Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2023-2025

By Robert E. Oshel, Ph.D

Robert Steinbrook, M.D.

Public Citizen's Health Research Group

November 12, 2026

Acknowledgments

This report was written by Robert E. Oshel, Ph.D., former Associate Director for Research and Disputed Report Resolution of the National Practitioner Data Bank and Advisor to Public Citizen's Health Research Group, and Robert Steinbrook, M.D., Director of Public Citizen's Health Research Group. Annie Ming Kowalik, Health Research Group intern, assisted with the preparation of this report. The report was copyedited by Fiona Lynn, Managing Editor of Public Citizen's Health Research Group.

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Contact Us

Main Office
1600 20th Street NW
Washington, D.C. 20009

Phone: 202-588-1000

Capitol Hill
215 Pennsylvania Avenue SE, #3
Washington, D.C. 20003

Phone: 202-546-4996

Texas Office
309 E 11th Street, Suite 2
Austin, Texas 78701

Phone: 512 477-1155

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Executive Summary

This report examines the extent to which medical-licensing boards are taking actions to protect the public from physicians who injure patients or behave inappropriately or illegally. The report, covering state medical boards' serious disciplinary actions from 2023 to 2025, is one of a series from Public Citizen's Health Research Group.

Because 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, we calculated and compared the rate of serious disciplinary actions per 1,000 physicians licensed in each state. Most states and the District of Columbia each have one board that licenses both M.D.s (Doctors of Allopathic Medicine) and D.O.s (Doctors of Osteopathic Medicine). The remaining states have separate licensing boards for M.D.s and D.O.s. We used state-level data on physician type (M.D. or D.O.) and the March 31, 2026, Public Use Data file from the National Practitioner Data Bank (NPDB). We defined "serious disciplinary actions" as those that had a clear impact on a physician's ability to practice. We summed the number of serious disciplinary actions taken by each state licensing board for 2023, 2024, and 2025 and then divided this total by three to obtain the average annual number of serious disciplinary actions by the board or boards.

We obtained data on the number of physicians licensed in each state and the District of Columbia from an interactive map on the Federation of State Medical Board (FSMB) website. Although the FSMB previously provided separate licensing counts for allopathic physicians and osteopathic physicians, it no longer does so. Thus, we were unable to provide separate rankings for each board in states that have both an allopathic and an osteopathic licensing board. We ranked states by their average annual rate of serious disciplinary actions per 1,000 licensees for the 2023-2025 period. For states with two boards, the rankings combine the disciplinary actions and licensees of both boards.

Boards from the 50 states and the District of Columbia took 1,378 serious disciplinary actions in 2023, 1,406 in 2024, and 1,447 in 2025. With an average annual rate of 1.76 serious disciplinary actions per 1,000 physicians, Alaska had the highest rate of disciplining doctor misconduct for 2023-2025. Ohio ranked second, Alabama third, Kentucky fourth, and North Dakota fifth. Twenty-nine states and the District of Columbia had rates that were less than half of Alaska's rate. Indiana, with a rate of 0.28 serious disciplinary actions per 1,000 physicians per year, ranked lowest. Other low-ranking states included Georgia, Rhode Island, Idaho, Pennsylvania, and New Mexico and the District of Columbia.

To improve medical board performance, we recommend reforms such as appointing board members who do not have conflicts of interest, expanding oversight by state legislatures, increasing the use of the NPDB by state medical boards to identify physicians requiring additional scrutiny, and improving reporting of disciplinary actions.

Introduction

The system of licensing medical practitioners is 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 toward patients.

There is abundant evidence that many patients are injured while being treated, often through negligence or incompetence and rarely intentionally. A 2010 study by the Department of Health and Human Services' Office of Inspector General analyzed the records of a nationally representative sample of Medicare patients hospitalized in October 2008. The study 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 per month — were preventable. Nearly one-half of the preventable events involved substandard care, most frequently because of a delay in diagnosis or treatment. A 2023 study that examined medical records from eleven Massachusetts hospitals in 2018 found similar results. "Preventable adverse events were identified in approximately 7% of all admissions, and preventable adverse events categorized as serious, life-threatening, or fatal were identified in approximately 1%."[2] Of course physicians are not responsible for all preventable medical errors in hospitals, but physician misbehavior and physician errors outside the hospital must also be considered when examining the importance of state medical licensing in protecting the public from harm from those whose first duty is often said to be "do no harm."

This report examines 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 objective standards are lacking to measure board performance in the abstract, we compared the performance of the 50 states and the District of Columbia based

[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.

[2] Bates DW, Levine DM, Salmasian H, et al. The safety of inpatient health care. *N Engl J Med*. 2023;388:142-153.

on the annual average number of serious disciplinary actions taken by their licensing boards per 1,000 physician 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, the observed differences among the boards are more likely to reflect variations in board performance than variations in physician behavior across states.

This report covers state medical boards' serious disciplinary actions from 2023 to 2025. The report builds on previous reports from Public Citizen's Health Research Group covering serious disciplinary actions from 2019 to 2021[3] and 2021 to 2023.[4] Because the FSMB no longer provides data that allows us to separately rank the boards of states that have separate licensing boards for allopathic and osteopathic physicians, we have recalculated our rankings for 2019 to 2021 and 2021 to 2023 to conform with the state-based methodology required for this report.

