RANKING OF THE RATE OF STATE MEDICAL BOARDS' SERIOUS DISCIPLINARY ACTIONS, 2017-2019

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INTRODUCTION

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

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

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

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

BACKGROUND: THE NATIONAL PRACTIONER DATA BANK

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

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

METHODOLOGY

Public Citizen's Health Research Group calculated the rate of serious disciplinary actions per 1,000 physicians in each state with either M.D. (Doctor of Allopathic Medicine) only or combined M.D./D.O. (Doctor of Osteopathic Medicine) medical boards. We used state-level data on serious disciplinary actions from the NPDB's Public Use Data File for licensing reports received through March 31, 2020, limited to those serious disciplinary actions actually taken against physicians during 2017, 2018, and 2019, not the year the report was submitted to the NPDB.

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

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

limitations or restrictions, denials of renewal, and voluntary agreements to refrain or suspend pending completion of investigation.[3] The NPDB allows reporters to report up to five actions taken simultaneously on a single report. We therefore included a licensing report in our count only if one or more of the reported actions met our criteria for serious disciplinary actions. Regardless of the number of other serious actions specified in a single report, the report was counted only once.

To obtain the numerator for our calculation of serious disciplinary actions per 1,000 physicians, we added the number of serious disciplinary actions taken in each state for 2017, 2018, and 2019, and then divided this total by three to obtain the average number of serious disciplinary actions for each state per year during the entire three-year period.

Serious disciplinary actions against all licensed physicians were included in states which have either an M.D.-only or a combined licensing board for both allopaths (M.D.s) and osteopaths (D.O.s); serious disciplinary actions against osteopaths were excluded only for the 14 states with separate allopathic licensing boards. We therefore subtracted the number of osteopaths from the total number of physicians in those states with separate osteopathic boards so the rate would be limited to serious actions for M.D.s per 1,000 M.D.s in these states.

The most recent source of the number of licensed physicians in each state was obtained from the Federation of State Medical Boards' report, "A Census of Licensed Physicians in the United States, 2018,"[4] which included the total numbers of M.D.s and D.O.s during 2018 for all states. 2018 was the median year of our study period. Because some small states do not have many physicians, an increase or decrease of one or two serious actions in a year will have a much greater effect on the rate of discipline in such states (and, therefore, their rankings) than it would in states with larger numbers of physicians. To minimize such fluctuations, we calculated the average annual rate of serious disciplinary actions over a three-year period. Thus, the ranking is based on the average annual rate of serious actions taken in 2017, 2018, and 2019.

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

[4] Young A, Chaudhry HJ, Xiaomei Pei X, et al. Census of licensed physicians in the United States, 2018. *J Med Regulation*. 2019;105:7-23.

RESULTS

Table 1 below provides our ranking of states based on the 2017-2019 annual average rate of serious disciplinary actions per 1,000 physicians. Kentucky had the highest rate in the country with an average of 2.29 serious disciplinary actions per 1,000 physicians per year. The District of Columbia had the lowest rate with only 0.29 serious disciplinary actions per 1,000 physicians per year. Thus, the rate of serious disciplinary actions per 1,000 physicians per year in Kentucky was 7.9 times higher than in the District of Columbia (2.29 divided by 0.29). The average total number of serious disciplinary actions taken per year (2017-2019) by all states was 1,466.

The state of New York, which ranks behind only California and Texas in total number of licensed physicians, though it had the sixth highest rate in the country —1.61 serious disciplinary actions per 1,000 physicians per year — was still considerably (30%) lower than Kentucky's rate of 2.29. If New York had seriously disciplined physicians at the same rate as Kentucky, an additional 0.68 serious actions per 1,000 physicians would have occurred each year in that state. Since there were 97,592 licensed physicians in New York in 2018, a total of 66 (97.592 X 0.68) more serious disciplinary actions a year would have been taken by the New York Medical Board if it had taken such actions at the same rate as the Kentucky board.

