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Barriers to Medical Board Discipline: Cultural and Organizational Constraints

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BARRIERS TO MEDICAL BOARD DISCIPLINE: CULTURAL AND ORGANIZATIONAL CONSTRAINTS

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ABSTRACT

Medical boards are responsible for disciplining physicians who inflict egregious harm on their patients, yet they often fail to do so. This Article develops a cultural and organizational framework for explaining why boards so often fail to discipline physicians. The framework highlights three types of barriers that impede board action: (1) input barriers that prevent hospitals and clinics from reporting harm to boards, (2) processing barriers that prevent boards from taking sufficient action against physicians who do harm, and (3) output barriers that prevent boards from sharing information about physicians who do harm with other disciplinary agencies like other medical boards and law enforcement. The Article demonstrates how the interplay between these barriers reduces the likelihood that boards will discipline physicians who harm patients and also shows how boards behave like other kinds of organizations in similar situations. The Article concludes with a set of solutions to overcoming each type of barrier and explains why an organizational and cultural perspective is essential for identifying gaps between boards' stated goals and their actions and for developing effective solutions.

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I. INTRODUCTION

Sociologist Ruth Horowitz spent fifteen years as a public member on two state medical boards (SMBs) in the 1980s and 1990s.[1] As one of a handful of non-physicians, she brought unique perspectives to the board—that of a member of the public with no investment in helping physicians protect themselves, and that of a sociologist with extensive training in observing social phenomena.[2] What Horowitz discovered was shocking. As detailed in her book *In the Public Interest*, she found that even though medical boards began to include public members in the 1960s, today's public members struggle to get their voices heard and have difficultly acting on the public's behalf.[3] Horowitz demonstrates deep divisions between boards' stated goals of acting in the public interest and their actions that too often undermine that goal.[4]

Three decades later, Tristan McIntosh, Elizabeth Pendo, and their colleagues set out on a different mission.[5] Their goal was to uncover "particularly effective practices, resources, and statutory provisions that SMBs and policymakers can adopt to better protect patients from egregious wrongdoing by physicians."[6] They convened a modified Delphi panel composed of physicians, executive members, legal counsel, and public members of around half of U.S. medical boards.[7] What Pendo and her colleagues found was also shocking: not only did medical boards vary significantly in the frequency and severity of the disciplinary actions they imposed, but they overwhelmingly failed to act even in cases of egregious harm.[8] They show us what boards are doing wrong and describe what they should do about it.[9]

Taken together, Horowitz and McIntosh et al. offer two of the few glimpses we have into the innerworkings of professional medical boards—a critical, but underexamined, aspect of administrative law.[10] Horowitz offers a micro-level

1. RUTH HOROWITZ, IN THE PUBLIC INTEREST: MEDICAL LICENSING AND THE DISCIPLINARY PROCESS 4 (Rima D. Apple & Janet Golden eds., 2012).

2. *Id.* at 7.

3. *Id.* at 8.

4. *Id.* at 173.

5. *See generally* Elizabeth Pendo et al., *Protecting Patients from Physicians Who Inflict Harm: New Legal Resources for State Medical Boards*, 15 ST. LOUIS U. J. HEALTH L. & POL'Y 7 (2022); Tristan McIntosh et al., *Protecting Patients from Egregious Wrongdoing by Physicians: Consensus Recommendations from State Medical Board Members and Staff*, J. MED. REGUL., Oct. 2021, at 5–18.

6. Pendo et al., *supra* note 5, at 15; McIntosh et al., *supra* note 5, at 5.

7. McIntosh et al., *supra* note 5, at 6.

8. *Id.* at 5–6; Pendo et al., *supra* note 5, at 13–14.

9. Pendo et al., *supra* note 5, at 14; McIntosh et al., *supra* note 5, at 5–16.

10. HOROWITZ, *supra* note 1, at 1–9; *see generally* McIntosh et al., *supra* note 5; James M. DuBois et al., *Serious Ethical Violations in Medicine: A Statistical and Ethical Analysis of 280 Cases in the United States from 2008–2016*, AM. J. BIOETHICS, Jan. 2019, at 16–34 (2019); James

perspective that delves into the daily grind of board work by detailing how board members make decisions and the consequences of those decisions for patient care.[11] McIntosh et al. offer a macro-level perspective of those decisions and categorize boards' responses to bad behavior.[12]

Professional boards serve an important purpose. These administrative agencies protect the public by educating, licensing, and disciplining professionals. However, boards also represent a regulatory bargain that professionals have struck with the state. The state relinquishes control over professions and provides them the autonomy to regulate themselves as long as they promise to behave in ways that benefit the public. Horowitz and McIntosh et al. investigate whether boards uphold their end of the bargain.[13] Do they really operate in the public interest? Beyond medical boards' successes and failures, Horowitz and McIntosh et al. help us to understand something critical about the intersection between law and medicine. Boards make promises that they do not always keep, especially when they fail to regulate their licensees.[14]

A brief note on why medical boards are included under the term "administrative law": unlike lawyers who have a single type of organization—the bar association—that is responsible for advocating for the profession and disciplining professionals,[15] medicine and other health care professions like nursing and pharmacy have two types of organizations. They have (1) professional associations like the American Medical Association (AMA) and state medical associations that advocate for the profession, and (2) state medical boards that license and discipline providers.[16] These boards are part of the state apparatus and are governed by administrative law in the form of medical, nursing, and pharmacy practice acts that determine the kinds of decisions boards can make and how they can make them. Therefore, unlike bar associations, medical boards are governed by administrative law.

I am a medical sociologist and a socio-legal scholar who has conducted research on various types of boards for the last fifteen years.[17] As part of my research, I have interviewed board executives, board members, board

M. DuBois et al., *Sexual Violation of Patients by Physicians: A Mixed-Methods, Exploratory Analysis of 101 Cases*, 31 SEXUAL ABUSE 503, 503–23 (2019).

11. HOROWITZ, *supra* note 1, at 2, 115, 141, 175.

12. McIntosh et al., *supra* note 5, at 6–16.

13. HOROWITZ, *supra* note 1, at 1–9; McIntosh et al., *supra* note 5, at 5–6.

14. HOROWITZ, *supra* note 1, at 2–5, 54.

15. *See, e.g.*, *Center for Professional Responsibility*, A.B.A., https://www.americanbar.org/groups/professional_responsibility/ (last visited Oct. 2, 2020) ("The Center for Professional Responsibility advances the public interest by promoting and encouraging high ethical conduct and professionalism by lawyers and judges.").

16. HOROWITZ, *supra* note 1, at 51, 92.

17. *See, e.g.*, Elizabeth Chiarello, *Challenging Professional Self-Regulation: Social Movement Influence on Pharmacy Rulemaking in Washington State*, 38 WORK & OCCUPATIONS 303, 303–04 (2011).

investigators, expert witnesses, and lawyers who defend professionals in board proceedings.[18] Boards wield considerable power over professional practice, yet they often do not behave in the ways we might expect.[19] The public knows so little about boards that they are rarely a topic of conversation, especially in law and the social sciences, which is why the topic of this symposium is so important.

In the piece that catalyzed this symposium, McIntosh and her colleagues ask a critically important question: If medical boards are designed to protect the public from physician harm, why do they so often fail?[20] McIntosh et al. eliminate a number of ethical gray areas by focusing on egregious harm, such as sexual assault, opioid overprescribing, and fraudulent surgeries.[21] Though boards should be highly motivated to address these acute dangers, they overwhelmingly fail to act.[22] Each year, only 0.1% of all licensed physicians face disciplinary action that involves the most severe forms of punishment such as license suspension, surrender, or revocation.[23] Because of lax enforcement, many physicians harm their patients and face no consequences. We now have to deal with a mismatch between a board's mission to act in the public interest and a board's action, or more accurately *inaction*, to punish physicians who do harm.[24]

From a formal legal perspective, board inaction is surprising. If a board is legally designed to act, why does it not? To this legal question, Pendo et al. provide the answer with their cornerstone piece in this Issue. They unveil the professional bind in which boards' members find themselves—motivated to act but lacking the resources necessary to do so.[25] If, however, we move from the formal legal perspective to a sociological one, board inaction is not so surprising.[26] Boards, and the hospitals and clinics that report to them, engage in common organizational and economic practices—they protect their members

18. *Id.* at 315–16; Elizabeth Chiarello, *National Science Foundation Award No. 1753308, The Influence of Social Problems on Healthcare and Legal Institutions*, NAT'L SCI. FOUND. (May 1, 2018), https://www.nsf.gov/awardsearch/showAward?AWD_ID=1753308 [hereinafter NSF Award No. 1753308].

19. Chiarello, *supra* note 17, at 328; HOROWITZ, *supra* note 1, at 53–54.

20. *See generally* McIntosh et al., *supra* note 5 (implicitly addressing reasons why SMBs often fail to protect the public from physician harm).

21. *Id.* at 5.

22. *Id.*

23. *Id.*

24. *Id.* at 5–6; HOROWITZ, *supra* note 1, at 4–196.

25. Pendo et al., *supra* note 5, at 13; McIntosh et al., *supra* note 5, at 5, 15.

26. Elizabeth Chiarello & Calvin Morrill, *A Multi-Field Logics Approach to Theorizing Relationships Between Healthcare and Criminal Justice*, *in* RESEARCH HANDBOOK ON SOCIO-LEGAL STUDIES OF MEDICINE AND HEALTH 152, 160 (Marie-Andrée Jacob and Anna Kirkland eds., 2020).

and prioritize organizational survival.[27] For board behavior to change, their cultural and legal contexts must change as well.

This Article develops a cultural and organizational framework to illuminate why boards fail to protect the public from egregious harm. Sociological, socio-legal, and organizational theories are used to explain factors that shape the social context in which boards act or fail to act. I draw examples from a wide range of organizations, from universities[28] to the Catholic Church,[29] to explain the mechanisms that shape board behavior. I also draw on my own empirical research on boards to highlight key ideas, though I do not provide a systematic analysis of those data.[30] I conclude by providing a set of recommendations for how to interrupt processes that do not serve the public and how to reorient boards away from self-protection and towards patient-protection. After all, public protection is a board's core mission.[31] Before building this cultural and organizational framework, I begin by offering some background on boards, how they operate, and how they are described in literature on the professions. Note that even though boards vary significantly across states, here I discuss boards in general instead of delving into those differences.

II. BACKGROUND

The history of the professions is a story of power and competition.[32] Self-regulation is a mechanism that professions have used to carve out exclusive jurisdictions and to protect themselves from competitors and from state

27. *See, e.g.*, Laura L. Dunn, *Addressing Sexual Violence in Higher Education: Ensuring Compliance with the Clery Act, Title IX and VAWA*, 15 GEO. J. GENDER & L. 563, 564–71 (2013); PATRICIA EWICK & MARC W. STEINBERG, BEYOND BETRAYAL: THE PRIEST SEX ABUSE CRISIS, THE VOICE OF THE FAITHFUL, AND THE PROCESS OF COLLECTIVE IDENTITY 7–8 (Doug Mitchell & Elizabeth B. Dyson eds., 2019); JENNIFER S. HIRSCH & SHAMUS KHAN, SEXUAL CITIZENS: A LANDMARK STUDY OF SEX, POWER, AND ASSAULT ON CAMPUS 201–02 (Jodi Beder ed., 2020); Chrysanthi S. Leon, *Law, Mansplainin', and Myth Accommodation in Campus Sexual Assault Reform*, 64 U. KAN. L. REV. 987, 990–91, 1021–22 (2015); W. RICHARD SCOTT & GERALD F. DAVIS, ORGANIZATIONS AND ORGANIZING: RATIONAL, NATURAL, AND OPEN SYSTEMS PERSPECTIVES 4, 162, 324 (Pearson Educ., Inc. 2007).

28. Dunn, *supra* note 27, at 564; Leon, *supra* note 27, at 989–90.

29. EWICK & STEINBERG, *supra* note 27, at 47, 103, 109.

30. NSF Award No. 1753308, *supra* note 18.

31. HOROWITZ, *supra* note 1, at 64.

32. ELIOT FREIDSON, PROFESSIONALISM, THE THIRD LOGIC: ON THE PRACTICE OF KNOWLEDGE 13, 93 (Univ. of Chi. Press 2001); ELIOT FREIDSON, PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE 83 (Atherton Press 1970); MAGALI SARFATTI LARSON, THE RISE OF PROFESSIONALISM: A SOCIOLOGICAL ANALYSIS x (Grant Barnes & Gene Tanke eds., 1979); PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVEREIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY 4 (2nd ed. Basic Books 2017) (1982).

regulation.[33] The medical profession is the quintessential example of successful jurisdictional control,[34] even though some of that control has eroded in the past few decades.[35]

In this Part, I unpack the history of the professions and the history of professional boards. First, I describe the process by which professions achieve "closure" or exclusive control over designated knowledge and tasks.[36] Then, I highlight how medical boards began to look the way they do today, with a specific focus on the board's commitment to act in the public interest. In particular, I discuss how including public members on medical boards is designed to help the board serve the public interest.[37] It does not always work. The history of medical boards raises the question of whether boards were ever intended to protect the public interest, or if the "public interest" was a rhetorical strategy to help physicians achieve closure and ward off competitors.[38]

A. Professional Closure

To understand how professions gain and maintain power, it is useful to avoid thinking about professions in isolation and instead to think about them as a "system of professions" organized around types of knowledge and tasks over which they have staked control.[39] To paint a few of the health care professions with a very broad brush, physicians diagnose diseases and prescribe remedies, nurses administer treatment, and pharmacists dispense medications.[40] These tasks—diagnosing, prescribing, administering, and dispensing—belong to these professions' jurisdictions, or bodies of knowledge and sets of tasks recognized by others as belonging primarily or exclusively to a particular profession.[41] Sociology of the professions offers robust theories about the processes that establish jurisdictional boundaries and the processes that provoke change.[42] One

33. PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE, *supra* note 32, at 84; LARSON, *supra* note 32, at x, 9.

34. PROFESSIONALISM, THE THIRD LOGIC: ON THE PRACTICE OF KNOWLEDGE, *supra* note 32, at 154, 158; LARSON, *supra* note 32, at 12.