[3] Wolfe, S., Oshel, R. Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2019-2021. https://www.citizen.org/wp-content/uploads/230816_StateMedicalDisciplinaryReport.pdf. Accessed July 17, 2026.

[4] Oshel R, Steinbrook, R. Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2021-2023. Public Citizen's Health Research Group. August 16. 2023. https://www.citizen.org/article/ranking-of-the-rate-of-state-medical-boards-serious-disciplinary-actions-2021-2023/. Accessed June 22, 2026.

The National Practitioner Data Bank

All data on licensing board disciplinary actions come from the National Practitioner Data Bank (NPDB), a program of the U.S. Department of Health and Human Services. The NPDB opened on September 1, 1990. Since that time, reporting requirements have been expanded to include more types of actions for more types of licensed practitioners. At present, state licensing boards, hospitals, and other health care entities, professional societies, and some other entities that take actions against physicians and other licensed health practitioners are required to report to the NPDB certain adverse licensing and disciplinary actions against individual practitioners, including physicians, dentists, nurses, and all other healthcare personnel licensed by a state. Malpractice insurers and other payers are required to report all malpractice payments made on behalf of individual practitioners.

This practitioner-specific information is only made available from the NPDB in response to inquiries from licensing boards and eligible health care entities with a formal peer review process.[5] 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. Hospitals may fulfill this obligation by enrolling medical staff members and applicants in the NPDB's continuous query service. Other health care entities, such as health-maintenance organizations or medical or dental group practices, may query the NPDB or subscribe for continuous query if they have adopted a formal peer-review process. In December 2026 the two query options will be merged into a single "NPDB Query" service.[6]

State boards that license practitioners may similarly obtain NPDB information on their licensees and applicants and determine whether licensees have been disciplined in other states, have had adverse actions taken against them by hospitals or other entities, or have had malpractice payment reports.

The public is denied access to any information that identifies or might lead to the identification of individual practitioners or reporting entities other than state licensing boards.

For research purposes the NPDB makes available for free download a Public Use File that includes certain malpractice-payment and adverse-action data from each report in the NPDB. In the case of adverse-action reports, the nature of the action taken is identified along with information concerning why the action was taken. How each reported

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

[6] On December 4, 2026, the NPDB will release "NPDB Query," merging the Individual One-Time Query and Continuous Query services. All new queries will result in what amounts to a continuous query for one year. At the end of the year, the query can be renewed for another year or terminated. https://www.npdb.hrsa.gov/hcorg/queryMerge.jsp accessed July 25, 2026.

individual is licensed (M.D., D.O., dentist, etc.) and, in the case of licensing boards, the state of the board taking the disciplinary action are also included in the Public Use File. The file is updated quarterly.

Methodology

We used the NPDB's Public Use File covering reports as of March 31, 2026, to calculate the rate of serious disciplinary actions per 1,000 physicians licensed by boards of each state and the District of Columbia. At present, 37 states and the District of Columbia have one board that licenses both M.D.s and D.O.s).[7] Thirteen states have separate licensing boards for M.D.s and D.O.s. We based our analysis on serious disciplinary actions reportedly taken against physicians during calendar years 2023 – 2025 and, for comparison, earlier three-year periods, as explained below.

Some states license many more physicians than other states. In states that license fewer physicians, an increase or decrease of one or two serious actions in a year has a much greater effect on the rate of disciplinary actions (and, therefore, rankings) than a similar increase or decrease would have for states with more physicians. To minimize the effect of such year-to-year fluctuations, we calculated the average annual rate of serious disciplinary actions over a three-year period. Thus, a state's ranking is based on the average annual rate of serious actions taken in 2023, 2024, and 2025.

We performed a similar analysis for serious disciplinary actions taken in 2019 through 2021 and in 2021 through 2023, again using reports contained in the NPDB's Public Use File as of March 31, 2026. Each study period overlaps with the next study period by one year to minimize the effect of small changes in the number of actions taken by states with fewer physicians.

The rankings for 2019-2021 and 2021-2023 in this report may differ from those in previous reports because of the exclusion of Osteopathic boards in the 2019-2021 report and the inclusion of Osteopathic boards in the 2021-2023 report. Because the FSMB no longer separately identifies the number of allopathic and osteopathic licensees in each state, we could not calculate the rate of serious disciplinary actions taken by each of the boards in states with separate boards. To facilitate comparisons between the 2023-2025 analysis and the earlier time periods, we recalculated the previous rankings at the state level using the combined number of allopathic and osteopathic licensees in the state. There also may also be differences from previous rankings because of late reporting by state boards or deletion of previously reported actions because the licensing board voided an action or a court ordered an action voided.

We defined "serious disciplinary actions" as those that had a clear negative effect on a physician's ability to practice. We used the NPDB's reporting categories of license revocations, suspensions, summary restrictions, summary suspensions, voluntary license surrenders while under investigation, voluntary license limitations while under

[7] Maine will combine its two boards on January 1, 2027, resulting in 38 states with combined boards. New Mexico combined its previous two boards on July 1, 2021, during a rankings period previously studied by Public Citizen.

investigation, limitations or restrictions, denials of renewal, and voluntary agreements to refrain or suspend pending completion of investigation.[8] Probation was not considered to be a "serious disciplinary action." Even if conditions are imposed with probation, most of the conditions, such as a requirement for a chaperone to be present during a pelvic exam, are unenforceable or not enforced by state boards and often do not affect a physician's practice.