California, the state with the largest number of physicians, had a much lower rate of serious actions, ranking 33rd in the U.S. The California rate of 0.85 serious actions per 1,000 physicians was 1.44 lower (2.29 minus 0.85) than Kentucky's rate. With 149,206 licensed physicians in California in 2018, a total of 215 (149.2 X 1.44) more serious disciplinary actions a year would have been taken by the California Medical Board were its rate as high as that of Kentucky.

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

Of note, Kentucky is representative in terms of the size of its physician population, having 19,525 physicians, only slightly more than Louisiana, the state with the median number of physicians in the country in 2018: 17,538.

Based on the 2017-2019 data, if all states had increased their annual rate of serious disciplinary actions to match Kentucky's rate of 2.29 serious actions per 1,000 physicians per year for 2017 through 2019, there would have been a total of 1,535 more serious disciplinary actions taken per year against physicians throughout the U.S. This would have more than doubled the average annual number of serious state disciplinary actions nationally, from 1,466 to 3,001.

It should be noted that although Kentucky currently has the highest rate of serious disciplinary actions, with increased future attention to improving the rate of appropriate and necessary serious actions, Kentucky or another state could set an even higher standard in the future, further increasing the number of predicted new serious disciplinary actions for all states. There is no reason to believe that even the highest rate currently observed is adequate for protecting the public from dangerous physicians.

Table 1: Ranking of State Medical Boards by Annual Average Number of Serious Disciplinary Actions per 1,000 Physicians, 2017-2019

State	Rank	Rate of Serious Actions Per 1,000 Physicians*	Average Annual Serious Actions*	Licensed Physicians, 2018
Kentucky	1	2.29	44.67	19,528
Arizona	2	1.81	45.0	24,834
Pennsylvania	3	1.78	86.0	48,445
Michigan	4	1.70	61.33	36,085
Alaska	5	1.63	7.33	4,495
New York	6	1.61	157.33	97,592
West Virginia	7	1.57	11.0	6,987
Vermont	8	1.57	5.67	3,606
Maine	9	1.53	9.67	6,338
Illinois	10	1.51	71.67	47,494
Texas	11	1.50	125.33	83,334
New Mexico	12	1.43	13.0	9,092
Ohio	13	1.42	69.0	48,471
Colorado	14	1.40	35.0	25,070
Kansas	15	1.38	14.33	10,351
Arkansas	16	1.29	14.0	10,814
North Dakota	17	1.27	5.33	4,207
Iowa	18	1.21	15.33	12,712
Virginia	19	1.21	47.0	38,977
Missouri	20	1.14	32.0	27,950
Florida	21	1.14	83.0	72,729
Alabama	22	1.12	18.67	16,595
Mississippi	23	1.11	12.0	10,836
Wisconsin	24	1.06	29.33	27,675
Massachusetts	25	1.02	36.67	35,817
Rhode Island	26	1.02	5.67	5,543
Maryland	27	1.01	30.67	30,279
Oregon	28	0.99	16.0	16,101
Washington	29	0.93	26.33	28,412
Delaware	30	0.92	5.33	5,795
New Jersey	31	0.86	33.67	39,259
South Carolina	32	0.86	17.67	20,642
California	33	0.85	126.67	149,206
Wyoming	34	0.79	3.33	4,197
Tennessee	35	0.74	17.0	22,992
Oklahoma	36	0.70	8.0	11,466
Connecticut	37	0.65	13.0	20,146
North Carolina	38	0.64	27.0	41,878
Montana	39	0.61	3.67	6,044
Indiana	40	0.60	18.67	31,264
Louisiana	41	0.57	10.0	17,538
Idaho	42	0.56	3.67	6,599
Hawaii	43	0.50	5.0	9,931
Utah	44	0.50	5.33	10,687
Nevada	45	0.47	4.33	9,139
Nebraska	46	0.46	4.67	10,147
Minnesota	47	0.44	11.0	24,964
South Dakota	48	0.36	1.67	4,642
Georgia	49	0.32	12.0	37,320
New Hampshire	50	0.32	2.33	7,374
District of Columbia	51	0.29	3.33	11,513

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

Table 2: Calculated Increase in Annual Numbers of Serious Disciplinary Actions Each State Would Have Needed to Take to Have Matched the Rate for Kentucky, 2017-2019