35. Arnold S. Relman, *The New Medical-Industrial Complex*, 303 NEW ENG. J. MED. 963, 963–65, 969 (1980); W. RICHARD SCOTT ET AL., INSTITUTIONAL CHANGE AND HEALTHCARE ORGANIZATIONS: FROM PROFESSIONAL DOMINANCE TO MANAGED CARE 58, 61, 95 (2000).

36. ANDREW ABBOTT, THE SYSTEM OF PROFESSIONS: AN ESSAY ON THE DIVISION OF EXPERT LABOR 21 (1988); PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE, *supra* note 32, at 99–100; LARSON, *supra* note 32, at 131.

37. HOROWITZ, *supra* note 1, at 5–6.

38. *Id.* at 3–4.

39. ABBOTT, *supra* note 36, at 21–22.

40. *Id.* at 173, 249.

41. *Id.* at 77, 117–18.

42. *Id.* at 22; PROFESSIONALISM, THE THIRD LOGIC: ON THE PRACTICE OF KNOWLEDGE, *supra* note 32, at 158; PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE, *supra* note 32, at 95; LARSON, *supra* note 32, at 5.

might ask why registered nurses, who have extensive patient experience, cannot diagnose, or why pharmacists, who have six years of training including clinical rotations, cannot prescribe.[43] The answer has far less to do with the knowledge or skills of any particular professional group and far more to do with the mechanisms by which professions seize control of jurisdictions and ward off competitors.[44]

In his landmark book *The System of the Professions,* sociologist Andrew Abbott theorizes a set of six "settlements" that result from competition over jurisdictions: (1) one profession can claim the full jurisdiction, (2) one profession can be subordinated under the other, (3) professions can split the jurisdiction into two parts, (4) professions can share a jurisdiction, (5) one profession can advise another on certain tasks, or (6) professions can divide work based on type of clients.[45] However, even gaining professional status is a feat in itself.[46] Fundamentally, professions are interested in achieving "closure."[47] That is, they want to be recognized as professionals with their own exclusive domain of knowledge and tasks, and they want to defend that domain, or jurisdiction, from would-be competitors.[48] This is what sociologist Magali Sarfatti Larson calls a "professional project," or an effort to claim high social status and agency over one's work while being free from intrusion by others.[49]

State support is crucial for legitimizing this professional project.[50] States provide professions with a way to defend themselves from would-be competitors by legally allocating certain tasks to them and denying those tasks to others.[51] Two forms of state legitimation help professions to secure their jurisdictions: licensure and self-regulation.[52] Licensure helps to limit which workers can perform a specific task.[53] For example, in most states, a barber cannot perform

43. RICHARD R. ABOOD & DAVID B. BRUSHWOOD, PHARMACY PRACTICE AND THE LAW 84–86 (2nd ed. 1997); GREGORY L. WEISS & LYNNE E. LONNQUIST, THE SOCIOLOGY OF HEALTH, HEALING, AND ILLNESS 302 (8th ed. Routledge 2014).

44. ABBOTT, *supra* note 36, at 22, 135; ELIOT FREIDSON, PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE 337 (1st ed. 1970); LARSON, *supra* note 32, at 10, 12; STARR, *supra* note 32, at 229–31.

45. ABBOTT, *supra* note 36, at 145.

46. PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE, *supra* note 32, at 81; LARSON, *supra* note 32, at 12.

47. Kim A. Weeden, *Why Do Some Occupations Pay More than Others? Social Closure and Earnings Inequality in the United States*, 108 AM. J. SOCIO. 55, 61–92 (2002).

48. *Id.* at 70.

49. LARSON, *supra* note 32, at 51.

50. *Id.* at 14.

51. HOROWITZ, *supra* note 1, at 40–46.

52. PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE, *supra* note 32, at 83; HOROWITZ, *supra* note 1, at 46–48; LARSON, *supra* note 32, at 129.

53. PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE, *supra* note 44, at 21, 187.

surgery, a teacher cannot cut hair, and a waiter cannot give a massage without a medical license,[54] a cosmetology license,[55] or a massage license, respectively.[56] Licensure benefits professions because it limits the number of people who can perform a task and, as a result, reduces competition and keeps wages high.[57]

Licensure is also an aspect of self-regulation. One goal of the professional project is to achieve autonomy from the state.[58] As part of their broad police power, states control all aspects of work that are not constitutionally allocated to the federal government.[59] However, professions want to seize control from the state so the profession has exclusive power over its jurisdiction.[60] Professions do so by striking a regulatory bargain with the state, of which boards and the promise to act in "the public interest" are crucial elements.[61]

B. The Function of Medical Boards

Boards are regulatory agencies born out of professional quests for power. When medical boards were first developed, the medical profession bore little resemblance to the medical profession of today.[62] Before 1910, physicians did not enjoy elevated status over other health care professionals.[63] Instead, they were on par with pharmacists, nurses, midwives, and chiropractors, and there was a great deal of variation among physicians in terms of how they were trained, the techniques they used, and how much they charged.[64] That all changed when the Carnegie Foundation commissioned a team to evaluate the quality of medical schools.[65] Following on the heels of the AMA's licensing changes in 1906, the Flexner Report, published in 1910, evaluated which medical schools met the new requirements and found many of them severely lacking. Flexner's detailed and biting report precipitated a wave of medical school closings through 1920.[66] Still, physicians were wary of other professions

54. *Obtaining a Medical License*, AM. MED. ASS'N (May 15, 2018), https://www.ama-assn.org/residents-students/career-planning-resource/obtaining-medical-license.

55. *State Requirements for Cosmetologists*, NATL. ASS'N COMPLEMENTARY & ALT. MEDS., https://nacams.org/cosmetology-states/ (last visited Oct. 3, 2021).

56. *Massage Therapist License Requirements by State*, MASSAGE MAG. INS. PLUS, https://www.massageliabilityinsurancegroup.com/state-requirements/ (last visited Oct. 3, 2021).

57. STARR, *supra* note 32, at 102, 230.

58. LARSON, *supra* note 32, at 184.

59. U.S. CONST. amend. X.

60. PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE, *supra* note 44, at 72; PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE, *supra* note 32, at 83; LARSON, *supra* note 32, at 184–85.

61. HOROWITZ, *supra* note 1, at 33, 44.

62. *Id.* at 34; STARR, *supra* note 32, at 24–25.

63. HOROWITZ, *supra* note 1, at 35–36; STARR, *supra* note 32, at 82.

64. HOROWITZ, *supra* note 1, at 35; STARR, *supra* note 32, at 81.

65. HOROWITZ, *supra* note 1, at 50; STARR, *supra* note 32, at 118.

66. HOROWITZ, *supra* note 1, at 50–51; STARR, *supra* note 32, at 118.

who might challenge them for control over emerging medical tasks. So, physicians struck a regulatory bargain with the state: the state would grant physicians sole control over a subset of tasks and give them the autonomy to decide how to practice medicine.[67] In exchange, physicians would promise to regulate themselves in ways that protected the public interest.[68] That is the model on which boards are predicated today.

The irony is that physicians established boards at a time when many medical remedies lacked a sufficient basis in scientific evidence and sometimes harmed patients.[69] Medical boards, whose stated aim was to protect the public, were also closely aligned with medical associations like the AMA, whose aim was to protect the profession.[70] Horowitz observes, "it was difficult to pass public interest legislation when the medical society and boards were so closely aligned."[71] Additionally, boards and associations worked collaboratively to keep evidence of physician wrongdoing out of the public eye as negative public opinion would threaten the creation and power of these emerging professional entities. For example, professional codes deterred physicians from reporting and testifying against their colleagues. Physicians who dared to do so faced harsh consequences.[72]

For example, in the 1950s, one Illinois physician who cooperated with the state's attorney general to identify problematic practitioners found himself excluded from the profession.[73] When he attempted to practice in Arizona instead, his reputation followed him there as the Illinois board shared his offenses with the Arizona board.[74] A letter from the Illinois Attorney General was no help, and the physician was unable to practice until nine years later, when a court saw through the political smokescreen and required the board to license him.[75] This doctor's case left one to wonder: How could physicians uphold the highest ethical standards if they were prohibited from holding one another accountable? This got critics thinking that perhaps boards comprised entirely of physicians were ill-equipped to protect the public.[76] Maybe they lacked the neutrality necessary to uphold the standards they had set for themselves.[77]

67. HOROWITZ, *supra* note 1, at 42–44; STARR, *supra* note 32, at 141.

68. HOROWITZ, *supra* note 1, at 47; STARR, *supra* note 32, at 144.

69. HOROWITZ, *supra* note 1, at 35; David Johnson & Humayun J. Chaudhry, *The History of the Federation of State Medical Boards: Part One—19th Century Origins of FSMB and Modern Medical Regulation*, J. MED. REGUL., Mar. 2012, at 20, 24; STARR, *supra* note 32, at 138.

70. HOROWITZ, *supra* note 1, at 33, 89.

71. *Id.* at 70.

72. *Id.* at 54; Johnson & Chaudhry, *supra* note 69, at 21.

73. HOROWITZ, *supra* note 1, at 54.

74. *Id.*

75. *Id.*

76. *Id.* at 56; BENJAMIN SHIMBERG ET AL., OCCUPATIONAL LICENSING AND PUBLIC POLICY: FINAL REPORT 10 (1972).

77. HOROWITZ, *supra* note 1, at 55–56.

Perhaps boards needed input from those with no connection to the medical profession.[78] These concerns fueled the push to add public members to medical boards, a move that boards and associations vehemently opposed.[79]

C. The Role of the Public Member

Boards promised to act in the public interest, but board members were convinced that only they had the knowledge and skill to determine what the public interest was.[80] Two paternalistic ideas legitimated self-regulation, both of which centered on the public's ignorance: (1) the idea that physicians knew best how to protect the public, and (2) the idea that the public could not evaluate physician behavior for disciplinary purposes.[81] Certainly, patients could not differentiate between good medicine and bad—they had neither the knowledge nor the skills. Therefore, board members argued that patients should trust medical boards to regulate board members and their physician colleagues and to hold themselves to the highest possible ethical standards.[82] In their view, the idea of public members on boards was equally preposterous—members of the public could not possibly hope to understand the deep technical challenges that physicians faced and could not render a verdict on whether a physician's actions met professional standards.[83] This claim ignored the fact that many cases brought before medical boards were issues of ethics or access that did not require specialized knowledge.[84]

These twin notions helped physicians ward off public intervention for decades. However, these claims began to lose leverage in the 1960s and 1970s when political and cultural movements ushered in mobilization for consumer rights and a deep distrust of authority.[85] In the throes of this cultural melee, critics of professional boards began to insist that boards should include members of the public in their ranks.[86] Boards and professional organizations like the AMA initially resisted—they remained unconvinced that public members could adequately evaluate the quality of medical practice and feared that public intrusion onto boards would threaten the board's power to self-regulate.[87] Boards that allowed public members in the early days either kept them away from important board business or did not permit them to vote, leading many

78. *Id.* at 57.
79. *Id.* at 56, 62.
80. *Id.* at 48, 62.
81. *Id.* at 48.
82. HOROWITZ, *supra* note 1, at 47–48.
83. *Id.* at 65.
84. *Id.*
85. *Id.* at 56. *See generally* SHIMBERG ET AL., *supra* note 76.
86. HOROWITZ, *supra* note 1, at 9; SHIMBERG ET AL., *supra* note 76, at 264.
87. HOROWITZ, *supra* note 1, at 33.

public members to quit or disengage. However, after years of conflict, boards eventually grew to accept public members . . . to a degree.[88]

Board members began to see that including public members helped them solve a growing problem of legitimacy without actually threatening status quo board operations.[89] At the time, boards were seen as self-interested, self-serving bodies who were more interested in protecting their power and pocketbooks than in actually serving the public.[90] This public perception threw boards into a crisis of legitimacy in which they feared that if critics grew loud and powerful enough, state legislatures would take action that would compromise boards' ability to self-govern.[91] Allowing public members on boards helped to quell the critics.[92] When public members signed off on board decisions, they indicated that the interests of the boards and the public were aligned.[93] However, there were not enough public members on any board to actually transform board decisions or the mechanisms by which those decisions were made.[94] This resulted in public members acting as a sort of symbolic window dressing that legitimated board actions without catalyzing change.[95]

Not only was admitting public members a symbolic act, but boards and professional associations went to great lengths to shield physicians from scrutiny by the public members, hiding some of the worst offenders in physician health programs (PHPs, sometimes referred to as impaired physician programs). PHPs are programs run by professional associations to help physicians who have impairments such as substance use disorders or who engage in sexual misconduct.[96] Decisions to send physicians to PHPs were made in secret; board members were not to know if physicians were participating in PHPs and were to trust the association to determine whether the provider had been rehabilitated.[97] Patients, too, were none the wiser, and if the association allowed it, physicians who had sexually assaulted patients or had stolen patients' pain medication continued to provide care.[98] The AMA created a model Disabled Physician Act in 1974 that enabled PHPs' creation based on the idea that "impaired physicians needed effective rehabilitation, not punishment."[99]

88. *Id.* at 69, 98.
89. *Id.* at 76.
90. *Id.* at 56.
91. *Id.* at 24, 61.
92. HOROWITZ, *supra* note 1, at 64.
93. *Id.* at 163.
94. *Id.* at 175–76.
95. *Id.* at 176.
96. *Id.* at 86, 100.
97. HOROWITZ, *supra* note 1, at 66–67.
98. *Id.* at 68.
99. *Id.* at 66.

