Physicians Disciplined by a State Medical Board

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Context.—State medical boards discipline several thousand physicians each year. Although certain subgroups, such as those disciplined for malpractice, substance use, or sexual abuse, have been studied, little is known about disciplined physicians as a group.

Objective.—To assess the offenses, contributing factors, and type of discipline of a consecutive series of disciplined physicians.

Design.—Case-control study on publicly available data matching 375 disciplined physicians with 2 groups of control physicians, one matched solely by locale, and a second matched for sex, type of practice, and locale.

Subjects.—All disciplined physicians publicly reported by the Medical Board of California from October 1995 through April 1997.

Main Outcome Measures.—Characteristics of disciplined physicians, offenses leading to discipline, and type of discipline.

Results.—A total of 375 physicians licensed by the Medical Board of California (approximately 0.24% per year) were disciplined for 465 offenses. The most frequent causes for discipline were negligence or incompetence (34%), abuse of alcohol or other drugs (14%), inappropriate prescribing practices (11%), inappropriate contact with patients (10%), and fraud (9%). Discipline imposed was revocation of medical license (21%), actual suspension of license (13%), stayed suspension of license (45%), and reprimand (21%). Type of offense was significantly associated with severity of discipline (P = .03). In logistic regression models comparing disciplined physicians with controls matched by locale, board discipline was significantly associated with severity of discipline (P = .03). In logistic regression models comparing disciplined physicians with controls matched by locale, board discipline was significantly associated with specialty board certification (OR, 2.02; 95% CI, 1.39-2.92).0.42; 95% CI, 0.29-0.60) and positively associated with being in practice more than 20 years (OR, 2.02; 95% CI, 1.39-2.92).

Conclusions.—A small but substantial proportion of physicians is disciplined each year for a variety of offenses. Further study of disciplined physicians is necessary to identify physicians at high risk for offenses leading to disciplinary action and to develop effective interventions to prevent these offenses.

See also pp 1883 and 1915.

Previous reports have focused on loss of insurance coverage, negligence or incompetence, malpractice (a legal term not synonymous with negligence or incompetence), impairment by substance abuse or mental illness, sexual misconduct with patients, misrepresentation of credentials, and inappropriate prescribing practices. In a description of actions taken against a series of physicians in New York State during the 1980s, Post focused on the disciplinary process to the near exclusion of data about the DPs themselves. Donaldson described problematic behaviors in a series of 49 British physicians from 1 hospital over a 5-year period. A literature search from 1970 through November 1997 found no reports of a controlled, consecutive series of physicians disciplined by a medical board.

Methods

Approximately 104,000 physicians—about 15% of those licensed in the United States—are licensed by the Medical Board of California (MBC). Each year the board investigates approximately 10,000 complaints about physicians made by the public (approximately 63%), government agencies (19%), insurers (14%), and other miscellaneous sources (4%). About 80% of these complaints are closed after initial staff inquiry reveals lack of face validity; of the 20% assigned
for investigation, prosecution is recommended in about one fourth.20 Half of those—about 250 per year—ultimately result in disciplinary action.

Like many other states, California invokes the following 4 main levels of discipline: (1) Reprimand is the mildest form of discipline and signals behavior that, while cause for concern, does not warrant more substantial punishment.

(2) Probation, in which the physician’s license is technically suspended or revoked for up to 10 years. However, if that action is stayed, the physician can continue to practice provided certain conditions (eg, additional education, psychiatric examination) are observed. (3) Actual suspension of license, which ranges from a few days to 6 months or longer and usually leads to a longer period of probation. (4) Permanent revocation of license, which the physician may either contest or accept by default.

All recipients of formal discipline are listed in Action Report, a quarterly publication mailed to every health care professional licensed by California. The entries in Action Report are prepared by a senior investigator working from a concise abstract of charges used by the judge. These entries are checked for accuracy and completeness by a different MBC staff member; before publication, the work is reviewed by a third staff member. The published information includes name, city and state of record, cause and severity of the discipline, and whether disciplinary action was taken in response to the action of another jurisdiction.

For this study, we reviewed and abstracted data for all DPs listed in Action Report issues from October 1995 through April 1997. Action Report data were augmented by information from the Directory of Physicians in the United States.21 This biennial publication lists more than 723 000 physicians and reports medical school and year of graduation, current address, date of first license in that jurisdiction, self-designated specialties, type of practice (training, patient care, administration/research, retired or otherwise inactive), specialty certification, and possession of the Physician’s Recognition Award. Any further data necessary were obtained by request from the MBC.

