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Character, Competence, and the Principles of Medical Discipline

Nadia N. Sawicki

CHARACTER, COMPETENCE, AND THE PRINCIPLES OF MEDICAL DISCIPLINE

NADIA N. SAWICKI*

ABSTRACT

This Article presents a first-of-its-kind analysis of the disciplinary functions of state medical licensing boards—the frequently overlooked administrative agencies designed to serve as the "gatekeepers" of the medical profession. It concludes that medical boards may have lost sight of their primary goal of patient protection and suggests that a renewed focus on professional licensing boards may go a long way towards addressing some of the quality of care problems plaguing the American medical system.

This Article identifies three fundamental legal principles underlying medical boards' authority to discipline physicians: the goal of public protection, substantive due process limitations based on fitness to practice medicine, and the concept of disciplinary minimalism. It demonstrates that boards, which frequently sanction physicians who engage in criminal conduct and other forms of "unprofessional conduct" outside the clinical sphere, often exercise their disciplinary discretion in a manner inconsistent with these fundamental principles. A more effective use of medical boards' scarce resources would involve a focus on physicians whose misconduct is more clearly linked to clinical practice. Accordingly, this Article suggests that boards return their focus to the principles of professional discipline, prioritizing disciplinary actions taken on the basis of competence, rather than character.

* Assistant Professor at Loyola University Chicago School of Law, Beazley Institute for Health Law and Policy. J.D., University of Pennsylvania Law School; M.Bioeth., University of Pennsylvania School of Medicine. The author extends special thanks to the organizers and participants of the 2008 Health Law Scholars Workshop sponsored by the St. Louis University School of Law and the American Society of Law, Medicine, and Ethics, particularly commentators Sandy Johnson, Diane Hoffmann, Rebecca Dresser, and Ana Iltis. Thanks also go out to my able research assistants—Matt Miller (at Penn), and Michelle Garvey and Drew McCormick (at Loyola).

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INTRODUCTION

State medical boards are designed to play a significant role in ensuring medical quality.[1] As the state agencies responsible for the licensure and discipline of physicians, medical boards serve as the gatekeepers of the medical profession. However, critics frequently question whether boards have, in fact, been living up to their potential in this regard, particularly in the context of professional discipline.[2] Since the 1970s, state medical boards have faced criticism from a variety of sources for inappropriately screening applicants for medical licensure,[3] failing to discipline

1. *See* Robert C. Derbyshire, *How Effective Is Medical Self-Regulation?*, 7 LAW & HUM. BEHAV. 193, 193 (1983) (explaining that state licensing boards are generally responsible for disciplining physicians under the police powers of the state); Timothy Stoltzfus Jost, *Oversight of the Quality of Medical Care: Regulation, Management, or the Market?*, 37 ARIZ. L. REV. 825, 826 (1995) ("The task of quality oversight has long been assigned in the first instance to the regulatory boards that license and discipline health care professionals.").

2. *See, e.g.*, Timothy S. Jost et al., *Consumers, Complaints, and Professional Discipline: A Look at Medical Licensure Boards*, 3 HEALTH MATRIX 309, 332 (1993) ("Despite a general belief that medical licensure boards should play a major role in assuring the clinical competence of physicians, it is clear from our data that most disciplinary actions do not focus directly on issues of clinical competence.").

3. *See* Marc T. Law & Zeynep K. Hansen, *Medical Licensing Board Characteristics and Physician Discipline: An Empirical Analysis*, 35 J. HEALTH POL. POL'Y & L. 63, 66 (2010) ("[A]fter lawsuits for medical malpractice became more common in the 1970s, it became increasingly clear that physicians, in remaining inactive and silent, had failed to police and discipline their colleagues."); Sarah J. Polfliet, *A National Analysis of Medical Licensure Applications*, 36 J. AM. ACAD. PSYCHIATRY & L. 369, 369, 372–73 (2008) (suggesting that state medical boards' omission of questions on initial licensure applications and licensure renewal applications regarding mental illness and substance use, so as to comply with the Americans with Disability Act of 1990, leaves their duty to protect the public unfulfilled).

dangerous physicians,[4] and generally being lax in their oversight duties at the expense of a vulnerable public.[5] Whatever the reason for these alleged failures, medical boards only take disciplinary action against less than one-half of one percent of physicians annually[6]—not often enough, critics argue, to have a significant impact on professional quality.[7]

While there is likely some element of truth to the argument that medical boards discipline physicians too infrequently, this Article identifies a more substantive problem—namely, that when boards do choose to exercise their disciplinary discretion, they often focus on character-related misconduct, including criminal misconduct, that bears only a tangential relation to clinical quality and patient care. Consider, for example, a Nevada board's recent decision to discipline a chiropractor for unprofessional conduct after he was convicted of involuntary

4. *See generally* Derbyshire, *supra* note 1, at 197. Derbyshire indicates that between 1963 and 1972, roughly 0.06% of physicians in the United States were disciplined per year, and that in 1981, disciplinary actions against only 0.14% of all licensed physicians were reported to the Federation of State Medical Boards. *Id.* In comparison, Derbyshire estimates that 5% of all physicians in the United States are incompetent and unscrupulous. *Id.*

5. *See, e.g.*, Arnold S. Relman, Editorial, *Professional Regulation and the State Medical Boards*, 312 NEW ENG. J. MED. 784, 785 (1985) ("All the evidence suggests . . . that most if not all the states have been too lax—not too strict—in their enforcement of medical professional standards."); Doug J. Swanson, *Drug Past, Discipline Didn't Stop Doctor; State Board Took Years to Revoke License*, DALLAS MORNING NEWS, July 1, 2001, at 1A (explaining how the Texas State Board of Medical Examiners allowed a doctor to continue practicing medicine and performing surgeries despite evidence of cocaine use by the doctor); Cheryl W. Thompson, *D.C. Board Rarely Punishes Physicians*, WASH. POST, Apr. 11, 2005, at A1 (noting deficiencies in oversight by the District of Columbia medical board between 1999 and 2004).

6. *See* Sidney M. Wolfe & Kate Resnevic, *Public Citizen's Health Research Group Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2005-2007* (2008), *available at* http://www.citizen.org/documents/medicalboardtable.pdf (explaining that in 2007, states initiated an average of just 2.92 serious disciplinary actions per 1,000 physicians).

7. Economists, in particular, have long made similar arguments, questioning the value of licensure and self-regulation in highly insulated and self-protective professions, like medicine. These authors and others suggest that medical quality and patient safety could be better safeguarded through market-based solutions that close the information gap between physicians and consumers. *See generally* Charles H. Baron, *Licensure of Health Care Professionals: The Consumer's Case for Abolition*, 9 AM. J.L. & MED. 335 (1983) (criticizing medical licensure practices as both raising health care costs and failing to protect consumers); Walter Gellhorn, *The Abuse of Occupational Licensing*, 44 U. CHI. L. REV. 6, 16–18, 22, 25 (1976) (arguing that occupational licensing impedes access to needed services and serves only to protect those who have already been licensed, rather than protect the public from incompetent professionals); Anthony Ogus, *Rethinking Self-Regulation*, 15 OXFORD J. LEGAL STUD. 97 (1995) (offering general criticism of the self-regulatory model); Shirley V. Svorny, *Physician Licensure: A New Approach to Examining the Role of Professional Interests*, 25 ECON. INQUIRY 497 (1987). While some steps have been taken in this direction, it is highly unlikely that the current system of medical licensure would be abandoned in the foreseeable future. *See, e.g.*, Massachusetts Board of Registration in Medicine, http://profiles.massmedboard.org (last visited June 4, 2010) (allowing patients to search for physician profiles, including malpractice payments made in the past ten years). Accordingly, this Article does not pursue alternatives to medical licensure and discipline as a means to protecting patient health, but rather evaluates realistic improvements that might be made to the existing system.

manslaughter for shoving a man at a car wash.[8] In recent years, medical providers have been disciplined on grounds as varied as tax fraud,[9] failure to facilitate review of child support obligations,[10] soliciting sex in a public restroom,[11] possession of marijuana for personal use,[12] and reckless driving involving alcohol,[13] as well as other conduct allegedly bringing the medical profession into disrepute.[14] While these are not commendable activities by any stretch of the imagination, this Article questions whether, in light of the traditional goals of professional discipline, sanctioning physicians on these grounds (as opposed to grounds more clearly linked to clinical practice) is the most effective or efficient use of medical boards' resources.

Part I of this Article traces the development of the modern medical disciplinary system, and looks to the constitutional underpinnings of medical board authority to identify three fundamental principles of professional discipline in American law.[15] In Part II, I argue that medical boards may be acting in a manner inconsistent with these fundamental legal principles when they pursue disciplinary action against physicians for character-related misconduct outside the clinical sphere.[16] I also challenge some of the traditional justifications that have been offered in support of professional discipline for character-related misconduct[17] and

8. Annette Wells, *Board Finds Chiropractor Guilty of Unprofessional Conduct*, LAS VEGAS REVIEW-JOURNAL, Dec. 16, 2007, at 1B. The board revoked the chiropractor's license, but stayed the revocation for four and a half years (the time remaining in his felony probation). *Id.*

9. *See, e.g.*, Windham v. Bd. of Med. Quality Assurance, 163 Cal. Rptr. 566, 567–58, 573 (Cal. Ct. App. 1980) (upholding medical board's imposition of discipline on physician for tax evasion); *In re* Kindschi, 319 P.2d 824, 827 (Wash. 1958) (upholding suspension of physician's license as a result of his guilty plea in a tax evasion case against him).

10. *See, e.g.*, Dittman v. California, 191 F.3d 1020, 1032–33 (9th Cir. 1999) (holding that California's requirement that professional licensees disclose their social security numbers so that the state can determine if they failed to pay child support does not violate due process because being current in child support and tax obligations is an element of moral character and therefore related to fitness to practice).

11. *See, e.g.*, McLaughlin v. Bd. of Med. Exam'rs, 111 Cal. Rptr. 353, 354 (Cal. Ct. App. 1973) (disciplining a physician for soliciting a male adult to engage in a lewd or dissolute act).

12. *See, e.g.*, Weissbuch v. Bd. of Med. Exam'rs, 116 Cal. Rptr. 479, 480–81 (Cal. Ct. App. 1974) (sentencing a physician to two years probation and suspended license revocation for pleading guilty to marijuana possession).

13. *See, e.g.*, Griffiths v. Super. Ct., 117 Cal. Rptr. 2d 445, 449–51 (Cal. Ct. App. 2002) (upholding a medical board's order that a physician's license be revoked, stayed pending conditional three year probation, for unprofessional conduct stemming from multiple misdemeanor convictions involving the consumption of alcohol as a result of a number of drunk driving arrests).

14. *See, e.g.*, Foster v. Bd. of Med. Quality Assurance, 278 Cal. Rptr 117, 118–19 (Cal. Ct. App. 1991) (affirming the board's ninety-day suspension of a physician's medical license for unprofessional conduct after physician created a non-existent insurance company and claimed to have taken out a medical malpractice policy from this company).

15. *See infra* Part I.

16. *See infra* Part II.A.

17. *See infra* Part II.B.

posit a few possible explanations for why boards may choose to pursue these kinds of disciplinary actions.[18] Finally, this Article concludes by explaining how medical boards and society might benefit by applying a principles-based analysis in determining when professional discipline is appropriate.

I. PROFESSIONAL DISCIPLINE IN AMERICAN LAW

This Part describes the legal underpinnings of the current American system of medical licensure and discipline,[19] traces its historical development,[20] and briefly describes how the system currently operates in practice and the challenges that have been raised against it.[21] More importantly, this Part highlights three very important insights about the normative goals of the medical disciplinary system that can be derived from the constitutional justifications for professional licensure and discipline.[22]

A. Medical Board Authority: History and Practice

Among the unenumerated powers reserved to each state under the Tenth Amendment is the power to protect the health, safety, and welfare of its citizenry, commonly known as the police power.[23] As explained by the Supreme Court in *Dent v. West Virginia*,[24] it is "[t]he power of the State to provide for the general welfare of its people [that] authorizes it to prescribe all such regulations as, in its judgment, will secure or tend to secure them against the consequences of ignorance and incapacity as well as of deception and fraud."[25] It is pursuant to their police powers that states are authorized to regulate law, medicine, and other professions, which they typically do by delegating authority to professional licensing boards.[26]

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18. *See infra* Part II.C.

19. *See infra* notes 23–26 and accompanying text.

20. *See infra* notes 27–30 and accompanying text.

21. *See infra* notes 31–62 and accompanying text.

22. *See infra* Part II.B.

23. U.S. CONST. amend. X; Slaughter-House Cases, 83 U.S. (16 Wall.) 36, 62 (1872) (describing the police power as extending "to the protection of the lives, limbs, health, comfort, and quiet of all persons, and the protection of all property within the State").

24. 129 U.S. 114 (1889).

25. *Id.* at 122.

26. *See* D. Benjamin Barros, *The Police Power and the Takings Clause*, 58 U. MIAMI L. REV. 471, 477 (2004) (describing the modern view of the police power as primarily a regulatory power); Lawrence O. Gostin, *A Theory and Definition of Public Health Law*, 10 J. HEALTH CARE L. & POL'Y 1, 2–3, 5 (2007) (explaining that the power and duty of safeguarding public health has generally been the role of government because public health is the kind of good that can only be achieved through collective action, which only a government is able to carry out); Edward P. Richards, *The Police Power and the Regulation of Medical Practice: A Historical Review and Guide for Medical Licensing Board Regulation of Physicians in ERISA-Qualified Managed Care Organizations*, 8 ANNALS HEALTH L. 201, 201 (1999) (explaining that states have broad power to regulate medical practice through their police power, and have delegated this power to medical licensing boards).

As a constitutional grant of authority, this story is a relatively simple one; for those familiar with the history of medical licensure, however, it is much more complex. The first state medical boards were created in the late 1800s when private medical associations pushed state legislators to adopt laws regulating the practice of medicine.[27] These efforts were driven by physicians who, fearful of incursions on their territory by "irregulars" and "quacks", were convinced that well-drafted legislation—far from being self-defeating—could serve an important role in protecting their professional interests.[28] Though some historians suggest that professional self-protection, rather than concern for patient safety, was the driving force behind these lobbying efforts,[29] the medical practice acts that resulted were, as a matter of law, clearly adopted pursuant to the legislative authority to protect public health and safety.[30]

At a minimum, modern medical practice acts define the practice of medicine,[31] establish the requirements for medical licensure,[32] and set forth procedures for disciplinary action against licensees.[33] Medical practice acts also establish the composition of the state boards of medicine—the administrative agencies responsible for implementing and enforcing an act's provisions through its rulemaking and adjudicative powers.[34] Modern medical boards generally include

27. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 102–06 (1982); Ronald L. Akers, *The Professional Association and the Legal Regulation of Practice*, 2 LAW & SOC'Y REV. 463, 465 (1968).

