2022

Protecting Patients from Physicians Who Inflict Harm: New Legal Resources for State Medical Boards

Elizabeth Pendo
Saint Louis University School of Law, ependo@uw.edu

Tristan McIntosh
Washington University School of Medicine

Heidi Walsh
affiliation not provided

Kari Baldwin
Washington University in St. Louis School of Medicine

James M. Dubois
Saint Louis University

No. 2022-05

Protecting Patients from Physicians Who Inflict Harm: New Legal Resources for State Medical Boards

Elizabeth Pendo
Saint Louis University School of Law

Tristan McIntosh
Washington University School of Medicine

Heidi Walsh
affiliation not provided to SSRN

Kari Baldwin
Washington University in St. Louis School of Medicine

James M. Dubois
Saint Louis University

15(1) Journal of Health Law and Policy 1 (forthcoming 2022)

PROTECTING PATIENTS FROM PHYSICIANS WHO INFLICT HARM: NEW LEGAL RESOURCES FOR STATE MEDICAL BOARDS

ELIZABETH PENDO,* TRISTAN MCINTOSH,** HEIDI A. WALSH,*** KARI BALDWIN**** & JAMES M. DUBOIS*****

ABSTRACT

State medical boards (SMBs) protect the public by ensuring that physicians uphold appropriate standards of care and ethical practice. Despite this clear purpose, egregious types of wrongdoing by physicians are alarmingly frequent, harmful, and under-reported. Even when egregious wrongdoing is reported to SMBs, it is unclear why SMBs sometimes fail to promptly remove seriously offending physicians from practice. Legal and policy tools that are targeted, well-informed, and actionable are urgently needed to help SMBs more effectively protect patients from egregious wrongdoing by physicians.

Past reviews of SMB performance have identified features of SMBs associated with higher rates of severe disciplinary actions against physicians, including political and professional independence and adequate funding and staffing. However, there has been little attention paid to elements of the state-level legal framework that governs SMB licensing and disciplinary function, or what legal or policy tools would make SMBs more effective at protecting patients in serious cases.

* Elizabeth Pendo, Joseph J. Simeone Professor of Law, Center for Health Law Studies, Saint Louis University School of Law. Thank you to the Greenwall Foundation for providing funding for this project, the Center for Health Law Studies at Saint Louis University School of Law for hosting a symposium to present our findings, and to the Journal of Health Law and Policy for this symposium issue. Thank you also to Jessie Bekker (J.D., MHA anticipated, May 2023), Darian Diepholz, MBA, MPH, CHES (J.D. anticipated, May 2022), Caro Haglof (J.D. anticipated, May 2023), Julia McFarland (J.D. May 2021), and Maddy Quoss (J.D. May 2021) for excellent research assistance.
** Tristan McIntosh, PhD, Assistant Professor of Medicine, Bioethics Research Center, Washington University School of Medicine.

*** Heidi A. Walsh, MPH, CHES Senior Project Manager, Bioethics Research Center, Washington University School of Medicine.

**** Kari Baldwin, Senior Project Manager, Bioethics Research Center, Washington University School of Medicine.

***** James M. DuBois, Steven J. Bander Professor of Medical Ethics and Professionalism, Professor of Psychology and Brain Sciences, Bioethics Research Center, Washington University School of Medicine.

This Article offers solutions in the form of model language with commentary for five high-impact statutory provisions that address board composition and function, reporting to the board, and adjudication of disciplinary matters. It brings together consensus recommendations from an expert panel, the results of legal mapping of relevant state laws, and original legal and policy analysis. The model provisions and commentary are intended to serve as a new resource for SMBs, state legislatures, and other policymakers to encourage and support examination of existing medical practice acts to improve SMB function and better protect patients from harmful physicians.

TABLE OF CONTENTS

I. INTRODUCTION

In 2017, Larry Nassar was convicted on federal child pornography charges and multiple counts of criminal sexual misconduct under state law.[1] Nassar, a former Michigan State University physician and USA Gymnastics team doctor, committed thousands of sexual assaults under the guise of medical treatment until his arrest in the summer of 2016, following an exposé published in the Indianapolis Star.[2] For more than twenty years, girls, women, and parents raised complaints about Nassar's conduct to a number of authorities, including university coaches and trainers, university police, a counselor, the Title IX office, local police, private coaches, the USA Gymnastics Organization, and the U.S. Olympic & Paralympic Committee.[3] Despite these reports, Nassar continued to treat—and sexually abuse—patients until his arrest. In 2018, Michigan State University agreed to pay $500 million to settle lawsuits brought by 332 of Nassar's victims.[4] The same year, the Michigan Board of Osteopathic Medicine and Surgery permanently revoked Nassar's license based on his 2017 convictions.[5]

In 2020, Javaid Perwaiz was convicted on fifty-two counts of fraud related to medically unnecessary hysterectomies, sterilizations, and other invasive procedures performed over a ten-year period.[6] According to a recent in-depth investigation, there were clear signs of Perwaiz's behavior.[7] For at least thirty-five years, patients filed lawsuits, nurses raised concerns, a hospital revoked his privileges, and an insurance company identified him as an "extreme outlier" in certain procedures. In 1984, the Virginia Board of Medicine found that Perwaiz performed more than a dozen hysterectomies that were not medically necessary and were contrary to the standard of care. Despite this finding, the Board elected

1. JOAN MCPHEE & JAMES P. DOWDEN, REPORT OF THE INDEPENDENT INVESTIGATION: THE CONSTELLATION OF FACTORS UNDERLYING LARRY NASSAR'S ABUSE OF ATHLETES 30 (2018), https://www.nassarinvestigation.com/en.

2. *Id.* at 1; Tim Evans et al., *Former USA Gymnastics Doctor Accused of Abuse*, INDIANAPOLIS STAR, https://www.indystar.com/story/news/2016/09/12/former-usa-gymnastics-doctor-accused-abuse/89995734/ (last updated Jan. 24, 2018).