Framing board formation and licensure in terms of public interest resolved tension between patient choice and professional closure.[100] Public interest rhetoric pushed toward the latter by aligning the public's interest in safety with the profession's interest in power and prestige.[101] The argument went that patients deserved protection and would only receive it if the state allowed the medical profession to regulate itself and weed out negligent or nefarious practitioners.[102] The problem is that boards never did,[103] at least not to the extent that would have achieved real public protection.[104] Instead, boards used licensure as a cudgel to ward off would-be competitors and restrict medical practice to a privileged few.[105] Adding public members did little to shift board operations. Instead, it merely helped to dispel the public perception that physicians acted exclusively in their own interest.[106] Horowitz bluntly describes how self-regulation, boards, and licensure protected physicians when she states "[t]he medical profession had used its power to corner the market, jack up its status, and control peoples' bodies and lives."[107]

Fast forward to today. Physicians still self-regulate. All states have medical boards, and most boards have public members.[108] These boards claim that they act in the public interest, but evidence suggests that they often do not.[109] The number of physicians disciplined is far fewer than the number who commit egregious harm, and those that are disciplined often receive minimal rehabilitation before returning to work with the public.[110] The history of boards helps to partly explain why boards fail to fulfill their stated aim.[111] However, for

100. *Id.* at 68.

101. *Id.* at 7.

102. HOROWITZ, *supra* note 1, at 5.

103. *Id.* at 5, 116.

104. *Id.* at 116.

105. *Id.* at 75.

106. *Id.* at 64–65.

107. HOROWITZ, *supra* note 1, at 65.

108. FED'N OF STATE MED. BDS., BOARD MEMBERSHIP COMPOSITION 1 (2021), https://www.fsmb.org/siteassets/advocacy/regulatory/board-structure/board-membership-composition.pdf.

109. HOROWITZ, *supra* note 1, at 32–34; McIntosh et al., *supra* note 5, at 5–6; Pendo et al., *supra* note 5, at 13.

110. *Serious Ethical Violations in Medicine*, *supra* note 10, at 16–17; *Sexual Violation of Patients by Physicians*, *supra* note 10, at 506; Ariel Hart, *Doctors & Sex Abuse: Accused Doctors Go to Therapy, Then Return to Practice*, ATLANTA J.-CONST., http://doctors.ajc.com/sex_abuse_treatment_over_punishment/ (last visited Oct. 9, 2021); Carrie Teegardin & Danny Robbins, *Still Forgiven: The #MeToo Movement and Public Outcry over Dr. Larry Nassar's Sex Abuse Have Not Reformed the System that Disciplines Doctors*, ATLANTA J.-CONST., https://doctors.ajc.com/still_forgiven/ (last visited Oct. 9, 2021); McIntosh et al., *supra* note 5, at 5–6; Pendo et al., *supra* note 5, at 13.

111. HOROWITZ, *supra* note 1, at 180; SHIMBERG ET AL., *supra* note 76, at 357.

a more robust explanation, we must also dive into sociological research on culture and organizations.

III. A CULTURAL AND ORGANIZATIONAL PERSPECTIVE

Board members make decisions about physician misconduct in a cultural and organizational environment characterized by particular norms, values, processes, and power dynamics.[112] Attending to key mechanisms at work in these environments helps to explain why boards behave the way they do. I propose that to understand boards' behavior, we need to consider three types of barriers to physician discipline: (1) input barriers, (2) processing barriers, and (3) output barriers, as well as aspects of the cultural and organizational context in which these barriers manifest.

A. Input Barriers

Input barriers are those barriers that prevent information about egregious misconduct from reaching the board. One major reason that boards do not discipline physicians who inflict egregious harm is because boards never hear about it.[113] Boards are generally reactive rather than proactive. They act on tips that they receive from families, practitioners, other agencies, or concerned citizens instead of seeking out cases on their own.[114] Hospitals and clinics are legally required to report physician misconduct to boards, yet many either do not report or report information that is so vague that boards cannot even understand what happened, let alone act on it.[115] What prevents hospitals, clinics, patients, and families from reporting egregious misconduct to boards and why do hospitals and clinics that do report do so in a way that is difficult for boards to interpret? I argue that hospitals and clinics have different motivations for failing to report than patients and families, so I analyze these groups separately.

Research suggests that there are four main reasons that hospitals and clinics fail to report: (1) doing so could hurt them reputationally and financially, (2)

112. Paul J. DiMaggio & Walter W. Powell, *The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality in Organizational Fields*, 48 AM. SOCIO. REV. 147, 157 (1983); ROGER FRIEDLAND & ROBERT R. ALFORD, BRINGING SOCIETY BACK IN: SYMBOLS, PRACTICES, AND INSTITUTIONAL CONTRADICTIONS, *in* THE NEW INSTITUTIONALISM IN ORGANIZATIONAL ANALYSIS 232, 243–44, 253 (Walter W. Powell & Paul J. DiMaggio eds., 1991); SCOTT & DAVIS, *supra* note 27, at 277.

113. McIntosh et al., *supra* note 5, at 5; Pendo et al., *supra* note 5, at 13.

114. Elizabeth Chiarello, L. & Soc'y Ass'n Ann. Meeting, White Coat Crime: Regulatory and Criminal Investigations of Prescription Drug Diversion by Healthcare Professionals 10, 14 (2019) (on file with author).

115. McIntosh et al., *supra* note 5, at 5–6; Pendo et al., *supra* note 5, at 28.

there are no consequences for failing to report, (3) organizations in general often fail to hold their members accountable, and (4) many patients do not report.[116]

1. Preventing Reputational and Financial Harm

First, organizations, like people, have a survival instinct, so they resist taking action that could threaten their survival.[117] Hospitals and clinics rely on public trust to stay in business, and, in places where competition is fierce, any inklings of misconduct could repel patients and motivate them to seek care somewhere else.[118] Reporting physicians to the board creates opportunities for negative press coverage and raises questions about how administrators could have allowed this to happen, which undermines public trust and threatens the hospital or clinic's reputation and bottom line.[119]

Hospitals and clinics must balance concerns about finances and reputation with a legal duty to report.[120] They thread the needle by reporting in ways that make it difficult for boards (and journalists) to assess what went wrong.[121] By doing so, they fulfill their legal obligations without putting themselves at risk. From a socio-legal standpoint, we can think of this as "[p]laying with the [l]aw," treating law as a game and engaging in moves that allow the organization to emerge victorious within the confines of the law.[122] Even as they skirt the letter of the law, organizations that take this approach arguably behave more responsibly than those that fail to report at all.

2. No Consequences for Failing to Report

Second, many hospitals and clinics do not report misconduct to the board because they realize that there are no consequences for failing to report.[123] This demonstrates what socio-legal scholars call a gap between the "law on the books" and the "law in action."[124] There is a legal requirement to report and yet very few reports are made.[125] But what explains this gap is the fact that hospitals

116. Pendo et al., *supra* note 5, at 13, 28–29.

117. SCOTT & DAVIS, *supra* note 27, at 61, 252.

118. Suzanne C. Makarem & Mona Al-Amin, *Beyond the Service Process: The Effects of Organizational and Market Factors on Customer Perceptions of Health Care Services*, 17 J. SERV. RSCH. 399, 400, 411–12 (2014).

119. *See generally* M.L. Millenson, *Pushing the Profession: How the News Media Turned Patient Safety into a Priority*, 11 QUALITY & SAFETY HEALTH CARE 57, 60 (2002).

120. Makarem & Al-Amin, *supra* note 118, at 400; *see also* Pendo et al., *supra* note 5, at 28–29.

121. Hart, *supra* note 110; Teegardin & Robbins, *supra* note 110.

122. PATRICIA EWICK & SUSAN S. SILBEY, THE COMMON PLACE OF LAW: STORIES FROM EVERYDAY LIFE 129, 131 (William O'Barr & John M. Conley eds., 1998).

123. Pendo et al., *supra* note 5, at 29.

124. Austin Sarat, *Legal Effectiveness and Social Studies of Law: On the Unfortunate Persistence of a Research Tradition*, 9 LEGAL STUD. F. 23, 23 (1985).

125. Pendo et al., *supra* note 5, at 28.

and clinics face harm when they do report but face none when they do not.[126] Given this set of perverse incentives, it is no surprise that hospitals and clinics fail to report, or that some skirt the line by giving boards enough information to meet the legal requirement but not enough to investigate.

3. Organizations Protect Their Own

Third, organizations generally fail to hold their members accountable and tend to protect their members from consequences, particularly when it comes to sexual offenses—some of the most egregious harms that physicians can perpetuate.[127] We live in a society in which sexual harassment and sexual assault are rampant, and yet perpetrators of sexual offenses are rarely punished.[128]

About sixteen percent of American women and three percent of American men are sexually assaulted in their lifetime, and yet only thirty-one percent of sexual assaults are reported to the police.[129] Of those reported, only sixteen percent lead to an arrest, nine percent lead to a felony conviction, and eight percent of perpetrators serve time.[130] Add to that the fact that people who report sexual assault face the possibility that they will not be believed, and that some police departments make it a habit to investigate people who report for "false complaints," it is no surprise that sexual assault is so heavily underreported in this country.[131]

Now, consider assault in the context of the physician-patient relationship, where physicians have outsized power over the patient—the physician decides what treatments patients receive and what medications patients are prescribed. Physicians enjoy significant public trust and authority over patients. In that context, physicians can easily intimidate patients or suggest that any reports of misconduct will not be believed.[132] Difficulties inherent to transferring physicians, and other limitations on what physicians a patient can see, make

126. *Id.*

127. Chiarello & Morrill, *supra* note 26, at 159; *Sexual Violation of Patients by Physicians*, *supra* note 10, at 504–05; Fed'n of State Med. Bds., *Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, J. MED. REGUL., July 2020, at 21–22 (2020); Alan Judd, *Doctors & Sex Abuse: Condemnation Without Action*, ATLANTA J.-CONST. (July 6, 2016), https://doctors.ajc.com/ama_sex_abuse_doctors/.

128. KATE HARDING, ASKING FOR IT: THE ALARMING RISE OF RAPE CULTURE—AND WHAT WE CAN DO ABOUT IT 1 (2015).

129. *Scope of the Problem: Statistics*, RAPE ABUSE & INCEST NAT'L NETWORK, https://www.rainn.org/statistics/scope-problem (last visited Sept. 25, 2021); *The Criminal Justice System: Statistics*, RAPE ABUSE & INCEST NAT'L NETWORK, https://www.rainn.org/statistics/criminal-justice-system (last visited Sept. 25, 2021).

130. *The Criminal Justice System: Statistics*, *supra* note 129.

131. Corey Rayburn Yung, *Sex Panic and Denial*, 21 NEW CRIM. L. REV. 458, 468–69 (2018).

132. *Sexual Violation of Patients by Physicians*, *supra* note 10, at 504; Carrie Teegardin et al., *Doctors & Sex Abuse: License to Betray*, ATLANTA J.-CONST. (July 6, 2016), https://doctors.ajc.com/part_1_license_to_betray/; Teegardin & Robbins, *supra* note 110.

patients dependent on physicians, even when the physician misuses their power by engaging in assault.[133] In that context, we would expect reporting to be even less common than it is among the general public and consequences for misconduct even less severe.[134]

On top of that, physicians are situated in organizations like hospitals and clinics that have an interest in maintaining their workforce and warding off claims of misconduct.[135] For these and other reasons, many types of organizations protect perpetrators of sexual crimes from the consequences of their actions.[136] They do so by engaging in two processes: (1) buffering and (2) circulating.[137]

a. Buffering

Organizations buffer when they create legalistic structures and organization-specific disciplinary procedures that signal to the outside world that they are taking care of the problem when, in fact, they often offer far less severe consequences.[138] Consider, for example, how sexual assault is handled in American universities.[139] Universities are federally required to have Title IX offices, and they typically have student disciplinary proceedings for sexual assault.[140] Students who are assaulted can report to the Title IX office and often do so instead of going to the police.[141] Sexual assault is a crime, but universities buffer perpetrators from criminal consequences by sending students through university disciplinary proceedings whose worst punishments—suspension and expulsion—are far less punitive than outcomes like incarceration that can result from legal proceedings.[142]

133. *See, e.g.*, Lacie Glover & David Levine, *What to Do When Your Doctor Leaves Your Health Plan*, U.S. NEWS & WORLD REP. (Oct. 7, 2020), https://health.usnews.com/health-care/patient-advice/articles/what-to-do-when-your-doctor-leaves-your-health-plan.