28. *See* Akers, *supra* note 27, at 465–66 (noting that use of state regulation often arose to drive out "the undesirable practitioner").

29. *See, e.g.*, Stanley J. Gross, *The Myth of Professional Licensing*, 33 AM. PSYCHOLOGIST 1009, 1011 (1978) (arguing that medical professionals turned toward government for regulation in order "to secure public confidence and a monopoly of skill").

30. *See In re* Kindschi, 319 P.2d 824, 827 (Wash. 1958) (analyzing professional disciplinary proceedings through the lens of the protection of the public).

31. *E.g.*, N.Y. EDUC. LAW § 6521 (McKinney 2001) (defining the practice of medicine); N.C. GEN. STAT. § 90-1.1(5) (2009) (defining the practice of medicine and surgery); TENN. CODE ANN. § 63-6-204 (2004 & Supp. 2009) (defining the practice of medicine).

32. *E.g.*, N.Y. EDUC. LAW § 6524 (McKinney 2001 & Supp. 2010) (listing the requirements for a physician license) (McKinney 2001 & Supp. 2010); UTAH CODE ANN. § 58-67-302 (2007 & Supp. 2009) (listing the qualifications for licensure of physicians and surgeons); VT. STAT. ANN. tit. 26, § 1396 (2006) (defining the standard of requirements for admission to practice of medicine).

33. *E.g.*, N.Y. EDUC. LAW § 6530 (defining professional misconduct); *see generally* FED'N OF STATE MED. BDS., A GUIDE TO THE ESSENTIALS OF A MODERN MEDICAL AND OSTEOPATHIC PRACTICE ACT §§ IX–X (12th ed. 2009), *available at* http://www.fsmb.org/pdf/GRPOL_essentials.pdf (describing disciplinary actions against licensees and procedures for enforcement).

34. *E.g.*, MINN. STAT. ANN. § 147.01 (2005) (describing the Board of Medical Practice); N.Y. EDUC. LAW § 6523 (McKinney 2001) (describing the State Board for Medicine); VT. STAT. ANN. tit. 26, § 1351 (describing the Board of Medical Practice); *see also* Douglas v. Noble, 261 U.S. 165, 170 (1923) (holding that the delegation of professional regulatory powers to an administrative board is consistent with the U.S. Constitution). *See generally* FED'N OF STATE MED. BDS., *supra* note 33, § III (providing an overview of state medical boards); FED'N OF STATE MED. BDS., ELEMENTS OF A MODERN STATE MEDICAL AND OSTEOPATHIC BOARD § III (2009), *available at* http://www.fsmb.org/pdf/GRPOL_Elements_Modern_Medical_Board.pdf (discussing state medical boards in detail).

some public members but are dominated by physicians appointed by the governor.[35]

American licensure laws are exclusive in that they grant qualified individuals the right to engage in the lawful practice of medicine and prohibit the practice of medicine by unlicensed persons.[36] The requirements for obtaining a medical license are relatively consistent from state to state—generally, the applicant must be a graduate of an approved medical school, have completed at least one year of an approved graduate medical education program (residency or fellowship), and have passed the United States Medical Licensing Examination (USMLE).[37] Beyond imposing educational and training requirements, many medical practice acts also require that applicants for medical licensure demonstrate good moral character.[38]

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35. *See* CARL F. AMERINGER, STATE MEDICAL BOARDS AND THE POLITICS OF PUBLIC PROTECTION 48–51 (1999) (describing trends in state medical boards in the late 1900s); M. Christine Cagle et al., *Privatizing Professional Licensing Boards: Self-Governance or Self-Interest?*, 30 ADMIN. & SOC'Y 734, 750–51 (1999) ("With the exception of Rhode Island, most medical boards in the United States are primarily composed of physicians."); Eleanor Kinney, *Administrative Law Issues in Professional Regulation*, *in* REGULATION OF THE HEALTHCARE PROFESSIONS 103, 106 (Timothy S. Jost ed., 1997) ("In most states, licensure boards are composed chiefly of members of the regulated profession who are appointed by the governor.").

36. *See, e.g.*, N.Y. EDUC. LAW §§ 6512–6513 (defining the unauthorized practice of a profession and the unauthorized use of a professional title as crimes). Contrast exclusive licensing laws with certification laws, which grant qualified individuals the right to use the title of physician in connection with their practice of medicine and are exclusive only with respect to the use of that title, not with respect to medical practice generally. Also contrast licensing laws with registration laws, which require that medical practitioners register their names with a state agency, but impose no qualification requirements or restrictions on practice. *See generally* ROBERT L. HOLLINGS & CHRISTAL PIKE-NASE, PROFESSIONAL AND OCCUPATIONAL LICENSURE IN THE UNITED STATES: AN ANNOTATED BIBLIOGRAPHY AND PROFESSIONAL RESOURCE, at xvii–xviii (1997) (explaining that licensing is the most restrictive form of regulation and quoting the view that licensing allows a practitioner to perform acts that would otherwise be illegal). For scholarly criticisms of exclusive licensure, see ELIOT FREIDSON, PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE 23–24 (1970) (explaining the political nature of the medical profession's autonomy, and pointing out that the profession's dependence on the state in granting it this autonomy may actually lessen its autonomy); Harris S. Cohen, *On Professional Power and Conflict of Interest: State Licensing Boards on Trial*, 5 J. HEALTH POL. POL'Y & L. 291, 291–306 (1980) (arguing that fundamental change is needed to the medical licensing board model); Gellhorn, *supra* note 7, at 12 (noting that the restrictions imposed by licensing boards are achieved mostly by making entry into the profession expensive both in time and money); Gross, *supra* note 29, at 1011–12 (explaining that though modern professionals conceal their commercial interests in the area of occupational boards, they are apparent through the boards' restrictive procedures); *supra* note 7.

37. *See, e.g.*, CONN. GEN. STAT. ANN. § 20-10 (West 2008) (defining the qualification for licensure); DEL. CODE ANN. tit. 24, § 1720 (2005 & Supp. 2008) (listing the certification requirements to practice medicine); N.Y. EDUC. LAW § 6524 (McKinney 2001 & Supp. 2010) (defining the requirements to obtain a professional license). For a detailed comparison of state requirements, see generally AM. MED. ASS'N, STATE MEDICAL LICENSURE REQUIREMENTS AND STATISTICS 2007, at 22–24, 80–87 (2007) [hereinafter AMA LICENSURE REQUIREMENTS].

38. *E.g.*, N.Y. EDUC. LAW § 6524(7). *See generally* Hawker v. New York, 170 U.S. 189, 191 & n.1 (1898) (explaining that states may require good character as a prerequisite for allowing an individual to practice medicine and listing numerous jurisdictions with such requirements); AMA LICENSURE

Some states also impose additional requirements, such as proof of malpractice insurance coverage;[39] a clear criminal background check;[40] or age,[41] citizenship,[42] or residency requirements.[43]

Medical boards' ongoing duties include periodic re-registration of licensees, which is typically contingent on completion of specified hours of Continuing Medical Education training.[44] However, medical boards rarely impose additional requirements intended to ensure the quality of care, such as mandatory recertification or random practice audits, upon physicians who have already received their licenses.[45] As a result, the most important of state medical boards' oversight responsibilities with respect to medical quality is the discipline of professional licensees.

The medical disciplinary process is generally reactive, rather than proactive.[46] It begins when a member of the public files a complaint, or, in the case of discipline on the grounds of criminal or civil liability, when a court or law enforcement agency files a report with the medical board.[47] The board screens, and,

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REQUIREMENTS, *supra* note 37 (documenting the various state medical licensure requirements); COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AM. MED. ASS'N, CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION § 10.015, at 348 (2008–2009 ed. 2008) ("The practice of medicine . . . is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering.").

39. *E.g.*, FLA. STAT. ANN. § 458.320 (West 2001) (requiring proof of malpractice liability protection).

40. *E.g.*, S.C. CODE ANN. § 40-47-36 (Supp. 2009); TEX. OCC. CODE ANN. § 155.008 (Vernon 2004 & Supp. 2009).

41. *E.g.*, N.J. STAT. ANN. § 45:9–6 (West 2004); N.Y. EDUC. LAW § 6524(5).

42. *E.g.*, N.J. STAT. ANN. § 45:9–6; N.Y. EDUC. LAW § 6524(6). *But see In re* Griffiths, 413 U.S. 717, 718, 729 (1973) (finding unconstitutional a Connecticut rule requiring bar applicants to be United States citizens).

43. *E.g.*, GA. CODE ANN. § 43-34-26(a)(3) (Supp. 2009); UTAH CODE ANN. § 58-67-302(1)(f) (2007 & Supp. 2009).

44. *See* AMA LICENSURE REQUIREMENTS, *supra* note 37, at 48 (discussing re-registration requirements).

45. *See* OFFICE OF INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUMAN SERVS., PUB. NO. OEI-01-93-00020, FEDERAL INITIATIVES TO IMPROVE STATE MEDICAL BOARDS' PERFORMANCE 5 (1993), *available at* http://oig.hhs.gov/oei/reports/oei-01-93-00020.pdf [hereinafter FEBRUARY 1993 OIG REPORT] (proposing that state medical boards take a more proactive role in assessing and assuring the quality of medical care after initial licensure examinations).

46. *See* RANDALL R. BOVBJERG ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., STATE DISCIPLINE OF PHYSICIANS: ASSESSING STATE MEDICAL BOARDS THROUGH CASE STUDIES 33, 44–45 (2006) (discussing the reactive nature of medical licensing boards).

47. *See* RICHARD P. KUSSEROW, U.S. DEP'T OF HEALTH & HUMAN SERVS., PUB. NO. OEI-01-89-00560, STATE MEDICAL BOARDS AND MEDICAL DISCIPLINE (1990), *available at* http://oig.hhs.gov/oei/reports/oei-01-89-00560.pdf [hereinafter 1990 OIG REPORT] ("State medical boards rely primarily on referrals or complaints to identify cases for investigation."); Jost et al., *supra* note 2, at 310–11 (discussing how the disciplinary process generally begins). Many of these reports are also filed with the National Practitioner Data Bank, a resource maintained by the Department of Health and Human Services that provides medical boards, hospitals, and "other health care entities with information relating to the professional competence and conduct" of licensed medical professionals.

if appropriate, investigates the complaint; if the board finds the complaint is valid, it may exercise its discretion to pursue disciplinary action against the physician,[48] which can range from oral or written reprimand to license revocation or suspension.[49]

Although the substantive grounds for professional discipline vary from state to state, most state medical practice acts authorize discipline for gross incompetence, physical or mental impairment, alcohol or drug abuse, practicing without a license or aiding the unlicensed practice of medicine,[50] as well as reciprocal discipline against those providers who have been subject to disciplinary action in other states.[51] Moreover, most states authorize discipline under a broad category of "unprofessional conduct," which may include violations of codes of medical ethics,[52] conduct that brings the medical profession into disrepute,[53] or other unspecified forms of "dishonorable conduct," including criminal acts (typically felonies or crimes of "moral turpitude").[54] Because states have broad latitude in determining how best to exercise their police powers, and because the loss of a medical license does not implicate a fundamental right, rational basis review is applied when evaluating the constitutionality of such statutes.[55]

Given that medical boards are state agencies, their authority is subject to traditional constitutional constraints, including equal protection and procedural due process limitations.[56] Most importantly, however, medical board disciplinary proceedings are constrained by principles of substantive due process, which limit

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OFFICE OF INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUMAN SERVS., PUB. NO. OEI-01-90-00523, NATIONAL PRACTITIONER DATA BANK: USEFULNESS AND IMPACT OF REPORTS TO STATE LICENSING BOARDS, at i (1993), *available at* http://oig.hhs.gov/oei/reports/oei-01-90-00523.pdf.

48. Jost et al., *supra* note 2, at 326–30.

49. *Id.* at 330.

50. BARRY R. FURROW ET AL., HEALTH LAW § 3-20 (2d ed. 2000).

51. *See* RICHARD P. KUSSEROW, U.S. DEP'T OF HEALTH & HUMAN SERVS., PUB. NO. OEI-01-89-00562, STATE MEDICAL BOARDS AND MEDICAL DISCIPLINE: A STATE BY STATE REVIEW 14 tbl.9 (1990), *available at* http://www.oig.hhs.gov/oei/reports/oei-01-89-00562.pdf (listing states that have reciprocity provisions concerning disciplinary actions taken by the states' medical boards).

52. Kenneth Baum, *"To Comfort Always": Physician Participation in Executions*, 5 N.Y.U. J. LEGIS. & PUB. POL'Y 47, 72 (2001) (noting that many states link "unprofessional conduct" to violations of prevailing medical ethical norms).

53. *E.g.*, KY. REV. STAT. ANN. § 311.597(4) (West 2006).

54. *See, e.g.*, N.Y. EDUC. LAW § 6530(9), (20) (McKinney 2001 & Supp. 2010) (explaining that unprofessional conduct includes "[b]eing convicted of committing an act constituting a crime" and "[c]onduct in the practice of medicine [that] evidences moral unfitness to practice medicine").

55. *See generally* Williamson v. Lee Optical of Okla., Inc., 348 U.S. 483, 487–88 (1955) ("[A] law need not be in every respect logically consistent with its aims to be constitutional. It is enough that there is an evil at hand for correction, and that it might be thought that the particular legislative measure was a rational way to correct it.").

56. *See, e.g.*, Withrow v. Larkin, 421 U.S. 35, 46 (1975) ("[A] fair trial in a fair tribunal is a basic requirement of due process. This applies to administrative agencies [that] adjudicate as well as to courts." (citation omitted)).

the grounds upon which professional discipline can legitimately be imposed.[57] In foundational cases such as *Dent* and *Schware v. Board of Bar Examiners*,[58] the Supreme Court held that the criteria for licensure and discipline may not be vague, arbitrary, or unattainable,[59] and "must have a rational connection with the applicant's fitness or capacity to practice" his profession.[60] However, because no fundamental rights are implicated in the loss of a professional license,[61] courts review boards' disciplinary determinations under a highly deferential standard.[62]

B. Three Fundamental Principles of Professional Discipline

As straightforward as it may appear, this simple constitutional requirement—that the grounds for professional discipline be rationally related to an individual's fitness or capacity to practice a profession—actually provides three very important insights about the fundamental goals of professional discipline. Although, as demonstrated in Part II, these goals may not be reflected in medical boards' current

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57. The liberty component of the due process clause includes a right to choose one's field of employment, and medical licensure is thus considered a kind of property right. *See* Dent v. West Virginia, 129 U.S. 114, 121–22 (1889) (explaining that the right to choose one's profession "is often of great value to the possessors, and cannot be arbitrarily taken from them, any more than their real or personal property can be thus taken").