3. MCPHEE & DOWDEN, *supra* note 1, at 47.

4. Mitch Smith & Anemona Hartocollis, *Michigan State's $500 Million for Nassar Victims Dwarfs Other Settlements*, N.Y. TIMES (May 16, 2018), https://www.nytimes.com/2018/05/16/us/larry-nassar-michigan-state-settlement.html.

5. *LARA Permanently Revokes Nassar's Medical License, Issues Largest Fine in Department History*, MICH. DEP'T. OF LICENSING & REGUL. AFFS. (Apr. 6, 2018), https://www.michigan.gov/lara/0,4601,7-154-11472-465774--,00.html.

6. U.S. Atty's Off., E.D. Va., *Jury Convicts Doctor of Scheme to Perform Unnecessary Surgeries on Women*, U.S. DEP'T OF JUST. (Nov. 9, 2020), https://www.justice.gov/usao-edva/pr/jury-convicts-doctor-scheme-perform-unnecessary-surgeries-women.

7. Adrienne Mayfield et al., *The Patients v. Perwaiz*, WAVY.COM (2021), https://www.wavy.com/the-patients-v-perwaiz/. The facts provided in this description are drawn from the factual findings in this ten-part report, unless noted otherwise.

to censure him for bad recordkeeping and "lack of judgment" in connection with a sexual relationship with a patient but allowed him to continue seeing patients. Patients filed similar charges with the Board in 1991 and again in 2012, but no disciplinary action was taken. Perwaiz continued to see patients and perform surgeries until he was charged in 2019.

In 2011, Paul Volkman was convicted on multiple federal counts of unlawful distribution of a controlled substance, including four counts that the illegal distribution resulted in the deaths of four people.[8] When he could no longer obtain malpractice insurance, Volkman began working at an Ohio pain clinic in 2003 with approval from the U.S. Drug Enforcement Agency (DEA) to prescribe controlled substances.[9] Despite complaints from physicians and pharmacists, concerns raised during a pharmacy board inspection, raids by the DEA and local police, and multiple patient deaths from 2003 to 2006, Volkman continued to see patients and prescribe controlled substances until the DEA suspended his registration in 2006.[10] The Medical Board of Ohio suspended Volkman's license based on the DEA's suspension of registration, and the Board ultimately revoked his license in December 2008.[11]

These and other high-profile cases highlight the need to improve institutional responses to reports of egregious wrongdoing by physicians.[12] This Article focuses on the critical, yet under-examined, role of state medical boards (SMBs) to regulate medicine and protect the public from the physicians who commit these wrongful acts. There are seventy-one SMBs in the U.S., comprised of one or more boards in each state, the District of Columbia, and U.S. territories.[13] SMBs protect the public by ensuring that physicians uphold

8. *Jury Convicts Physician of Illegally Prescribing Pills That Led to Deaths of Four People*, DRUG ENF'T ADMIN. (May 10, 2011), https://www.dea.gov/press-releases/2011/05/10/jury-convicts-physician-illegally-prescribing-pills-led-deaths-four.

9. Volkman v. U.S. Drug Enf't Admin., 567 F.3d 215, 217 (6th Cir. 2009).

10. *Id.* at 218–19.

11. *License Look-Up*, ELICENSE OHIO PRO. LICENSURE, https://elicense.ohio.gov/OH_HomePage (last visited May 31, 2021); *see also* Decision and Final J. Entry Affirming the State Med. Bd. of Ohio's Permanent Revocation of App.'s Certificate To Prac. Med. and Surgery at 1, Paul H. Volkman v. State Med. Bd. of Ohio C.P. No. 08CVF12-18288 (April 29, 2011), https://med.ohio.gov/formala/35070722.pdf.

12. *See, e.g.*, Shawn Hubler et al., *U.S.C. Agrees to Pay $1.1 Billion to Patients of Gynecologist Accused of Abuse*, N.Y. TIMES (Mar. 25, 2021), https://www.nytimes.com/2021/03/25/us/usc-settlement-george-tyndall.html; *Explore the AJC's Investigation of Physician Sexual Misconduct*, ATLANTA J.-CONST., http://doctors.ajc.com/table_of_contents/ (last visited Aug. 27, 2021); Samah Assad & Ron Regan, *Problem Doctors Went Unchecked for Years as the Opioid Crisis Exploded. Here's How We Found Out.*, NEWS 5 ABC CLEV. (Nov. 11, 2018, 4:58 PM), https://www.news5cleveland.com/news/local-news/investigations/problem-doctors-went-unchecked-for-years-as-the-opioid-crisis-exploded-heres-how-we-found-out.

13. *Contact a State Medical Board*, FED'N OF STATE MED. BDS., https://www.fsmb.org/contact-a-state-medical-board/#AL (last visited Oct. 18, 2021).

appropriate standards of care and ethical practice.[14] To achieve this aim, state laws authorize SMBs to regulate physician licensing and discipline to achieve this aim, although there are variations among the states.

Despite this clear purpose, sexual abuse of patients and other serious types of wrongdoing by physicians are alarmingly frequent, harmful, and under-reported. This project focuses on egregious wrongdoing—which we define as a clear violation of codes of ethics, law, or both—that directly harms patients and, if found to be true, would merit suspension or revocation of a physician's medical license (e.g., sexual abuse of patients, unnecessary invasive procedures, or improper prescribing of controlled substances).[15] Egregious forms of wrongdoing by physicians are often not reported to SMBs.[16] Even when reported to SMBs, boards often fail to take serious disciplinary action against physicians.[17] Studies and investigations have found that physicians were allowed to continue practicing medicine and continued committing egregious offenses even after being referred to SMBs.[18] It is unclear why SMBs sometimes fail to promptly remove seriously offending physicians from practice. This suggests that targeted, expert-informed, and actionable legal and policy tools are urgently needed to help SMBs more effectively protect patients from egregious wrongdoing by physicians.