134. *Sexual Violation of Patients by Physicians*, *supra* note 10, at 504.

135. Danny Robbins, *Doctors & Sex Abuse: Hospital Believed Doctor over Victims*, ATLANTA J.-CONST. (Dec. 9, 2016), https://doctors.ajc.com/wisconsin_university_hospital_doctor/.

136. Chiarello & Morrill, *supra* note 26, at 159.

137. *Id.*; Sonja K. Lilienthal & Rebecca J. Mowrey, *Stop "Passing the Trash": Addressing the Circulation of Repeat Sex Offenders in Coaching*, J. PHYSICAL EDUC., RECREATION & DANCE, Sept. 2006, at 3, 3.

138. Chiarello & Morrill, *supra* note 26.

139. HIRSCH & KHAN, *supra* note 27, at 215; Leon, *supra* note 27, at 999.

140. *Title IX*, KNOW YOUR IX, https://www.knowyourix.org/college-resources/title-ix/ (last visited Oct. 9, 2021); *see, e.g.*, Celene Reynolds, *The Mobilization of Title IX Across U.S. Colleges and Universities, 1994-2014*, 66 SOC. PROBS. 245, 245–73 (2019).

141. *Why Schools Handle Sexual Violence Reports*, KNOW YOUR IX, https://www.knowyourix.org/issues/schools-handle-sexual-violence-reports/ (last visited Oct. 9, 2021).

142. Chiarello & Morrill, *supra* note 26.

b. Circulating

A second strategy that organizations use to protect their members is circulating. I use the term circulating to describe the process of sending offenders to a different organization rather than punishing them. Instead of motivating offenders to stop their behavior or protecting current victims, this strategy simply spreads harm around and puts new groups at risk.

Circulating helps to protect the organization's reputation while also getting rid of the perpetrator. The Catholic Church famously used this strategy to get rid of priests who were sexually assaulting young boys, a process known as "priest shuffling."[143] This strategy is also used by universities to get rid of professors who assault students, by police departments to get rid of officers who harm citizens, and by high schools to get rid of coaches who assault players.[144] Sometimes circulating is direct, such as when organizations send perpetrators off with glowing references and a promise not to disclose wrongdoing to their new employers.[145] In other cases, circulating is indirect, such as when organizations fire perpetrators without taking other steps to mitigate harm.[146] Both direct and indirect circulating create the opportunity for the perpetrator to harm others at their new job.

McIntosh and her colleagues find examples of indirect circulating in the medical setting.[147] Hospitals and academic medical center administrators who identify unsafe practitioners will, at times, dismiss a dangerous practitioner in a way that does not require reporting.[148] They limit harm to their own patients by offloading that harm onto patients at other facilities.[149] This circumvents the board and does nothing to reduce harm more generally.

If the physician leaves "voluntarily," the hospital is not required to report the physician to the National Practitioner Data Bank, a system that "tracks malpractice payouts and adverse actions taken against doctors, such as being

143. EWICK & STEINBERG, *supra* note 27, at 5–7; Nina Shapiro, *Breach of Faith*, SEATTLE WKLY. (Oct. 9, 2006, 12:00 AM), https://www.seattleweekly.com/news/breach-of-faith/.

144. Shapiro, *supra* note 143; Timothy Williams, *Cast-Out Police Officers Are Often Hired in Other Cities*, N.Y. TIMES (Sept. 10, 2016), https://www.nytimes.com/2016/09/11/us/whereabouts-of-cast-out-police-officers-other-cities-often-hire-them.html; Christian Willmsen & Maureen O'Hagan, *Coaches Continue Working for Schools and Private Teams After Being Caught for Sexual Misconduct*, SEATTLE TIMES (Dec. 14, 2003, 12:00 AM), http://special.seattletimes.com/o/news/local/coaches/news/dayone.html; Sarah L. Young & Kimberly K. Wiley, *Erased: Why Faculty Sexual Misconduct Is Prevalent and How We Could Prevent It*, 27 J. PUB. AFFS. EDUC. 276, 282–83 (2021).

145. Lilienthal & Mowrey, *supra* note 137.

146. Williams, *supra* note 144.

147. McIntosh et al., *supra* note 5, at 5–6.

148. *Id.* at 6.

149. Laura Beil, *A Surgeon So Bad It Was Criminal*, PROPUBLICA (Oct. 2, 2018, 5:00 AM), https://www.propublica.org/article/dr-death-christopher-duntsch-a-surgeon-so-bad-it-was-criminal.

fired, barred from Medicare, handed a long suspension, or having a license suspended or revoked."[150] Failure to report protects both the physician's and the hospital's reputation, even as doing so disseminates harm to unsuspecting patients.[151] Journalists have documented physicians moving from institution to institution, despite inappropriate behavior, without sanction.[152] These physicians harm students/trainees, ancillary health care professionals, peer physicians, as well as patients.[153] Like moving polluted water around a pool instead of draining it away, organizations that circulate dangerous physicians compromise the integrity of the entire profession.

4. Lack of Patient Reporting

Hospitals and clinics are not the only entities that fail to hold bad physicians accountable. Patients who have been harmed and their families often fail to report to either the physician's employer or the board.[154] However, their motivations differ from those of organizations and depend on the type of harm perpetuated.[155] Consider two types of egregious harm that McIntosh et al. and Pendo et al. investigate: sexual assault and over-prescribing opioids.[156]

Patients who are sexually assaulted by their physicians likely do not report the assault for the same reasons that sexual assault survivors more generally do not report—survivors fear they will not be believed, or they fear they will face retaliation.[157] The small proportion of patients who do report struggle to determine the best outlet for their report.[158] Options include the police, the hospital or clinic, and the board. They can certainly report to all three but

150. *Id.*

151. *Id.*; McIntosh et al., *supra* note 5, at 5–6.

152. Ginger Christ & Brie Zeltner, *System to Screen and Credential Newly-Hired Doctors Can Miss Previous Sexual Assault Allegations, Ohio State Case Shows*, CLEVELAND.COM, https://www.cleveland.com/healthfit/2018/01/system_to_screen_and_credentia.html; Jayne O'Donnell, *Confidential Deals Can Obscure Sexual Misconduct Allegations Against Doctors as Cleveland Clinic Case Shows*, USA TODAY, https://www.usatoday.com/story/news/politics/2018/01/05/confidential-deals-can-obscure-sexual-misconduct-allegations-against-doctors-alleged-rape-doctors/868921001/ (last updated Jan. 6, 2018, 8:36 AM).

153. Christ & Zeltner, *supra* note 152; O'Donnell, *supra* note 152; Michelle A. Petrovic & Adam T. Scholl, *Why We Need a Single Definition of Disruptive Behavior*, CUREUS, Mar. 18, 2018, at 1, 1–7; Jose de Leon et al., *Dealing with Difficult Medical Colleagues*, 87 PSYCHOTHERAPY & PSYCHOSOMATICS 5, 5–6 (2018).

154. *Sexual Violation of Patients by Physicians*, *supra* note 10, at 504; Hart, *supra* note 110; Teegardin & Robbins, *supra* note 110.

155. *Sexual Violation of Patients by Physicians*, *supra* note 10, at 504.

156. McIntosh et al., *supra* note 5, at 5; Pendo et al., *supra* note 5, at 13.

157. *Sexual Violation of Patients by Physicians*, *supra* note 10, at 504; Teegardin & Robbins, *supra* note 110.

158. *Serious Ethical Violations in Medicine*, *supra* note 10, at 29.

figuring out the best place to report can prove challenging, and each of these organizations has a reputation for failing to act.[159]

Patients who are over-prescribed opioids likely have different motivations for failing to report. Unlike sexual assault, where patients receive something that they did not ask for and to which they did not consent, patients often want and need opioids to treat pain, to manage an opioid use disorder, or both.[160] Therefore, it may be families of patients on opioids who seek to curb opioid prescribing rather than the patients themselves. As legal scholar Kelly Dineen points out, organizations also operate in a gray area around opioid prescribing since there is no clear standard for how much medication is too much.[161] It is thus reasonable to expect that causes of underreporting are due to different factors and circumstances.

Processing barriers impede information about physician wrongdoing from getting to the board. Given what we know about other organizations, it would be reasonable to expect that hospitals and clinics engage in buffering and circulating instead of reporting to the board.[162] Buffering helps to protect the organization's financial and reputational interests, while circulating helps to protect the organization's reputation. At the same time, patients rarely report wrongdoing to hospitals and clinics, which adds another layer of filtration to processing barriers—hospital and clinic administrators can only act on the information they receive.[163]

With a reactive board and a lack of reporting, it is no wonder that boards do not act—they often do not receive the information they need to do so.[164] Patient hesitancy and organizational processes like buffering and circulating help explain why boards do not receive the information that they should.[165] But what

159. *Serious Ethical Violations in Medicine*, *supra* note 10, at 20, 29; *Sexual Violation of Patients by Physicians*, *supra* note 10, at 504; Hart, *supra* note 110; Teegardin & Robbins, *supra* note 110; Pendo et al., *supra* note 5, at 13; Corey Rayburn Yung, *Concealing Campus Sexual Assault: An Empirical Examination*, 21 PSYCH. PUB. POL'Y & L. 1, 1–2, 6 (2015).

160. Elizabeth Chiarello, *The War on Drugs Comes to the Pharmacy Counter: Frontline Work in the Shadow of Discrepant Institutional Logics*, 40 L. & SOC. INQUIRY 86, 90 (2015) [hereinafter *The War on Drugs Comes to the Pharmacy Counter*]; TRAVIS RIEDER, IN PAIN: A BIOETHICIST'S PERSONAL STRUGGLE WITH OPIOIDS 39 (2019).

161. Kelly K. Dineen, *Definitions Matter: A Taxonomy of Inappropriate Prescribing to Shape Effective Opioid Policy and Reduce Patient Harm*, 67 U. KAN L. REV. 961, 966–69 (2019).

162. Chiarello & Morrill, *supra* note 26, at 159.

163. *Sexual Violation of Patients by Physicians*, *supra* note 10, at 504; Hart, *supra* note 110; Teegardin & Robbins, *supra* note 110.

164. Chiarello, *supra* note 114, at 14; McIntosh et al., *supra* note 5, at 5–6, 15; Patricia A. King et al., *Contextualizing and Strengthening State Medical Board Responses to Physician Sexual Misconduct*, 15 ST. LOUIS U. J. HEALTH L. & POL'Y 151, 160 (2022).

165. Chiarello & Morrill, *supra* note 26; *Sexual Violation of Patients by Physicians*, *supra* note 10, at 504; Teegardin & Robbins, *supra* note 110.

about the information that *is* communicated to them? Why do boards so often fail to discipline physicians of whose harmful behavior they are made aware?

B. Processing Barriers

The answer lies in processing barriers. Processing barriers are those barriers that prevent boards from acting effectively on the information they receive. Several factors likely shape how boards process information, including factors like buffering and circulating that prevent boards from receiving complaints in the first place.[166] Board members face conflicts between their professional identities, their duty to fulfill the board's obligation to discipline physicians, and their responsibility to protect the public.[167] Boards often resolve these conflicts in ways that prioritize their fellow professionals over the public.[168] First, I will trace contours of this fundamental conflict between the interests of the profession and the public, then I will show three ways that board members privilege physicians over patients: (1) the white wall of silence, (2) buffering impaired professionals, and (3) involving physician experts in board investigations.

1. Grappling with Conflict

The contemporary structure of medical boards raises some important questions about the board's mission, physicians' professional identities, and what it means to protect the public.[169] When it comes to the board's mission, board members are required to act in ways that protect the public, part of which involves disciplining physicians who inflict egregious harm.[170] This puts them at odds with physicians who behave badly. However, when it comes to professional identity, the vast majority of board members are physicians themselves, and this puts the board members in a position to identify with other physicians despite the fact that those physicians are causing harm.[171] True, boards have public members, but the number of physicians has always far outweighed the number of public members, so public members have little capacity to challenge physicians' power on the board.[172]

How do physician board members contend with competing impulses to protect the public and to protect fellow professionals? Evidence suggests that

166. Chiarello & Morrill, *supra* note 26, at 159; Lilienthal & Mowrey, *supra* note 137.

167. HOROWITZ, *supra* note 1, at 11.

168. *Sexual Violation of Patients by Physicians*, *supra* note 10, at 517; HOROWITZ, *supra* note 1, at 22; Hart, *supra* note 110; Teegardin & Robbins, *supra* note 110.

169. HOROWITZ, *supra* note 1, at 3; SHIMBERG ET AL., *supra* note 76, at 12.

170. HOROWITZ, *supra* note 1, at 3, 7.

171. *Sexual Violation of Patients by Physicians*, *supra* note 10, at 517; HOROWITZ, *supra* note 1, at 16; SHIMBERG ET AL., *supra* note 76, at 11–12.