We also selected 2 control groups of physicians for comparison with the study group. The first control group comprised, for each DP, the next physician listed in the Directory of Physicians in the United States21 who matched for location (city and state). The second control group was composed of an equal number of physicians, matched with each DP for location, sex, and type of practice. The same data as were obtained for DPs were recorded for physicians in each control group.

Reasons for imposing discipline were similar to those cited by Post,28 with “miscellaneous” reasons divided into other crimes, misrepresentation of credentials, and employment of or working for an unlicensed entity. When physicians were disciplined for multiple offenses, the principal cause was usually clear from the Action Report documentation. In the 14 cases for which the principal cause was not evident, the principal cause was assigned according to 2 rules: (1) Substance abuse and mental disorders took precedence when mentioned because these offenses often induce abnormal behaviors. (2) More serious charges (negligence or incompetence, sexual or otherwise inappropriate patient contact, fraud and other illicit financial dealings, other crimes) took precedence over behaviors that carry less potential for harm.

Multivariate logistic regression models were used to identify factors associated with disciplinary action. Due to a lack of previous research in this area, we attempted to keep explanatory variables binary, thus limiting the number of parameters estimated in the model and preserving the overall power of the models to detect significant differences. Given a sample size of 375 pairs of cases and controls and assuming the estimated proportions of disciplined physicians in the controls and cases to be 0.1 and 0.2, respectively, odds ratios (ORs) of at least 1.79 could be detected with 80% power.22

Factors of interest were entered into regression models stepwise and retained based on the residual score statistic.23 Physician sex and type of practice (direct patient care or other) were examined in the control group matched for location. Time of practice (<20 years or ≥20 years), international medical education (domestic and/or foreign), board certification (yes or no), Physician’s Recognition Award (yes or no), and specialty were included in the analysis of the control group matched for location and for other characteristics. Association of the type of offense and severity of punishment was tested using Cochran-Mantel-Haenszel methods.24 All tests were based on a significance level of .05 with a Bonferroni correction for multiple comparisons. Data were analyzed using the SAS System (Version 6.12; SAS Institute, Inc, Cary, NC).

**RESULTS**

During the 18-month study period analyzed, 375 California physicians (a rate of approximately 0.24% per year) were reported to have received some form of disciplinary action by the state medical board. Of these, 103 (27%) were currently living in another state or jurisdiction. During the same interval, another 73 physicians voluntarily surrendered their licenses, thereby halting the investigative process.
Of the 375 DPs, 32 (9%) were women, and 283 (77%) had been in practice at least 20 years. A total of 227 (67%) were involved in direct patient care, 31 (8%) were retired or inactive, 11 (3%) were in academic administrative practice, and 6 (2%) were resident physicians. Compared with controls matched by location, DPs were less likely to be women (OR, 0.44; 95% confidence interval [CI], 0.28-0.70) and were more likely to be involved in direct patient care (OR, 2.56; 95% CI, 1.75-3.75).

Compared with controls matched by location, sex, and type of practice, DPs were more likely to have been in practice more than 20 years and were less likely to be board certified. Of the self-reported specialties with sufficient numbers for meaningful comparison, only anesthesia and psychiatry appeared overrepresented among DPs, although neither reached statistical significance (Table 1). The 375 physicians had been disciplined for a total of 465 offenses (Table 2). Seventy-four physicians (19%) had been disciplined for multiple offenses (58 for 2 offenses, 16 for 3) but accounted for 29 unstayed revocations (36%), 13 actual suspensions from practice (27%), 29 actions that were stayed (17%), and 3 letters of reprimand (4%). Multiple offenders were more likely (OR, 3.18; 95% CI, 1.91-5.28) than single offenders to receive severe discipline (unstayed revocation or actual days of suspension).

Overall, 130 DPs (35%) received severe discipline (Table 3). These included 15 physicians (79%) who were cited principally for mental or physical impairment, 7 (58%) who had violated probation, and 19 (54%) who had committed fraud. For all other categories, rates of severe discipline ranged from 11% (working for an unlicensed entity to 41% (sexual or inappropriate conduct). Public reprimand most often resulted from the lesser offenses in the "other" category, although 14 (33%) of the 42 actions for drug prescriptions and dispensing were reprimands. Generalized Mantel methods showed a significant association between type of offense and ordered severity of punishment (P = .03). Women were more likely (OR, 2.56; 95% CI, 1.30-5.41) than men to be disciplined severely. Type of practice did not significantly differentiate male from female physicians.