14. FED'N OF STATE MED. BDS., U.S. MEDICAL REGULATORY TRENDS AND ACTIONS 8 (2018), https://www.fsmb.org/siteassets/advocacy/publications/us-medical-regulatory-trends-actions.pdf. While some state boards regulate non-physician licensees as well as physician licensees, we focus here on board authority to address egregious wrongdoing by physicians.

15. James M. DuBois et al., *Preventing Egregious Ethical Violations in Medical Practice: Evidence-Informed Recommendations from a Multidisciplinary Working Group*, 104 J. MED. REGUL., Dec. 1, 2018, at 23, 23.

16. *See* James M. DuBois et al., *Exploring Unnecessary Invasive Procedures in the United States: A Retrospective Mixed-Methods Analysis of Cases from 2008-2016*, 11 PATIENT SAFETY SURGERY., 2017, at 1, 1 [hereinafter *Exploring Unnecessary Invasive Procedures in the United States*]; James M. DuBois et al., *A Mixed-Method Analysis of Reports on 100 Cases of Improper Prescribing of Controlled Substances*, 46 J. DRUG ISSUES 457 (2016); Gary D. Carr, *Professional Sexual Misconduct - An Overview*, 44 J. MISS. STATE MED. ASS'N. 283, 285 (2003); *see also* Jeff Ernsthausen, *Why a National Tracking System Doesn't Show the Extent of Physician Sexual Misconduct*, ATLANTA J.-CONST., https://doctors.ajc.com/sex_abuse_national_database/?ecmp=doctorssexabuse_microsite_nav (last visited May 31, 2021).

17. John Alexander Harris & Elena Byhoff, *Variations by State in Physician Disciplinary Actions by US Medical Licensure Boards*, 26 BMJ QUALITY & SAFETY 200, 200 (2017); SIDNEY WOLFE & ROBERT E. OSHEL, PUB. CITIZEN'S HEALTH RSCH. GRP., RANKING OF THE RATE OF STATE MEDICAL BOARDS' SERIOUS DISCIPLINARY ACTIONS, 2017-2019 11 (2021), https://www.citizen.org/article/report-ranking-of-the-rate-of-state-medical-boards-serious-disciplinary-actions-2017-2019/.

18. *Exploring Unnecessary Invasive Procedures in the United States*, *supra* note 16; Mayfield et al., *supra* note 7; Danny Robbins, *He Was Caught on Video, but Georgia Doctor Kept His Medical License*, ATLANTA J.-CONST. (Apr. 27, 2018), https://www.ajc.com/caught_on_video_but_kept_georgia_medical_license/.

Studies show that SMBs have widely varying rates of severe disciplinary actions against physicians (e.g., revoking a license) for similar types of egregious wrongdoing.[19] Past reviews of SMB performance have identified features of SMBs associated with higher rates of severe disciplinary actions taken by boards, including political and professional independence and adequate funding and staffing.[20] A prior study of six SMBs described how boards operate and identified strategies for improving board disciplinary actions.[21] However, there has been little attention paid to elements of the state-level legal framework that governs SMB licensing and disciplinary function, or what specific legal or policy tools would make SMBs more effective in protecting patients in serious cases.

This Article offers solutions in the form of model language with commentary for five high-impact statutory provisions that address improved board composition and function, increased reporting to the board, and consistent adjudication of disciplinary matters. The recommendations are based on an innovative project that identified particularly effective SMB practices, resources, and statutory provisions as well as barriers to implementing those practices.[22] From the full findings, we selected five high-impact recommendations appropriate for statutory analysis. The model provisions and commentary in this Article are the first of their kind and are intended to serve as a new resource for SMBs, state legislatures, and other policymakers to encourage and support examination of existing medical practice acts in order to improve SMB function and better protect patients from harmful physicians.

Part I provides an overview of the design and findings of the project, the selection of the five provisions for this Article, and the state law mapping process. Part II provides an overview of the legal framework governing the operation of SMBs with a focus on the procedures and standards set by state-enabling laws (typically referred to as medical practice acts), state administrative laws, and relevant judicial decisions. Part III presents model statutory language with commentary for five high-impact statutory provisions that: (1) mandate gender diversity in SMB membership; (2) mandate racial and ethnic diversity in SMB membership; (3) authorize penalties against hospitals and other entities for

19. WOLFE & OSHEL, *supra* note 17, at 7, 11; Harris & Byhoff, *supra* note 17; SIDNEY M. WOLFE ET AL., PUB. CITIZEN'S HEALTH RSCH. GRP., RANKING OF THE RATE OF STATE MEDICAL BOARDS' SERIOUS DISCIPLINARY ACTIONS, 2004-2006 4 (2007), https://www.citizen.org/article/ranking-of-state-medical-boards-serious-disciplinary-actions-2004-2006/.

20. Harris & Byhoff, *supra* note 17, at 206.

21. Randall R. Bovbjerg et al., *State Discipline of Physicians: Assessing State Medical Boards through Case Studies*, at v (Feb. 2006), https://aspe.hhs.gov/sites/default/files/private/pdf/74616/stdiscp.pdf.

22. 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 5–6, 15–16.

failure to report egregious wrongdoing by physicians; (4) require criminal background check requirements upon renewal of a license; and (5) establish a standard of evidence in disciplinary actions. This Part brings together the expert-informed findings of the project, analysis of existing approaches, and original legal and policy analysis. The results of legal mapping of state approaches for each provision are also included as tables.

