State Medical Boards, Licensure, and Discipline in the United States

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Medical practice acts and state medical boards have evolved since their conception in the mid-19th century. Today, state medical boards are usually responsible for a variety of functions, with the main function being the detection and discipline of unprofessional and unethical conduct by physicians and other medical professionals. In this article, a brief history of medical licensing and regulation is first provided, with an overview of the structure and process of state medical boards, and how they vary across states. Next, common causes for medical board complaints are discussed, with a focus on complaints against psychiatrists. Last, the author provides general medical–legal considerations that a psychiatrist should contemplate if he or she is the subject of a medical board complaint.

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In the early 1900s, John Brinkley wanted to become a doctor. The United States and the world of medical education appeared much different at that time than it does today. Allopathic schools existed, but individuals also had the option of attending schools that specialized in "eclecticism," a type of medicine that relied on herbal remedies (1). Brinkley had high ambitions but was a poor student. He initially joined the Bennett Eclectic Medical College in Chicago for $25 but failed to complete his studies. He then made his way to Missouri and bought a diploma from the Kansas City Eclectic Medical University, thereafter "practicing" in multiple states (1). Brinkley set up shop initially in South Carolina and began injecting patients with colored water, telling them it was "electric medicine from Germany" (1). However, Brinkley's ultimate "success" came after he began to surgically implant goat testicles into men for $750 per operation (1). Brinkley touted this procedure as curative for male impotence, claiming that patients experienced "an astonishing sexual vigor" (1). Despite his lack of sufficient medical training and concerns about his drinking, Brinkley continued to perform the goat testicle transplant operation on patients and was financially successful until the public, and Morris Fishbein of the American Medical Association (AMA), began to take notice of unfortunate patient outcomes, including deaths, that occurred under Brinkley's care. In 1930, Brinkley's license was revoked by the Kansas Medical Board (1). Some years after, Fishbein published an expose about Brinkley, and Brinkley sued him for libel. Brinkley lost the lawsuit and was labeled a fraud. Following the verdict, Brinkley encountered multiple lawsuits, including an Internal Revenue Service (IRS) suit for tax fraud. Ultimately, Brinkley declared bankruptcy and died of heart failure in 1942 (1).

John Brinkley's story illustrates the ease with which charlatans or quacks were able to practice their trade in the 19th and early 20th centuries in the United States. Although the AMA had been established in 1847 and some medical boards were functioning by the early 1900s, these institutions did not have the power, organization, or oversight that they have today to regulate medical practice. Undergraduate and graduate medical education were not well regulated, and entities such as the Federation of State Medical Boards (FSMB) and the National Practitioner Data Bank (NPDB) were either not in existence or in the early stages of development. This left individuals such as Brinkley with the ability to proliferate and "treat" patients with minimal to no medical training or monitoring. As I discuss later in this article, the licensing and regulatory functions of state medical boards (SMBs) have evolved significantly since that time, with the hope that individuals such as Brinkley would be detected and stopped before inflicting patient harm.

The purpose of this article is to first provide a brief history of medical licensing and regulation in the United States, with an ultimate focus on the structure, organization, and process of medical boards. I then discuss common causes for medical board complaints, specifically those against psychiatrists. Finally, I discuss the medical and legal considerations that a psychiatrist should contemplate should he or she be faced with a medical board complaint.

HISTORY AND DISCIPLINARY ROLE OF SMBS

Under the unenumerated powers of the Tenth Amendment, a state has the power to protect the health, safety, and welfare of its citizenry (2). This police power gives states the

authority to create and maintain regulatory agencies such as SMBs. In *Dent v. West Virginia*, a unanimous Supreme Court confirmed that states can regulate medicine and other professions via professional licensing boards (3). North Carolina was one of the first states to create a medical board; it passed a medical practice act in 1859. An applicant need not have attended medical school but had to be at least 25 years old, pay $10, and pass the state board exam (4). By 1910, nearly all states had licensing boards.