172. HOROWITZ, *supra* note 1, at 12–13.

they typically err on the side of protecting fellow professionals.[173] McIntosh et al. tell us that very few physicians face the most severe forms of disciplinary action—suspension, surrender, or revocation of a license.[174] What prevents boards from using the strongest weapons at their disposal to stop patient harm? I suggest that there are intraprofessional and structural forces at play, and that these forces result in buffering and circulating at the board level.[175]

2. Professional Identity: The White Wall of Silence

Professionals have a shared identity.[176] They undergo extensive training that socializes them into particular ways of thinking about the world and about themselves.[177] For physicians, this shared training, that is by all accounts rigorous and relentless, looks not unlike a fraternity hazing process where the newest members perform grunt work to prove themselves to established professionals.[178] Individuals are broken down by sleep deprivation, long work hours, and demanding tasks, and built up into freshly minted, if world-weary, professionals.[179] Like other individuals who undergo extensive training and socialization processes—fraternity members, college athletes, members of the military, and cult members—physicians emerge from their training with a strong sense of connection to their fellow travelers.[180] Intensive socialization helps to explain why physicians shield fellow professionals from accountability for certain offenses.[181]

Professionals tend to protect their own. Much like the so-called "blue wall of silence" that motivates police officers to protect one another even in light of egregious wrongdoing,[182] scholars argue that physicians experience a white wall of silence that motivates them to protect one another despite evidence of patient

173. *Sexual Violation of Patients by Physicians*, *supra* note 10, at 504; HOROWITZ, *supra* note 1, at 5; Hart, *supra* note 110; Teegardin & Robbins, *supra* note 110; McIntosh et al., *supra* note 5, at 5–6.

174. McIntosh et al., *supra* note 5, at 5–6.

175. Chiarello & Morrill, *supra* note 26, at 154.

176. Elizabeth H. Gorman & Rebecca L. Sandefur, *"Golden Age," Quiescence, and Revival: How the Sociology of Professions Became the Study of Knowledge-Based Work*, 38 WORK & OCCUPATIONS 275, 286 (2011).

177. HOWARD SAUL BECKER ET AL., BOYS IN WHITE: STUDENT CULTURE IN MEDICAL SCHOOL 4–6 (1984); KATHERINE C. KELLOGG, CHALLENGING OPERATIONS: MEDICAL REFORM AND RESISTANCE IN SURGERY 30 (2011).

178. KELLOGG, *supra* note 177, at 21–22, 32.

179. BECKER ET AL., *supra* note 177, at 206, 218; KELLOGG, *supra* note 177, at 30.

180. Patricia A. Adler & Peter Adler, *Intense Loyalty in Organizations: A Case Study of College Athletics*, 33 ADMIN. SCI. Q. 401, 407 (1988); ERVING GOFFMAN, ON THE CHARACTERISTICS OF TOTAL INSTITUTIONS (1957), http://www.markfoster.net/neurelitism/totalinstitutions.pdf; KELLOGG, *supra* note 177, at 30–31.

181. HOROWITZ, *supra* note 1, at 128.

182. Louise Westmarland, *Police Ethics and Integrity: Breaking the Blue Code of Silence*, 15 POLICING & SOC'Y 145, 151, 161 (2005).

harm.[183] Physicians struggle to determine whether another physician did something wrong, and even when they uncover wrongdoing, feel more compelled to protect their fellow professionals than to care for the patient.[184] Codified punishments for testifying against other doctors are the foundation on which the white wall of silence was built, and self-protective impulses are the mortar that keeps it in place.[185] Horowitz explains how norms established decades ago result in infrequent reporting of physicians by other physicians.[186] For decades, boards punished doctors for testifying against other members of their profession, and even though those formal sanctions are no longer in place, their legacy persists.[187] Beyond that, physicians today hesitate to condemn their peers for wrongdoing lest they find themselves in the crosshairs.[188] A sort of gentleman's agreement protects physicians from criticism by their peers.[189] However, protection is not a foregone conclusion.

Social science research on how professionals behave in contexts outside of their disciplines suggests that workers who are torn between their professional identities and organizational expectations cope by adopting new roles or preserving old ones.[190] For example, Nelson and Nielsen's study of corporate lawyers found that these professionals struggled to maintain their professional identities and norms when working in corporations that pushed them to behave differently.[191] Lawyers responded by acting as cops, counsel, or entrepreneurs, either maintaining or relaxing their professional roles.[192] In my own work, I find that pharmacists who face pressures to engage in both medical and legal gatekeeping tasks cope by constructing their roles in ways that enable them to engage in treatment, enforcement, or avoidance.[193] This research suggests that physician board members could react in various ways. They could eschew camaraderie with fellow professionals to affirm their role as board members, or they could ease their obligations as board members in favor of allying with

183. ROSEMARY GIBSON & JANARDAN PRASAD SINGH, WALL OF SILENCE: THE UNTOLD STORY OF THE MEDICAL MISTAKES THAT KILL AND INJURE MILLIONS OF AMERICANS 136 (2003); E. Haavi Morreim, *Am I My Brother's Warden?: Responding to the Unethical or Incompetent Colleague*, HASTINGS CTR. REP., May–June 1993, at 19, 20.

184. GIBSON & SINGH, *supra* note 183; Morreim, *supra* note 183, at 20.

185. HOROWITZ, *supra* note 1, at 53, 55.

186. *Id.* at 123.

187. *Id.* at 53, 55.

188. GIBSON & SINGH, *supra* note 183, at 137; Morreim, *supra* note 183, at 20.

189. GIBSON & SINGH, *supra* note 183; Morreim, *supra* note 183, at 20.

190. Robert L. Nelson & Laura Beth Nielsen, *Cops, Counsel, and Entrepreneurs: Constructing the Role of Inside Counsel in Large Corporations*, 34 L. & SOC'Y REV. 457, 477–78, 483 (2000).

191. *Id.* at 471.

192. *Id.* at 462.

193. *The War on Drugs Comes to the Pharmacy Counter*, *supra* note 160, at 88, 103.

fellow professionals. Research on boards demonstrates that they are more likely to do the latter.[194]

3. Buffering Impaired Professionals

Silence from fellow professionals is only one factor that prevents boards from taking action against physicians who do harm. Another factor is the use of Physician Health Programs (PHPs).[195] PHPs are a form of channeling that occurs at the board level.[196] Designed to help impaired physicians, PHPs do more than help providers get treatment; they protect those providers from the board.[197] By allowing providers to voluntarily enter a PHP, boards relinquish power to rehabilitation programs that maintain strict confidentiality (even from the boards).[198]

PHPs are typically run by professional associations whose mission is to protect the profession, not to protect the public.[199] PHPs place physicians who do harm beyond the board's reach, thereby cutting off input from public members and shielding impaired physicians from discipline.[200] Some physicians who participate in these programs have committed those offenses that Pendo et al. and McIntosh et al. label "egregious," such as sexual assault.[201] Some of these physicians go through treatment as minor as a three-day training program, and there is debate about whether that kind of program prepares them to return to practice.[202]

By contrast, programs for physicians with substance use disorders—physicians whose primary harm is to themselves—can drag on for years and fail to provide evidence-based care.[203] One physician, Peter Grinspoon, has been outspoken about his experience with a PHP.[204] He reports that he was sent to

194. *Sexual Violation of Patients by Physicians*, *supra* note 10, at 504; HOROWITZ, *supra* note 1, at 128; McIntosh et al., *supra* note 5, at 5–6.

195. FED'N OF STATE MED. BDS., POLICY ON PHYSICIAN ILLNESS AND IMPAIRMENT: TOWARDS A MODEL THAT OPTIMIZES PATIENT SAFETY AND PHYSICIAN HEALTH § II (2019), https://www.fsmb.org/siteassets/advocacy/policies/policy-on-physician-impairment.pdf.

196. HOROWITZ, *supra* note 1, at 65–66; Hart, *supra* note 110; Teegardin & Robbins, *supra* note 110.

197. HOROWITZ, *supra* note 1, at 66; Hart, *supra* note 110; Teegardin & Robbins, *supra* note 110.

198. POLICY ON PHYSICIAN ILLNESS AND IMPAIRMENT, *supra* note 195; HOROWITZ, *supra* note 1, at 66.

199. HOROWITZ, *supra* note 1, at 60, 64.

200. *Id.* at 66.

201. McIntosh et al., *supra* note 5, at 5; Pendo et al., *supra* note 5, at 13.

202. Hart, *supra* note 110; Teegardin & Robbins, *supra* note 110.

203. Leo Beletsky et al., *Practicing What We Preach — Ending Physician Health Program Bans on Opioid-Agonist Therapy*, 381 NEW ENG. J. MED. 796, 796–97 (2019).

204. Selena Simmons-Duffin, *For Health Workers Struggling with Addiction, Why Are Treatment Options Limited?*, NPR (Sept. 6, 2019, 12:11 PM), https://www.npr.org/sections/health-

Christian-based treatment programs even though he is a Jewish atheist and was barred from using effective medications for opioid use disorder such as buprenorphine and methadone.[205] Instead, he was required to remain abstinent throughout the program.[206] When PHPs provide treatment that lacks a strong evidence base, these programs are unlikely to solve the problems that led to patient harm or to protect patients from harm when the provider returns to the workplace.[207] As a result, PHPs appear to be mechanisms for maintaining the white wall of silence more than they look like effective remedies for preventing patient harm.[208]

4. Expert Physician Involvement in Disciplinary Processes

Even when physicians face the board instead of being channeled into PHPs, professionals still find ways to protect one another from consequences. Protectionism manifests in the standard of care as a basis for determining harm and in physician involvement in board investigations.[209]

Board members typically use the standard of care to determine whether a physician has engaged in wrongdoing.[210] The standard of care is a somewhat fluid concept that depends on whether the physician is behaving in a way that vastly diverges from the behavior of physicians in their specialty.[211] With this in mind, many boards build in physician experts at many steps of the disciplinary process to ensure that the physician is actually violating the standard of care.[212]

Now, the standard of care is less important in cases that involve egregious misconduct because those acts violate professional ethical and legal standards even if everyone else is doing them.[213] Still, professional expertise typically remains a part of board's choices about pursuing cases.[214] Pair these structural requirements with the white wall of silence, and it is no surprise that board members are so hesitant to pursue the strongest levels of discipline.[215]

shots/2019/09/06/757990241/for-health-workers-struggling-with-addiction-why-are-treatment-options-limited.

205. *Id.*

206. *Id.*

207. HOROWITZ, *supra* note 1, at 67; Hart, *supra* note 110; Teegardin & Robbins, *supra* note 110.

208. HOROWITZ, *supra* note 1, at 66, 74; Hart, *supra* note 110; Teegardin & Robbins, *supra* note 110.

209. HOROWITZ, *supra* note 1, at 106, 124; Sandra H. Johnson, *Customary Standard of Care: A Challenge for Regulation and Practice*, 43 HASTINGS CTR. REP. 9, 9 (2013); NSF Award No. 1753308, *supra* note 18.

210. HOROWITZ, *supra* note 1, at 70, 187.

211. Johnson, *supra* note 209, at 9.

212. NSF Award No. 1753308, *supra* note 18.

213. HOROWITZ, *supra* note 1, at 134, 158; Pendo et al., *supra* note 5, at 13.

214. HOROWITZ, *supra* note 1, at 110, 135; NSF Award No. 1753308, *supra* note 18.

215. GIBSON & SINGH, *supra* note 183, at 136–37; Morreim, *supra* note 183, at 20.

To understand how this works, consider an example from my own research in California.[216] Over the last ten years, I have interviewed criminal and administrative investigators, board members, and board executives in several states about how they contend with cases of opioid overprescribing. I was surprised to learn how differently the medical board and the pharmacy board operate.[217]

At the time of my interviews, the executive director of the pharmacy board was a consumer advocate.[218] Her master's degree was in consumer science with a focus on consumer protection, and she had no special relationship to pharmacy as a profession.[219] She saw her job as protecting the public, not protecting pharmacists.[220] The executive director of the medical board also had extensive experience in consumer protection before coming to work for the board.[221] So, on the surface, both executives were committed to protecting the public. But the pharmacy board was far more inclined to pursue pharmacists for over-dispensing than the medical board was to pursue physicians for overprescribing.[222] The investigatory structure explains why.

Like many agencies, both boards were reactive instead of proactive.[223] They did not go out looking for cases, but rather responded to each complaint they received.[224] However, at the pharmacy board, decisions about which cases to pursue were made by the executive director in conjunction with her lead investigator, someone with a law enforcement background.[225] By contrast, at the medical board, decisions about which cases to pursue were made by physician experts who decided at several points in the process whether or not a case should move forward.[226]

The pharmacy board had two people with no connection to pharmacy making decisions about pharmacists, but the medical board had a medical expert vulnerable to the professional norms of the white wall of silence who decided whether the case moved forward.[227] It makes sense, then, that the pharmacy board was more inclined to pursue harsh punishment than the medical board.[228] To be clear, I am not suggesting that all physician experts want to stop the board from disciplining physicians. I have certainly met experts who embraced this

216. NSF Award No. 1753308, *supra* note 18.
217. *Id.*
218. Chiarello, *supra* note 114, at 13.
219. *Id.*
220. *Id.* at 5, 13.
221. *Id.* at 13.
222. *Id.* at 3.
223. Chiarello, *supra* note 114, at 11.
224. *See, e.g.*, *id.* at 11, 16.
225. *Id.* at 14.
226. *Id.* at 13.
227. *Id.* at 2, 13–14.
228. Chiarello, *supra* note 114, at 3.

gatekeeping role, but given what research tells us about how professionals protect each other, it would be reasonable to expect that an investigatory structure that requires physician involvement buffers physicians from the harshest consequences.