II. CONSENSUS RECOMMENDATIONS FROM AN EXPERT PANEL

The purpose of our study was to identify cutting-edge and particularly effective practices, resources, and statutory provisions that SMBs and policymakers can adopt to better protect patients from egregious wrongdoing by physicians. We convened a panel of SMB members and other experts, including physicians, executive members, legal counsel, and public members from approximately fifty percent of the seventy-one SMBs that serve the U.S., District of Columbia, and U.S. territories. Using a modified Delphi panel,[23] expert consensus was reached on fifty-six recommendations that were rated as highly important for SMBs. The findings include fifty-six effective recommendations with at least moderate or strong consensus among panelists, and seven recommendations with weak consensus. The full findings of the modified Delphi consensus panel are published in the Journal of Medical Regulation.[24]

A. Selection of Legal Provisions

From the full findings, we selected five, high-impact recommendations that we believe are most appropriate for statutory analysis. The selected recommendations are: (1) mandate gender diversity in SMB membership, (2) mandate racial and ethnic diversity in SMB membership (these recommendations are addressed together), (3) authorize penalties against hospitals and other institutions for failure to report egregious wrongdoing by physicians, (4) require criminal background check requirements upon renewal of a license, and (5) establish the standard of proof in disciplinary actions.

We first set aside recommendations from the overall findings that SMBs may be able to adopt without the need for state legislative or other external government action. These recommendations will be addressed in a separate paper.[25] For example, three recommendations address reporting of disciplinary complaints, actions, or both in medical school and post-graduate training as a

23. *See* Mark J. Clayton, *Delphi: A Technique to Harness Expert Opinion for Critical Decision-Making Tasks in Education*, 17 EDUC. PSYCH. 373, 377 (1997); James M. DuBois et al., *Curricular Priorities for Business Ethics in Medical Practice and Research: Recommendations from Delphi Consensus Panels*, 14 BMC MED. EDUC., 2014, at 2.

24. McIntosh et al., *supra* note 22, at 6.

25. Tristan McIntosh et al., *What Can State Medical Boards Do To Effectively Address Serious Ethical Violations?* (unpublished manuscript) (on file with author).

condition of licensure.[26] This information is relevant because behavior resulting in disciplinary action during medical school is predictive of disciplinary action by SMBs later in a physician's career.[27] SMBs could obtain this information by adopting a rule or practice requiring licensure applicants to disclose disciplinary complaints, findings, or both, while in medical school and post-graduate training and to sign a waiver permitting the board to verify the information with those institutions. This is the practice followed by State Bars in connection with applications for a license to practice law.[28]

Because the focus of this Article is state statutory law, we also set aside recommendations that are more likely to be adopted by a legal mechanism other than state statutory law. Requiring information sharing between SMBs and the Veteran's Administration, including information about physicians, for example, would require changes to federal policy rather than state law.[29]

We deprioritized recommendations that appeared impracticable or inadvisable. For example, one recommendation calls for raising a potentially broad swath of misdemeanor sexual offenses to the felony level, an area of law far outside the regulation of physicians.[30] Another recommendation suggests routine checks of the Prescription Drug Monitoring Program (PDMP) for suspicious patterns of prescribing or dispensing opioids.[31] A closer examination of emerging literature suggests this approach is unlikely to produce the desired results and may cause other harms.[32]

26. McIntosh et al., *supra* note 22, at 12. The three recommendations are: (1) "Board requires all physicians to report any disciplinary action during medical school at the time of their application (e.g., suspension, warning, probation, expulsion, being requested or allowed to resign in lieu of discipline)"; (2) "Board requires medical schools and post-graduate training programs to report egregious wrongdoing as a condition to licensure eligibility"; and (3) "Board requires medical schools and post-graduate training programs to report any disciplinary complaints about physicians during medical school as a condition for licensure eligibility." *Id.*

27. Maxine A. Papadakis et al., *Unprofessional Behavior in Medical School Is Associated with Subsequent Disciplinary Action by a State Medical Board*, 79 ACAD. MED. 244, 244 (2004).

28. *See, e.g.*, *Character and Fitness*, U. OF HOUS. L. CTR., https://www.law.uh.edu/admissions/apply-now-character-and-fitness.asp (last visited Aug. 23, 2021); AM. BAR ASS'N, STANDARDS AND RULES OF PROCEDURE FOR APPROVAL OF LAW SCHOOLS 2020-2021, at 504 (2020).

29. McIntosh et al., *supra* note 22, at 12; *see also FSMB Calls for Improved Information Sharing Between VA and State Medical Boards*, FED'N OF STATE MED. BDS. (Dec. 1, 2017), https://www.fsmb.org/siteassets/advocacy/news-releases/2017/2017-12-01_house_va_committee_testimony.pdf.

30. McIntosh et al., *supra* note 22, at 11, 13.

31. *Id.*

32. Kelly K. Dineen, Assistant Professor of Law, Creighton University School of Law, Saint Louis University 33rd Annual Health Law Symposium, Defining Egregious Prescribing Misconduct (Mar. 5, 2021); Jennifer D. Oliva, Associate Professor, Seton Hall University School of Law, Saint Louis University 33rd Annual Health Law Symposium, Issues of Bias (Mar. 5, 2021); Jennifer D. Oliva, *Dosing Discrimination: Regulating PDMP Risk Scores*, 110 CALI. L. REV. 47,

Finally, we conducted preliminary legal research to verify the rate of statutory adoption. In some cases, the verified adoption rate differs from the panelist-reported adoption rate, which reflects perceived adoption by board practice or policy. We also reviewed the academic and professional literature related to SMBs and the panel recommendations, as well as comments provided by the panelists as part of the Delphi process, for additional context.

B. Legal Mapping Process

State laws relevant to the five recommendations were collected and coded using policy surveillance standards.[33] The legal mapping process consisted of a complete survey of state laws applicable to SMBs in place between June 1, 2020, and April 1, 2021, that address each of the recommendations. The legal research team[34] used Westlaw, LexisNexis, and SMB websites to search for current laws in all fifty states and the District of Columbia. Because the purpose was to collect data related to SMBs, the laws were primarily drawn from state medical practice acts. The resarch was updated through an effective date of July 1, 2021.