58. Schware v. Bd. of Bar Exam'rs, 353 U.S. 232 (1957).

59. *See id.* at 248–49 ("Refusal to allow a man to qualify himself for the profession on a wholly arbitrary standard or on a consideration that offends the dictates of reason offends the Due Process Clause.").

60. *Id.* at 239. The Court in *Dent* stated:

> The nature and extent of the qualifications required must depend primarily upon the judgment of the State as to their necessity. If they are appropriate to the calling or profession, and attainable by reasonable study or application, no objection to their validity can be raised because of their stringency or difficulty. It is only when they have no relation to such calling or profession, or are unattainable by such reasonable study and application, that they can operate to deprive one of his right to pursue a lawful vocation.

129 U.S. at 122.

61. *See* Williamson v. Lee Optical of Okla., Inc., 348 U.S. 483, 487–88 (1955) (applying a rational basis standard to an Oklahoma business law).

62. Justice Frankfurter stated in a dissenting opinion in *Barsky v. Bd. of Regents*:

> Reliance on the good faith of a State agency entrusted with the enforcement of appropriate standards for the practice of medicine is not in itself an investiture of arbitrary power offensive to due process. Likewise there is nothing in the United States Constitution [that] requires a State to provide for judicial review of the action of such agencies. Finally, when a State does establish some sort of judicial review, it can certainly provide that there be no review of an agency's discretion, so long as that discretion was exercised within the gamut of choices, however extensive, relevant to the purpose of the power given the administrative agency.

347 U.S. 442, 470 (1954) (Frankfurter, J., dissenting); *see also* Bettencourt v. Bd. of Registration in Med., 904 F.2d 772, 774 (1st Cir. 1990) (stating that the Massachusetts Supreme Judicial Court may overturn a decision of the state medical board only if the agency's decision exceeds statutory authority, is based on an error of law, or is arbitrary or capricious, among other reasons); Kinney, *supra* note 35, at 114 ("[B]oth state and federal courts have accorded the decisions of state licensure boards considerable deference . . . .").

practice, they form the normative foundations of professional regulatory powers under American law and, as such, ought to guide boards in determining when to exercise their disciplinary discretion.

First, the constitutional fitness to practice requirement indicates that the primary goal of (and justification for) professional discipline is public protection. As an extension of the state's police power, the medical board's disciplinary authority is aimed at protecting medical consumers from the harms they may incur at the hands of incompetent or dishonest physicians.[63] This is reflected in the sanctions that may be imposed on physicians, which range from alerting the medical board and community of a potential for harm (via a public letter of reprimand) to withdrawing the physician's right to practice (delicensure).[64] Unlike criminal law, which is aimed at punishing wrongdoers, or civil law, which is aimed at victim compensation,[65] professional discipline seeks to protect public welfare by incapacitating or rehabilitating dangerous physicians.

Second, the existence of a constitutional fitness to practice requirement gives us an important insight into the substantive boundaries of professional discipline—namely, that there *are* such boundaries. That is, if it is to serve as a meaningful limitation on medical board authority, the substantive due process requirement that the criteria for licensure and discipline be rationally related to the practice of medicine necessarily implies that there are at least some criteria that *do not* satisfy this standard. For example, while requiring that physicians counsel their patients about the importance of voting in local and national elections would likely further the public good, it is not clear that this would be a proper subject for medical licensure or discipline, because it bears no clear connection to the competent practice of medicine.[66] As a matter of practice, the dominance of physicians in the

63. *See* Baron, *supra* note 7, at 339 (discussing that the primary aim of medical boards is to protect consumers).

64. *See, e.g.*, ARK. CODE ANN. § 17-95-704(c)(1) (Supp. 2009) (allowing a variety of incremental sanctions to apply, in lieu of a finding of gross and ignorant malpractice); CAL. BUS. & PROF. CODE § 2233 (West 2003 & Supp. 2010) (allowing a medical board to issue a public letter of reprimand rather than filing or prosecuting a formal accusation).

65. *See* Marc Galanter & David Luban, *Poetic Justice: Punitive Damages and Legal Pluralism*, 42 AM. U. L. REV. 1393, 1394 (1993) (distinguishing between criminal and civil law by pointing out that "civil law provides victims with compensation, while criminal law inflicts punishment on wrongdoers").

66. Under even a relatively uncontroversial account, the "competent practice of medicine" is dependent on a physician's education, training, and character. This kind of definition provides that an individual will be deemed fit to practice medicine if he possesses the basic qualities needed to practice in a manner that does not cause harm to his patients. At a minimum, he must possess: (a) scientific knowledge of the human body and its functions, obtained by way of education; (b) the practical skill to implement this knowledge safely, obtained by way of a residency, fellowship, or other hands-on experience, as well as the physical ability to do so; and (c) the moral reasoning needed to understand that his medical knowledge and experience should not be used to harm patients. In effect, fitness to practice is best understood as a "toolkit" of basic skills that each professional must have before he begins practicing. Many states have included aspects of the "competent practice of medicine" directly in

composition of state medical boards tends to support this understanding.[67] That is, in relying on administrative boards dominated by physicians for the implementation and enforcement of licensure and discipline laws, the American system implicitly recognizes that professional members are better situated to evaluate the unique question of fitness to practice; a board composed of laypeople would have much greater difficulty evaluating, for example, whether a licensed physician's practice is consistent with the standard of care in his medical community.[68]

The reason it is necessary to highlight this apparently obvious point is because it is one that is all too easy to miss when reviewing the case law surrounding professional discipline.[69] When physicians appeal the disciplinary decisions made by state medical boards, the reviewing courts typically acknowledge the substantive due process limitations on professional discipline, but rarely, if ever, reverse the boards' decisions on these grounds.[70] This should come as no surprise, given that the standard of review in these cases is the highly deferential rational basis test—surely, the state can identify some rational connection between almost any kind of physician misconduct and the safe and effective practice of medicine. However, just because a category of professional discipline is not constitutionally prohibited does not mean that it is an optimal category for the board to pursue.[71]

A final, and related, insight that can be gleaned from the constitutional limitations on professional discipline is one of scale, rather than substance. That is, professional licensure and discipline standards are established to ensure a minimal level of competence, rather than to identify aspirational standards of professional conduct. This principle of disciplinary minimalism is reflected in the fact that American law identifies the professional license as a property right requiring procedural due process protections,[72] and also in the constitutional requirement that

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their statutes. *See, e.g.*, IND. CODE ANN. § 25-22.5-3-1 (2007) (enumerating the minimum requirements of education and scientific knowledge, skill gained in residency, and moral aptitude).

67. *See* Gail B. Agrawal, *Resuscitating Professionalism: Self-Regulation in the Medical Marketplace*, 66 MO. L. REV. 341, 379–80 n.169 (2001) (noting that while modern state medical boards frequently include lay members, physicians still tend to comprise a majority); Cagle et al., *supra* note 35, at 750 (noting that state medical boards are dominated by physicians).

68. *See* Wesley M. Oliver, *A Round Peg in a Square Hole: Federal Forfeiture of State Professional Licenses*, 28 AM. J. CRIM. L. 179, 189 (2001) (arguing that the members of the Board of Medical Examiners who are medical professionals are specially suited to determine standards of care and appropriate sanctions).

69. *See infra* Part II.C.

70. *See infra* pp. 317–20.

71. *See infra* Part II.B.

72. *See, e.g.*, Schware v. Bd. of Bar Exam'rs, 353 U.S. 232, 238–39 (1957) ("A State cannot exclude a person from the practice of law or from any other occupation in a manner or for reasons that contravene the Due Process or Equal Protection Clause of the Fourteenth Amendment."); Mishler v. Nev. State Bd. of Med. Exam'rs, 896 F.2d 408, 409–10 (9th Cir. 1990) ("That a professional license is

the standards for licensure and discipline be "reasonably attainable."[73] As a practical matter, licensure requirements are aimed at improving the quality of medical care and, in turn, public health. Accordingly, they are bounded by the recognition that overly aspirational or stringent licensure laws may have the counterintuitive effect of actually decreasing public health, as compared to a purely free-market system, if they too severely limit the number of licensed physicians available to serve the community's health needs.[74]

The appropriate view of professional licensure, then, is as a floor beyond which practitioners may not drop, rather than an ideal towards which they must strive. In other words, though we view a medical license as evidence that a physician possesses the basic tools necessary to practice medicine safely, the license does not ensure that he will actually use these tools correctly going forward.[75] Moreover, a medical license does not distinguish the merely competent provider from the excellent provider—that distinction takes place at the marketplace level. For example, private professional associations, like the American Medical Association (AMA), can (and do) set highly aspirational standards of practice and professionalism for their members.[76] Patients have a variety of resources at their fingertips to assist them in selecting and evaluating medical providers from among those that have been deemed competent by the state and are free to choose their providers based on any number of factors that bear no relation to fitness to practice (e.g., age, gender, race, or hospital affiliation).[77]

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property and is protected by the Constitution is recognized by both Nevada law . . . and by federal law." (citations omitted)).

73. Dent v. West Virginia, 129 U.S. 114, 122 (1889) ("If [the nature and extent of the qualifications] are appropriate to the calling or profession, and attainable by reasonable study or application, no objection to their validity can be raised because of their stringency or difficulty.").

74. *See generally* Frances H. Miller, *Medical Discipline in the Twenty-First Century: Are Purchasers the Answer?*, 60 LAW & CONTEMP. PROBS. 31, 36–40 (1997) (explaining how the current market-driven health care system requires that purchasers have access to good information and a meaningful choice of providers in order to succeed).

75. Professional discipline, of course, is aimed at addressing this issue.

76. *See generally* Am. Med. Ass'n, Principles of Medical Ethics, *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.shtml. Note, however, that although the standards of ethics and practice set by the AMA are merely advisory, some of these standards may have a legal impact. Many state medical practice acts that authorize board discipline of physicians who engage in "unprofessional conduct" or violate "ethical norms" actually define these terms in part by reference to the AMA's policies. *See, e.g.*, OHIO REV. CODE ANN. § 4731.22(B)(18) (LexisNexis 2006 & Supp. 2009) (requiring that the state medical board "keep on file current copies of the codes of ethics of the various national professional organizations" and providing that the board "shall" discipline or limit the right to practice of a medical provider for "violation of any provision of a code of ethics of the American [M]edical [A]ssociation . . . or any other national professional organizations that the board specifies by rule").

77. Some states have made such easy access to physician profiles mandatory by law. One review indicates that:

> Massachusetts and Florida currently have legislation requiring profiles of all licensed physicians be available on the Web. Similar legislation has been introduced in California,

These guiding principles for professional discipline in American law should be relatively uncontroversial. While critics of the American system of medical discipline may question whether current practice accurately reflects these principles as a descriptive matter,[78] I argue that, as a normative matter, these principles are not only sound, but desirable.

C. Quantitative and Qualitative Concerns

Despite the fact that the theoretical underpinnings of the American medical disciplinary regime are sound, the system as it is being practically implemented boasts few supporters.[79] Most critics challenge boards for initiating disciplinary action too infrequently to substantially impact patient safety and public health.[80] Here, I argue that a more concerning problem may be the qualitative issue of how boards set disciplinary priorities when faced with various categories of physician misconduct.

The most common criticism that has been traditionally levied against medical boards is that they simply do not discipline physicians often enough to have a substantial impact on patient safety and public health.[81] As a historical matter, low rates of professional discipline have been the primary drivers of public discontent with medical boards.[82] While these challenges have resulted in some cyclical variation in the frequency of professional discipline[83] as well as recent legislative

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Connecticut, Illinois, Maine, Maryland, Rhode Island, Texas and Vermont. The medical licensing boards of Arizona, California, Iowa, Massachusetts, North Carolina and Texas all now profile physicians holding licenses at <www.docboard.org> as well.

Frances H. Miller, *Health Care Information Technology and Informed Consent: Computers and the Doctor-Patient Relationship*, 31 IND. L. REV. 1019, 1035 n.99 (1998) (citation omitted).

78. *See generally* Jost et al., *supra* note 2, 309–38 (discussing the weaknesses of the current medical disciplinary board system).

79. *See, e.g.*, *id.* at 332 (noting that although there is a general belief that medical licensure boards should play a major role in assuring clinical competence, the truth is that most disciplinary actions have no direct correlation with issues of clinical competence).

80. *See id.* at 330 (reporting that just 2.5% of public complaints resulted in formal disciplinary action); Steven R. Smith, *Medical and Psychotherapy Privileges and Confidentiality: On Giving with One Hand and Removing with the Other*, 75 KY. L.J. 473, 484 (1987) (remarking that the infrequency in which boards resort to discipline in the medical and mental professions does little to protect patients and their confidentiality).

81. *See, e.g.*, Thompson, *supra* note 5, at A1 ("The [D.C.] board received roughly 318 complaints against physicians between 1999 and 2004 for allegations ranging from negligent medical care to sexual assault, but only four of the physicians were disciplined.").

82. *See* AMERINGER, *supra* note 35, at 5; Timothy S. Jost, *Oversight of the Competence of Healthcare Professionals*, *in* REGULATION OF THE HEALTHCARE PROFESSIONS, *supra* note 35, at 17, 20–21 (explaining that despite a shift from discipline to quality improvement within the health care community, poor-performing practitioners remain).

83. *See* AMERINGER, *supra* note 35, at 5; Jost, *supra* note 82, at 20–21 (acknowledging shifting priorities in the health care community).

efforts to broaden medical board authority,[84] estimates suggest that less than one-half of one percent of licensed physicians face serious discipline annually.[85] Moreover, consumer advocates continue to cite high rates of medical malpractice as evidence that professional discipline is ineffective in protecting the public or improving the quality of medical care.[86]

While there may be some truth to the claims that boards do not pursue professional discipline often enough, an unmediated focus on the rate of medical discipline alone is unlikely to tell us much about boards' overall effectiveness in protecting public interests.[87] The rate at which medical professionals face serious discipline annually is comparable to the rate of serious professional discipline in other professions, including law.[88] It is also comparable to the rate of felony convictions among the American public.[89] While professional boards and prosecutors certainly could be doing more to pursue those who violate professional standards or break the law, given the parallels between the rates of professional

84. *See* Kevin B. O'Reilly, *Doctor Disciplinary Actions Down for Third Year*, AM. MED. NEWS (May 12, 2008) (reporting that Indiana, New Mexico, and Washington enacted legislation in 2008 to "beef[] up board authority," and that nine other states are considering similar changes); Nadia N. Sawicki, *Doctors, Discipline, and the Death Penalty: Professional Implications of Safe Harbor Policies*, 27 YALE L. & POL'Y REV. 107, 167 & n.284 (2008).

85. *See* Wolfe & Resnevic, *supra* note 6 (stating that between 2000 and 2007, roughly 3.5 physicians out of every thousand faced serious disciplinary action by state medical boards).