The NPDB allows for the reporting of up to five actions taken simultaneously on a single report. We included a licensing report in our count if one or more of the reported actions met our criteria for a serious disciplinary action. 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 physician licensees, we summed the number of serious disciplinary actions reported by each state licensing board during 2023, 2024, and 2025. We performed the same calculation for 2019-2021 and 2021-2023. We divided the three-year totals by three to obtain the average number of serious disciplinary actions per year.

We used an interactive map on the FSMB website to obtain the number of physicians licensed by each state for 2024 (the most recent year for which data were available), 2022, and 2020, the middle years of the three-year periods (See **Appendix**).[9] Our analyses used the number of physicians licensed in these years.

[8] Additional serious actions involving multiple states include multi-state license-privilege revocations, multi-state license-privilege suspensions, multistate license-privilege summary restrictions, multistate license-privilege summary suspensions, multistate license-privilege voluntary surrenders, multistate license-privilege voluntary limitations, and multistate 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 nonserious 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 of rarely reported actions do not materially affect the rankings.

[9] As of June 27, 2026, the Federation of State Medical Boards interactive map was at: https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/u.s.-medical-licensing-and-disciplinary-data/physician-licensure/

Results

The state licensing boards of the 50 states and the District of Columbia took an average annual total of 1,410 serious disciplinary actions during 2023-2025 (1,378 in 2023, 1,406 in 2024, and 1,447 in 2025). The average annual total was 1,401 during the 2021-2023 period and 1,471 during the 2019-2021 period (**Table 1**).[10] The 2023-2025 average annual total represents a 4.1% decrease in the average number of serious disciplinary actions taken over the study periods.

From the 2019-2021 to the 2023-2025 periods, the total number of medical board licensees increased substantially. In 2020 there were 1,387,360 licenses,[11] in 2022 there were 1,535,862 licenses, and in 2024 there were 1,671,477 licenses. Some physicians are licensed in more than one state.

Based on the total number of medical licenses nationally and the total number of serious disciplinary actions taken by licensing boards, we found that the overall annual rate of serious disciplinary actions per 1,000 licenses for 2023-2025 was 0.84. That rate is a 1.0% decrease from the annual rate of 0.86 serious actions per 1,000 licenses for 2021-2023 and a 14.2% decrease from the 0.98 annual rate for 2019-2021. Although the number of serious actions taken by medical-licensing boards has only decreased by 4.1% over the three study periods, the likelihood that any medical license will have a serious disciplinary action taken against it has decreased by over 16% (**Table 2**).

We ranked the states based on their 2023-2025 annual average rate of serious disciplinary actions per 1,000 physicians **(Table 2).** For comparison, similar rankings are presented for 2021-2023 and 2019-2021.

Alaska, which licenses about 6,500 physicians, had the highest annual rate of serious disciplinary actions, with an average of 1.76 serious disciplinary actions per 1,000 physician licensees per year during the 2023-2025 period. Indiana, which licenses about 36,200 physicians, had the lowest rate, with only 0.28 serious disciplinary actions per 1,000 physicians per year. Thus, a physician in Alaska was more than six times more likely to have a serious disciplinary action taken against their license than was a physician licensed

[10] Note that the numbers and rankings for 2019-2021 and 2021-2023 may differ from those in previous reports, as noted in the methodology section, because of exclusion of Osteopathic boards in the 2019-2021 report and inclusion of Osteopathic boards in the 2021-2023 report. Because the FSMB no longer provides separate licensee counts for Allopathic and Osteopathic boards, we can only calculate rates at the state level and only present counts of serious licensure actions at that level. There may also be differences from previous rankings because of late reporting by state boards and/or deletion of previously reported actions because the licensing board voided the action or a court ordered it voided.

[11] Licensee counts are from the Federation of State Medical Boards. Note that an individual physician may be licensed in more than one state. For this reason, the national count of state licenses is greater than the national total number of licensed physicians. Within a state, there is only one license per physician.

in Indiana **(Table 2)**. There is no reason to believe that physicians in Alaska are more than six times less competent or more than six times more likely to have behavior deserving of licensure disciplinary actions than physicians in Indiana.

Table 3 shows the additional serious disciplinary actions each board would have needed to take to match the rate of Alaska, the highest-ranked board, during the 2023-2025 period. **Table 3** also shows how many more serious disciplinary actions each board would have needed to take to match the rate of the Michigan board during the 2019-2021 period, when Michigan was the highest-ranked board.

For example, California had the highest number of state licensees in 2024, 176,195. California ranked 30th in the 2023-2025 period, with an annual rate of 0.65 serious disciplinary actions per 1,000 licensees, compared to Alaska's annual rate of 1.76 serious disciplinary actions per 1,000 licensees. If California had matched Alaska's rate, it would have taken 2.7 times more serious disciplinary actions per year during 2023-2025. The number of serious disciplinary actions taken in California in 2025 was 3.6% lower than it was in 2019 despite an increase of about 16% in the number of physician licensees.