In accordance with quality control standards, ten states were randomly selected to calculate reliability by completing redundant coding. Two researchers would complete the same set of five states. Any discrepancies were discussed and resolved. Results tended to show very high reliability (uniform answers between both researchers), ranging from ninety percent to one hundred percent across the coded variables. If the overall rate of divergence or non-uniform responses of the first ten states were above five percent, the teams would continue redundant coding until the overall rate fell below five percent and created a reliability rate that was greater than ninety-five percent. Divergences were examined by the supervising researcher and resolved within the data set.

The full text of each statute or rule was coded and collected in one step. MonQcle data software[35] was used to code the laws and organize the mapping information. The final list of variables included dichotomous or categorical questions measuring whether states address each of the factors above and, if so, what requirements did the policies include, if any.

50–51, 85–107 (2022) (offering a data science critique of PDMP risk scoring methodology and evaluation of its impact on marginalized patients).

33. *See generally* Scott Burris et al., *Policy Surveillance: A Vital Public Health Practice Comes of Age*, 41 J. HEALTH POLS., POL'Y & L. 1151, 1151–73 (2016).

34. Many thanks to Jessie Bekker (J.D., MHA anticipated, May 2023), Darian Diepholz, MBA, MPH, CHES (J.D. anticipated, May 2022), Caro Haglof (J.D. anticipated, May 2023), Julia McFarland (J.D. May 2021), and Maddy Quoss (J.D. May 2021) for excellent work on the legal mapping process.

35. Ctr. for Pub. Health L. Rsch., *Home*, MONQCLE, https://monqcle.com/ (last visited Aug. 27, 2021).

III. LEGAL BACKGROUND

There are seventy-one SMBs in the U.S., comprised of one or more boards in each state, the District of Columbia, and U.S. territories.[36] SMBs protect the public by ensuring that physicians are competent and adhere to appropriate standards of care and ethical guidelines.[37] Similar to other administrative bodies, SMBs are governed by procedures and standards set by state-enabling laws (typically referred to as medical practice acts), state administrative laws, and relevant judicial decisions. State medical practice acts authorize SMBs to regulate the practice of medicine and administer physician licensing and disciplinary processes. In almost all states, SMBs are authorized to adopt policies, rules, and regulations related to medical practice necessary to achieve these goals.[38] Although there is variation among the states, this Part provides an overview of that legal framework.

A. Board Composition and Structure

Boards vary in size, composition, and structure.[39] They range in size from as large as twenty-one members in Connecticut and Washington to as small as five members in Vermont and New Mexico.[40] According to the Federation of State Medical Boards (FSMB), factors to be considered in determining the size of a SMB include the number of physicians in the state, the composition and function of the SMBs' committees, and the ability to separate prosecutorial and judicial powers within the SMB.[41] The FSMB also advises the size of the board should be sufficient to allow for recusals due to conflicts of interest and absences without hindering final decisions.[42]

State law governs the size and composition of SMBs and provides requirements for board membership. Composition requirements can include board size, number of allopathic and osteopathic physicians, number of public

36. *Contact A State Medical Board*, *supra* note 13.

37. U.S. MEDICAL REGULATORY TRENDS AND ACTIONS, *supra* note 14, at 7–8, 18.

38. These rules are generally published on a SMB's website and may be codified state code. *See, e.g.*, *Administrative Rules*, ALA. BD. MED. EXAM'RS & MED. LICENSURE COMM'N, https://www.albme.org/resources/legal/rules/ (last visited June 1, 2021); ALA. ADMIN. CODE r. 540-X-1-.07 (2018); U.S. MEDICAL REGULATORY TRENDS AND ACTIONS, *supra* note 14, at 50.

39. U.S. MEDICAL REGULATORY TRENDS AND ACTIONS, *supra* note 14, at 6.

40. *Id.* at 47 (number of board members for Vermont and New Mexico reflect Osteopathic Medical Boards).

41. FED'N OF STATE MED. BDS., ELEMENTS OF A STATE MEDICAL AND OSTEOPATHIC BOARD 7 (2015), https://www.fsmb.org/siteassets/advocacy/policies/elements-modern-medical-board.pdf.

42. FED'N OF STATE MED. BDS., GUIDELINES FOR THE STRUCTURE AND FUNCTION OF A STATE MEDICAL AND OSTEOPATHIC BOARD 16 (2021), https://www.fsmb.org/siteassets/advocacy/policies/guidelines-for-the-structure-and-function-of-a-state-medical-and-osteopathic-board.pdf.

members, and the gender, geographical, and racial diversity of board members.[43] SMB members are "typically . . . volunteer physicians and members of the public who are, in most cases, appointed by the governor."[44] However, state medical societies and organizations often suggest candidates.[45]

SMBs are authorized to issue licenses for the general practice of medicine and to investigate and discipline physicians who engage in professional misconduct. Some states have separate medical boards for licensing and disciplining functions, while other states have a single board that performs both functions. For example, Illinois has a Medical Disciplinary Board and a Medical Licensing Board.[46] In comparison, Ohio has one medical board that possesses authority for both licensing and discipline.[47] In addition, some SMBs are independent and possess all licensing and disciplinary authority, while others are part of a larger agency.[48] Most boards also have access to administrative staff, including investigators, licensing specialists, and legal counsel, who may be shared with other state regulatory agencies.[49]

B. Licensing Function

SMBs establish requirements to practice medicine in their specific jurisdictions. Licensing standards ensure that physicians have the required education and training and that they adhere to standards of professional conduct.[50] Generally, physicians must verify their education, training, and work history, and must disclose any information that may affect their ability to practice competently and ethically, such as criminal convictions, malpractice resolutions, and relevant health conditions.[51] For example, as discussed in the next Part, the majority of states require a criminal background check at the time of initial licensure application as a matter of state law or board policy. In participating states, physicians can apply for licensure through the Interstate Medical Licensure Compact to streamline the process of applying in multiple states.[52]

43. FED'N OF STATE MED. BDS., BOARD COMPOSITION: BOARD-BY-BOARD OVERVIEW (2019), https://www.fsmb.org/siteassets/advocacy/key-issues/state-medical-board-composition.pdf; *see, e.g.*, IOWA CODE § 69.16(A), (C) (2009).