Up until the 1960s, state boards tended to view physician regulation and discipline as a secondary effort and primarily focused on "unlicensed practitioners and defending the physicians' statutory scope of practice against incursions by other health professions" (4, p. 156). However, the AMA released a report in 1961 that criticized state boards for failing to pursue discipline against physicians and called for increased transparency in the disciplinary process (4). The 1960s and 1970s subsequently saw an increased push for public accountability. In response to this increased pressure for accountability and increased focus on evidence-based medicine, state boards evolved to include members of the public (by 1999, all but three boards had public members); to formalize investigative and disciplinary processes; and to increase involvement and oversight of physician licensure, maintenance of licensure, and other regulatory functions (4). Advances and improvements in undergraduate and graduate medical education, along with an increased focus on evidence-based medicine, allowed SMBs to create and propagate essential standards of practice for physicians in a given state, often through the administration of SMB exams. Despite this progress, medical boards today have continued to face scrutiny from the public and advocacy groups regarding rigor of the disciplinary process and detection of unethical or incompetent practices, with calls for increased transparency and enhanced protection of consumers.

HISTORY OF THE FSMB

In 1912, the FSMB was created (4). The FSMB is a nonprofit organization that now represents all 70 SMBs and osteopathic licensing boards in the United States and its territories. Its functions include sponsorship (along with the National Board of Medical Examiners) of the U.S. Medical Licensing Exam and the creation and maintenance of the Federation Physician Data Center, a repository of U.S. physician licensing and credentialing information. The FSMB also assists medical boards in the creation of policies, advocacy, and research that shapes health care quality, physician regulation, and continuing medical education (5). The FSMB has evolved over the years and is seen as a prominent resource for medical boards today.

STRUCTURE AND FUNCTIONING OF SMBS

Each jurisdiction has a medical practice act (MPA) that governs the practice of medicine in the state and authorizes medical boards or other entities to issue licenses and regulate physician conduct. Although MPAs vary somewhat from state to state, the FSMB recommends that a model MPA invest boards with the power to "determine a physician's initial and continuing qualification and fitness for the practice of medicine" as well as "to initiate proceedings against unprofessional, improper, incompetent, unlawful, fraudulent, deceptive, or unlicensed practice of medicine, and enforce the provisions of the medical practice act and related rules" (6). Unprofessional conduct is a broad category and may include alcohol/substance use, sexual misconduct, conviction of a felony, fraud, inadequate record keeping, failing to meet continuing medical education requirements, deviating from the standard of care, prescribing drugs negligently, and others (7). Acts that the physician commits that are unrelated to his or her medical practice might also be considered in pursuing disciplinary action, including crimes of "moral turpitude." For example, in *Haley v. Medical Disciplinary Board*, the Washington Supreme Court held that a physician's conviction for tax fraud raised a "reasonable apprehension" that he might be dishonest or abuse the trust of his patients and, therefore, was fair game in pursuing a disciplinary action (8). The broad discretion of an SMB in pursuing complaints and demanding access, even to physicians' own treatment records, has led physicians in some circumstances to avoid seeking treatment for mental illness or impairment, for fear that they could face scrutiny by the SMB and/or lose their source of livelihood (9).

The structure and composition of SMBs vary from state to state. In some states, separate boards deal with licensing issues and disciplinary functions. States may have separate boards for medical and osteopathic regulation. In many states, boards function as independent agencies, but in some, they may function semi-independently, under the supervision of the department of health or other regulatory agency or function only in an advisory capacity (7). Nearly all SMBs have both public and physician members; the FSMB has recommended that boards should comprise at least 25% public members (6). Board members are usually appointed by the governor and selected on an annual or biennial basis (7).

WHO IS BEING DISCIPLINED?

In 2015, approximately 4,000 physicians were subjected to disciplinary actions from state boards (7). This annual number has remained relatively constant from 2008 to 2015. However, this number does not reflect the number of physicians who were investigated by an SMB. Until the 1990s, SMBs mainly focused on physicians with substance use problems and criminal convictions (10). However, over time, this focus has shifted. In an analysis of 375 physicians disciplined by the Medical Board of California, the most frequent causes for discipline were negligence, abuse of substances, inappropriate prescribing, inappropriate contact with patients, and fraud (11). These behaviors are similar to those found in other state surveys (12, 13).