86. Frank P. Grad, *Medical Malpractice and the Crisis of Insurance Availability: The Waning Options*, 36 CASE W. RES. L. REV. 1058, 1061–62 (1986) (arguing that the high number of medical malpractice claims filed each year "belies the argument that private medical malpractice claims are an important device to maintain professional discipline and competence."). This sentiment is shared by even some medical board members. *See* BOVBJERG ET AL., *supra* note 46, at 33 (noting the "frustration" expressed by board members that the current disciplinary process "was not finding enough of what might be termed 'problem physicians' or not finding them soon enough").

87. *See, e.g.*, Darren Grant & Kelly C. Alfred, *Sanctions and Recidivism: An Evaluation of Physician Discipline by State Medical Boards*, 32 J. HEALTH POL. POL'Y & L. 867, 872 (2007) ("[I]t would be preferable not to assess board effectiveness by the rate of discipline alone."); Jost et al., *supra* note 2, at 309–10, 336 ("[C]ounts of disciplinary actions . . . do not give us a full picture of board activity. . . . [E]valuating board success solely on the basis of formal disciplinary actions is inadequate because boards may be more active at the informal level than is commonly supposed.").

88. *See* Susan Daicoff, *Asking Leopards to Change Their Spots: Should Lawyers Change? A Critique of Solutions to Problems with Professionalism by Reference to Empirically-Derived Attorney Personality Attributes*, 11 GEO. J. LEGAL ETHICS 547, 549 n.13 (noting that the rate of discipline for attorneys is less than three-tenths of one percent); Jost, *supra* note 82, at 25 ("There is little reason to believe that boards licensing other professions are doing better than medical boards in addressing problems of competence through the disciplinary process.").

89. According to the U.S. Department of Justice, roughly 1,079,000 adults were convicted of felonies in 2004. MATTHEW R. DUROSE & PATRICK A. LANGAN, U.S. DEP'T OF JUSTICE, FELONY SENTENCES IN STATE COURTS, 2004, at 1 (2007), *available at* http://bjs.ojp.usdoj.gov/content/pub/pdf/fssc04.pdf. According to the Central Intelligence Agency in July 2009, the estimated population of the United States was 307,212,123. Cent. Intelligence Agency, World Fact Book, https://www.cia.gov/library/publications/the-world-factbook/geos/us.html (last visited Mar. 30, 2010). The estimated number of convicted felons is, thus, approximately 0.3% of the total United States population.

discipline and criminal conviction, the degree of invective levied at medical boards by public advocates seems disproportionate. If low rates of board discipline suggest a failure of the medical disciplinary system in protecting the public, then surely the same criticism could be made about the effectiveness of state attorneys general in prosecuting criminals. Moreover, consider these data in terms of numbers rather than percentages: if each of the 3,000 physicians seriously disciplined each year sees an average of 3,000 patients annually,[90] then medical board discipline has a direct impact on at least nine million patient interactions annually that might otherwise be at risk. In sum, while the frequency of serious medical disciplinary action is surely relevant to the question of whether medical boards have succeeded in their mission of protecting the public, it is hardly the only relevant factor.[91]

Arguably more important in determining whether medical boards are likely to be successful in protecting the public is the qualitative issue of which physicians are being disciplined and on what substantive grounds. That is, if medical boards can pursue only 3,000 serious disciplinary actions against physicians each year, boards ought to ensure that the actions they do choose to take are on grounds likely to have a substantial impact on patient safety and public health. Indeed, boards inevitably make these kinds of judgment calls whenever they exercise their disciplinary discretion.

When making these decisions, I argue that boards ought to be guided by the three insights identified in Part I.B—that is, when comparing possible grounds for discipline, they ought to ask which is likely to have the greatest impact on patient protection,[92] which has the closest link to fitness to practice,[93] and where each falls on the spectrum from minimal competencies to aspirational standards.[94] As noted earlier, the constitutional floor for disciplinary action is low—because professional discipline is subject to deferential review, boards only need to demonstrate that their disciplinary actions satisfy a rational basis test.[95] However, while the substantive due process standard does little to constrain medical boards as a matter

90. *See* David C. Goodman, *Twenty-Year Trends in Regional Variations in the U.S. Physician Workforce*, HEALTH AFF., Oct. 7, 2004, at VAR-90, VAR-95 http://content.healthaffairs.org/cgi/reprint/hlthaff.var.90v1 ("The most stringent federal definition of primary care underservice is more than 3,000 people per generalist physician within a 'rational service area.'").

91. Grant & Alfred, *supra* note 87, at 872. These competing complaints call to mind the old joke memorialized by Woody Allen in his film, Annie Hall. As his character, Alvy Singer, tells it, "Two elderly women are at a Catskills mountain resort, and one of 'em says: 'Boy, the food at this place is really terrible.' The other one says, 'Yeah, I know, and such . . . small portions.'" ANNIE HALL (United Artists 1977).

92. *See supra* p. 295.

93. *See supra* pp. 295–96.

94. *See supra* p. 296–97.

95. *See supra* notes 62, 72 and accompanying text.

of law, the fundamental principles underlying this standard can and should serve a valuable function in helping boards prioritize their actions as a matter of practice.

Imagine that instead of a rational basis standard, medical boards were required to demonstrate a "substantial relationship" between the grounds for professional discipline and the state's admittedly important interest in ensuring an individual's fitness to practice medicine. Under such an intermediate standard, some categories of professional discipline would likely be constitutionally impermissible—for example, disciplining physicians for failure to comply with the hypothetical requirement (described above) that they counsel their patients about voting in elections.[96] As the standard of constitutional scrutiny gets higher, medical boards would have fewer and fewer permissible categories of discipline from which to choose. While the standard of review for medical board discipline is currently set very low, boards can and should use the sliding scale of scrutiny to guide them in prioritizing their disciplinary decisions. In other words, boards should expend greater resources on discipline that is narrowly tailored and least restrictive to achieve the goal of ensuring fitness to practice—sanctioning physicians who cheat on their medical licensing examinations, for example. In contrast, grounds for discipline that bear only a rational or tangential relationship with fitness to practice would not be deemed to be pressing concerns.[97]

While efforts to more clearly delineate the scope of justifiable professional discipline may be misconstrued as inappropriately limiting medical boards' ability to protect the public,[98] these concerns are unfounded. The relevant issue is not whether boards are disciplining physicians often enough, but rather whether boards are exercising their disciplinary powers in the most effective and efficient manner. Despite some recent expansions of authority, medical boards generally operate under significant financial constraints, and necessarily maintain a system of triage in matters of discipline.[99] Given that the frequency of board discipline is significantly resource-driven,[100] modifying boards' disciplinary priorities is likely to be more effective than pushing for increased rates of discipline when resources are scarce. The active pursuit of baseless or irrelevant complaints detracts from the boards' ability to focus on professional misconduct that may have a far more direct impact on patient safety and the protection of public health.[101] Understanding how

96. *See supra* note 66 and accompanying text.

97. *See infra* Part II.B.

98. *See, e.g., In re* Kindschi, 319 P.2d 824, 827 (Wash. 1958) (stating that medical board disciplinary proceedings are designed to protect the public and that medical boards have discretion in deciding what types of unprofessional conduct should face discipline).

99. *See* BOVBJERG ET AL., *supra* note 46, at 9–10, 23 (describing the many challenges facing disciplinary boards, including lack of funding); *infra* notes 174–76 and accompanying text.

100. BOVBJERG ET AL., *supra* note 46, at 16–17 (noting that most of states studied operate "more frugally than average" and that "constrained funding" limits boards' disciplinary capacity).

101. Imagine the potential impact if all the resources spent by medical boards in disciplining character-related misconduct occurring outside the clinical sphere were instead redirected to address

boards' disciplinary authority can justifiably be exercised and shifting resources towards discipline that is narrowly tailored to achieve medical boards' goals is likely to lead to substantial gains in both efficacy and efficiency.

II. APPLYING THE PRINCIPLES OF PROFESSIONAL DISCIPLINE

Having established that the frequency of medical discipline warrants less study than the qualitative question of how medical boards set their disciplinary priorities, this Part makes the case that the underlying principles of professional discipline described in Part I do not support the imposition of severe disciplinary sanctions against physicians whose misconduct falls outside the clinical sphere or otherwise does not implicate patient safety or public health—including many physicians with criminal convictions and those charged with unspecified "unprofessional conduct," who are often disciplined under the current regime.[102] This Part concludes that unless medical boards are able to offer some other strong justification for restricting medical licenses on these grounds, they should not expend significant resources in these areas and ought to instead focus on issues more closely linked to clinical competency and fitness to practice.[103]

A. Common Grounds for Disciplinary Action—Character, Not Competence

While precise figures are hard to come by, reviews of serious disciplinary actions taken against licensed medical professionals in the past thirty years reveal that medical boards rarely take disciplinary action on the basis of incompetent medical practice or poor quality of care. Studies by the Office of the Inspector General in the 1980s and 1990s, for example, consistently concluded that issues of medical quality rank very low among medical boards' disciplinary priorities.[104]

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behavior with a more direct impact on patient health and welfare—for example, substandard care or intentional violation of patient informed consent. *See* NAT'L QUALITY FORUM, SERIOUS REPORTABLE EVENTS IN HEALTHCARE 1 (2002), *available at* http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=1221 (describing the occurrence of "never events," which are serious preventable adverse health events and relate directly to patient care); Paul Jung et al., *U.S. Physicians Disciplined for Criminal Activity*, 16 HEALTH MATRIX 335, 350 tbl.4 (2006) (noting that almost seventy-five percent of offenses by physicians in the study impacted patients or the health system generally).

102. *See infra* Part II.A–B.

103. *See infra* Part II.C.

104. *See* 1990 OIG REPORT, *supra* note 47, at 15 (noting the infrequency of quality of care cases among those that resulted in disciplinary action, and reporting that in 1988, "incompetence" cases accounted for only 11.5% of all disciplinary actions taken by state boards, while 57% of actions involved misprescribing, impairment, or narcotics violations); OFFICE OF ANALYSIS & INSPECTIONS, U.S. DEP'T OF HEALTH & HUMAN SERVS., MEDICAL LICENSURE AND DISCIPLINE: AN OVERVIEW 13–14 (1986), *available at* http://oig.hhs.gov/oei/reports/oai-01-86-00064.pdf [hereinafter 1986 OIG REPORT] (revealing that inappropriate writing of prescriptions and self-abuse of drugs or alcohol are the two dominant types of violations that are grounds for disciplinary action by state boards, while incompetency cases are rare).

"[W]e've never had a disciplinary action based on malpractice," reported one medical board director, and "when there is a malpractice case, we tend to look for another basis for disciplinary action."[105] Indeed, my own review of data provided by the Federation of State Medical Boards (FSMB)[106] suggests as much—fewer than 15% of professional disciplinary actions taken between 1999 and 2008 appear to have been taken on grounds clearly related to clinical competence.[107] Other studies show slightly higher figures—Grant and Alfred's analysis of data compiled by the Public Citizen Health Research Group found that 18.8% of sanctions were based on "substandard care, incompetence, or negligence,"[108] while their analysis of FSMB data suggested that up to a third of serious disciplinary actions may be taken on grounds related to competency in medical practice.[109] Regardless of the exact figures, it is surprising that in an era of "never events" and rising malpractice premiums,[110] the state boards charged with granting medical licenses and ensuring continued fitness to practice medicine do not seem to be prioritizing competency-related issues.

If medical boards are not regularly pursuing discipline against physicians who engage in malpractice or clearly violate standards of clinical quality, then what categories of misconduct do they pursue? Although the majority of disciplinary actions are taken on unspecified grounds,[111] the ones that are categorized tend to

105. 1986 OIG REPORT, *supra* note 104, at 14.

106. Many thanks to Dr. Aaron Young, Senior Director for Research and Analytics at the Federation of State Medical Boards (FSMB), for providing the data used for this analysis. Note that the data provided by FSMB is a compilation of state-level data reported by the state boards of medicine, which are not necessarily consistent in how they categorize the grounds for professional discipline. Accordingly, these figures may be imprecise; I have used them only to get a very broad sense of the frequency of various disciplinary grounds.

107. Clinically-related grounds for discipline include, *inter alia*, practicing with lapsed license, malpractice, inappropriate treatment/diagnosis, failure to conform to minimal standards of acceptable medical practice, failure to adequately supervise, and performing improper or unnecessary surgery. According to my review of FSMB data, *supra* note 106, these actions accounted for 14.2% of all disciplinary actions reported to FSMB between 1999 and 2008.

108. Grant & Alfred, *supra* note 87, at 875 tbl.2.

109. *See id.* (finding based on FSMB data that "negligence" accounted for 14.5% of sanctions, "failure to conform to minimal standards of acceptable medical practice" accounted for 12.2%, and "gross negligence" accounted for 7%).

110. JAY ANGOFF, FALLING CLAIMS AND RISING PREMIUMS IN THE MEDICAL MALPRACTICE INSURANCE INDUSTRY 1, 6 chart 1 (2005), *available at* http://www.centerjd.org/archives/studies/ANGOFFReport.pdf (noting the recent doubling of medical malpractice premiums); NAT'L QUALITY FORUM, *supra* note 101, at 1 (discussing "never events").

111. *See* Grant & Alfred, *supra* note 87, at 875 tbl.2. Unfortunately, the most commonly reported disciplinary code—*not applicable*, appearing in over sixty-five percent of cases—provides no useful information about the grounds for professional discipline. *Id.* According to Grant and Alfred, *not applicable* is used when the board and physician enter the equivalent of a settlement agreement, "in which the physician agrees to the [sanction] . . . but without being found guilty of violating the statute for which he or she is under investigation. Since the disciplined physician is never legally found guilty of the offense, the nature of the investigation is not reported." *Id.* at 874. My own review of FSMB data,

fall within three broad categories—drug or alcohol abuse, criminal convictions, and unspecified unprofessional conduct.[112]

According to the Office of the Inspector General, until the 1990s, medical boards frequently concentrated on physicians with drug and alcohol abuse problems, as well as those with criminal convictions.[113] However, more recent studies of disciplinary data nationwide suggest that medical boards' disciplinary priorities have changed somewhat in the past two decades.[114] Currently, discipline on the basis of drug- and alcohol-related misconduct accounts for between fifteen and twenty percent of actions.[115] The studies that distinguish between drug-related misconduct that is directly linked to medical practice (e.g., signing blank prescription forms, practicing medicine while under the influence, and overprescribing drugs) and general substance abuse problems that may not manifest themselves in the professional sphere (e.g., conviction for driving under the influence or chemical dependency) suggest that less than ten percent of these cases are directly tied to medical practice.[116]

Another significant category of professional discipline is discipline on the basis of criminal misconduct or conviction, which accounts for approximately ten percent of actions (with some estimates as high as seventeen percent).[117] Moreover, recent studies confirm that many of the most serious disciplinary actions taken on the basis of criminal convictions involve criminal misconduct with no immediately apparent impact on patient safety or public health.[118] One recent study used data

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supra note 106, indicated that 24.7% of cases were recorded as *not applicable*, and 1.2% were recorded as *not reported*.