The trend for Pennsylvania, which had 69,947 licensees in 2024, is concerning. In 2019 Pennsylvania took 83 serious disciplinary actions; in 2025 it took only 25. Pennsylvania's annual rate of serious disciplinary actions per 1,000 licensees for the 2019-2021 period was 1.12. For the 2023-2025 period, the rate was 0.39. The state's overall rank decreased from 21st to 47th. If Pennsylvania had taken serious disciplinary actions at the same rate as Alaska for the 2023-2025 period, it would have taken an average of 123 serious disciplinary actions per year rather than its average of 27.3 serious actions each year.

Rhode Island, which had 6,758 licensees in 2024, fell even farther in the rankings, from 20th to 49th from the 2019-2021 period to the 2023-2025 period.

Some states showed marked improvements in the 2023-2025 period compared with the 2019-2021 period. Wyoming improved from 32nd to 7th, Montana from 45th to 14th, Nevada from 49th to 20th, and Alaska from 23rd to 1st .

Some states consistently ranked high or low over the study periods. During the three study periods, both Ohio and North Dakota were in the top five and Georgia and Indiana were in the bottom five.

If all states had taken serious disciplinary actions at the same rate as the highest-ranked board (Alaska) during the 2023-2025 period, there would have been 2,942 serious disciplinary actions taken during 2025, about double the number of serious actions that were taken that year.

Even in Alaska, there is room for improvement. For example, although Alaska had the highest ranking for 2023-2025 (1.76 serious disciplinary actions per 1,000 licensees), if its rate had matched Michigan's rate of 2.21 for the 2019-2021 period, it would have taken

about 25% more serious disciplinary actions than it took. If all states in 2025 had taken serious disciplinary actions at Michigan's 2019-2021 rate, there would have been 3,694 serious disciplinary actions taken, about 250% more than the 1,447 serious disciplinary actions that were taken.

Discussion

The observed wide variation in serious disciplinary actions taken per 1,000 physicians among the licensing boards of the 50 states and the District of Columbia during the 2023-2025 period suggests that many are inadequately enforcing their medical practice acts. Low rates of serious disciplinary actions in comparison with other states, as well as with other boards in previous periods, suggest that the boards are taking insufficient actions to hold physicians accountable for negligent medical care or behavior that is unacceptably dangerous to patients.

The observed differences in the rates of state disciplinary action cannot be explained by differences in the competence or conduct of the physicians practicing in the various states. Nor is there any evidence that the rates of serious disciplinary actions taken by Alaska and other high-ranked states are sufficient to protect patients from dangerous doctors.

Suggested Reforms at the State Level

These state reforms could substantially improve the performance of medical boards:

- **Appoint licensing board members without conflicts of interest.**

State governors, who typically appoint the members of state medical boards, should appoint members whose qualifications include being committed to changing the culture of the boards so that their priority is to protect the public from incompetent or miscreant physicians, not to protect the livelihood of questionable physicians. Appointees should include a substantial number of public members without conflicts of interest.

- **Expand legislative oversight.**

State legislatures should expand oversight of licensing boards to ensure that they are prioritizing protecting the public from dangerous physicians. Although most if not all funding for state boards comes from physicians' licensing fees, ensuring a properly functioning medical board — one that vigorously enforces the state's medical practice act —requires more oversight than boards currently receive. Oversight should be fully independent of special-interest groups such as state and national medical associations or societies. Disturbingly, the news media generally provides more effective oversight of state medical boards than do state legislatures.

- **Increase medical boards' use of the NPDB.**

The Health Care Quality Improvement Act of 1986, which created the NPDB, requires hospitals to make a background query every time a physician seeks admitting privileges

and every two years thereafter on all members of their medical staff.[12] Enrollment of their medical staff members in the NPDB's continuous query service (or, beginning in December 2026, the unified "NPDB Query" service) meets this requirement. There is no similar requirement for medical boards. Obtaining information from the NPDB is just as essential for licensing boards as it is for hospitals. If Congress does not require all licensing boards to enroll all their licensees and applicants in the NPDB's continuous query service, individual state legislatures should require enrollment by their boards.

If the boards consistently received NPDB information on all their licensees or applicants, they would learn of all adverse actions taken by licensing boards in other states, all malpractice payments, all adverse actions taken by hospitals or other health care entities, all criminal convictions related to health care, all exclusions from participation in Medicare and Medicaid, and other actions that might affect their licensing decisions. Without enrollment, state medical boards may be inadequately informed of a physician's record when making licensing and discipline decisions. With enrollment, within 24 hours of the NPDB receiving a new report about an action taken by a hospital or other health care entity, another state's licensing action, a malpractice payment, or other actions, the NPDB will transmit the information to the board.

At present, the cost for continuous query enrollment is $2.50 per enrollee per year. In the context of the hundreds of dollars of license fees paid by physicians, this amount is trivial.

Data the NPDB provided to Public Citizen show how infrequently many boards request NPDB information.[13] In 2025 four states did not query the NPDB or enroll any of their licensees for continuous query.[14] Another 22 states queried on about 10% or fewer of their licensees. Only five states queried on substantially all their licensees or enrolled them for continuous query: Florida, Massachusetts, New Jersey, Texas, and Wyoming. Alabama and Kansas appeared to have queried on or enrolled all their licensees over a two-year period. The remaining states queried on or enrolled approximately 10-40% of their licensees.