44. Bovbjerg et al., *supra* note 21; U.S. MEDICAL REGULATORY TRENDS AND ACTIONS, *supra* note 14, at 6.

45. *See, e.g.*, N.Y. PUB. HEALTH LAW § 230 (McKinney 2020); LA. STAT. ANN. § 37:1263 (2018); *see also* Bovbjerg et al., *supra* note 21.

46. 225 ILL. COMP. STAT. 60/7 (2014); 225 ILL. COMP. STAT. 60/8 (2011).

47. OHIO REV. CODE ANN. § 4731.01 (West 1990).

48. U.S. MEDICAL REGULATORY TRENDS AND ACTIONS, *supra* note 14, at 6.

49. *Id.*

50. *Id.*

51. *Id.*

52. *A Faster Pathway to Physician Licensure*, INTERSTATE MED. LICENSURE COMPACT, https://www.imlcc.org/a-faster-pathway-to-physician-licensure/ (last visited Aug. 26, 2021).

SMBs also evaluate applications of license renewals, typically every one to two years.[53] The renewal process generally requires physicians to show that they have maintained standards of medical practice and ethics, have engaged in continuing medical education, and have not engaged in improper conduct.[54]

C. Disciplinary Process

The majority of SMB time and resources are spent on physician disciplinary issues.[55] Physician disciplinary actions are administrative proceedings. They are distinct from civil malpractice actions (a lawsuit seeking damages for medical care that falls below the standard of care) and criminal prosecutions (prosecution of a defendant for criminal behavior), though the same conduct by a physician may form the basis of more than one type of action.

The physician discipline process is primarily complaint-driven.[56] The majority of complaints are made by patients and their families,[57] although boards also receive information from other SMBs, hospitals and health care organizations, other government agencies, and malpractice insurers.[58] Complaints are screened to determine if they fall under the board's legal jurisdiction. State law defines grounds for physician discipline, which generally include failure to meet accepted standard of care, sexual misconduct, improper prescribing, substance use disorders, felony convictions, and fraud.[59]

If the complaint is within the board's jurisdiction, the complaint is prioritized for investigation.[60] If the board determines there is imminent danger to the public, it may immediately suspend the physician's license pending investigation.[61] The board investigates the facts behind the complaint by gathering records and speaking to the individuals involved. Consistent with due process requirements, the physician is notified of the charges. In cases involving standard of care issues, medical review may be appropriate.[62] In some cases, a board may bring in "an expert with professional credentials in the same specialty as the physician in question . . . to provide an additional opinion about the care provided."[63]

53. U.S. MEDICAL REGULATORY TRENDS AND ACTIONS, *supra* note 14, at 6.
54. *Id.*
55. *Id.* at 7; Bovbjerg et al., *supra* note 21, at vi.
56. Bovbjerg et al., *supra* note 21, at 21.
57. *Id.*
58. U.S. MEDICAL REGULATORY TRENDS AND ACTIONS, *supra* note 14.
59. *Id.*; Nadia N. Sawicki, *Character, Competence, and the Principles of Medical Discipline*, 13 J. HEALTH CARE L. & POL'Y 285, 288, 293 (2010).
60. U.S. MEDICAL REGULATORY TRENDS AND ACTIONS, *supra* note 14, at 10.
61. *Id.*
62. *Id.*
63. *Id*.

Based on the results of the investigation, boards generally have a variety of options under state law.[64] For less serious offenses, for example, the board may issue a letter of concern to the physician (which is typically private), require an appearance before the board, or dismiss the complaint without formal action. In serious cases, the board may file a formal complaint against the physician, leading to disciplinary action (which are typically public).

If the board files a formal complaint, the next step is to schedule a hearing before all or part of the board or, in some states, a hearing officer or administrative law judge.[65] At the hearing, evidence and witnesses are presented. Due process requirements such as the right to an impartial decision maker(s), the right to present evidence, and the right to question adverse witnesses must be observed.[66] Cases may be settled prior to the conclusion of the hearing by agreement of the board and the physician. If the case is not settled, it proceeds to adjudication. The standard of proof or level of evidence required for the board to find a violation has occurred is typically by a "preponderance of evidence" or, less commonly, by "clear and convincing evidence."[67] If a board finds that a violation has occurred and takes disciplinary action, the information becomes part of the physician's public, professional record and is shared with other SMBs.[68]

Physicians have the right to appeal the final decision of the board in state court.[69] Grounds for appeal may include failure to provide due process, unequal treatment compared to others in a similar situation, or bias.[70] To obtain judicial review, courts have stated that one must first exhaust any administrative remedies available before bringing the suit to federal court.[71] For example, under California law, a physician may petition the SMB for reconsideration up to thirty days after the decision was made.[72] The state court reviews the final decision of the board, which will be upheld unless the court finds that the decision is not

64. *Id.*

65. U.S. MEDICAL REGULATORY TRENDS AND ACTIONS, *supra* note 14, at 10.

66. *Id.*

67. *Id.* at 43.

68. *Id.* at 11.

69. *See, e.g.*, Jones v. Conn. Med. Examining Bd., 72 A.3d 1034, 1037–38 (Conn. 2013).

70. Valarie Blake, *Home or Hospital—Your Medical Board Is Watching*, 13 AMA J. ETHICS 707, 709–10 (2011) (discussing grounds for appeal). For more on due process claims, *see also* Mathews v. Eldridge, 424 U.S. 319, 332, 335 (1976) (creating a three-part balancing test to evaluate the constitutional adequacy of administrative procedures for due process claims); *see also Jones*, 72 A.3d at 1040; Firman v. Dep't of State, State Bd. of Med., 697 A.2d 291, 295 (Pa. Commw. Ct. 1997).