112. Grant & Alfred, *supra* note 87, at 874–75 & tbl.2. Other less-frequently occurring grounds for discipline include fraud, physical or mental impairment, sexual misconduct, failure to maintain medical records, and administrative reasons (prior violations, failure to comply with terms of probation). *Id.*

113. 1990 OIG REPORT, *supra* note 47, at 15 (reviewing data as of 1988 and concluding that between 57% and 66% of disciplinary actions taken were on alcohol- or drug-related grounds); 1986 OIG REPORT, *supra* note 104, at 13–14 (identifying inappropriate writing of prescriptions, self-abuse of drugs or alcohol, and conviction of a felony or fraud as the most common grounds for discipline).

114. Grant & Alfred, *supra* note 87, at 875 & tbl.2.

115. *See id.* at 875 tbl.2. Grant and Alfred's review of FSMB data between 1994 and 2002 concluded that *substance abuse* accounted for 9.5% of sanctions and *chemical dependency* accounted for 6.5% of actions. *Id.* In the same article, the review of data collected by Public Citizen Health Research Group between 1990 and 1999 found that *substance abuse* accounted for 10% of sanctions and *misprescribing or overprescribing drugs* accounted for 7.7% of sanctions. *Id.* My own review of data provided by FSMB between 1999 and 2008, *supra* note 106, indicates that approximately 3.8% of actions are taken on the basis of drug-related misconduct directly tied to clinical practice and 7.6% of actions are taken on the basis of drug or alcohol violations generally.

116. *E.g.*, Grant & Alfred, *supra* note 87, at 876.

117. *Id.* at 875 tbl.2 (finding that "criminal conviction" accounts for 17.2% of discipline based on Public Citizen Health Research Group data); Jung et al., *supra* note 101, at 340 (stating that between 1990 and 1999, actions related to criminal convictions ranged from 8.0% to 11.5%). My own review of FSMB data, *supra* note 106, suggests that approximately 4.7% of actions are taken on the basis of criminal conviction.

118. *E.g.*, Jung et al., *supra* note 101, at 350 tbl.4.

compiled by Public Citizen's Health Research Group to look at all disciplinary actions taken in the 1990s on the basis of a physician's criminal conduct, and classified these disciplinary actions based on whether the misconduct at issue involved patients, the health care system broadly defined, or neither.[119] The authors demonstrated that almost a quarter of these actions involved conduct that impacted *neither* patient care nor the medical system broadly defined.[120] Moreover, those categories of misconduct not directly linked to medicine or patient care (i.e., sex offenses, murder and manslaughter, public drunkenness, general criminal conduct) tend to be disciplined *more* severely than categories of misconduct that bear a closer connection to competent medical practice (i.e., prescribing violations, "criminal misconduct related to medicine," insurance fraud).[121]

However, according to a review of data compiled by FSMB between 1994 and 2002, unspecified "unprofessional conduct" was the single most frequently cited ground for discipline, appearing in approximately a third of all cases.[122] Without further information, of course, it is impossible to know whether and to what extent the targeted conduct implicates patient safety or public health,[123] but a review of the kinds of disciplinary actions that rise to the level of judicial review offers some troubling implications. Medical boards have suspended medical licenses on the grounds of "unprofessional conduct" for a variety of criminal and character-related misconduct, including personal income tax fraud,[124] shoplifting,[125]

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119. *Id.* at 337–38.

120. *Id.* at 350 tbl.4.

121. *Id.* at 342, 348 tbl.2. On a category-by-category basis, this certainly seems to be the case; indeed, the authors note that "offenses in categories that involve the health-care system resulted in a wide range of orders of differing severity." *Id.* at 344. That said, the authors note that on an offense-by-offense basis, offenses involving patients generally tend to result in "more severe orders." *Id.*

122. Grant & Alfred, *supra* note 87, at 875 tbl.2 (reporting that 33.4% of actions were taken on the basis of "unprofessional conduct," not including sexual misconduct, which accounted for an additional 7.1% of sanctions). Public Citizen Health Research Group's data had slightly lower figures. *Id.* (finding 12.9% of actions for "professional misconduct" and 12.2% of actions for "noncompliance with a professional rule"). My own review of FSMB data from 1999 to 2008, *supra* note 106, suggests that approximately 14.1% were unspecified unprofessional or unethical conduct.

123. *See* Grant & Alfred, *supra* note 87, at 876 (noting that the databases used are not "sufficiently precise that one can pinpoint the number of actions directly or indirectly related to quality of care"). One solution to this problem, and one I wholeheartedly endorse, is for state medical boards to use standardized and more specific categories for reporting disciplinary actions to FSMB. *Id.* at 868, 870, 874–75 (describing one criticism of medical boards as "nonuniformity of sanctions across states" and noting the geographical variations in certain categories of sanctions). In order for scholars to evaluate whether boards are achieving their stated goals, it is important to collect more specific data, which are currently unavailable at a national level. *See id.* at 868, 870 (acknowledging structural differences between states).

124. *E.g.*, Windham v. Bd. of Med. Quality Assurance, 163 Cal. Rptr. 566, 570 (Cal. Ct. App. 1980) ("[W]e find it difficult to compartmentalize dishonesty in such a way that a person who is willing to cheat his government out of . . . taxes may yet be considered honest in his dealings with his patients."); *In re* Kindschi, 319 P.2d 824, 825, 827 (Wash. 1958) (holding that a guilty plea to a charge of tax evasion constitutes an adequate showing of moral turpitude before a medical disciplinary board).

failure to facilitate review of child support obligations,[126] soliciting sex in a public restroom,[127] possession of marijuana for personal use,[128] reckless driving involving alcohol,[129] and witness intimidation.[130]

Often, when boards take serious disciplinary action on the basis of unprofessional behavior or criminal conduct, the sanctioned physicians challenge their suspensions on due process grounds, arguing that their behavior, while possibly indicative of poor personal judgment or character, is simply not relevant to their fitness to practice medicine.[131] Consider, for example, the case of Dr. Ansar, a physician who practiced at a veterans' hospital, providing medical care to an underserved population.[132] In the midst of a bitter divorce and custody dispute, Dr. Ansar called the police to report that his wife had attacked him with a knife when in fact, his injury was self-inflicted, a feeble attempt to gain advantage in the legal proceedings.[133] When the police arrived and Dr. Ansar realized that they were going to take his wife into custody, he immediately recanted his statement, but was nevertheless charged and convicted of filing a false police report.[134] Subsequently, the state medical board suspended his license to practice medicine for six months on the grounds that Dr. Ansar had committed a "misdemeanor involving moral turpitude."[135] The board's decision was upheld on appeal.[136]

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125. *E.g.*, Mao v. Super. Ct., No. C058547, 2008 WL 4997602, at *7–*8 (Cal. Ct. App. Nov. 25, 2008) (concluding that shoplifting multiple times per month "will certainly interfere with [one's] ability to care for . . . 'extremely ill' patients" and "demonstrate[s] an unfitness to practice medicine").

126. *E.g.*, Dittman v. California, 191 F.3d 1020, 1032–33 (9th Cir. 1999) (holding that California's requirement that professional licensees disclose their social security numbers so that the state can determine if they failed to pay child support does not violate due process because being current in child support and tax obligations is an element of moral character and therefore related to fitness to practice).

127. *See, e.g.*, McLaughlin v. Bd. of Med. Exam'rs, 111 Cal. Rptr. 353, 354 (Cal. Ct. App. 1973) (involving the offense of "soliciting a male adult to engage in a lewd and dissolute act").

128. *E.g.*, Weissbuch v. Bd. of Med. Exam'rs, 116 Cal. Rptr. 479, 480–81, 483 (Cal. Ct. App. 1974) (stating that the medical board found the physician guilty of unprofessional conduct after being convicted of possession of marijuana, but holding that the board should dismiss the proceeding).

129. *E.g.*, Griffiths v. Super. Ct., 117 Cal. Rptr. 2d 445, 448 (Cal. Ct. App. 2002).

130. *E.g.*, McDonnell v. Comm'n on Med. Discipline, 483 A.2d 76, 81 (Md. 1984) (reversing a medical board's decision to discipline a physician who was being sued by a former patient for medical malpractice where the physician allegedly engaged in the intimidation of expert witnesses); *In re* Lustgarten, 629 S.E.2d 886, 892 (N.C. Ct. App. 2006) (reversing the North Carolina Medical Board's decision to discipline a physician testifying as an expert witness for allegedly testifying in bad faith that another physician was testifying falsely).

131. *E.g.*, *McLaughlin*, 111 Cal. Rptr. at 356.

132. Ansar v. State Med. Bd., No. 08AP-17, 2008 WL 2514818, at *1 (Ohio Ct. App. June 24, 2008).

133. *Id.*

134. *Id.* at *1, *3.

135. *Id.* at *1; *see also* OHIO REV. CODE ANN. § 4731.22(B)(13) (LexisNexis 2006 & Supp. 2009) (providing that the state medical board "shall, to the extent permitted by law, limit, revoke, or suspend an individual's certificate to practice, refuse to register an individual, refuse to reinstate a certificate, or reprimand or place on probation" a physician who pleads guilty to or is convicted of "a misdemeanor involving moral turpitude").

B. An Imperfect Fit with the Principles of Professional Discipline

The fact that physicians are frequently sanctioned for engaging in character-related or criminal misconduct is troubling in light of the three fundamental principles of professional discipline identified in Part I. The constitutional limitations on medical board action suggest that boards ought to be primarily concerned with enforcing minimal standards of fitness to practice in an effort to protect consumers of medical services.[137] It hardly seems obvious why, given the harms suffered by patients on a daily basis as a result of "never events"[138] and other medical errors and instances of medical negligence, boards should be using their scarce resources to discipline physicians for character-related misconduct occurring outside the clinical sphere, particularly where such behavior is already subject to criminal or civil sanctions.[139]

To take just one concrete example, consider the case of Dr. Ansar, described above. If the State Medical Board of Ohio had considered the fundamental principles of professional discipline in determining whether or not to revoke Dr. Ansar's medical license, it is by no means clear that the case would have come out as it had.

Consider first whether the state's goal of public protection was well-served by allowing the medical board to exercise its disciplinary discretion in this manner—in other words, was restricting Dr. Ansar's right to practice medicine for six months likely to protect his patients or others from harm? It is difficult to identify any specific patient harm that would occur if Dr. Ansar were permitted to continue practicing, let alone harm that could be traced to the incident in which he filed a false police report against his wife. Of course, Dr. Ansar's behavior did cause physical harm to himself (the self-inflicted stab wound) and had the potential to harm his wife, an innocent victim of wrongful prosecution. His conduct also caused harm to the public more broadly, given that the state expended resources dealing with a false alarm rather than responding to true emergencies. However, given that these concerns are adequately addressed by the criminal laws under which Dr. Ansar was prosecuted,[140] it is hard to say that professional discipline would have a significant impact on public protection in this regard. In contrast, it is likely that restricting his right to practice resulted in some harm to an underprivileged

136. *Ansar*, 2008 WL 2514818, at *7.

137. *See supra* Part II.B.

138. The National Quality Forum has identified 27 "never events" that should never happen in any clinical setting—including surgery performed on the wrong patient or the wrong part of the body, unintended retention of a foreign object in a patient's body during surgery, and similar events. NAT'L QUALITY FORUM, *supra* note 101, at 6–7 tbl.1.

139. *See* Jung et al., *supra* note 101, at 350 tbl.4 (finding that 23.5% of disciplinary actions that are conviction-related did not involve patients or the health system generally).

140. *Ansar*, 2008 WL 2514818, at *3–*4.

population already at a high risk of receiving inadequate care,[141] given that Dr. Ansar practiced in a veterans' hospital.[142]

To justify prioritizing this kind of disciplinary action, the Ohio Medical Board should have been able to demonstrate that its decision to revoke Dr. Ansar's license was based on minimal, rather than aspirational, standards of physician competency. Moreover, it should have demonstrated some clear connection between Dr. Ansar's criminal conduct and his fitness to practice medicine—that is, while only a rational connection may be required as a constitutional matter, the board should have applied higher standards internally as it determined whether to proceed against Dr. Ansar or direct its resources toward other cases.

Three kinds of arguments have typically been offered to support the claim that character-related misconduct is closely linked to fitness to practice—but whether grounded in prediction, trust, or social contract theory, none are compelling enough to suggest that boards should actively pursue discipline on these grounds.

One of the arguments that medical boards and courts have often used to justify discipline for character-related misconduct outside the professional sphere is that it may be predictive of misconduct or error in clinical practice. One can imagine, for example, the board in Dr. Ansar's case arguing for such a predictive link—if Dr. Ansar feels no qualms about filing a false police report and wrongfully accusing his wife of assault, then perhaps he would be similarly inclined towards dishonesty in Medicare billing, or in falsely documenting his conversations with patients when informed consent is at issue. Courts have long used these kinds of predictive arguments in upholding the disciplinary determinations made by medical boards.[143] The Washington Supreme Court, for example, held in *Haley v. Medical Disciplinary Board*[144] that a physician's conviction for tax fraud indicates a lack of

141. *See generally* NAT'L RESEARCH COUNCIL, NAT'L ACAD. OF SCIS., S. REP. NO. 95-4, STUDY OF HEALTH CARE FOR AMERICAN VETERANS 1–3 (1977) (arguing that health care programs are inadequately equipped to handle the number of patients who need care); Robert Pear, *Report Outlines Medical Errors in V.A. Hospitals*, N.Y. TIMES, Dec. 19, 1999, at 1, *available at* http://www.nytimes.com/1999/12/19/us/report-outlines-medical-errors-in-va-hospitals.html (describing a report that found almost 3,000 medical mistakes, of which 700 patients died, in less than two years in veterans hospitals in the United States).

142. *Ansar*, 2008 WL 2514818, at *1.

143. *See, e.g.*, Griffiths v. Super. Ct., 117 Cal. Rprt. 2d 445, 455 (Cal. Ct. App. 2002) (denying a petition for a writ of administrative mandate, which challenged a sanction imposed by the state medical board for three convictions involving alcohol consumption, based on the state's interest in preventing future harm to the public through such conduct); Krain v. Med. Bd., 84 Cal. Rptr. 2d 586, 592 (Cal. Ct. App. 1999) ("[T]he intentional solicitation to commit a crime [that] has as its hallmark an act of dishonesty cannot be divorced from the obligation of utmost honesty and integrity to the patients whom the physician counsels . . . ."); Haley v. Med. Disciplinary Bd., 818 P.2d 1062, 1069 (Wash. 1991) ("Being convicted of tax fraud does not indicate any lack of competence in the technical skills needed to be a physician. Rather, it indicates a lack of the high degree of trustworthiness the public is entitled to expect from a physician.").

