be immediately notified of any new reports about their licensees. Hospitals are already required to routinely query the NPDB. This legal requirement should be expanded to include state boards. The licensing boards are the last line of defense for the public from incompetent and miscreant physicians. Ideally, this amendment should include free continuous query access by medical boards for all their licensees.

In the absence of any action by Congress, individual state legislatures should require their licensing boards to query all their licensees or enroll in continuous query, as a few states already do.

- **Open the NPDB to the Public**

Congress also should amend the Health Care Quality Improvement Act so that any person can get the information to do a background check on a physician they are considering or are already seeing.

Opening the NPDB to the public would not only benefit patients, but would also provide licensing boards with further incentives to query the NPDB. If licensing boards routinely queried the NPDB, they would not be faulted by the public and state legislators for not knowing about malpractice payments or disciplinary actions affecting their licensees and therefore not taking reasonable actions concerning their licensees found to have poor records.

Having successfully stopped public access to the NPDB during the legislative battles preceding passage of the Health Care Quality Improvement Act, the American Medical Association (AMA) has continued to oppose patients' rights to conduct background checks on their physicians, as well as physicians' rights to conduct background checks on other physicians, as one basis for referrals.

In 1993, going even further, the AMA passed a resolution stating the following: "Resolved, that the American Medical Association... call for the dissolution of the National Practitioner Data Bank." One of us (SMW) subsequently published an article entitled "Congress should open the National Practitioner Data Bank to all":

[9]NJ Stat §45.1-32.1a(1) and (2); Texas HB1998 signed by governor June 13, 2023.

"As more information about more physicians is entered into the Data Bank, its usefulness can only increase. The main problem with the NPDB, however, is neither the accuracy nor the usefulness of the data but the unconscionable secrecy whereby this Federal repository of important information about American physicians is kept from American patients and other physicians.[10]"

Senator Ron Wyden, the author of the Health Care Quality Improvement Act of 1986, strongly supports public access to the NPDB despite the AMA's opposition. Recently, in an interview, Senator Wyden said it's past time to make the information public. "When we're talking about proven, flagrant abuses, the public has a right to know," Wyden said. "It's time for the law to be updated."[11]

- **Significantly increase state legislative oversight of state medical boards**

Although most if not all funding for state boards comes from physicians' licensing fees, the critical importance of a properly functioning medical board — vigorously enforcing the state's medical-practice act — deserves much more oversight than currently exists in too many states. Steps should be taken to ensure the oversight is not unduly influenced by special-interest groups such as state and national medical societies. Disturbingly, there is generally considerably more oversight of state medical boards by the news media than by state legislatures.

What else can be done to improve state medical boards' performance?

Medical boards could likely do a better job in disciplining physicians if the following conditions were also met:

- Adequate funding: All money from physicians' license fees should go to fund board activities instead of sometimes going into the state treasury for general purposes.
- Adequate staffing.
- Proactive investigations rather than only reacting to complaints.
- Independence from state medical societies, including greatly reducing the number of physicians on medical boards and replacing them with members of the public with no ties to the medical profession, hospitals, or other individuals or businesses in healthcare.

[10] S M Wolfe. Congress should open the National Practitioner Data Bank to all. *Public Health Reports*. 1995. Jul-Aug; 110(4): 378–379.

[11] https://kpic.com/news/local/most-extensive-database-for-doctor-misconduct-is-unviewable-to-public-dhhs-national-practitioner-data-bank-healthcare-records-malpractice-lawsuit-history February 27, 2023. Accessed August 5, 2023.

If a board needs additional, focused medical expertise to investigate or adjudicate individual cases, independent consultant physicians could be hired.

- Independence from other parts of the state government so that the board has the ability to develop its own budgets and regulations, including adequate funds to enforce its regulations.

- A reasonable legal standard for disciplining physicians ("preponderance of evidence" rather than "beyond a reasonable doubt" or "clear and convincing evidence")

- Creation of a more patient-oriented board culture so that protecting the public takes precedence over protecting physicians' livelihoods.

- Amend the Health Care Quality Improvement Act or its implementing regulations as necessary to close the "corporate shield" loophole which allows some malpractice payments against physicians to go unreported. As an increasing number of physicians are employees of hospitals or health systems, this reform is particularly needed.

- Amend the Health Care Quality Improvement Act to eliminate other loopholes for reporting malpractice payments, including the "written demand" loophole. The Health Care Quality Improvement Act requires that only malpractice payments made as the result of a "written claim or demand for payment" are reportable. As a result, some malpractice payers encourage claimants not to request payment in writing so that no payment report would be required. Although not requesting payment in writing may facilitate payment for individual malpractice victims, this procedure prevents licensing boards from identifying physicians with dangerous malpractice records.

- Amend the Health Care Quality Improvement Act to improve reporting of clinical privileges actions. Hospitals and other healthcare entities that report clinical privileges are known to evade reporting by making deals with physicians to resign just prior to the initiation of an investigation or immediately after closure of an investigation before any action has been taken. As a result of the timing of the resignation, at present it would not be reported to the NPDB, as would otherwise be required by law.

The NPDB should be provided with the authority to audit clinical privileges reporting and impose severe penalties on reporting entities and their management personnel if clinical privileges actions are not fully reported.

CONCLUSIONS

If adopted, the reforms called for in this report could go a long way toward correcting the deficiencies we have identified in the performance of state medical boards. Even the best-rated boards and the public they serve would benefit from their adoption. These reforms are especially urgently needed in states whose boards having the lowest rates of serious disciplinary actions against physicians. The proposed reforms would provide the boards with the will and the resources to better protect the public. The public would benefit by knowing that the physicians serving them are held to the highest standards. The vast majority of physicians, are competent and appropriate in providing medical services. These physicians would also benefit from the suggested improvements to the system for regulating physicians', thereby raising the quality of practice in their states.

If all states improved their rate of serious disciplinary actions to match that of Michigan, there would be nearly twice as many such actions nationally per year: approximately 2,400 instead of the 1,281 we found for 2019-2021. Implementing the above suggestions could reduce the health risk to thousands of patients being injured by the minority of physicians who should not be practicing or should have their practices restricted but are still fully licensed because of inadequate discipline by state boards.

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