71. McCarthy v. Madigan, 503 U.S. 140, 156 (1992).

72. CAL. GOV'T CODE § 11521(a) (West 2005); *see also Medical Board of California: The Enforcement Process*, MED. BD. OF CAL. (Jan. 2019), https://www.mbc.ca.gov/Download/Documents/enforcement-process.pdf; Bonnell v. Med. Bd. of Cal., 82 P.3d 740, 742 (Cal. 2003).

supported by substantial evidence.[73] This is a deferential standard of review used when courts review agency interpretations.[74]

IV. MODEL STATE STATUTORY PROVISIONS AND COMMENTARY

This Part offers model statutory language with commentary for five high-impact statutory provisions that address board composition and function, reporting relevant information to the board, and adjudication of disciplinary matters. It brings together the expert-informed findings of the project, with legal and policy analysis. The commentary includes a clear and concise explanation of the statutory language, including the purpose and justification for the provision, references to approaches taken by the states identified by legal mapping and supporting research, as appropriate. The results of legal mapping of state approaches for each provision are also included as tables. For areas in which more than one approach may support expert consensus or where variations may be desirable, an explanation is provided.

1. Mandate Substantive Gender Diversity of Board Members

2. Mandate Substantive Racial and Ethnic Diversity of Board Members

Model Language

Section 101. Diversity of members of state medical boards

(1) To the extent practicable, the members appointed to the state medical board(s) authorized to issue a license, address professional misconduct, or both shall reflect the geographic, racial, ethnic, and gender diversity of the State.

Existing Approaches

The model language reflects existing approaches to a range of demographic factors, qualifying language, and reference to the demographic composition of the state. It is also in keeping with existing laws that govern other aspects of board composition, such as geographic diversity and diversity of medical specialty.

As shown in Table 1, eight states have statutory language applicable to SMBs that addresses gender diversity, and eight states have statutory provisions that address racial and ethnic diversity with respect to SMBs. The approaches taken by these states vary. Six states combine references to diversity based on gender, race and ethnicity, and other characteristics in a single statutory provision. For example, Maryland requires that SMB composition reflect the

73. *See, e.g.*, Fisch v. Bd. of Registration in Med., 769 N.E.2d 1221, 1226 (Mass. 2002); Gray v. Med. Licensing Bd. of Ind., 102 N.E.3d 917, 923–24 (Ind. Ct. App. 2018); IND. CODE § 4-21.5-5-14(b), (d)(5) (1987).

74. Auer v. Robbins, 519 U.S. 452, 461 (1997).

geographic, racial, ethnic, cultural, and gender diversity of the state, to the extent possible. Other states address diversity based on gender (North Dakota and Iowa) or race and ethnicity (Oregon and Louisiana), but not both.

The intended outcome of these statutory provisions also varies. Four states seek composition of SMB membership that reflects the composition of the state population (Alabama, Arkansas, Maryland, and North Carolina), while a fifth refers to the composition of the population qualified to serve (North Dakota). Three states seek "balanced" boards, without defining what is meant by that term (Iowa, North Dakota, and Oregon). Finally, one state requires, to the extent feasible, the appointment of at least one woman and at least one African-American person (Tennessee).

Three other states require consideration of diversity in some form but focus on the nomination or appointment process rather than the outcome. One state requires, to the extent possible, the governor to take affirmative steps to appoint women and "members of minority groups" (Missouri), and another requires the appointing authorities to consider recommendations from "minority health-related professional associations" (Arkansas). Finally, one state targets the nomination process, requiring the list of nominations prepared for the governor to regularly include at least one "minority appointee" (Louisiana).

Commentary

There are several reasons to support gender, racial and ethnic, and other types of diversity in state board membership (e.g., equality of opportunity, representation, impartiality).[75] In keeping with the purpose of the project, this Article focuses on the impact of diversity on SMB ability to address egregious wrongdoing by physicians. It is also important to establish diversity requirements as a matter of law, rather than solely as a SMB policy or practice. In many states, SMB members are appointed by the governor or a nominating committee through a formal process that relies on nominations from state medical organizations, SMBs, and other sources.[76]

Professional organizations and experts have called for diversity in SMB membership to improve board function. In May 2020, the FSMB adopted a new *Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct* that addresses diversity in terms of board function.[77] In a section titled "Implicit Bias," the report states that "[d]iverse representation on state

75. *See, e.g.*, Yaron Nili, *Beyond the Numbers: Substantive Gender Diversity in Boardrooms*, 94 IND. L.J. 145, 159–64 (2019).

76. U.S. MEDICAL REGULATORY TRENDS AND ACTIONS, *supra* note 14, at 42, 49.

77. Fed'n of State Med. Bds., *Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, J. MED. REGUL., July 2020, at 17–36.

medical boards in terms of gender, age, and ethnicity is important for ensuring balanced discussion and decisions."[78] The section provides:

> In any case that comes before a state medical board, it is important for those responsible for adjudicating the case to be mindful of any personal bias that may impact their review and adjudication. . . . Training about implicit bias is recommended for board members and staff in order to help identify implicit bias and mitigate the impact it may have on their work.[79]

Medical sociologist Ruth Horowitz also addressed the value of diverse SMB membership in her influential account of her experience as a public member of two SMBs and her observations of two other SMBs.[80] She recommended that members of the board be nominated through an open process and selected to "highlight diversity, including regional, ethnic, and gender diversity, and various medical specialties among board members."[81] More recently, the FSMB called for diversity, equity, and inclusion in state board membership and staff to further its commitment to an equitable health care system that addresses structural inequalities and racism in medicine, health care, and medical regulation.[82]

Identifying and addressing implicit bias is important throughout the disciplinary process. The FSMB report highlights the impact of implicit bias in cases involving allegations of sexual misconduct.[83] Other research highlights the impact of implicit bias in cases involving allegations of improper prescribing.[84] Finally, studies of disciplinary complaints filed against attorneys suggest that there may be bias in the type of patients who file complaints and the physician against whom complaints are filed.[85] In addition to mandating diversity, SMBs should require all members to go through formal training and adopt formal practices to minimize the impact of implicit bias.