144. 818 P.2d 1062.

trustworthiness, raising a "reasonable apprehension" that he might likewise "abuse the trust inherent in professional status."[145] Writing of the disciplined physician, the court explained its difficulty in "compartmentaliz[ing] dishonesty in such a way that a person who is willing to cheat his government out of $65,000 in taxes may yet be considered honest in his dealings with his patients."[146] In other words, if maintaining honesty in patient relations is an element of safe and effective medical practice, disciplinary action may be appropriate against a physician who engages in dishonest behavior in the personal realm on the grounds that he is likewise predisposed to dishonesty in the context of medical practice.

While prediction theory may seem promising at first glance, it does not actually resolve the question of whether the substantive grounds for professional discipline bear a rational relationship to fitness to practice. Taken at face value, prediction theory might justify disciplining a physician with any characteristic that correlates with medical misconduct or poor clinical judgment in the patient care setting, regardless of its relevance to fitness to practice. Imagine, for example, that a retrospective study reveals that male OB/GYNs practicing in rural areas, or physicians who engage in extramarital affairs, are found fifty times more likely to commit medical errors or lose patient malpractice suits.[147] Surely this predictive

145. *Id.* at 1069.

146. *Id.* at 1070; *see also Krain*, 84 Cal. Rptr. 2d at 592 (finding that soliciting the subordination of perjury, an act of dishonesty, is inherently tied to the physician's obligations of honesty and integrity).

147. Little empirical research has been done on the predictors of professional misconduct and discipline in the legal or medical realms. *See* Deborah L. Rhode, *Moral Character as a Professional Credential*, 94 YALE L.J. 491, 556 (1985) (summarizing research on predictors of attorney discipline). In the context of medical practice, most studies examining the predictors of clinical misconduct or disciplinary complaints look only at correlations with length of practice, gender, race, and other similar demographic characteristics. *See, e.g.*, Roberto Cardarelli et al., *Predicting Risk for Disciplinary Action by a State Medical Board*, 100 TEXAS MED. 84, 84 (2004) ("The primary variables in the database [of disciplined physicians in Texas] included years in practice, sex, race or ethnicity, medical degree and training, primary specialty, and method of licensure."); James Morrison & Peter Wickersham, *Physicians Disciplined by a State Medical Board*, 279 JAMA 1889, 1890–91 (1998) (examining discipline based on location, gender, and type of practice). Others look at medical school grades and examination scores, but not aspects of character or personality. *See, e.g.*, Hossam Hamdy et al., *BEME Systematic Review: Predictive Values of Measurements Obtained in Medical Schools and Future Performance in Medical Practice*, 28 MED. TEACHER 103, 105 (2006) (reviewing studies that evaluated, among other things, medical school scores and ratings when predicting outcomes in clinical practice); Robyn Tamblyn et al., *Physician Scores on a National Clinical Skills Examination as Predictors of Complaints to Medical Regulatory Authorities*, 298 JAMA 993, 999 (2007) (using patient-physician communication examination scores to predict future complaints in practice). The only marginally useful studies of predictors of medical misconduct reveal high rates of disciplinary recidivism, Grant & Alfred, *supra* note 87, at 868, or a connection between "unprofessional conduct" in medical school and board discipline. Maxine A. Papadakis et al., *Disciplinary Action by Medical Boards and Prior Behavior in Medical School*, 353 NEW ENG. J. MED. 2673, 2679 (2005). Of course, lack of empirical support in an area where little empirical research has been done is not a reason to reject the predictive argument altogether. If a strong theoretical argument can be made in support of a connection between discrete elements of personal character and clinical harm to patients, then perhaps this hypothesis can be used to direct future empirical research about the predictive value of character-related misconduct. Moreover,

link alone would not justify preemptive discipline, absent a separate finding that the physician lacks the intrinsic characteristics of education, training, and character that form the foundation of competent medical practice. If we are serious about a substantive due process limitation that demands that licensure and discipline requirements be rationally related to fitness to practice, the prediction theory is a poor substitute.

Alternatively, a medical board could use trust theory to justify a disciplinary inquiry into character-related misconduct. Trust theorists posit that misconduct outside the clinical sphere is a legitimate subject for professional discipline if it is likely to cause public distrust of the medical profession.[148] The Ansar opinion touched on this issue briefly, where the appeals court upheld the trial court's "conclusion that Dr. Ansar's conduct violated moral sentiment and the accepted moral standards of the community, thereby potentially eroding the public's esteem for him."[149] Taking this statement at face value, it is difficult to understand how inquiries into personal misconduct that lowers public opinion of the profession (but does not otherwise harm patients) relates to the state's interests in protecting public health and welfare. Indeed, few courts have ever expressly identified why the state's police powers justify disciplinary action that serves only to protect the medical profession's position in society.[150] Perhaps the strongest defense was provided by the Washington Supreme Court in *Haley*, where it affirmed that "preserving [medical] professionalism is not an end in itself," but merely "an instrumental end pursued in order to serve the state's legitimate interest in promoting and protecting the public welfare."[151] The court wrote:

> To perform their professional duties effectively, physicians must enjoy the trust and confidence of their patients. Conduct that lowers the

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even if empirical research did demonstrate a link between personal character and safe medical practice, it is by no means clear that the existing system of medical licensure and discipline would be the most accurate or effective mechanism for evaluating personal character. *See generally* Rhode, *supra*, at 556 (noting that further empirical research is needed on whether disciplinary authorities can assess individual morality and fitness based on discrete prior acts).

148. *See, e.g.*, *In re* Kindschi, 319 P.2d 824, 826 (Wash. 1958) ("[D]isciplinary action is to be taken against [a physician] in order to maintain sound professional standards of conduct for the purpose of protecting . . . the standing of the medical profession in the eyes of the public."); Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 491 (2002) ("[T]he authority to discipline doctors for unprofessional conduct relate[s] directly to trust.").

149. Ansar v. State Med. Bd., No. 08AP-17, 2008 WL 2514818, at *7 (Ohio Ct. App. June 24, 2008).

150. The Washington Supreme Court in *In re Kindschi*, for example, identified the dual goals of professional discipline as protecting the public and protecting "the standing of the medical profession in the eyes of the public." 319 P.2d at 826. More recently, the court held that "conduct may indicate unfitness to practice medicine if it . . . lowers the standing of the medical profession in the public's eyes." *Haley*, 818 P.2d at 1069; *see also In re* Lesansky, 17 P.3d 764, 767 (Cal. 2001) ("Attorney discipline is imposed when necessary 'to protect the public, to promote confidence in the legal system, and to maintain high professional standards . . . .'").

151. *Haley*, 818 P.2d at 1070.

> public's esteem for physicians erodes that trust and confidence, and so undermines a necessary condition for the profession's execution of its vital role in preserving public health through medical treatment and advice.[152]

This link between public trust and professional efficacy has been widely recognized by legal scholars, most notably by Mark Hall, who posits that trust is a fundamental element of the healing relationship,[153] without which vulnerable patients would not be willing to seek care[154] and the medical profession would not be able to effectively achieve the state's goals in patient welfare and public health.[155] Under this view, then, any behavior that diminishes patients' confidence in the medical profession could be an appropriate subject for professional discipline.

This approach towards character-related physician misconduct is problematic for the same reasons as the predictive theory. Even accepting a connection between private misconduct and public trust in medicine,[156] this kind of correlation alone may not be a strong enough justification for state intervention when other kinds of misconduct are likely to have a greater negative impact on patient care. Patients may place faith in their physicians for any number of reasons—their religion, their affiliation with a particular hospital, their personal appearance—and it is by no means clear why a state should facilitate patient decisions that are based on non-clinical, irrelevant, or potentially discriminatory factors that have no clear link with fitness or competency to practice medicine.[157] In defining a physician's character by reference to public perception, courts have effectively defined it outside of the scope of fitness to practice, which under even a relatively uncontroversial definition speaks to the physician's intrinsic capabilities in the realm of education, training,

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152. *Id.*

153. Hall, *supra* note 148, at 480.

154. *Id.* at 478; Mark A. Hall et al., *Trust in Physicians and Medical Institutions: What Is It, Can It Be Measured, and Does It Matter?*, 79 MILBANK Q. 613, 614 (2001).

155. *See* David Mechanic, *The Functions and Limitations of Trust in the Provision of Medical Care*, 23 J. HEALTH POL. POL'Y & L. 661, 662 (1998) ("The erosion of trust . . . damages the effectiveness of medical interventions . . . ."); STARR, *supra* note 27, at 5 (addressing the importance of clinical authority to the therapeutic process).

156. Empirical evidence of whether a single physician's misconduct actually affects public trust in the profession as a whole, and whether disciplinary action taken by a state medical board actually serves to counteract this effect, is by no means conclusive. *See* Hall, *supra* note 148, at 498 (noting that two competing viewpoints exist regarding patient trust in the medical profession: one is that patients' trust is contingent and can be affected by legal rules and attitudes, while the other viewpoint assumes that medical trust is inherently strong and will persist regardless of what the law says or how physicians behave).

157. *See generally* Robert Gatter, *Faith, Confidence, and Health Care: Fostering Trust in Medicine Through Law*, 39 WAKE FOREST L. REV. 395, 406–07 (2004) (distinguishing between trust as faith and trust as confidence in competence); Mark A. Hall, *Caring, Curing, and Trust: A Response to Gatter*, 39 WAKE FOREST L. REV. 447, 447–48 (2004) (stating that faith and confidence are intertwined in medical arenas and the necessity to enforce conditions of trustworthiness by requiring levels of competence and loyalty that approximate what patients expect of their physicians).

and character. In contrast, when courts write about protecting the profession's standing, they are describing a change in public perception, rather than a change in qualities intrinsic to the medical professional.[158] Defining the character element of fitness to practice by reference to public perception has the potential to encompass even some categories of conduct that bear only the weakest connection to the state's interest in protecting the public's health and medical welfare. For example, though a physician's possession of two unregistered submachine guns may tend to "undermine[] public confidence in the integrity of the profession,"[159] it is difficult to see how this fact alone would call into question the physician's ability to practice medicine safely and with the best interests of patients at heart. Accordingly, although the argument from public trust may offer one explanation of how professional discipline serves the state's police power goals, it alone is not an adequate justification for discipline that does not otherwise satisfy constitutional scrutiny, or that has a less direct impact on patient safety or public health.[160]

A final argument that can be made to justify professional discipline for character-related misconduct is grounded in social contract theory. While it may bear some similarities to the trust arguments described above, it is worth discussing in its own right. In the context of medicine, social contract theory posits that medical professionals are entitled to the privileges of exclusive licensure and self-regulation only by virtue of an (implicit or explicit) agreement to take responsibility for the provision of important social goods[161] and to hold themselves

158. *See, e.g.*, Raymond v. Bd. of Registration, 443 N.E.2d 391, 394 (Mass. 1982) (noting the medical board's conclusion that a "lack of good moral character and conduct that undermines public confidence in the integrity of the medical profession are grounds for discipline").

159. *Id.* at 395.

160. Another common criticism is that defining fitness to practice by reference to public trust is evidence of the profession's "shallow vanity," rather than any concern for public welfare. *Cf.* Keith Swisher, *The Troubling Rise of the Legal Profession's Good Moral Character*, 82 ST. JOHN'S L. REV. 1037, 1062 (2008) (criticizing the legal profession's concern with its own self-image). Swisher argues that:

> The bar is not concerned with reputable character in any meaningful sense. As we have seen, it routinely denies applicants of present reputable character. Such denials would be wholly arbitrary under a reputable character standard. Instead, the bar is more concerned with 'reputable *relational* character'—that is, whether an applicant's past conduct is consistent with the bar's perceived self-image. This outlandish definition reconciles the cases—'fitness' to practice law is fitness to cohere with the bar's exalted self-image.

Id.

161. *See generally* MICHAEL D. BAYLES, PROFESSIONAL ETHICS 12 (1989) (stating that professions such as medicine have created monopolies with self-regulation that are created for the benefit of society and are unjustified if they do not fulfill this societal benefit); WILBERT E. MOORE, THE PROFESSIONS: ROLES AND RULES 6 (1970) ("[T]he professional proceeds by his own judgment and authority; he thus enjoys autonomy restrained by responsibility."); WILLIAM M. SULLIVAN, WORK AND INTEGRITY: THE CRISIS AND PROMISE OF PROFESSIONALISM IN AMERICA 4–5 (2d ed. 2005) (arguing that professionalism entails partnership between the public and professional group, where the profession is given the privilege of setting standards and disciplining with the public welfare in mind); CORINNE LATHROP GILB, HIDDEN HIERARCHIES: THE PROFESSIONS AND GOVERNMENT 53–54 (1966) (observing that

to higher standards of conduct than the general population.[162] Accordingly, if a physician breaches this social contract, the state would be justified in restricting his right to practice.

The primary problem with this approach is that it is not clear either that such a social contract exists, or that it binds physicians to particular standards of personal character or behavior. After all, if reasonable decisionmakers can disagree as to whether tax fraud constitutes "unprofessional conduct" subject to professional discipline,[163] it is difficult to conclude that there is a social contract between physicians and society prohibiting this behavior. Moreover, if we think of the many kinds of obligations that *could* be imposed on physicians as a condition of licensure but that American law fails to recognize in that context—for example, the obligation to provide uncompensated care to indigent patients,[164] or the obligation to treat patients during a public health emergency even at their own risk[165]—social contract theory seems even less relevant in justifying obligations with a more tenuous link to public health and patient safety. Indeed, social contract theory is typically used to defend the ethical obligations, rather than the legal obligations, of

professionals desire peer-group control and, to justify this special position of authority, the professional ethic emphasizes truth and justice to reassure the public).

162. *See* SULLIVAN, *supra* note 161, at 2 (finding that these professions hold these "positions of honor on the basis of the social contract with the public they serve"); William M. Sullivan, *What Is Left of Professionalism After Managed Care?*, 29 HASTINGS CENTER REP., Mar.-Apr. 1999, at 7, 8 (stating that since professionals "require significant individual discretion" they are "thought to require a stronger sense of moral dedication than most occupations").

163. *Compare* Haley v. Med. Disciplinary Bd., 818 P.2d 1062, 1069 (Wash. 1991) (stating that being convicted of tax fraud indicates a lack of trustworthiness causing reasonable apprehension a physician might abuse the trust inherent in professional status), *and In re* Kindschi, 319 P.2d 824, 826 (Wash. 1958) (holding that conduct of a member of the profession can warrant disciplinary action to maintain sound professional standards of conduct), *with* Rossiter v. Ohio State Med. Bd., No. 01AP-1252, 2002 WL 723811, at *1, *3 (Ohio Ct. App. Apr. 25, 2002) (finding that a physician's failure to file a tax return was not a crime of moral turpitude warranting suspension of his medical license).