Rank/State	Actual Average Annual Serious Actions	Calculated Additional Serious Actions Per Year Needed to Have Matched the Rate in Kentucky	Calculated Percent Increase in Average Number of Annual Serious Disciplinary Actions Needed to Have Matched Kentucky's Rate
1/Kentucky	44.67	N/A	N/A
2/Arizona	45.0	11.8	26.2
3/Pennsylvania	86.0	24.8	28.8
4/Michigan	61.33	21.2	34.6
5/Alaska	7.33	2.9	40.2
6/New York	157.33	65.9	41.9
7/West Virginia	11.0	5.0	45.3
8/Vermont	5.67	2.6	45.6
9/Maine	9.67	4.8	50
10/Illinois	71.67	37.0	51.6
11/Texas	125.33	65.3	52.1
12/New Mexico	13.0	7.8	60.0
13/Ohio	69.0	41.9	60.7
14/Colorado	35.0	22.3	63.8
15/Kansas	14.33	9.3	65.2
16/Arkansas	14.0	10.7	76.7
17/North Dakota	5.33	4.3	80.4
18/Iowa	15.33	13.7	89.6
19/Virginia	47.0	42.2	89.7
20/Missouri	32.0	31.9	99.8
21/Florida	83.0	83.4	100.4
22/Alabama	18.67	19.3	103.3
23/Mississippi	12.0	12.8	106.5
24/Wisconsin	29.33	34.0	115.8
25/Massachusetts	36.67	45.3	123.4
26/Rhode Island	5.67	7.0	123.7
27/Maryland	30.67	38.6	125.8
28/Oregon	16.0	20.8	130.2
29/Washington	26.33	38.7	146.8
30/Delaware	5.33	7.9	148.5
31/New Jersey	33.67	56.1	166.7
32/South Carolina	17.67	29.5	167.3
33/California	126.67	214.6	169.4
34/Wyoming	3.33	6.3	188
35/Tennessee	17.0	35.6	209.4
36/Oklahoma	8.0	18.2	227.8
37/Connecticut	13.0	33.1	254.5
38/North Carolina	27.0	68.8	254.8
39/Montana	3.67	10.2	277
40/Indiana	18.67	52.8	283.1
41/Louisiana	10.0	30.1	301.1
42/Idaho	3.67	11.4	311.7
43/Hawaii	5.0	17.7	354.3
44/Utah	5.33	19.1	358.3
45/Nevada	4.33	16.6	382.4
46/Nebraska	4.67	18.5	397.3
47/Minnesota	11.0	46.1	419.1
48/South Dakota	1.67	9.0	537.1
49/Georgia	12.0	73.4	611.4
50/New Hampshire	2.33	14.5	622.9
51/District of Columbia	3.33	23.0	690.0

DISCUSSION: WHAT COULD IMPROVE MEDICAL BOARDS' PERFORMANCE IN SERIOUSLY DISCIPLINING PHYSICIANS?

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

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

In addition to the variation from state to state in licensure disciplinary action rates by state medical boards, other evidence from NPDB data demonstrating that licensing boards are often lax in taking disciplinary actions includes a recent analysis by one of this report's authors (RO) of data from the NPDB showing that by the end of 2019, 8,633 U.S. physicians have had five or more malpractice payment reports since the NPDB began collecting such information in 1990. This is a malpractice record worse than 99% or more of all physicians who practiced since then. Yet, dangerously and unacceptably, approximately three-quarters (76%) of these 8,633 physicians have never had a medical board licensure action of any kind, serious or nonserious.[5]

We believe the following reforms could materially improve the performance of medical boards:

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

[5] A recent unpublished analysis by Robert Oshel

nonconflicted public members, also known to have the first priority of protecting the public.

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

The Health Care Quality Improvement Act of 1986, which created the NPDB, requires all hospitals to make a background query every time a physician seeks admitting privileges and every two years thereafter upon renewal.[6] No such requirement exists for medical boards, even if a complaint about a physician is made to the board by a patient or another physician. If the boards consistently queried the NPDB on all their licensees, they would learn of all adverse actions taken by licensing boards in other states where their licensees may also be licensed, all malpractice payments, and all adverse actions taken by hospitals or other health care entities concerning their licensed physicians. Unless they routinely query the NPDB or enroll all their licensees in the NPDB's continuous query service, there is no guarantee that state medical boards will be informed of all malpractice payments or other adverse actions concerning their licensees.