The 73 physicians who had voluntarily relinquished their licenses had graduated an average of 10 years earlier than DPs, although their areas of specialty did not differ significantly (data not shown). Insofar as could be deduced from available records, their alleged principal offenses were on average more serious than those of the DP group—40 (65%) of 61 that could be clearly ascertained were related to incompentence (n = 27) or sexual misconduct (n = 13).

**COMMENT**

In our study of physicians disciplined by a state medical board, we evaluated 375 principal offenses and 465 total offenses and found that no single cause for action dominated these data. The largest component, accounting for about one third of all cases, was negligence or incompetence. Kusserow et al reported that incompetence contributed only minimally to the total of medical board actions and suggested that it and sexual impropriety were difficult for medical boards to pursue. Posner noted that negligence or incompetence was the most common (28% of all actions) category in the spectrum of physician offenses in New York State.

California law requires judgments against physicians to be reported to MBC, which evaluates these cases and assigns an investigator whenever it seems that negligence or incompetence, sexual misconduct, or unprofessional conduct appears to be involved. With charges eventually filed in about 5% of cases, MBC officials estimate that approximately 20% of disciplinary actions stem from malpractice suits. Available data do not permit further characterization of these physicians or comparison with the larger group of DPs. However, if the percentage of actions related to negligence or incompetence is any guide, MBC appears to be dealing with physician incompetence more successfully than medical boards did a decade ago.

Comprising nearly one fifth of all causes for disciplinary action, issues related to physicians' health were the next most common cause for action. The 3:1 ratio of abuse of alcohol or other drugs to physical or other mental disorders is similar to findings reported by Shore and a series of impaired physicians. Talbott et al reported that medical licensure had been affected in only about one third of chemically impaired physicians, suggesting that there are more impaired physicians practicing unsupervised than were identified by the California board. However, during the study period, 43 additional chemically dependent physicians were involved in the California state diversion program. These physicians were largely self-referred (only a few entered the program in lieu of disciplinary action) and the total number of these physicians is small. If included as DPs, they probably would have only minimally reduced the average severity of discipline. Overall, the data reaffirm the continuing importance of physician impairment as a cause of discipline, although physical illness appears to be a less frequent source of physician impairment than mental disorder and substance abuse.

Illegal activities and other inappropriate voluntary behaviors not associated with mental disorders or substance
abuse precipitated another strong minority of actions. Sexual misconduct constituted the major offense for 10% of DPs, although that proportion seems low considering reports that up to 9% of physicians admit having sex with 1 or more patients.27 Post et al28 found that throughout the 1980s, 24% of the DP cases in New York State resulted from fraud, which caused only 9% of actions in our present data. These offenses included kickback schemes and overt theft from patients, but the vast majority represented illegal billing or Medicaid fraud. Misrepresenting credentials was a principal or secondary offense of only 8 DPs (2%). This proportion also seems small compared with similar problems reported by 2 other studies: misrepresentation by 5% of physicians applying to 1 health care organization29 and false claims of board certification by nearly 18% of 650 Veterans Administration physicians.30 In aggregate, these factors suggest that, despite a 50% increase in the percentage of MBC disciplinary actions in 4 years,30 many actionable offenses may go unreported or unaddressed.

Of all DPs, 12 (3%) were cited in part for violation of previous disciplinary action, compared with only 1 probation violation (of 221) mentioned by Post.31 This discrepancy may reflect the recent increase in disciplinary actions, which creates more physicians on probation who can violate the stipulations of their probation. Bloom et al32 found more malpractice claims than expected among physicians who had been investigated for prescribing practices, and Bovbjerg and Petronis33 reported that a history of malpractice payout predicted later claims.

Most offenses by DPs involve some aspect of patient care (negligence or incompetence, inappropriate prescribing, sexual contact, Medicare fraud) or tend to attract attention in the context of patient care, such as substance abuse or mental impairment. Even the 11 physicians primarily involved in academics and administration had offenses in the context of patient care: negligence or incompetence in 6 cases, substance abuse in 3, and inappropriate sexual contact with a patient in 1. Only 1 instance of research fraud related to a physician’s academic duties was reported. Marked underrepresentation of physicians in training (ie, only 6 physicians in residency or fellowship were disciplined) may reflect the close supervision resident receive and is in agreement with speculation2 that it takes time to develop a detectable pattern of discipline-prone behavior. The only previous study with relevant data34 reported that more than 65% of anesthesiologists who abused substances worked in an academic setting, either as faculty or trainee, but selective referral patterns as an explanation of the finding could not be ruled out.