Together, a shared professional identity that results in a white wall of silence and systematic involvement of physician experts in board investigations constitute processing barriers that protect physicians from the consequence of inflicting egregious harm.[229] These help to explain why boards do not discipline physicians even when they are aware of wrongdoing. However, boards do discipline some physicians, which raises the question of whether and how information obtained by boards makes its way into other institutional arenas with the power to punish.

C. Output Barriers

The third barrier to physician discipline is output barriers. How do medical boards' practices of sharing or withholding information affect outcomes for physicians who perpetuate egregious harm? Boards are only one organization with the power to discipline providers. They have the option to revoke a physician's license and essentially end their livelihood.[230] However, other disciplinary organizations have tools that can equally hamstring physicians' practices or impose even harsher discipline.[231] For example, the Centers for Medicare and Medicaid Services (CMS) at the state and federal level can put limits on a physician's National Provider Identifier (NPI), a number that enables them to bill government insurance.[232] The Drug Enforcement Administration (DEA) can revoke a physician's DEA registration, which allows them to prescribe controlled substances.[233] The DEA can also pursue criminal charges against a physician with the goal of putting them in prison.[234]

These disciplinary efforts appear, at first glance, to be independent because they involve different kinds of workers in different kinds of agencies, but a pharmacy law expert explained to me that they can have a "domino effect."[235] Obviously, if a physician loses their license to practice medicine or is put in

229. BECKER ET AL., *supra* note 177, at 428, 430; Chiarello, *supra* note 114, at 4, 6; Morreim, *supra* note 183, at 20, 25–26.

230. HOROWITZ, *supra* note 1, at 1.

231. *See* Chiarello, *supra* note 114, at 8 fig. 2 (depicting various enforcement agencies and the types of enforcement available to them).

232. Andrew Breza, *The Complete History of the NPI Number*, BULLETINHEALTHCARE (Dec. 14, 2018), https://www.bulletinhealthcare.com/the-complete-history-of-the-npi-number/; *see* 42 C.F.R. § 424.540(a) (2020) (providing that CMS may deactivate a physician's Medicare billing privileges, which is tied to the physician's NPI).

233. 21 C.F.R. § 1301.36(a) (2020).

234. Controlled Substances Act, 21 U.S.C. § 841(a)–(b).

235. NSF Award No. 1753308, *supra* note 18.

prison, their entire livelihood falls apart. However, even what appear to be more minor punishments, like NPI restrictions or DEA registration revocation, can seriously impede practice. Few hospitals or clinics are willing to hire or retain physicians who cannot prescribe controlled substances or who cannot bill government insurance.[236] Beyond that, consequences in one arena often trigger consequences in another.[237] Enforcement agents I interviewed explained how the medical board would piggyback on their work such that when they successfully prosecuted a physician, the medical board would use the prosecution as an excuse to revoke their medical license.[238] This was often expressed as frustration with the medical board's unwillingness to act. Sometimes, the opposite occurs and the DEA pursues criminal charges against a physician after the medical board takes actions.[239] Regardless of directionality, the point is that these kinds of disciplinary procedures mutually impact one another.[240] The question is how? How does information about physician wrongdoing travel from one agency to another and what facilitates or impedes that process?

1. Boards Circulate Perpetrators by Withholding Information

There are two organizations with whom we might expect boards to share information: medical boards in other states and law enforcement. Many physicians are licensed in multiple states, so we would expect boards that discipline a physician in one state to alert boards in other states so they can take similar action.[241]

We would also expect boards to share information with law enforcement. The egregious acts that warrant suspension or revocation of a medical license also tend to be crimes.[242] Sexual assault, overprescribing opioids, and fraudulent surgeries are all criminal activities, so when those cases come to the board's attention, it would be reasonable to expect the board to alert organizations responsible for investigating those crimes such as local police, state medical fraud units, the DEA, or the Health and Human Services Office of the Inspector General.[243]

236. *Id.*

237. *See* Chiarello, *supra* note 114, at 3, 8.

238. *Id.* at 3.

239. *Id.* at 9.

240. *Id.*

241. Aaron Young et al., *FSMB Census of Licensed Physicians in the United States, 2018*, J. MED. REGUL., July 1, 2019, at 7, 9.

242. Pendo et al., *supra* note 5, at 35 (suggesting from publicized cases that "physicians continue to practice after arrest, conviction, or other determination related to criminal conduct that harms patients").

243. *See* OFF. OF INSPECTOR GEN., U.S. DEP'T HEALTH & HUM. SERVS., A ROADMAP FOR NEW PHYSICIANS: AVOIDING MEDICARE AND MEDICAID FRAUD AND ABUSE 3 (n.d.) (noting that

Yet, it is not entirely clear how often boards share information about their own investigations. According to the Federation of State Medical Boards (FSMB),

> [w]hen a state medical board is notified that a physician licensed in its jurisdiction received a board action in another jurisdiction, the board can choose to open its own investigation or in many cases will choose to take a reciprocal action. . . . In 2020, 1,491 physicians were disciplined for the first time and 1,008 reciprocal actions were taken by state boards.[244]

However, this leaves no clear indication of how information is shared or what legal and logistical burdens prevent communication between boards. The experts interviewed by McIntosh et al. overwhelmingly prioritized suspending a physician's license when it had been suspended in another state for egregious wrongdoing.[245]

As I mentioned above, revoking a license can destroy a physician's livelihood by prohibiting them from practicing, but this punishment is far less severe if they can simply continue to practice in another state, especially one with a "soft" regulatory regime.[246] We can think about boards' failure to act as a form of circulating. Like parishes, universities, police departments, and sports teams, some boards take an out-of-sight, out-of-mind approach—as long as the bad actor is not under their purview, the bad actor is not their problem.[247] This creates an opportunity for bad physicians to circulate throughout states, harming patients along the way. Aggregated information about physicians does exist in the form of the FSMB's Physician Data Center and the National Practitioner Data Bank. Still, boards often fail to directly communicate with one another. It is unknown whether boards do not share with other boards because they are legally restricted from doing so, because there is no systematic way to exchange

fraudulent claims are a criminal offense, and that the Office of Inspector General may impose administrative civil monetary penalties for such actions); *State Law Database*, RAPE ABUSE & INCEST NAT'L NETWORK, https://apps.rainn.org/policy/?_ga=2.217812694.1789709361.1632282440-2058441927.1632282440 (last visited Oct. 9, 2021) (providing information on sexual violence laws in each state); Controlled Substances Act, 21 U.S.C. § 841(b).

244. *Physician Discipline*, FED'N OF STATE MED. BDS. (2020), https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/u.s.-medical-licensing-and-disciplinary-data/physician-discipline/.

245. McIntosh et al., *supra* note 5, at 13.

246. *Id.* at 6.

247. *See* Shapiro, *supra* note 143 (noting "priest shuffling and secrecy" by church officials); Williams, *supra* note 144 (noting how problematic police officers drift from department to department); Willmsen & O'Hagan, *supra* note 144 (noting how a coach accused of sexual misconduct was "nudged" out of town and allowed to obtain another coaching job elsewhere); EWICK & STEINBERG, *supra* note 27, at 3, 7 (noting the shuffling of priests accused of sexual misconduct from parish to parish); Young & Wiley, *supra* note 144, at 276 (noting how universities and higher education programs are designed to support a culture of complicity and complacency around sexual misconduct).

information across boards, or because they want to protect physicians from overly harsh punishment. However, it would be reasonable to expect some combination of these motivations to explain why boards withhold information and, through their inaction, permit physicians to continue to harm patients.

2. Tension and Lack of Communication Between Boards and Law Enforcement

Similar barriers might explain why boards do not share information with law enforcement. These, and other barriers, uniquely compromise the board/law enforcement relationship. In my own research, I have uncovered quite a bit of tension between boards and agencies that investigate opioid crimes.[248] Both organizations find the other to be an impediment to their own investigations.[249] Board members and executives complain that federal agencies like the DEA take records that they need and refuse to share.[250] Criminal investigators complain that boards catch wind of their cases, do audits on the targeted physician, and ruin years of undercover work.[251] These frustrations can be attributed to legal and organizational differences that put organizations that engage in administrative investigations, like SMBs, at odds with organizations that engage in criminal investigations, like the DEA and state fraud units.[252]

These organizations have different goals, resources, and legal requirements that lead to different strategies and put the organizations on very different timelines.[253] Boards aim to suspend or revoke licenses of physicians who impose harm while enforcement agencies aim to put them in prison.[254] The best resource that boards have to conduct investigations is the audit—a tactic that puts physicians on high alert since they know they are being watched and that could scare physicians into changing their behavior.[255] The best resource that enforcement agencies have is undercover investigations, which they can use to show a pattern of illegal behavior.[256] This strategy requires secrecy; if the physician knows they are being investigated, they might change their behavior or kick the undercover investigator out of their practice, either of which would compromise the investigation.[257] Audits can happen quickly, whereas undercover investigations can take months, sometimes years.[258] These

248. *See* Chiarello, *supra* note 114, at 10.
249. *Id.* at 10–11.
250. *Id.* at 10.
251. *Id.* at 11.
252. *Id.* at 8.
253. Chiarello, *supra* note 114, at 8–9.
254. *Id.* at 8.
255. *Id.* at 11.
256. *Id.*
257. *Id.*
258. Chiarello, *supra* note 114, at 9.

organizations also have different burdens of proof. In most states, boards must show either a "preponderance of the evidence," meaning that it is more likely than not that the physician did what the board claims they did, or "clear and convincing evidence," meaning that it must be substantially more probable than not that the physician did what the board claims.[259] By contrast, enforcement agencies like the DEA must prove their case "beyond a reasonable doubt," meaning that the proof is so strong that a reasonable person would have no plausible reason to believe otherwise.[260] Boards also have the option of an interim suspension order, meaning they can immediately stop the physician from practicing if the physician is found guilty of a felony, poses an imminent danger to their patient's health, or has been disciplined in another jurisdiction (though the availability of interim suspension orders differs across states).[261]

Both types of organizations are obligated to stop physicians from harming the public, but how they do so varies, and their different goals, resources, and timelines create opportunities for them to get in each other's way.[262] For example, one federal investigator I interviewed in Missouri explained how a board audit cost him his case against a physician. A board investigator was aware that the agency was investigating the case and confronted the physician before the investigation was complete. He explains, "a Board went to a practitioner and said 'You're so bad that the DEA is looking at you. You need to knock off what you're doing.'" The physician responded by firing most of his patients, including those involved in the undercover investigation, and prescribing far more cautiously. The federal investigator explained the source of his frustration with the board investigator: "We had enough to support a criminal investigation but not necessarily to move forward with a prosecution yet. So here we are building our investigation and [the board investigator] torpedoed the whole thing."[263] These kinds of "burns" create contention between boards and enforcement agencies that makes it difficult for them to see one another as allies in preventing patient harm.[264]

Although enforcement agents were sometimes frustrated when boards stepped in too soon, more often they were frustrated with medical board inaction.[265] Their reasoning was that boards have a lower burden of proof and

259. U.S. DEP'T HEALTH & HUM. SERVS., STATE DISCIPLINE OF PHYSICIANS: ASSESSING STATE MEDICAL BOARDS THROUGH CASE STUDIES (2006).

260. United States v. Black, 512 F.2d 864, 867 (9th Cir. 1975).

261. Cathal T. Gallagher et al., *The Legal Underpinnings of Medical Discipline in Common Law Jurisdictions*, 39 J. LEGAL MED. 15, 24–25 (2019).

262. *See* Chiarello, *supra* note 114, at 2; HOROWITZ, *supra* note 1, at 83; Controlled Substances Act, 21 U.S.C. § 801 (explaining the purpose and goals of the Controlled Substances Act).

263. NSF Award No. 1753308, *supra* note 18.

264. Chiarello, *supra* note 114, at 10–11.

265. *See id.* at 9, 11 (noting friction arising from the administrative agents' shorter timelines, as well as tension when a board waits to discipline providers).

have the power to issue an immediate suspension order to stop bad doctors from practicing.[266] They believe that boards are too lenient with physicians and find that boards wait until the criminal investigation is done before acting when they could act much sooner to prevent patient harm.[267] Enforcement agents are of two minds about the role of the board: on the one hand, enforcement agents would like boards to act sooner and, on the other hand, they do not want boards to act too soon in ways that prevent them from securing the harshest penalties for criminal providers.[268] In both cases, tensions between enforcement agents and boards constrain their ability to work together.[269]

The reason that boards do not share information with law enforcement is probably also due to buffering mechanisms that I described earlier with physician board members motivated to protect their own.[270] However, structural barriers exist as well. There are rarely any established pathways for routine communication between board members and law enforcement, so they are unlikely to know who to call even if they wanted to report.[271] The enforcement agents I spoke with who routinely communicated with board investigators had established interpersonal relationships, often serendipitously, that facilitated information exchange.[272] However, this was not the norm.[273] There was a great deal of communication among law enforcement agencies, but far less between enforcement agents and boards.[274]As a result, contentious and non-existent relationships between boards and law enforcement may motivate the lack of information exchange between boards and law enforcement.[275]

Collectively, input barriers, processing barriers, and output barriers help explain why boards do not punish physicians who engage in egregious harm. This organizational and cultural analysis explains why hospitals and clinics resist sharing information with boards, why boards fail to impose the harshest penalties, and why boards resist sharing information with other boards and with law enforcement. This analysis highlights the processes by which organizations

266. *Id.* at 9.