Factors associated with an increased risk of discipline included male gender, involvement in direct patient care, and being in practice for more than 20 years (11). Male gender, increasing age, lack of board certification, and international medical school education were all associated with elevated risk of disciplinary action (14). In an analysis of information from the Oklahoma SMB since its inception, men, nonwhites, and non-board-certified physicians were most frequently disciplined (15). Complaints were most often initiated by the general public (66%). In Texas, Cardarelli found that there was a greater likelihood of license revocation for disciplined physicians the longer they had been in practice (16).

In terms of who is most at risk of discipline by medical boards, psychiatrists have been found to be overrepresented compared with those in other specialties (14, 15, 17). Kohatsu found the highest numbers of disciplinary actions among family medicine, general medicine, obstetrics/gynecology, and psychiatry (14). Khaliq found a similar pattern in Oklahoma with the addition of emergency medicine (15).

Psychiatrists have been disciplined for a wide variety of problematic or unprofessional behaviors. Some studies have found that psychiatrists are overrepresented in physically/mentally impaired physician samples, although these data have not been consistent (18–21). Psychiatrists have also been found to be overrepresented in cases involving allegations of sexual misconduct (22). One study reported that psychiatrists had more disciplinary actions for sex-related offenses than any other specialty, nearly two times that of obstetrics/gynecology (23). They found that practitioners in psychiatry or child psychiatry were most likely to be disciplined and to be of an older age than the general population. Morrison and Morrison similarly found that psychiatrists were more likely to be disciplined for sexual misconduct than nonpsychiatrists and comprised 34% of the physicians disciplined for such behavior (17). It is not clear why psychiatrists are more at risk for discipline for sexual misconduct; Morrison and Morrison pointed out that psychiatrists have more personal contact, have longer individual sessions, and tend to work more in isolation than other specialties but recognized that these factors do not fully explain this overrepresentation and that there is inadequate research or data addressing this question.

Morrison and Morrison (17) analyzed California Medical Board data over a 30-month period and found that psychiatrists represented 12.8% of all disciplined physicians. Generally, psychiatrists were at overall risk of greater severity of discipline, although the difference was not significant. Violation of sexual boundaries, negligence/incompetence, mental/physical impairment or impairment due to substance use, and fraud were the top reasons for investigation. Curiously, psychoanalysts tended to be underrepresented as a subspecialty. The authors hypothesized that perhaps this was due to the prolonged training that analysts undergo, making them more aware of potential boundary violations, and/or more limited opportunity, given that analysts tend to see fewer patients than nonanalysts.

How to address and prevent psychiatrists from committing boundary violations is an open question. Recommendations for further study included increased education and discussion of boundary issues in undergraduate and graduate medical education, as there has been a link between unprofessional behavior in medical school, such as irresponsibility and diminished ability to improve concerning behaviors, and subsequent board disciplinary actions. Although not significant, lower Medical College Admission Test (MCAT) scores and grades during the first 2 years of medical school were also linked with an increased risk of board actions once in practice (24).

In terms of discipline for criminal convictions/actions, Jung found that between 8% and 11.5% of SMB actions were related to criminal convictions, whereas others have estimated a much lower percentage, around 4% (25, 26). Jung also found that general psychiatry and child and adolescent psychiatry are the second and fourth specialties, respectively, in terms of discipline for crimes. Interestingly, Jung and colleagues found that nearly 75% of criminally convicted disciplined physicians were older than age 45 (26). Of note, the Supreme Court has upheld the right of a state to ban a physician from practice who has been convicted of a felony (26).

DISCIPLINARY ACTIONS OF STATE BOARDS

The primary purpose of the SMB is to protect medical consumers from potential harm. How SMBs are best equipped to do this remains an open question. Some question whether the process and procedures of SMBs are actually driven by a quest to improve health care quality, given the reactive nature of the disciplinary process. SMBs receive complaints from a variety of sources, including general members of the public (whether patients or not); other physicians; medical staff; hospitals; and/or entities such as managed care organizations, local professional societies, and/or courts. Some states allow anonymous reporting and/or online complaints (27). In Oklahoma, complaints surged 40% in the 2 years after the implementation of online filings (27). SMB complaints typically have no statute of limitations; thus, unlike malpractice actions, individuals can file complaints years after the alleged offense occurred (28).