164. Such obligations are found in the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2006), and other laws, providing for fines in the case of noncompliance, but are unrelated to licensing standards.

165. *See generally* Judith C. Ahronheim, *Service by Health Care Providers in a Public Health Emergency: The Physician's Duty and the Law*, 12 J. HEALTH CARE L. & POL'Y 195, 206–32 (2009) (discussing the physician's duty of care during public health emergencies); Heidi Malm et al., *Ethics, Pandemics, and the Duty to Treat*, AM. J. BIOETHICS, Aug. 2008, at 4, 16 (discussing the general duty of health care professionals to treat patients); Nadia N. Sawicki, *Without Consent: Moral Imperatives, Special Abilities, and the Duty to Treat*, AM. J. BIOETHICS, Aug, 2008, at 33, 35 (stating that the duty to treat is a moral imperative). The highly controversial Model State Emergency Health Powers Act attempts to tie physician licensure requirements to obligations during emergencies. MODEL STATE EMERGENCY HEALTH POWERS ACT § 608 (Ctr. for L. & Pub.'s Health at Georgetown & Johns Hopkins Univs., Proposed Draft 2001), *available at* http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf; *see also* Ahronheim, *supra*, at 229–30 (discussing the mandate to serve under the Model State Emergency Health Powers Act).

professionals.[166] Moreover, even assuming that physicians enter into a clear social contract prohibiting character-related misconduct when they receive their medical licenses, social contract theory faces the same problems as prediction theory and trust theories: while requiring that licensed professionals satisfy higher standards of character may serve the state's goals in protecting public welfare, it may run afoul of the fitness to practice limitation on professional licensure and discipline.

In sum, while most instances of discipline on character-related grounds, like that against Dr. Ansar, may serve the state's police power goals, they fail to take into account the fundamental legal principles underlying professional discipline, particularly the constitutional limitation that professional board action bear a rational relationship to fitness to practice.[167] Moreover, when compared to other kinds of misconduct by physicians—for example, carving one's initials into a patient during surgery,[168] or sexually assaulting a patient[169]—character-related misconduct like Dr. Ansar's seems much less closely tied to the competent practice of medicine, and so much less likely to have a significant impact on patient safety. Indeed, the Court reviewing the board's decision acknowledged as much, noting that "Dr. Ansar's conviction is not among the most serious misdemeanors involving moral turpitude" cited in the case law.[170] If we believe in the concept of disciplinary minimalism, it would seem that the public's goals are better served when boards exercise their disciplinary discretion against physicians who violate the most basic standards of professionalism and competency—for example, those who cheat on their medical licensing exams, who use their positions of power to abuse or take advantage of patients, or who repeatedly engage in practices that violate the standard of medical care—than when they try to enforce aspirational standards of conduct. That is, while medical boards may be able to justify most of the disciplinary actions they take on constitutional grounds, there is little evidence that boards have actually used constitutional standards to prioritize their exercise of disciplinary discretion.

C. Explaining This Phenomenon

If medical boards are failing to achieve the public goals with which they have been tasked, it is important to understand why this might be the case before proposing any solutions. While at least one prominent legal scholar has explored

166. *See* Sawicki, *supra* note 165, at 33 (discussing the duty to treat in terms of morality rather than legal obligation).

167. *See, e.g.*, Williamson v. Lee Optical of Okla., Inc., 348 U.S. 483, 487–88 (1955) (holding that the measure must be a rational way of correcting a problem).

168. Edward Wong, *Doctor Carved His Initials into a Patient, Lawsuit Says*, N.Y. TIMES, Jan. 22, 2000, at B3.

169. Tamar Lewin, *Accused as Molester, Pediatrician Ends Work*, N.Y TIMES, Mar. 21, 2009, at A9.

170. Ansar v. State Med. Bd., No. 08AP-17, 2008 WL 2514818, at *4 (Ohio Ct. App. June 24, 2008).

the motivations of state bar examiners in investigating attorney character,[171] no similar studies have been done of state medical boards.[172] Accordingly, there is little consensus as to why medical boards choose to pursue discipline against certain kinds of physician misconduct but not others.[173] That said, at least a few potential explanations have been proposed.

According to a 2006 report prepared for the U.S. Department of Health and Human Services, high costs and limited financial and human resources are among the major obstacles to effective disciplinary enforcement by medical boards.[174] Because of these resource limitations, boards generally take a reactive rather than proactive approach to medical discipline and are often unable to investigate all the complaints that are made against physicians, necessarily triaging those of highest priority while leaving others unexamined.[175] A recent empirical study seemed to confirm this finding, noting a correlation between the extent of a board's financial resources and its rate of discipline.[176] These reports suggest that increasing medical boards' budgets would go a long way towards increasing the frequency of medical discipline. Moreover, to the extent that boards choose to pursue certain substantive categories of discipline rather than others on the basis of financial limitations—relying on court reports to identify physicians who have been convicted of criminal activity, for example, is likely to be less labor-intensive than actively investigating physicians who provide medical care that consistently falls short of professional standards[177]—perhaps increasing board resources might have an impact on the quality, not just the quantity, of professional discipline.

Another common explanation for medical boards' lax approach to professional discipline is that the boards are "captured" by professional interests or

171. *See* Rhode, *supra* note 147, at 499–502 (determining that higher barriers for entry into the legal profession arose in response to the influx of Eastern European immigrants during the 1920s and the economic pressures of the 1930s).

172. One of the only recent studies that addresses similar themes in the medical context is BOVBJERG ET AL., *supra* note 46.

173. *See supra* Part II.A–B.

174. BOVBJERG ET AL., *supra* note 46, at 17, 38, 40–41; *see also* 1990 OIG REPORT, *supra* note 47, at 7 ("Significant staff shortages continue to impede the [medical] boards' disciplinary efforts."); 1986 OIG REPORT, *supra* note 104, at 2 (finding that medical boards are in "an extremely vulnerable position," and that they lack the funds to handle the jobs before them); Derbyshire, *supra* note 1, at 199 ("[A]nother obstacle to self-discipline of the medical profession is lack of adequate resources.").

175. BOVBJERG ET AL., *supra* note 46, at 21, 33, 35.

176. Law & Hansen, *supra* note 3, at 90; *see also* Andis Robeznieks, AM. MED. NEWS (Am. Med. Ass'n), Nov. 11, 2002 (attributing a recent increase in New York medical board's disciplinary actions, according to the Health Department spokeswoman, to a double in licensing fees).

177. *See* BOVBJERG ET AL., *supra* note 46, at 38 (finding that board managers and staff often pursue grounds for discipline based on difficulty of investigation and prosecution); 1990 OIG REPORT, *supra* note 47, at 10, 15 (noting that because quality of care inquiries tend to be time-consuming, "boards tend to look for another basis to take action"); 1986 OIG REPORT, *supra* note 104, at 14 (stating that cases involving incompetency are more difficult to develop than cases involving conviction for a felony or fraud).

otherwise lack meaningful public oversight.[178] Indeed, one of the most prominent criticisms of the medical profession in the 20th century has been that it is self-protective, monopolistic, and more attuned to the economic security of its members than to the welfare of the public at large.[179] In the context of medical discipline, some have argued that the boards' approaches to various substantive grounds for discipline are likewise driven by internal constraints within the medical community[180]—for example, the push to improve the public standing of physicians by emphasizing their moral superiority, which compared to their technical skill, is much easier for laypersons to judge. While there can be no denying that the history of American medicine is replete with examples of professional self-protection by the AMA and other professional organizations,[181] it is not clear that the problems with medical discipline can be traced to a lack of public oversight.[182] Indeed, many studies suggest that boards that operate with greater statutory and structural independence may in fact be more effective in disciplining physicians.[183] These data have ultimately led some scholars to conclude that claims that "the medical profession has captured the regulatory apparatus" have been "overstated."[184]

The issues described above—financial constraints, professional self-protection, and lack of independence—are unlikely to be resolved without significant political and professional buy-in.[185] However, the boards responsible for

178. BOVBJERG ET AL., *supra* note 46, at 45; Cohen, *supra* note 36, at 304; *see also* Derbyshire, *supra* note 1, at 201 (discussing various attitudes toward licensing and disciplining of physicians).

179. *See generally* STARR, *supra* note 27, at 223 (discussing medicine's historical opposition to the establishment of independent regulatory schemes for professionals such as midwives, chiropractors, and osteopaths).

180. *See* Cohen, *supra* note 36, at 292 (noting the issue of bias and self-interest on licensing boards).

181. *See, e.g.*, Wilk v. Am. Med. Ass'n, 895 F.2d 352, 378 (7th Cir. 1990) (upholding the district court's conclusion that the AMA violated federal antitrust laws by conspiring to eliminate the chiropractic profession); *In re* Am. Med. Ass'n, 94 F.T.C. 701, 1014 (1979) (prohibiting medical associations and state medical boards from enforcing their ethical guidelines regarding advertisement and price fixing).

182. *See* Robeznieks, *supra* note 176 (noting that boards with higher numbers of public members do not necessarily have higher rates of serious disciplinary action).

183. *See, e.g.*, BOVBJERG ET AL., *supra* note 46, at 9 (finding independence from state medical societies and other parts of government as a factor in allowing boards to run effective disciplinary processes); 1990 OIG REPORT, *supra* note 37, at 8 (noting that limitations of boards' authority to conduct cases and impose disciplinary actions impede their success); Law & Hansen, *supra* note 3, at 5 (finding that boards were more likely to take disciplinary action when they were more structurally independent from state government; boards with a higher proportion of public (that is, non-professional) members were found to be no more likely to engage in vigorous disciplinary enforcement); *see also* Robeznieks, *supra* note 176 (noting that the Alabama, Mississippi, and Louisiana medical boards have physician-only membership, and have "some of the most aggressive disciplinary rates").

184. Law & Hansen, *supra* note 3, at 5.

185. Increasing funding and structural independence, for example, would require strong support from state legislatures and executives. Reducing the profession's self-protective instincts, on the other hand, would take a significant amount of buy-in from the profession that is, quite frankly, unlikely to happen. *See* Derbyshire, *supra* note 1, at 199 (stating that the laws probably will not completely solve

professional discipline also face another significant challenge that can be more easily resolved—namely, a lack of clear direction in setting disciplinary priorities. Existing legal doctrine has neither adequately defined fitness to practice nor resolved the question of why personal character is relevant to safe and effective medical practice, so it is no wonder that boards face challenges in exercising their disciplinary discretion in a principled manner.

As noted in Part I, legislatures grant medical boards disciplinary authority pursuant to broadly worded medical practice acts authorizing discipline for, among other things, "unprofessional conduct."[186] Although such language seems to provide little guidance for medical boards engaged in concrete disciplinary decisionmaking, courts have consistently upheld such broad categories of discipline against challenges of vagueness and overbreadth, finding that they provide boards with the flexibility and discretion necessary to effectuate public goals.[187] The Washington Supreme Court, for example, upheld a statute authorizing professional discipline for "moral turpitude" against a vagueness challenge, noting that when the statute is "construed in relation to the purposes of professional discipline, considered in the context of a specific application, and supplemented by the shared knowledge and understanding of medical practitioners, its content is sufficiently clear to put [practitioners] . . . on notice that certain conduct is prohibited."[188]

And yet, most courts attempting to define fitness to practice or explain how a particular category of professional misconduct relates to professional fitness are able to offer little more than circular reasoning in support of their conclusions. As noted by Deborah Rhode in her paradigmatic 1985 article on moral character as a

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the problem of the curtain of silence and that the medical societies' have actively opposed any form of regulation other than self-regulation).

186. *See supra* Part I.A.

187. As Justice Frankfurter wrote in *Schware v. Board of Bar Examiners*, the fact that the definition of moral character "has shadowy rather than precise bounds" and its determination "involves an exercise of delicate judgment" does not imply that a state may not require it as a condition of practice. 353 U.S. 232, 248–49 (1957) (Frankfurter, J., concurring). For state court decisions rejecting vagueness challenges to professional discipline statutes, see, e.g., Abrahamson v. Dep't of Prof'l Regulation, 568 N.E.2d 1319, 1324 (Ill. App. Ct. 1991) ("good moral character"), *rev'd on other grounds*, 606 N.E.2d 1111 (Ill. 1992); Sanchick v. Mich. State Bd. of Exam'rs in Optometry, 70 N.W.2d 757, 759 (Mich. 1955) ("unprofessional, unethical and dishonest conduct of a character likely to deceive the public"); Ketring v. Sturges, 372 S.W.2d 104, 111 (Mo. 1963) ("dishonorable conduct"); Brody v. Barasch, 582 A.2d 132, 137 (Vt. 1990) ("moral unfitness"); Haley v. Med. Disciplinary Bd., 818 P.2d 1062, 1072–74 (Wash. 1991) ("moral turpitude").

188. *Haley*, 818 P.2d at 1074. The North Carolina Supreme Court acknowledged in *In re* Wilkins, 242 S.E.2d 829 (N.C. 1978), that there may be "room for difference of opinion" as to the outer edges of the concepts of "unprofessional" or "dishonorable" conduct, but stated that "there is at and around the central core of these concepts much conduct [that] so clearly constitutes improper practice that few, if any, members of the profession would seriously claim to be unaware that such conduct is not consistent with these concepts." *Id.* at 840. Rather than impose upon states the burden of cataloging "every conceivable improper practice in which the licensee is forbidden to engage," the court held that unprofessional conduct statutes be evaluated by reference to the test of "whether a reasonably intelligent member of the profession would understand that the conduct in question is forbidden." *Id.* at 840–41.

credential for the practice of law, what passes for legal analysis in these cases is highly conclusory and "border[s] on tautology."[189] Even *Hawker v. New York*,[190] the case that speaks most directly to the issue of character-related criteria for professional licensure and discipline, offers little guidance. In *Hawker*, the Supreme Court upheld a New York state law prohibiting the practice of medicine by those who have been convicted of a felony, but provided little support for its conclusion that personal "[c]haracter is as important a qualification as knowledge" for professional practice and is therefore subject to discipline.[191] In two brief sentences, the Court offered the following meager explanation of its conclusion: "The physician is one whose relations to life and health are of the most intimate character. It is fitting, not merely that he should possess a knowledge of diseases and their remedies, but also that he should be one who may safely be trusted to apply those remedies."[192] While these factors serve to emphasize the importance of disciplining physicians compared to other professionals,[193] they do not satisfactorily explain why any particular grounds for discipline are appropriate. Indeed, most state court decisions in disciplinary matters simply conclude that moral character broadly defined is a necessary component of fitness to practice without providing adequate support for this assertion.[194]

Substantive due process challenges to medical board disciplinary actions taken on the basis of unprofessional conduct statutes have resulted in equally

189. Rhode, *supra* note 147, at 552.

190. 170 U.S. 189 (1898).