For two dollars per physician per year, boards can purchase "continuous query" from the NPDB for each licensee. This means that within 24 hours of the NPDB receiving new information about an action taken by hospitals or other health care entities, another state medical board action, or a malpractice payout made on behalf of any licensee, the information is transmitted from the NPDB to the board. Published data documents how infrequently boards seek data from the NPDB. In 2018, nine states had not enrolled any physicians in continuous query, and 12 more had enrolled fewer than 100 of the many thousands or more physicians licensed in each of those states.[7] Presently, according to the NPDB, only the medical boards in Florida, Massachusetts, and Wyoming (in addition to a couple of osteopath boards) use the NPDB's continuous query service for *all* their licensees.[8]

Congress should amend the Health Care Quality Improvement Act of 1986 to require state licensing boards to routinely query the NPDB on all applicants for licensure and periodically when they renew their licensees or enroll all their licensees in the NPDB's continuous query service. Hospitals are required to routinely query the NPDB. This legal requirement should be expanded to include state boards. The licensing boards are the

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

[7] Marso A. This tool can help state medical boards spot problem doctors. Why do so few use it? *The Kansas City Star*. June 21, 2019. https://www.kansascity.com/news/business/health-care/article231444518.html. Accessed March 17, 2021.

[8] Personal communication, NPDB.

last line of defense for the public from incompetent and miscreant physicians. This amendment should include free continuous query access by medical boards for all their licensees.

- **Open the NPDB to the Public**

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

This would not only benefit patients, it would also further incentivize licensing boards to query the NPDB to assure they will not be faulted by the public and state legislators for not knowing about malpractice payments or disciplinary actions affecting their licensees and therefore not taking reasonable actions concerning their licensees found to have poor records.

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

But in 1993, going even further, the AMA passed a resolution stating: "Resolved, that the American Medical Association... call for the dissolution of the National Practitioner Data Bank." We subsequently published an article entitled "Congress should open the National Practitioner Data Bank to all":

> As more information about more physicians is entered into the Data Bank, its usefulness can only increase. The main problem with the NPDB, however, is neither the accuracy nor the usefulness of the data but the unconscionable secrecy whereby this Federal repository of important information about American physicians is kept from American patients and other physicians.[9]

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

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

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

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

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

- Adequate funding: All money from physicians' license fees should go to fund board activities instead of sometimes going into the state treasury for general purposes.
- Adequate staffing
- Proactive investigations rather than only reacting to complaints
- Independence from state medical societies, including greatly reducing the number of physicians on medical boards and replacing them with members of the public with no ties to the medical profession, hospitals, or other providers. If a board needs additional, focused medical expertise to investigate or adjudicate individual cases, independent consultant physicians could be hired.
- Independence from other parts of the state government so that the board has the ability to develop its own budgets and regulations, including adequate funds to enforce its regulations
- A reasonable legal standard for disciplining physicians ("preponderance of evidence" rather than "beyond a reasonable doubt" or "clear and convincing evidence")
- Creation of a more patient-oriented board culture so that protecting the public takes precedence over protecting physicians' livelihoods.
- Amend the Health Care Quality Improvement Act or its implementing regulations as necessary to close the "corporate shield" loophole which allows some

malpractice payments against physicians to go unreported. This has become a particularly needed reform in light of the fact that as many as half of physicians are now employees of hospitals or health systems.

- Amend the Health Care Quality Improvement Act to eliminate the increasingly used "written demand" loophole for reporting malpractice payments

CONCLUSION

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

If all states improved their rate of serious disciplinary actions to match that of Kentucky, there would be more than twice as many such actions nationally per year: approximately 3,000 instead of the current 1,466. Implementing the above suggestions could reduce the health risk to thousands of patients being injured by the minority of physicians who should not be practicing or should have their practices restricted but are still fully licensed because of inadequate discipline by state boards.

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