States automatically receive copies of NPDB reports for malpractice payments and adverse actions taken in their state. This may explain why some states do not query on or enroll substantially all their licensees. However, states that do not query or enroll do not receive reports of actions taken against their licensees in other states. This gap in information availability is particularly important for states that have population centers

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[12] 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 September 29, 2026.

[13] Data received by Public Citizen on July 31, 2026, in response to a research request to the Health Resources and Services Administration, U.S. Department of Health and Human Services.

[14] During 2025 Colorado, Delaware, Illinois, and Missouri submitted no queries to the NPDB and had no licensees enrolled for continuous query.

at or near state boundaries, where physicians are often licensed in more than one of the adjacent states.[15]

Another way states may obtain NPDB reports for their licensure applicants is to require them to submit NPDB self-query results with their license applications.

● **Improve reporting by state licensing boards to the NPDB.**

While comparing counts for serious actions for the "overlap" years (2019, 2021, and 2023) in this and our previous reports, we discovered that some states had been at least three months late in reporting some disciplinary actions. Licensing boards must file timely reports to the NPDB to ensure that all entities querying the data bank learn of serious disciplinary actions in a timely manner.

● **Provide licensing boards with adequate funding and staffing.**

License fees should be set at the amount necessary to adequately fund the boards. In some states, license fees are paid to the state's general fund, and the boards do not receive all the money collected. This practice is an unfair tax on physicians. Revenue from physicians' license fees should be fully used to fund board activities and not diverted to other state programs. Moreover, states should not set arbitrary restrictions on hiring or the number of positions allocated to the boards. Adequate levels of appropriately qualified staff are essential.

● **Allow boards to conduct proactive investigations as well as investigations in response to complaints**.

Boards should have the legal authority and adequate staffing to investigate potential violations of the state medical practice act that are brought to their attention, even if a formal complaint has not been filed.

● **Ensure board independence from state medical societies.**

State medical societies often have undue influence on the appointment process for board members and on the boards. To reduce the likelihood that boards prioritize protecting physicians over protecting the public, the number of physicians on medical boards should be reduced and the number of public members with no ties to the medical profession, hospitals, or businesses or individuals involved in health care should be increased. When a board needs additional, focused medical expertise to investigate or adjudicate individual cases, independent consultant physicians with no conflicts of interest should be hired.

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[15] Examples are New York, New Jersey, and Connecticut; Maryland, Virginia, and the District of Columbia; Missouri and both Kansas and Illinois; Illinois and both Indiana and Wisconsin; Iowa and both South Dakota and Nebraska; and Oregon and Washington.

● **Ensure board independence from other parts of the state government.**

Licensing-board independence would allow boards to develop their own budgets and regulations, including ensuring adequate funding and staffing for investigations and to enforce regulations.

● **Require a reasonable legal standard for disciplining physicians.**

Adopting the "preponderance of the evidence" standard for imposition of disciplinary action rather than "beyond a reasonable doubt" or "clear and convincing evidence" would enhance the ability of the boards to protect the public while still maintaining fairness for licensees.[16]

● **Create more patient-oriented board cultures.**

In many states, licensing board members see their role as protecting the ability of physicians to practice despite requirements in licensing laws to protect the public. If the boards are to meet their mandates, they must prioritize protecting the public over protecting physicians' livelihoods.

Suggested Reforms at the Federal Level

These federal reforms could substantially help state medical boards improve their performance:

● **Require state licensing boards to enroll all their licensees and applicants in the NPDB.**

Congress should amend the Health Care Quality Improvement Act of 1986 to require state licensing boards to enroll all their applicants and licensees in the NPDB's continuous query services. Such a federal requirement would allow state boards to routinely use more complete information about malpractice payments, disciplinary actions, and other adverse actions and be immediately notified of new reports. Congress should also require free query access by medical boards for all their licensees.

● **Open the NPDB to the public.**

Congress should amend the Health Care Quality Improvement Act so that any person can receive conduct and competence information from NPDB reports about individual physicians. Opening the NPDB to the public would provide licensing boards with further incentives to use NPDB information and allow individuals to make better-informed decisions about where they obtain care.

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[16] In October 2024 a New Hampshire law (House Bill 518) took effect. The law increased the legal standard of proof from "preponderance of the evidence" to "clear and convincing." The legislation also abolished the state's Medical Review Subcommittee, which investigated licensee complaints.

The American Medical Association successfully prevented public access to the NPDB during the legislative battles preceding passage of the Health Care Quality Improvement Act of 1986 and has continued to oppose the public's right to conduct background checks on physicians as well as physicians' rights to conduct background checks on other physicians to whom they might refer patients, as Public Citizen has discussed and criticized in prior reports.[17, 18]

- **Close the corporate shield loophole.**

Congress should amend the Health Care Quality Improvement Act or its implementing regulations should be revised as necessary to close the "corporate shield" loophole, which allows malpractice payments by hospitals or other entities based on malpractice or misbehavior of employed physicians to go unreported if the claim and payment names only the employer and not the employed physician. This reform is urgently needed because most physicians are now employees of hospitals, health systems, or other corporate entities. Although few physicians were employees when the act became law in 1986, the legislation should be updated to reflect current physician employment norms.