Although the Bonferroni correction precludes definite conclusions, 2 specialties—anesthesiology and psychiatry—appeared somewhat overrepresented among DPs. Previous studies reported special risk for malpractice, addiction, sexual misconduct, or other disciplinary problems among anesthesiologists8,33,35,36 and psychiatrists.8,37,38 However, several studies have reported that psychiatrists are at especially low risk for malpractice-related problems.27,28 These contradictory findings suggest the need for further evaluation of the possibility that some specialties carry extra risk for behaviors (eg, substance abuse or sexual relationships with patients) that can lead to physician discipline.

Kusserow et al39 reported a consensus of medical boards that educational quality of international medical graduates was a premier problem facing American medicine. Our data do not support this assertion, as we found that international medical graduates were not overrepresented as receiving discipline. Schwartz and Mendelson30 found no excess of international medical graduates among physicians who had lost their malpractice insurance. In our study, DPs were more likely than controls to lack specialty certification, which nearly all relevant prior studies have found to be inversely correlated with disciplinary actions. Adamson et al40 reported that surgeons terminated from a trust for having a high malpractice claim rate were less likely to have completed a fellowship or to be board certified. Caulford et al41 found that board certification was an independent predictor of competence for family practitioners.

Underrepresentation of women among DPs is also has been a consistent finding. Galanter et al42 noted that only 7 of 100 impaired physicians were women, and Gallegos et al43 found that females composed only 5% of impaired physicians (at that time) but 15% of all physicians nationally. These data are not especially surprising, given that women generally have a lower incidence of substance abuse. Taranin et al44 reported that male physicians were 3 times more likely than female physicians to be at high risk for malpractice. They suggested that female physicians may interact more effectively with patients, reducing the likelihood of complaint. Levinson et al45 have recently demonstrated that effective communication reduces malpractice risk. Although the small number of female DPs in our study does not allow meaningful statistical comparison, the current data suggest that, when women are disciplined, it is for the same spectrum of offenses as men, including inappropriate personal relationships with patients.

However, female DPs in our study appeared to be disciplined more severely than male physicians. This finding may reflect the fact that women were less likely than men to surrender their licenses voluntarily (1 woman in 73) before board action could be completed. Voluntary resignation of additional female (or fewer male) physicians who received severe discipline would have reduced the apparent sex discrepancy. Two other possible explanations, that female physicians are only referred for board scrutiny when the offense is particularly egregious, or once referred, women are held to a higher standard of conduct, are unsupported by available evidence. Indeed, female physicians with substance abuse problems may be less likely than male physicians with substance abuse problems to have actions taken against their licenses.46 More study of sex differences, including voluntary surrender of license, among DPs is necessary.

Several factors address the generalizability of a study based on the actions of a single medical board. First, as the most populous state, California has under license approximately 15% of all physicians registered in the United States. Second, discipline reported by other jurisdictions prompted 27% of the California board actions. Third, the FSMB’s composite action index1 is the arithmetic mean of the 4 possible pairings of total actions or total prejudicial actions with total licensed or total practicing physicians within a state. Although published with a statistical caveat about using this hybrid score to compare state boards, for 1996 the composite action index ranks California well within the mainstream of medical board experiences. Nonetheless, because this is the only controlled study to survey a consecutive sample of DPs, these findings must be confirmed by reports from other jurisdictions. Also, because our analyses were exploratory in nature with the purpose of promoting further study, our results should be viewed with caution.

In the face of increasing consumer complaints,30 our data suggest that medical boards may have increased their ability (and resolve) to deal with physicians who commit offenses that require discipline. Despite these efforts, definitive national data about the number of physicians disciplined per year are lacking. In 1996, the FSMB reported7 that more
than 3200 physicians received discipline nationally, but this figure makes no allowance for the fact that many actions are taken by reciprocity with other medical boards and do not represent additional physicians or even new offenses. The apparent increase in disciplined physicians could be partly an artifact of improved reporting. If FSMB created a national unduplicated count of DP s, monitoring and analysis of physician disciplinary actions would be enhanced. If the California data reflect national experience and 75% of those reported represent unduplicated data, approximately 2400 physicians nationally are disciplined each year. Further study of DP populations may help identify in advance those individuals likely to violate 1 or more standards of practice. Efforts to identify these physicians represent an important aspect of the medical profession’s struggle to protect patients and to ensure the delivery of quality care.

We want to acknowledge Candis Cohen, MA, JD, of the California Medical Board and G. Arul, MD, for their help in the conduct of this study.

References
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