Physicians who are found in violation of the MPA may be disciplined by an SMB; this process is to be distinguished from that of malpractice actions, which require a showing of negligence and actual patient harm; SMB actions must only show substandard or unethical conduct. However, there is overlap between malpractice suits and SMB actions in that SMBs may monitor or use evidence of malpractice charges or settlements as an alert that unprofessional conduct may be occurring. When seeking discipline or remediation, SMBs have a variety of actions available to them, ranging from revocation or suspension of a medical license to probation, to restrictions of practice, reprimand, advisory letters, fines, and mandatory education/treatment of the physician. In

2015, the most common actions taken by SMBs were license restriction, reprimand, administrative remedies, and fines.

States vary in terms of how often or how severely they discipline physicians for proscribed conduct. Harris and Byhoff found that, from 2010 to 2014, medical boards reported 21,647 disciplinary actions, of which 23.7% were serious actions involving revocation or suspension of a license (29). They further found that there was a fourfold variation between states in terms of disciplinary actions. This variability between states has been criticized by organizations such as Public Citizen, a consumer advocacy organization. Public Citizen ranks states from best to worst by which states levy the most disciplinary actions against physicians (30). Public Citizen relied upon FSMB annual data from the Annual Summary of Board Actions report to generate these rankings until 2012, when the FSMB released its final report. The FSMB stopped releasing the Annual Summary in lieu of a more nuanced report that aims to "give the full flavor and fabric of what boards are doing and what resources they have to do it with." (30) Lisa Robin, FSMB's chief advocacy officer, pointed out that Public Citizen's focus on serious disciplinary actions may do a disservice to the work of SMBs in that a less serious disciplinary action such as a reprimand or fine may still address problem behaviors and improve quality and safety. However, it is viewed as less punitive and, therefore, less effective than a more serious disciplinary action (31).

However, the number of disciplinary actions taken by a state could also signal a decreased capacity to respond to complaints, and often SMB funding and resources are scarce and subject to legislative control and constraints. Certain demographic and organizational factors may play a role in which SMBs discipline physicians more (32). Boards with more members, staff and independence from state legislators tend to have higher rates of discipline (33). The variability of response between states toward providers faced with a malpractice suit or allegation of unprofessional conduct has also been criticized. The NPDB allows certain agencies to query its database to determine whether providers have faced disciplinary actions and in which states. The NPDB was created, in part, to prevent physicians from traveling across state lines to practice when their license has been suspended or revoked in another state. However, states are inconsistent when deciding how to respond to claims or even disciplinary actions arising in other states.

FACING A MEDICAL BOARD COMPLAINT

Facing and dealing with an SMB complaint may be one of the more stressful events that a physician grapples with during his or her career and may generate a range of responses from fear and anxiety to anger, denial, and resentment. Physicians facing these processes may even feel helpless and suicidal and contemplate a change in career (34). Although states vary somewhat in terms of the investigative process, the general sequence of events is outlined in the following paragraphs, along with common mistakes that psychiatrists may make when faced with a board complaint.

As mentioned previously, SMBs have some latitude in determining which complaints to address or pursue. In 2014, approximately 25% of complaints in Texas never reached the investigative stage (35). Generally, when a complaint is received, the SMB notifies the physician in writing that a complaint has been filed and gives the licensee a specified time period (i.e., 30 days) to respond in writing. The SMB usually asks for a response to the allegations and/or relevant patient records. The licensee may ask for an extension to respond. One error that psychiatrists may make is to view the complaint as frivolous, without merit, or a nuisance and not respond to this initial request and/or quickly respond in a manner that is dismissive or self-incriminating. Failure to respond to the complaint may itself be an act of professional misconduct (12). In addition, psychiatrists should immediately contact their malpractice carrier once a complaint has been received, as many insurance carriers provide legal representation for an SMB defense. If the psychiatrist's malpractice carrier does not provide for legal representation, then an attorney should be consulted as soon as possible. The psychiatrist should work in conjunction with his or her attorney to draft a response to the SMB; general advice to the psychiatrist is to be honest and accurate yet humble, and retain his or her focus as a patient advocate (11). The psychiatrist should refrain from reaching out to the complainant or discussing the details of the investigation with anyone other than his or her attorney.