191. *Id.* at 189–90, 193–94. Because the Supreme Court decided *Hawker* decades before it elucidated the fitness to practice requirement in *Schware*, 353 U.S. 232, the analysis in *Hawker* does not lend itself to an easy discussion of the connection between personal character and fitness to practice medicine.

192. *Id.* at 194; *see also id.* at 191 ("[No] business so directly affect[s] the lives and health of the people as the practice of medicine."); *In re* Kindschi, 319 P.2d 824, 826 (Wash. 1958) ("The daily practice of medicine concerns life and death consequences to members of the public.").

193. *See Schware*, 353 U.S. at 247 (Frankfurter, J., concurring). In his concurrence, Justice Frankfurter wrote that because the legal profession is charged with the important responsibilities of "defen[ding] . . . right and . . . ward[ing] off wrong," it is particularly important that members of the profession have "a high sense of honor, [be] of granite discretion, [and have] . . . the strictest observance of fiduciary responsibility." *Id.*; *see also In re* Polk, 449 A.2d 7, 18 (N.J. 1982) (describing the less stringent burden of proof in medical disciplinary proceedings compared to legal disciplinary proceedings as reflecting "society's important interest in individual life and health").

194. *See, e.g.*, Dittman v. California, 191 F.3d 1020, 1032 (9th Cir. 1999) (citing *Schware*, 353 U.S. 232, and concluding that "[a] state may require good moral character as a qualification for entry into a profession, when the practitioners of the profession come into close contact with patients or clients"); Foster v. Bd. of Med. Quality Assurance, 227 Cal. App. 3d 1606, 1610 (1991) (stating that a physician's "intentional dishonesty" regarding his malpractice coverage "demonstrates a fundamental lack of moral character [that] is incompatible with the honesty required to properly maintain the doctor-patient relationship"); Raymond v. Bd. of Registration in Med., 443 N.E.2d 391, 395 (Mass. 1982) ("A physician's bad moral character may reasonably call into question his ability to practice medicine.").

unhelpful judicial analysis.[195] Consider, for example, *In re Kindschi*,[196] a Washington Supreme Court case that set the precedent for numerous cases upholding medical discipline on character-related grounds.[197] The court upheld a medical board's decision to suspend the license of a physician who had committed tax fraud, on the basis of a statute authorizing discipline for "unprofessional conduct," including "conviction in any court of any offense involving moral turpitude . . . ."[198] Finding "a rational connection between income tax fraud and one's fitness of character or trustworthiness to practice medicine," the court held that the board's discipline for tax fraud did not violate due process.[199] In justifying its decision on the grounds that "[t]he public has a right to expect the highest degree of trustworthiness of the members of the medical profession," the Washington Supreme Court effectively paved the way for professional discipline against physicians who engage in any conduct suggesting untrustworthiness or violating "sound standards of conduct . . . ."[200]

Of course, there are good reasons for legislatures to grant medical boards such broad authority, as well as good reasons for courts to defer to board decisions, provided they satisfy a reasonableness test. On the legislative side, given that professional expectations are likely to evolve over time and across various contexts,[201] it would be problematic if unprofessional conduct statutes were drafted to capture specific and defined instances of misconduct, rather than offer a significant degree of flexibility. Moreover, granting medical boards broad directives and allowing them to make judgments on their own without overly stringent judicial review is consistent with the principles of professional discipline that provide for physician-dominated boards as best suited to identify and enforce professional standards.[202] However, while such a deferential stance may be

195. *See, e.g.*, *Dittman*, 191 F.3d at 1025, 1030–32 (failure to facilitate review of child support obligations); Griffiths v. Super. Ct., 117 Cal. Rptr. 2d 445, 448, 454 (Cal. Ct. App. 2002) (reckless driving involving alcohol); Windham v. Bd. of Med. Quality Assurance, 163 Cal. Rptr. 566, 570–71 (Cal. Ct. App. 1980) (tax fraud); Weissbuch v. Bd. of Med. Exam'rs, 116 Cal. Rptr. 479, 481–82 (Cal. Ct. App. 1974) (marijuana possession); McLaughlin v. Bd. of Med. Exam'rs, 111 Cal. Rptr. 353, 354 (Cal. Ct. App. 1973) (soliciting sex); Deatherage v. State Exam'ing Bd. of Psychology, 948 P.2d 828, 830, 832 (Wash. 1997) (improper expert witness testimony); *In re* Kindschi, 319 P.2d at 825–26 (tax fraud).

196. 319 P.2d 824.

197. *See id.* at 826–27 (finding a connection between tax fraud and fitness to practice medicine).

198. *Id.* at 825.

199. *Id.* at 826.

200. *Id.*

201. *See* John V. Jacobi, *Competition Law's Role in Health Care Quality*, 11 ANNALS HEALTH L. 45, 45 (2002) (explaining that the American expectation for regulation of health care quality "survives evolving attitudes regarding the proper balance of government, professional and market control of health care delivery"); *see also In re* Polk, 449 A.2d 7, 19 (N.J. 1982) (discussing the impracticability of requiring "the Legislature to catalogue and specify every act or course of conduct").

202. *See supra* Part I.B.

appropriate as a matter of both law and policy, the meagerness of judicial discussion in professional discipline cases makes it difficult for boards to derive clear principles and guidelines for future action. By failing to provide a fuller analysis in substantive due process cases, courts are missing a key opportunity to explain to boards why the boundaries of constitutional action lie where they do.

Given the lack of guidance provided to boards by the legislatures in their initial grant of disciplinary authority and by the courts in their judicial review of disciplinary decisions, it is no wonder that the disciplinary actions taken by state medical boards are sometimes inconsistent with the principles of professional discipline. In the absence of legislative or judicial guidance, boards are free to take action on these "noisy" cases based not on sound theories of discipline, but on the pressures imposed by public officials, private interests, and the public, none of which are necessarily the best drivers of administrative decisionmaking.

CONCLUSION

Accepting that medical boards' inability to appropriately prioritize their disciplinary pursuits is due in part to a lack of guidance from legislatures and courts, my hope is that this Article's inquiry into fundamental disciplinary principles will be instructive. If they return their focus to the principles of public protection, fitness to practice, and disciplinary minimalism, medical boards have the potential to be a driving force in improving the quality of American medical care.[203] While boards will still be charged with making case-by-case determinations, and will still have significant flexibility in exercising their disciplinary discretion, there are some very real benefits to be gained by using a principles-based analysis at every level of action—whether by legislators determining grounds for professional discipline, medical boards reviewing professional misconduct, or courts reviewing board disciplinary actions.

First, using principles-based analysis to reprioritize medical boards' actions may free up boards' limited resources so they can focus less on character-related misconduct and more on misconduct that is arguably more likely to harm patients and the public—for example, gross incompetence, sexual assault of patients, and repeated violations of the standard of the care.[204] Given that financial problems are among the most significant systemic issues faced by modern medical boards,[205] boards should take every effort to re-examine their disciplinary priorities and determine whether there might be a better allocation of resources that would result in more effective disciplinary enforcement. This would, in turn, help boards

203. *See supra* Part I.C.

204. *See supra* Parts I.C, II.B.

205. *See supra* note 174 and accompanying text.

respond to both the qualitative and quantitative criticisms of the approach they take towards physician discipline.[206]

Of course, critics may question whether eliminating the kinds of disciplinary actions I deem most problematic—actions on the basis of unprofessional or criminal misconduct with no direct link to patient safety or public health—is likely to significantly increase the resources available for boards to deal with more pressing cases. After all, many of these kinds of disciplinary actions are among the least costly to pursue, especially as compared to actions relating to clinical competency or quality of care.[207] A criminal conviction against a licensed physician, for example, is automatically reported by the court to the state board of medicine;[208] it then requires very little investigation on the part of the board to conclude that a crime, in violation of the medical practice act, has actually occurred.[209] Internal or institutional sanctions imposed by hospitals are also reported to state boards of medicine;[210] these cases generally require less investigation at the board level because of the existing documentation at the hospital level.[211] Contrast this with disciplinary sanctions taken on the basis of gross negligence, incompetence, or deviations from the standard of care—much like civil malpractice suits, these kinds of actions require significant discovery and investigation, and may take months or even years to conclude.[212] Given the board resources required to successfully pursue discipline on quality of care grounds, critics may suggest that it is indeed efficient (or, at worst, harmless) for boards to focus on less resource-intensive disciplinary inquiries.[213]

My response to this challenge is to point out that, while allocating boards' financial resources more appropriately is one aspect of this project, it is hardly the only one. The ultimate goal of professional discipline is to protect medical consumers from harm. And while a medical board's ability to achieve this goal is

206. *See supra* text accompanying note 177.

207. *See* Jost et al., *supra* note 2, at 332 (discussing the requirements of pursuing action based on allegations of clinical incompetence).

208. *See id.* at 310–11 (explaining that state boards initiate investigations based on information from "reports and referrals" from outside sources).

209. *See id.* at 331 n.36, 337 (reporting that these complaints more often result in disciplinary action).

210. *Id.* at 310–11.

211. *See id.* at 331 n.36, 337 (attributing the increased likelihood that these complaints will result in disciplinary action to the fact that the problems are identified by trained professionals and are often investigated prior to the filing of the complaint).

212. *See* FEBRUARY 1993 OIG REPORT, *supra* note 45, at 1 (discussing the significance of state medical board quality-of-care cases); *see also* Jost et al., *supra* note 2, at 332 (describing the process of pursuing actions based on clinical incompetence allegations).

213. *E.g.*, Jost et al., *supra* note 2, at 335–36 ("[G]iven the resource constraints . . . and the substantial commitment of resources required when formal action is taken, . . . informal action . . . [may be] a more rational strategy . . . .").

certainly driven in part by the resources it has at its disposal, other factors also come into play.

Much like criminal law, professional discipline serves an important signaling function for the medical community. It is the rare doctor who, in an effort to understand the boundaries of permissible professional behavior, turns first to the local law library to brush up on recent state legislation and case law. More likely, he receives periodic disciplinary updates from his state medical board, reads about cases of professional discipline in the media, and hears about the experiences of colleagues and friends. Given that some of the most public and visible cases of professional discipline deal with cases of misconduct that bear little connection to the practice of medicine,[214] I argue that modern medical boards that discipline on character-related grounds may not be sending the most constructive signals to physicians trying to conform their behavior to the law. Of course, we can imagine that some physicians are, like Al Capone,[215] simply so dangerous to the community that they must be removed from practice, even if the ultimate grounds for sanction bear little or no relation to their dangerous conduct. But while this approach may be necessary for the "Al Capones" of the medical profession, such cases are few and far between.[216] Regularly disciplining on grounds unrelated to quality of care[217] sets a dangerous precedent, suggesting to physicians that the true indicators of professionalism and competency are character-related.[218]

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214. *See supra* Part II.A.

215. Though the primary charges against him alleged racketeering, Al Capone was ultimately convicted on grounds of tax evasion. United States v. Capone, 93 F.2d 840, 840 (7th Cir. 1937).

216. *Cf.* Robert E. Kessler, *Time to Talk: Feds Catch Doctor Who Left LI Amid Poisoning Probe*, NEWSDAY (New York), July 25, 1997, at A03. After serving two years in prison for poisoning his co-workers, Dr. Michael Swango lied about his criminal record in his application for another residency position. *Id.* When officials learned about the lies Swango was fired from his hospital residency position; despite concerns about potential poisonings, however, no charges were filed in connection with those allegations. *Id.* Instead, a federal fraud charge for "obtaining federal money by making 'a false of fictitious statement'" was filed against Swango because it "was the easiest [charge] to bring in order to arrest Swango . . . ." *Id.*

217. Recall the medical board director who said: "[W]e've never had a disciplinary action based on malpractice. . . . [W]hen there is a malpractice case, we tend to look for another basis for disciplinary action." 1986 OIG REPORT, *supra* note 104, at 14.

218. This issue hearkens back to the early days of medical licensing, when boards were criticized for excluding practitioners who did not fit idealized (and self-serving) conceptions of professionalism. *See generally* Gross, *supra* note 29, at 1009–11 (recounting the "historical antecedents" of exclusionary professional licensing laws); Shirley Svorny & Eugenia Froedge Toma, *Entry Barriers and Medical Board Funding Autonomy*, 97 PUB. CHOICE 93, 94 (1998) ("[S]tate medical boards [have historically] maintained a variety of exclusionary rules . . . ."). Indeed, some scholars contend that medical boards still unfairly discriminate against alternative practitioners not on quality of care grounds, but because they do not fit traditional norms of professionalism. *See* Andrew K. Dolan & Nicole D. Urban, *The Determinants of the Effectiveness of Medical Disciplinary Boards: 1960-1977*, 7 LAW & HUM. BEHAV. 203, 206 (1983) ("[T]he boards may aggressively pursue mavericks within the profession [including] those who disregard orthodox therapeutic notions or accepted economic forms of practice.").

Using a principles-based approach will rid the disciplinary process of a significant degree of uncertainty, better guiding physicians and increasing the likelihood of consistency in outcomes over time. Currently, physicians are not being put on notice as to what kind of conduct will subject them to discipline, boards are not getting adequate guidance from the courts about the constitutional limitations on professional discipline, and courts have very little principled jurisprudence to look to in evaluating due process challenges.[219] Given the fact that many state legislatures are currently moving to expand the scope of medical boards' disciplinary authority in response to public concerns,[220] it is particularly important that this authority be exercised in a principled way. Using a principles-based analysis, although it will not be outcome-determinative, will help determine some categories of conduct that are relevant to disciplinary inquiries, and may categorically exclude others—for example, many non-violent felonies. Moreover, to the extent that boards have been criticized for taking an inconsistent approach to medical discipline—imposing greater sanctions on providers who engage in tax fraud than those who engage in Medicare fraud[221]—applying this kind of principled analysis may help redeem them in the eyes of the public. It will set the stage for a more consistent application of constitutional principles of due process in the context of professional discipline, which will help to ensure that medical boards exercise their disciplinary discretion in a manner that best serves the public interest.

Signaling functions aside, studying cases of professional discipline on the basis of criminal conduct, personal character, and activities outside the clinical sphere is likely to have a larger impact on our understanding of the role of professional boards generally.[222] These "noisy" cases of discipline often test constitutional boundaries and ultimately face judicial scrutiny, thus offering unique opportunities for clarifying the boundaries of permissible board discipline.[223] The lessons learned in these cases can then be used to provide guidance for professional discipline in other contexts as well.

219. *See supra* Part II.B.

220. *See generally* Miriam Reisman, *Role of Medical Board Discipline*, PHYSICIAN'S NEWS DIGEST, Feb. 2007, http://www.physiciansnews.com/cover/207pa.html (discussing state efforts to reform boards' disciplinary actions).

221. *See* Jung et al., *supra* note 118, at 349 tbl.3.

222. *See supra* Part II.

223. *See supra* Part I.