- **Eliminate other malpractice-payment reporting loopholes.**

Congress should amend the Health Care Quality Improvement Act to eliminate other loopholes for reporting malpractice payments, including the "written demand" loophole. The 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 and other queriers from identifying a physician's complete malpractice records.

- **Improve reporting of clinical-privileges actions.**

Congress should amend the Health Care Quality Improvement Act of 1986 to improve reporting of clinical-privileges actions. Hospitals and other health care entities that are obligated to report clinical-privileges actions may evade NPDB reporting through agreements with physicians to resign prior to the initiation of an investigation or after completion of an investigation but before an action is taken. If a physician resigns or surrenders clinical privileges to avoid an investigation or during an investigation, the

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[17] Wolfe, S., Oshel, R. Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2019-2021. https://www.citizen.org/wp-content/uploads/230816_StateMedicalDisciplinaryReport.pdf. Accessed October 2, 2026.

[18] Oshel R, Steinbrook, R. Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2021-2023. Public Citizen's Health Research Group. August 16. 2023. https://www.citizen.org/article/ranking-of-the-rate-of-state-medical-boards-serious-disciplinary-actions-2021-2023/. Accessed October 2, 2026.

resignation is reportable, but not the underlying circumstances. Congress should provide the NPDB with the authority to audit clinical-privileges reporting and to impose severe penalties on reporting entities and their management personnel for evading reporting requirements.

Conclusions

Public Citizen found wide variation in serious disciplinary actions taken per 1,000 physicians among licensing boards of the 50 states and the District of Columbia during the 2023-2025 period. Our findings suggest that many licensing boards are inadequately enforcing their states' medical practice acts. Low rates of serious disciplinary actions in comparison with other states, as well as with other boards in previous periods, suggest that the boards are taking insufficient actions to hold physicians accountable for negligent medical care or behavior that is unacceptably dangerous to patients.

The observed differences in the rates of state disciplinary action cannot be explained by differences in the competence or conduct of the physicians practicing in the various states. Nor is there any evidence that the rates of serious disciplinary actions taken by Alaska and other high-ranked states are sufficient to protect patients from dangerous doctors.

Implementing the state and federal reforms that we have suggested could improve the performance of state medical boards and help them better protect the public against the small minority of physicians who should not be practicing at all or should have their licenses restricted but are still fully licensed. These reforms are particularly urgent in states whose boards have the lowest rates of serious disciplinary actions against physicians. Physicians who provide appropriate medical services would also benefit from reforms that would improve the quality of medical care in their states.

Appendix

Table 1: Serious Medical Licensure Disciplinary Actions by State, 2019-2025

State	2019	2020	2021	2022	2023	2024	2025
Alaska	7	1	7	3	8	11	15
Alabama	21	25	29	39	42	36	24
Arkansas	14	10	11	14	7	15	14
Arizona	67	37	33	36	32	31	42
California	139	127	147	121	108	99	134
Colorado	46	43	49	23	36	29	36
Connecticut	16	11	8	9	16	9	11
Dist. of Columbia	5	5	4	6	8	4	6
Delaware	6	3	1	4	3	6	4
Florida	119	116	109	87	99	100	116
Georgia	11	11	12	14	11	15	14
Hawaii	11	7	4	6	7	6	5
Iowa	7	14	10	12	6	14	14
Idaho	5	7	6	5	3	5	4
Illinois	64	29	78	85	73	75	69
Indiana	16	12	4	7	8	9	13
Kansas	17	10	12	4	8	7	11
Kentucky	42	26	24	41	26	42	39
Louisiana	20	16	4	16	9	17	7
Massachusetts	44	52	18	15	27	25	15
Maryland	46	34	40	49	27	46	66
Maine	10	7	11	7	11	12	10
Michigan	74	77	84	60	58	56	61
Minnesota	23	14	14	20	17	22	15
Missouri	23	9	35	23	20	25	14
Mississippi	11	12	14	12	8	6	10
Montana	4	2	3	5	9	9	14
North Carolina	22	29	27	34	28	34	42
North Dakota	6	10	10	5	9	5	15
Nebraska	9	3	6	11	9	15	6
New Hampshire	1	4	1	8	7	10	6
New Jersey	29	20	17	20	22	24	27
New Mexico	17	5	5	6	9	6	0
Nevada	4	2	4	10	11	19	13

New York	150	131	104	105	122	76	97
Ohio	79	68	117	93	95	77	92
Oklahoma	19	16	13	12	13	12	13
Oregon	13	23	17	19	16	24	18
Pennsylvania	83	55	44	20	21	36	25
Rhode Island	7	6	7	1	1	4	2
South Carolina	12	4	8	10	8	15	17
South Dakota	2	5	2	7	4	3	5
Tennessee	15	11	14	27	25	27	31
Texas	145	106	112	111	123	130	114
Utah	12	12	5	16	8	10	8
Virginia	47	44	38	38	40	37	35
Vermont	6	6	2	9	3	5	2
Washington	26	43	44	47	46	51	34
Wisconsin	45	20	43	51	49	32	44
West Virginia	14	16	5	15	13	15	8
Wyoming	6	4	1	10	9	8	10
Total	**1,637**	**1,360**	**1,417**	**1,408**	**1,378**	**1,406**	**1,447**