267. *Id.* at 11.

268. *Id.*

269. Chiarello, *supra* note 114, at 9–11.

270. *See* Williams, *supra* note 144 (providing an example of how law enforcement protects their own); Chiarello & Morrill, *supra* note 26, at 159 (noting how buffering prevents intrusion); HOROWITZ, *supra* note 1, at 123 (noting health care providers' reluctance to report physicians).

271. Chiarello, *supra* note 114, at 11.

272. *See id.* at 9–11 (providing excerpts of conversations from enforcement agents who worked with boards).

273. *See id.* at 10 (noting relationships are "fragile" and originate "from a place of distrust" that develops into trust).

274. *Id.* at 12.

275. *See id.* at 11 (noting how limited interaction between boards and law enforcement impacts the extent of their working relationships).

protect their members and the structural barriers that prevent information exchange across organizations.

IV. INTERVENTIONS

If input, processing, and output barriers prevent boards from acting in the public interest, what should be done to overcome those barriers? A cultural and organizational approach offers a pathway forward to arrive at effective solutions and to fortify boards' capacity to act in the public interest.

Many of the problems I have uncovered here stem from deeply-rooted cultural norms and institutionalized organizational practices.[276] Neither culture nor organizational practices are easy to change.[277] Doing so requires a concerted effort and renders the status quo untenable such that the new, more desirable behaviors become the path of least resistance.[278] I offer three strategies for reorienting boards towards the public interest and discuss how each strategy can help to overcome one of the three types of barriers. When applicable, I discuss how the strategies I propose comport with those Pendo et al. propose in their article in this Issue.[279]

Before diving into solutions, I would like to first draw the reader's attention to two sociological concepts that help to explain the goals we would like to achieve: isomorphism and general deterrence.[280] Isomorphism is the process by which organizations begin to act in similar ways.[281] Organizational theorists identify three main types of isomorphism: coercive, normative, and mimetic, of which coercive is most useful for our purposes.[282] Coercive isomorphism "results from both formal and informal pressures exerted on organizations by other organizations upon which they are dependent and by cultural expectations in the society within which organizations function."[283] When organizations fear sanctions from the same governing body, they behave alike to avoid those sanctions.[284] Yet, boards, and the organizations that report to them, lack isomorphism. McIntosh et al. show us that there is great variability in the

276. Chiarello & Morrill, *supra* note 26, at 152; DiMaggio & Powell, *supra* note 112, at 147; FRIEDLAND & ALFORD, *supra* note 112, at 242; SCOTT & DAVIS, *supra* note 27, at 3.

277. *See* DiMaggio & Powell, *supra* note 112, at 148 (noting organizations construct "an environment that constrains their ability to change"); *see* KELLOGG, *supra* note 177, at xi.

278. *See* KELLOGG, *supra* note 177, at 186 (noting "institutional change is not likely to occur" without changes to the status quo).

279. *See generally* Pendo et al., *supra* note 5.

280. *See generally* DiMaggio & Powell, *supra* note 112 (discussing isomorphism); Kirk R. Williams & Richard Hawkins, *Perceptual Research on General Deterrence: A Critical Review*, 20 L. & Soc'y Rev. 545, 545–72 (1986) (discussing general deterrence).

281. DiMaggio & Powell, *supra* note 112, at 149.

282. *Id.* at 150.

283. *Id.*

284. *See id.* ("The existence of a common legal environment affects many aspects of an organization's behavior and structure.").

frequency and severity of disciplinary actions imposed by SMBs against physicians who engage in egregious wrongdoing.[285] Variation exists in terms of input, processing, and output—hospitals and clinics unevenly report wrongdoing to the board, the board unevenly disciplines, and boards unevenly share information with other disciplinary agencies.[286] This raises questions about why this variation occurs and if, perhaps, boards are not sufficiently concerned about sanctions to behave in similar ways.

The second concept is general deterrence.[287] Criminologists theorize that punishment does more than just teach the person undergoing the punishment a lesson.[288] It extends that lesson to other would-be wrong-doers by showing what could happen to them were they to get caught.[289] In this way, punishment serves as a mechanism of "general deterrence," preventing crime on the whole by making an example of those who are caught.[290] Boards fail to achieve general deterrence because they inadequately sanction organizations that fail to report, inadequately discipline physicians, and do not collaborate with other disciplinary organizations to keep physicians who do harm away from the public.[291] These failures add up to a missed opportunity to make an example out of bad actors and wayward organizations and to prevent others from behaving the same way.[292]

The strategies I propose below are designed to achieve both isomorphism and general deterrence, particularly since the fifty-six recommendations proposed consensually by the Delphi panel that McIntosh et al. convened are oriented around these two processes, even though they do not use these exact terms.[293] The Delphi panel captured these goals in the following statement:

> [W]e sought to identify cutting-edge and particularly effective practices, resources and statutory provisions that SMBs can use to more uniformly: 1) encourage and enable reporting of physicians who engage in egregious wrongdoing, 2) investigate physicians who have been accused of egregious wrongdoing, 3) discipline physicians determined to have engaged in egregious wrongdoing, and 4) deter physicians from engaging in egregious wrongdoing, protect and empower patients and increase transparency.[294]

285. McIntosh et al., *supra* note 5, at 5–6.

286. *Id.* at 5–7.

287. Williams & Hawkins, *supra* note 280, at 546.

288. *Id.*

289. *Id.* at 547.

290. *See id.* (noting how "the perceived threat or fear" of punishment deters people).

291. *See* HOROWITZ, *supra* note 1, at 82, 84 (providing examples of boards' failures); McIntosh et al., *supra* note 5, at 5–6.

292. *See* HOROWITZ, *supra* note 1, at 4, 294 (providing an example of such a failure and noting how failures allow physicians to continue practicing which "adversely affects the public interest").

293. McIntosh et al., *supra* note 5, at 6; Pendo et al., *supra* note 5, at 15.

294. McIntosh et al., *supra* note 5, at 6.

Here, the word "uniformly" speaks to isomorphism and the word "deter" speaks to general deterrence.[295]

Until now, this Article has been organized around the movement of problems into and out of the board—from input to processing to output. However, I begin the solutions section with processing barriers because these are the most important, and they are the changes that will make the other two solutions more effective. Think about it this way: if a car engine is not working, it does not help to provide it with more fuel or to fix the exhaust. Only when the engine itself is fixed will it efficiently process fuel and produce exhaust. The same is true with boards. When boards fail to sanction physicians for the egregious harms about which they know, it does not help to inform them about *more* egregious harms. Doing so only creates more opportunities for failure. We also cannot expect boards that fail to punish bad physicians to report those physicians to other boards or to law enforcement—if boards cannot handle their own problems, how can they communicate those problems to others? We must begin, then, by fixing the board's engine, the way that it processes cases.

A. Processing: Changing the Way Boards Do Business

Boards are not doing their jobs. Too many physicians get away with causing egregious harm to patients, even when boards are made aware of their misdeeds.[296] I explained in a previous Section how fundamental tensions between professional identity and board goals result in processing barriers such as the white wall of silence, involvement of physician experts in disciplinary decisions, and buffering impaired professionals—which prevent boards from sanctioning physicians who do egregious harm.[297] Removing these barriers requires rethinking who serves on the board and identifying how powerful organizations can motivate boards to change.

Two remedies are available to tear down the white wall of silence that prevents board members from sanctioning fellow professionals: either rules need to change to motivate existing board members to act in the public interest or the composition of the board needs to change to bring on more public members who do not struggle with the tension between professional identity and public protection.

To change the rules, we first must ask which organizations have coercive power over boards. Three immediately come to mind: the National Governors Association (NGA), the National Conference of State Legislatures (NCSL), and

295. DiMaggio & Powell, *supra* note 112, at 149; Williams & Hawkins, *supra* note 280, at 546.

296. *Sexual Violation of Patients by Physicians*, *supra* note 10, at 504. HOROWITZ, *supra* note 1, at 169–70; McIntosh et al., *supra* note 5, at 5–6; Pendo et al., *supra* note 5, at 13.

297. *See infra* Section III.B.

the FSMB.[298] Governors and legislatures are responsible for appointing medical board members, legislatures create states' medical practice acts, and the FSMB develops best practices for boards.[299] However, governors and legislatures are as varied as the boards themselves, so they are not terribly effective forces for achieving isomorphism. That is why umbrella organizations like the NGA, the NCSL, and the FSMB offer so much promise.[300] When they work together to set standards for boards and state medical practice acts, we are likely to see states adopt the recommended practices and begin to behave similarly.[301] These organizations also have power to encourage states to restructure boards when boards prove ineffective at protecting the public.

California's medical board offers an illustrative case. For decades, the Medical Board of California had operated relatively independently with its own investigators that worked for it exclusively, but like many other boards, it had failed to adequately regulate those physicians who engaged in egregious harm. In 2013, the California legislature "threatened to dissolve the agency unless it 'show[ed] significant progress' in protecting patients from dangerous doctors."[302] When the board failed to meet legislators' demands, legislators restructured the board and moved their investigators into a new unit under the umbrella of the Department of Consumer Affairs, making medical board investigators part of a pool of investigators shared with other boards in the state.[303] This strong-arm move on the part of the legislature was a way of punishing the medical board for failure to act, though watchdog groups point to mixed evidence that restructuring helped to protect patients.[304] I am not suggesting that all legislatures follow California's model. However, I am suggesting that those with power over boards have both carrots and sticks at their disposal: organizations like NGA, NCSL, and the FSMB can encourage boards to adopt standards that prioritize patient welfare over protecting physicians,

298. *Federation of State Medical Boards*, FED'N OF STATE MED. BDS., https://www.fsmb.org/ (last visited Oct. 9, 2021) [hereinafter *FSMB Homepage*]; NAT'L CONF. OF STATE LEGISLATURES., https://www.ncsl.org/bookstore/state-legislatures-magazine.aspx (last visited Oct. 9, 2021); NAT'L GOVERNORS ASS'N., https://www.nga.org/ (last visited Oct. 9, 2021).

299. *FSMB Homepage*, *supra* note 298; NAT'L CONF. OF STATE LEGISLATURES, *supra* note 298; NAT'L GOVERNORS ASS'N, *supra* note 298.

300. NAT'L CONF. OF STATE LEGISLATURES, *supra* note 298; NAT'L GOVERNORS ASS'N, *supra* note 298.

301. DiMaggio & Powell, *supra* note 112, at 152.

302. Lisa Girion & Scott Glover, *Legislators Threaten to Kill State Medical Board*, L.A. TIMES (Apr. 11, 2013, 12:00 AM), https://www.latimes.com/local/la-xpm-2013-apr-11-la-me-0412-rx-medical-board-threat-20130412-story.html.

303. *Struggles with Delay in Doctor Discipline; Despite Effort at Reform, Cases Are Taking Longer to Resolve*, CONSUMER WATCHDOG (Mar. 10, 2016, 4:00 PM), https://www.consumerwatchdog.org/california-struggles-delay-doctor-discipline-despite-effort-reform-cases-are-taking-longer-resolve.

304. *Id.*

while governors and legislatures can impose sanctions on boards that fail to fulfill their mission. It is important to note that board structure varies by state, so interventions would have to be tailored to each state context, but the general point remains the same—powerful organizations can compel boards to honor their mission.[305]

Changing the rules of the game is one approach; another is changing the players.[306] It is a common saying that "it is hard to teach an old dog new tricks." To that end, it is difficult to upend deeply entrenched cultural values and professional identities that motivate physicians to protect their own.[307] If trying to get physician board members to behave otherwise promises to be a strenuous and fruitless task, then changing the composition of the boards may be more generative. The current structure of most boards allows for public members, but as I described earlier, and as Horowitz describes in detail, those members are often marginalized and are occasionally prevented from participating in some of the most consequential board decisions.[308] As a result, they sometimes serve a symbolic function more than an instrumental one.[309]

McIntosh and her colleagues suggest that diversifying the board in terms of race and class could result in better outcomes, as could having a role-diverse investigatory team.[310] Diversification sounds appealing, and I agree that more diversity is necessary, but to have the most impact we should go beyond enhancing diversity to focus on redistributing power.[311] The impetus behind diversification rests on standpoint theory—that is, the idea that people with different social positions in terms of race, class, gender, ability, sexuality, religion, etc. have different life experiences that lead them to approach problems differently, and as a result, they have different things to offer to the process of collective decision-making.[312] However, people who are diverse across one social category, such as race or gender, are not necessarily diverse across other

305. DiMaggio & Powell, *supra* note 112, at 154; *FSMB Homepage*, *supra* note 298; Denise F. Lillvis & Robert J. McGrath, *Directing Discipline: State Medical Board Responsiveness to State Legislatures*, 42 J. HEALTH POLS., POL'Y & L. 123, 149–50 (2017).