Once the SMB receives and reviews the licensee's response, SMBs may request further information, such as a personal interview or a hearing before the board, and/or ask the licensee to undergo an independent medical or psychiatric examination. One mistake that psychiatrists may make at this stage is feeling a false sense of security when conversing with an investigator who seems friendly and nonadversarial. Psychiatrists should, again, exercise caution, understanding that they are involved in a quasi-criminal process and that statements made during an investigation could not only be used against them during future SMB proceedings but also may be used in related malpractice suits and/or as grounds to pursue further SMB violations. Of course, psychiatrists should also not alter or destroy patient records that are requested during the course of the investigation.

As mentioned previously, SMBs have a variety of options to pursue after completion of the investigative stage. Oral or written reprimands, advisory letters, or fines may occur. Temporary suspension of a license, even without a hearing, may occur if there is an imminent threat to the public (as in, e.g., sexual assault allegations). The SMB may pursue an informal settlement agreement or request a formal hearing, the latter of which may take place before the full board. Psychiatrists should consider representation by counsel at a formal hearing, as this may be in their best interest and the only opportunity to confront the complainant. Licensees

have constitutional rights during these proceedings, such as the right to equal protection and due process. Due process rights include the right to notice, to confront the evidence, to a hearing, and to be represented by an attorney. One way in which physicians may appeal adverse SMB decisions is if their due process rights have been violated. However, even then, courts give SMBs a large degree of deference and generally uphold their decisions unless the decisions can be proven to be arbitrary, vague, or in clear violation of constitutional rights (10).

In most states, the standard of proof required in board disciplinary matters is that of preponderance of evidence (7)—the persuasive burden of proof used in civil cases in which monetary damages are at stake, which is met if the fact finder concludes that a particular fact or event was more likely than not to have occurred. Some states use a higher standard of proof, clear and convincing evidence, which is the standard used in civil commitment proceedings and termination of parental rights. Following a hearing, the SMB may decide to dismiss a complaint or can proceed to a serious disciplinary action, which may include revoking or suspending the physician's license and/or placing the physician on probation. The consequences of these actions are far reaching in that a physician may not only be prevented from earning a living but also may lose hospital privileges, be dropped by a malpractice insurance carrier, be reported to the NPDB, and be unable to obtain licensure in other states.

Although psychiatrists may not be able to prevent a complaint from occurring, they can remain hypervigilant in monitoring and adhering to standards of care. Psychiatrists should consult their medical board website to gain advice on how the SMB monitors compliance and ensure that they are meeting continuing medical education requirements. They should communicate with patients verbally and in writing about practices related to informed consent, confidentiality, billing, and scheduling and adhere to best practices in prescribing controlled and noncontrolled substances. Psychiatrists should ensure adequate training and conscientious monitoring of boundaries, given the overrepresentation of allegations of sexual boundary violations in the field.

CONCLUSIONS

Medical licensure regulations and the discipline of physicians by SMBs has come a long way from the 19th and early 20th centuries. State medical practice acts were passed in nearly all states by the early 1900s and authorized SMBs to license and discipline physicians to protect the public from unethical, unprofessional, and dangerous physicians. Over the years, SMBs have increasingly incorporated public members and responded to calls for increased transparency in the disciplinary process. However, some feel that SMBs lack a clear mission, are unable to correlate disciplinary functions with improved quality of health care or patient safety, and have too much discretion and subjective freedom in determining the validity of complaints and what constitutes professional misconduct. Ultimately, a medical board complaint, investigation, and disciplinary actions can have devastating effects on a physician's career. Psychiatrists should inform themselves of their state's standards in terms of board monitoring and compliance. They should also take a medical board complaint seriously, no matter how frivolous, and seek legal assistance, given the potential grave consequences that can result from an adverse action.

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