Table 2: Ranking of States by Annual Average Number of Serious Disciplinary Actions per 1,000 Physicians 2023-2025 and Comparison to 2021-2023 and 2019-2021

State	Rank 2023-2025	Mean Rate of Serious Actions per 1,000 Licensees per Year, 2023-2025	Rank 2021-2023	Mean Rate of Serious Actions per 1,000 Licensees per Year, 2021-2023	Rank 2019-2021	Mean Rate of Serious Actions per 1,000 Licensees per Year, 2019-2021
Alaska	1	1.76	16	1.08	23	1.04
Ohio	2	1.58	1	1.91	4	1.67
Alabama	3	1.44	2	1.78	11	1.34
Kentucky	4	1.41	8	1.35	7	1.52
North Dakota	5	1.33	5	1.39	2	1.73
Maryland	6	1.25	13	1.13	14	1.26
Wyoming	7	1.25	14	1.12	32	0.77
Michigan	8	1.24	3	1.49	1	2.21
Illinois	9	1.22	6	1.38	18	1.19
Texas	10	1.20	9	1.20	10	1.36
Washington	11	1.16	7	1.38	12	1.31
Wisconsin	12	1.15	4	1.48	16	1.24
Maine	13	1.13	15	1.11	9	1.41
Montana	14	1.08	29	0.70	45	0.43
West Virginia	15	1.08	12	1.14	6	1.62
Florida	16	1.06	18	1.05	8	1.50
Colorado	17	0.99	11	1.18	5	1.66
Oregon	18	0.98	20	0.93	26	1.02
Arizona	19	0.95	10	1.19	3	1.73
Nevada	20	0.91	34	0.62	49	0.34
Nebraska	21	0.90	26	0.76	44	0.48
New York	22	0.87	19	1.02	15	1.25
Tennessee	23	0.87	25	0.78	40	0.56
Arkansas	24	0.85	23	0.84	27	1.01
Virginia	25	0.77	22	0.86	25	1.03
North Carolina	26	0.75	30	0.69	38	0.59
Iowa	27	0.70	33	0.63	33	0.76
New Hampshire	28	0.67	38	0.58	51	0.25
Oklahoma	29	0.67	27	0.75	17	1.21
California	30	0.65	28	0.75	28	0.90
Minnesota	31	0.60	36	0.61	37	0.64
Kansas	32	0.60	37	0.60	19	1.19

Utah	33	0.60	32	0.67	30	0.84
Missouri	34	0.58	24	0.83	34	0.76
Vermont	35	0.57	17	1.08	13	1.29
Mississippi	36	0.55	21	0.88	22	1.05
Massachusetts	37	0.55	40	0.52	24	1.04
South Dakota	38	0.53	31	0.67	42	0.54
Louisiana	39	0.52	39	0.53	35	0.74
Hawaii	40	0.51	41	0.52	36	0.70
South Carolina	41	0.50	48	0.36	46	0.36
Delaware	42	0.48	49	0.36	41	0.55
Connecticut	43	0.48	44	0.48	39	0.56
New Jersey	44	0.47	47	0.43	43	0.51
New Mexico	45	0.41	35	0.61	29	0.88
Dist. of Columbia	46	0.40	45	0.46	48	0.34
Pennsylvania	47	0.39	46	0.43	21	1.12
Idaho	48	0.36	42	0.49	31	0.78
Rhode Island	49	0.35	43	0.48	20	1.14
Georgia	50	0.29	50	0.30	50	0.30
Indiana	51	0.28	51	0.20	47	0.35
All States Mean		0.82		0.86		0.98
All States Maximum		1.76		1.91		2.21

Table 3: Calculated Increase in Annual Numbers of Serious Disciplinary Actions Needed for Each State To Match Alaska's 2023-2025 Rate and Comparison to Michigan's 2019-2021 Rate

State Board	Rank 2023-2025	Mean Number of Serious Actions Taken, 2023-2025	Mean Rate of Serious Actions per 1,000 Licensees per Year, 2023-2025	Calculated Percent Increase Needed To Match Alaska's 2023-2025 Rate	Calculated Number of Serious Actions Needed Each Year To Match Alaska's, 2023-2025 Rate (1.76 per 1,000 Licensees)	Calculated Percent Increase Needed To Match Michigan's 2019-2021 Rate	Calculated Number of Serious Actions Needed Each Year to Match Michigan's 2019-2021 Rate (2.21 per 1,000 Licensees)
Alaska	1	11.33	1.76	---	---	25.5%	14
Ohio	2	88.00	1.58	11.1%	98	39.3%	123
Alabama	3	34.00	1.44	22.1%	42	53.1%	52
Kentucky	4	35.67	1.41	24.5%	44	56.2%	56
North Dakota	5	9.67	1.33	31.9%	13	65.5%	16
Maryland	6	46.33	1.25	40.1%	65	75.8%	81
Wyoming	7	9.00	1.25	41.2%	13	77.2%	16
Michigan	8	58.33	1.24	41.8%	83	77.9%	104
Illinois	9	72.33	1.22	44.2%	104	81.0%	131
Texas	10	122.33	1.20	46.9%	180	84.4%	226
Washington	11	43.67	1.16	51.4%	66	90.0%	83
Wisconsin	12	41.67	1.15	52.3%	63	91.0%	80
Maine	13	11.00	1.13	55.2%	17	94.8%	21
Montana	14	10.67	1.08	63.0%	17	104.6%	22
West Virginia	15	12.00	1.08	63.4%	20	105.0%	25
Florida	16	105.00	1.06	65.7%	174	107.9%	218
Colorado	17	33.67	0.99	77.8%	60	123.1%	75
Oregon	18	19.33	0.98	79.9%	35	125.7%	44
Arizona	19	35.00	0.95	84.3%	65	131.2%	81
Nevada	20	14.33	0.91	92.8%	28	141.9%	35
Nebraska	21	10.00	0.90	94.5%	19	144.0%	24
New York	22	98.33	0.87	101.1%	198	152.3%	248
Tennessee	23	27.67	0.87	102.6%	56	154.2%	70
Arkansas	24	12.00	0.85	105.8%	25	158.2%	31
Virginia	25	37.33	0.77	129.5%	86	187.9%	107
North Carolina	26	34.67	0.75	135.8%	82	195.9%	103
Iowa	27	11.33	0.70	151.6%	29	215.6%	36