306. *See* SCOTT & DAVIS, *supra* note 27, at 336 (noting external players complicate the world for organizational participants by making demands on what organizations could or should be doing).

307. BECKER ET AL., *supra* note 177, at 419; KELLOGG, *supra* note 177, at 176, 199; GIBSON & SINGH, *supra* note 183, at 136; Morreim, *supra* note 183, at 24.

308. HOROWITZ, *supra* note 1, at 64–65.

309. DAVE ELDER-VASS, THE REALITY OF SOCIAL CONSTRUCTION 61, 63 (1967).

310. McIntosh et al., *supra* note 5, at 10, 14–15; Pendo et al., *supra* note 5, at 23–24.

311. ELLEN BERREY, THE ENIGMA OF DIVERSITY: THE LANGUAGE OF RACE AND THE LIMITS OF RACIAL JUSTICE 35 (2015).

312. PATRICIA HILL COLLINS, BLACK FEMINIST THOUGHT: KNOWLEDGE, CONSCIOUSNESS, AND THE POLITICS OF EMPOWERMENT 300 (Heidi Freund ed., Taylor & Francis e-Library 2000).

social categories, such as professional identity.[313] It might be the case that a male physician and a female physician see the world differently, but they are both physicians who have been deeply socialized into the norms of the field.[314] Therefore, we could expect the female physician to make decisions that more closely resemble those of the male physician compared to those of a female public member, especially if professional identity trumps other kinds of identity.

Representation, then, is not enough to solve the problem of professional cohesion.[315] Diversity of perspective promises to offer more than mere demographic diversity and that diversity must be sufficiently represented to prevent the problems of tokenism.[316] That is why legislatures should think very strategically about how many public members to include on the board, and governors should think very strategically about whom to appoint as board members. When it comes to problems of egregious harm like sexual assault, feminist and anti-racist perspectives are particularly important.[317] Boards should invite public members who are already critical thinkers—members like Horowitz, who belong to another profession but who bring their own body of knowledge and professional expertise along with them.[318]

Including more non-physician experts does not solve every problem inherent to board composition—public members can represent the public, but they do not have enough expertise to make sense of the nuances of medical practice.[319] However, since many of the egregious harms perpetuated by physicians are social and cultural rather than technical in nature, board members with independent professional expertise in gender inequality, rape culture, substance use disorder, and other areas are particularly well-poised to address these issues in a board setting.[320] As Horowitz notes, "doctors are trained to make an expert call in cases involving technical medical issues, but they cannot legitimately claim particular expertise to pass judgment on a problem physician's character or to assess the balance of anticipated and unanticipated consequences that a particular board holding will set in motion."[321] Efforts to constrain egregious harm that derives from social, rather than medical, problems is what motivated

313. Kimberle Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color*, 43 STAN. L. REV. 1241, 1296, 1299 (1991).

314. BECKER ET AL., *supra* note 177, at 419; KELLOG, *supra* note 177, at 199.

315. ROSABETH MOSS KANTER, MEN AND WOMEN OF THE CORPORATION 6 (1993).

316. Alison Cook & Christy Glass, *The Power of One or Power in Numbers? Analyzing the Effect of Minority Leaders on Diversity Policy and Practice*, 42 WORK & OCCUPATIONS 183, 203 (2015); KANTER, *supra* note 315, at 282.

317. COLLINS, *supra* note 312, at 158; Crenshaw, *supra* note 313, at 1274.

318. HOROWITZ, *supra* note 1, at vii.

319. *Id.* at 63.

320. *Id.* at 26–27.

321. *Id.* at 5.

the movement to include public members on medical boards in the first place.[322] It is also why professional experts are such an asset to boards today.[323]

However, it is important to prevent these non-medical experts from being sidelined as public board members so often are.[324] The organizational theorist Rosabeth Moss Kanter offers a powerful solution.[325] Speaking to corporations that tend to tokenize, sideline, and vilify members of minority groups, such as women and people of color, Kanter proposes bringing in a critical mass of minority group members. This approach would ensure that minority group members' voices are amplified so that they can make real change and not just serve as symbolic markers of the corporation's openness to diversity.[326] Her work on corporations is applicable to organizations more generally, including boards.[327] The lesson boards can take from Kanter's work is that adding more public members and lowering the physician-to-public-member ratio can upset entrenched power dynamics and allow for a more critical approach to discipline.[328] The benefit of these kinds of changes is that they create opportunities to honor the nuances in the kinds of harm perpetuated and arrive at appropriate sanctions.[329] Once boards process cases more effectively, we can turn our attention to input and output barriers.[330]

B. Inputs: Routinizing Reporting

Hospitals and clinics often fail to report physician harms to boards, and it is easy to see why.[331] Pendo et al. spell out the potential negative consequences that might accompany reporting, such as loss of revenue, loss of patients, and insurance companies' unwillingness to pay for the provider's services.[332] They argue that boards should levy fines against hospitals and academic medical centers for failing to report instances of egregious wrongdoing.[333]

From a sociological perspective, this is yet another challenge related to isomorphism, one that requires looking more broadly at the health care field.[334] Viewed in isolation, individual organizations' failure to report to boards makes sense for all of the reasons that Pendo, McIntosh, and their colleagues

322. *Id.*; SHIMBERG ET AL., *supra* note 76, at 264.
323. HOROWITZ, *supra* note 1, at vii.
324. KANTER, *supra* note 315, at 156.
325. *Id.* at 11.
326. *Id.*
327. *Id.* at 3.
328. *See id.* at 199, 200, 202–03.
329. KANTER, *supra* note 315, at 284.
330. *Id.*
331. *See generally* Pendo et al., *supra* note 5.
332. *See id.* at 28–29 ("Risks to public reputation and financial standing are frequently cited as disincentives to reporting, and there is often a lack of consequences for failure to report.").
333. *Id.*; McIntosh et al., *supra* note 5, at 13.
334. DiMaggio & Powell, *supra* note 112, at 149.

identify.[335] However, there is a bigger picture that must also be considered. That is, the norm across the health care field is to not report.[336] Doing so invites a host of negative consequences, while failing to do so has few repercussions.[337] Health care is a competitive business. Hospitals and clinics compete against one another for revenue, patients, and the top providers.[338] When organizations are transparent about the harms their providers inflict, they place themselves at significant disadvantage vis-à-vis their peer institutions.[339] Since most organizations do not report, doing so makes the organization stand out as a bad organization instead of as an honest one.[340]

To think about this problem in a different context, lack of reporting and lack of sanctions for not reporting help explain why universities so often fail to disclose Title IX offenses.[341] Like health care, education is a competitive field and universities have the added challenge of convincing parents to send their newly adult children to reside with them for four years.[342] Reporting Title IX offenses can indicate that a university is dangerous and can motivate parents to send their children elsewhere.[343] Universities that do not report Title IX offenses look safer to parents, even if they have as many (or even more) offenses than universities that report.[344]

In both education and health care, uneven reporting offers some organizations protection and allows them to capitalize on assumptions that they are safer than their competitors.[345] Given these perverse incentives, boards must find a way to reverse the motivations that guide the field.[346] That is, they must find a way to make reporting the norm and not the exception.[347] If everyone reports, the competitive advantage that comes from not reporting disappears and hospitals and clinics will be more likely to report if failing to do so comes at a cost.[348]

335. Pendo et al., *supra* note 5, at 28–29; McIntosh et al., *supra* note 5, at 5–6.

336. Pendo et al., *supra* note 5, at 28.

337. *Id.*

338. SCOTT ET AL., *supra* note 35, at 142.

339. Yung, *supra* note 159, at 6.

340. *Id.*

341. Dunn, *supra* note 27, at 556; Leon, *supra* note 27, at 1015, 1021; Yung, *supra* note 159, at 5, 7.

342. Doug Lederman, *Four-Year-College Leaders Not Feeling Ready for the Future*, INSIDE HIGHER ED. (Oct. 22, 2019), https://www.insidehighered.com/digital-learning/article/2019/10/22/four-year-college-leaders-not-feeling-ready-future.

343. Yung, *supra* note 159, at 6.

344. *Id.*

345. *See id.*

346. DiMaggio & Powell, *supra* note 112, at 149.

347. *Id.*

348. *Id.*

The question is what kinds of costs motivate organizations to behave differently? Pendo et al. and others, such as Patricia King of the FSMB, argue that the threat of a fine will elicit more reporting.[349] However, making fines the key strategy for overcoming input barriers overlooks a number of challenges. First, organizations might simply fold the fine into the normal costs of doing business, especially if refusing to report brought in more money than the fine cost.[350] Second, boards have few ways of knowing if unreported wrongdoing is occurring, making it difficult to levy a fine.

I suggest that pairing fines with other strategies will be more effective. Fines are a material resource, and they are certainly important to organizations. However, organizations thrive on symbolic resources as well, such as reputation.[351] Boards can threaten the organizations' reputations by publicly sanctioning those that fail to report or that inadequately report.[352] They can create grades similar to those doled out by the health department and make reporting a key factor for determining those grades.[353] This would be especially powerful if boards published these grades and used them to compare peer institutions.[354] And boards can use their audit power to uncover wrongdoing that would not otherwise come to light. Together, fines and public broadcasting of organizations' wrongdoing, paired with audits, are likely to convince organizations that failing to report simply is not worth the cost. Putting these strategies in place to increase inputs raises questions about how to improve outputs.

C. Outputs: Standardizing Communication[355]

Output barriers are fundamentally a communication problem. Boards lack systematic ways to communicate with other boards and with law enforcement. Developing these communication pathways could go a long way towards stopping harm to patients.

Technology could help to improve communication among boards. Software engineers could create systems that automatically alert a board when one of its

349. Patricia A. King et al., *State Medical Board Recommendations for Stronger Approaches to Sexual Misconduct by Physicians*, 325 JAMA 1609, 1610 (2021). *See* Pendo et al., *supra* note 5, at 27, 29 (providing model language to authorize penalties against hospitals and other entities for failure to report); McIntosh et al., *supra* note 5, at 13 (recommending that a board fine "hospitals and academic medical centers for failure to report instances of egregious wrongdoing").

350. Dorothy S. Lund & Natasha Sarin, The Cost of Doing Business: Corporate Crime and Punishment Post-Crisis 40 (Feb. 17, 2020) (unpublished manuscript) (on file with the University of Pennsylvania Carey School of Law Legal Scholarship Repository).

351. SCOTT & DAVIS, *supra* note 27, at 184–85.

352. Sharon Yadin, *Regulatory Shaming*, 49 ENV'T. L. 407, 415–16, 426 (2019).

353. Janet Fleetwood, *Scores on Doors: Restaurant Hygiene Ratings and Public Health Policy*, 40 J. PUB. HEALTH POL'Y 410, 410–11, 415 (2019).

354. Yadin, *supra* note 352, at 415–16, 426.

355. NSF Award No. 1753308, *supra* note 18.

licensees is under investigation by another board. This could be created through the FSMB, who could urge boards to participate in the system. Boards would then designate liaisons to communicate with other boards about the case and provide the evidence they can provide within the bounds of the law. This kind of isomorphic process would help to prevent the kind of buffering that often occurs at the board level because it would take discretion about sharing a case against a physician out of the hands of board members, who are likely to be somewhat sympathetic to physicians, and instead create a systematic mechanism for sharing cases across locales.

Boards can improve communication with law enforcement by having a law enforcement liaison who works with criminal investigators within the bounds of the law to share information about cases. They could also encourage law enforcement to have designated liaisons who work with boards. Opening these channels of communication could tamp down on the frustration and resentment that boards and law enforcement feel towards one another and could prevent problems like "burning" undercover investigations or refusing to share information necessary to complete a board case.[356] Systematically linking these organizations would likely be far more effective than the one-off interpersonal communication that occurs now.

V. CONCLUSION

We began this symposium by asking why medical boards that have a duty to protect the public so often fail to do so—that is, why they fail to use their harshest punishments even in the most egregious cases. Pendo, McIntosh, and their colleagues offer one set of answers that center on absent resources that board members say they need to help them do a better job disciplining physicians.[357] Based on my reading of their research findings, I am convinced that resources matter, but I think that organizational and cultural factors have an equal role to play. I have demonstrated three forms of barriers—input barriers, processing barriers, and output barriers—that prevent boards from fully disciplining physicians who impose egregious harm. Organizational tendencies to buffer and circulate their members help explain each of these barriers—why hospitals and clinics do not report to boards, why boards do not enact harsher discipline, and why boards do not share information with boards in other states and with law enforcement.[358]

My framework suggests that beyond providing boards with the resources they need, we also need to disrupt the organizational processes that prevent disciplinary cases from moving forward and to change the incentives that hospitals, clinics, and boards face to protect physicians. When organizations

356. Chiarello, *supra* note 114, at 12–13; NSF Award No. 1753308, *supra* note 18.

357. McIntosh et al., *supra* note 5, at 10–15; Pendo et al., *supra* note 5, at 15.

358. Chiarello & Morrill, *supra* note 26, at 159.

buffer and circulate physicians instead of disciplining them, they not only fail to punish past harm, but also help to facilitate future harm.[359] And there is no doubt that these maneuvers fail to serve the public interest.

359. *Id.* at 160; Lilienthal & Mowrey, *supra* note 137.