New Hampshire	28	7.67	0.67	162.6%	20	229.5%	25
Oklahoma	29	12.67	0.67	163.6%	33	230.7%	42
California	30	113.67	0.65	172.6%	310	242.0%	389
Minnesota	31	18.00	0.60	190.8%	52	264.9%	66
Kansas	32	8.67	0.60	191.3%	25	265.5%	32
Utah	33	8.67	0.60	194.7%	26	269.7%	32
Missouri	34	19.67	0.58	203.0%	60	280.2%	75
Vermont	35	3.33	0.57	207.2%	10	285.4%	13
Mississippi	36	8.00	0.55	217.0%	25	297.7%	32
Massachusetts	37	22.33	0.55	222.1%	72	304.1%	90
South Dakota	38	4.00	0.53	230.5%	13	314.7%	17
Louisiana	39	11.00	0.52	236.9%	37	322.6%	46
Hawaii	40	6.00	0.51	242.6%	21	329.8%	26
South Carolina	41	13.33	0.50	253.9%	47	344.1%	59
Delaware	42	4.33	0.48	262.9%	16	355.3%	20
Connecticut	43	12.00	0.48	267.0%	44	360.5%	55
New Jersey	44	24.33	0.47	271.0%	90	365.4%	113
New Mexico	45	5.00	0.41	331.4%	22	441.3%	27
Dist. of Columbia	46	6.00	0.40	335.5%	26	446.4%	33
Pennsylvania	47	27.33	0.39	350.0%	123	464.6%	154
Idaho	48	4.00	0.36	393.3%	20	518.8%	25
Rhode Island	49	2.33	0.35	409.3%	12	539.0%	15
Georgia	50	13.33	0.29	508.0%	81	662.8%	102
Indiana	51	10.00	0.28	537.1%	64	699.3%	80

Table 4: Licensed Physicians by State

State	2020	2022	2024
Alaska	4,791	5,540	6,445
Alabama	18,629	20,591	23,601
Arkansas	11,565	12,651	14,046
Arizona	26,397	28,384	36,680
California	152,450	167,246	176,195
Colorado	27,681	30,568	34,038
Connecticut	20,817	22,908	25,045
Dist. of Columbia	13,714	12,986	14,861
Delaware	6,102	7,475	8,942
Florida	76,395	93,686	98,942
Georgia	38,367	41,659	46,098
Hawaii	10,515	10,960	11,689
Iowa	13,530	14,712	16,213
Idaho	7,667	9,605	11,220
Illinois	47,846	56,875	59,331
Indiana	30,649	32,017	36,228
Kansas	10,967	13,309	14,359
Kentucky	20,156	22,443	25,259
Louisiana	18,052	18,406	21,072
Massachusetts	36,591	38,566	40,906
Maryland	31,841	34,348	36,921
Maine	6,601	8,680	9,711
Michigan	35,506	45,175	47,038
Minnesota	26,574	28,083	29,770
Missouri	29,477	31,271	33,888
Mississippi	11,742	12,881	14,421
Montana	6,973	8,094	9,890
North Carolina	44,015	42,882	46,489
North Dakota	5,005	5,765	7,253
Nebraska	12,376	11,337	11,059
New Hampshire	8,019	9,206	11,450
New Jersey	43,563	45,637	51,334
New Mexico	10,277	10,927	12,267
Nevada	9,898	13,368	15,717
New York	102,361	107,789	112,466
Ohio	52,720	53,110	55,579
Oklahoma	13,250	16,819	18,986
Oregon	17,321	18,594	19,781
Pennsylvania	54,136	65,624	69,947
Rhode Island	5,838	6,233	6,758
South Carolina	22,307	24,248	26,837
South Dakota	5,588	6,422	7,519
Tennessee	23,872	28,162	31,874
Texas	88,747	96,058	102,223
Utah	11,477	14,471	14,522
Virginia	41,588	44,832	48,723

Vermont	3,609	4,338	5,823
Washington	28,722	33,140	37,607
Wisconsin	29,110	32,165	36,078
West Virginia	7,219	9,677	11,148
Wyoming	4,747	5,939	7,228
Total	**1,387,360**	**1,535,862**	**1,671,477**

Source: Federation of State Medical Boards