The positive impact of diversity on group performance is supported by research in other fields. Studies have highlighted that diverse teams may lead to improved and more accurate group thinking, including a more careful and

78. *Id.* at 25.

79. *Id.*

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

81. *Id.* at 181–82.

82. *FSMB Statement on Diversity, Equity and Inclusion in Medical Regulation and Health Care*, FED'N OF STATE MED. BDS. (Apr. 15, 2021), https://www.fsmb.org/advocacy/news-releases/fsmb-statement-on-diversity-equity-and-inclusion-in-medical-regulation-and-health-care/.

83. *See* Patricia A. King et al., *Contextualizing and Strengthening State Medical Board Responses to Physician Sexual Misconduct: Recommendations from the Federation of State Medical Boards*, 15 ST. LOUIS U. J. HEALTH L. & POL'Y 151, 166 (2022).

84. *See* sources cited *supra* note 32.

85. Lissa L. Broome & John M. Conley, *Diversity from the Perspective of Corporate Boards and Lawyer Disciplinary Boards*, 15 ST. LOUIS U. J. HEALTH L. & POL'Y 121, 138 (2022).

deliberative focus on the available facts.[86] In addition, a growing number of studies have linked gender-diverse corporate boards with improved group decision-making and governance.[87]

The model language calls for SMB membership to reasonably reflect the diversity of the state population.[88] Given the well-documented lack of diversity in medicine,[89] the general population of the state may be more diverse than the population of licensed physicians. For example, though about thirteen percent of the U.S. population is Black, only about five percent of physicians are Black.[90]

Still, based on surveys of licensed physicians, the diversity target in the model language is feasible. In terms of gender, according to a national survey conducted by the FSMB, 36.2% of state licensees identified as women in 2020.[91] Representation ranged from a low of 26% (Wyoming and Utah) to a high of 42.5% (Massachusetts).[92] In addition, female physicians outnumbered their male counterparts in younger physician cohorts,[93] suggesting a recent shift toward equitable gender representation in the physician workforce. In terms of race and ethnicity, a national survey conducted by the Association of American Medical Colleges in 2018 found that more than half (56.2%) of active physicians were white.[94] Physicians who identified as Asian made up the second-largest group (17.1%), followed by Hispanic physicians (5.8%) and Black or African

86. David Rock & Heidi Grant, *Why Diverse Teams Are Smarter*, HARV. BUS. REV. (Nov. 4, 2016), https://hbr.org/2016/11/why-diverse-teams-are-smarter. *But see* Kimberly D. Krawiec et al., *The Danger of Difference: Tensions in Directors' View of Corporate Board Diversity*, 2013 U. ILL. L. REV. 919, 920–21, 925, 948 (2013).

87. Nili, *supra* note 75, at 160; Broome & Conley, *supra* note 85, at 142–43.

88. State population data from the Census Bureau's American Community Survey distributed by sex can be found at *Population Distribution by Sex*, KAISER FAM. FOUND., https://www.kff.org/other/state-indicator/distribution-by-sex/ (last visited Sept. 14, 2021); State population data from the Census Bureau's American Community Survey by race/ethnicity can be found at *Population Distribution by Race/Ethnicity,* KAISER FAM. FOUND., https://www.kff.org/other/state-indicator/distribution-by-raceethnicity/ (last visited Sept. 14, 2021).

89. May Lee & John L. Coulehan, *Medical Students' Perceptions of Racial Diversity and Gender Equality*, 40 MED. EDUC. 691, 691, 694–95 (2006); *see also* LISA M. MEEKS & NEERA R. JAIN, ACCESSIBILITY, INCLUSION, AND ACTION IN MEDICAL EDUCATION: LIVED EXPERIENCES OF LEARNERS AND PHYSICIANS WITH DISABILITIES 8–9 (Ass'n of Am. Med. Colls., 2018).

90. Valerie Montgomery Rice, *Diversity in Medical Schools: A Much-Needed New Beginning*, 325 JAMA 23, 23 (2021).

91. *Physician Census: Interactive Census Map*, FED'N OF STATE MED. BDS., https://www.fsmb.org/physician-census/ (last visited Sept. 15, 2021).

92. *Id.*

93. ASS'N OF AM. MED. COLLS., DIVERSITY IN MEDICINE: FACTS AND FIGURES 2019 EXECUTIVE SUMMARY 3 (2019).

94. *Diversity in Medicine: Facts and Figures 2019*, ASS'N AM. MED. COLLS., https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018 (last updated July 1, 2019)

American physicians (5.0%).[95] The survey noted, however, that 13.7% of physicians—the third largest subgroup—were of an unknown race.[96] It may be helpful to partner with organizations that advocate for greater diversity in medicine to capitalize on existing diversity, especially in states where the population of licensed physicians is significantly less diverse than the general population of the state.[97]

The diversity requirements reflected in the model language are not strict mandates because they are tempered by qualifying language (e.g., "to the extent possible"). This could be coupled with a requirement to disclose current board diversity, an explanation from the appointing authority (typically the governor) if the diversity target is not met, or both.[98] Disclosure and explanation would be valuable, as we do not have data on existing diversity in SMB membership across the country.

States may choose to apply diversity requirements beyond the SMB. Maryland's statute, for example, applies to each health occupations board authorized to issue a license or certificate.[99] States may also choose to require additional forms of diversity, such as cultural diversity,[100] disability diversity, or inclusion of board members who identify as LGBTQ+.

Finally, attention should be paid to the intersection of different kinds of diversity in SMB membership. The research on diversity in corporate governance suggests that more attention should be paid to "substantive gender diversity," meaning a real opportunity to make an impact, rather than simple minimum representation.[101] For example, most states require that SMBs include one or more public members.[102] However, public members have a wide range of authority and influence—some may not be voting members or may not play a robust role in disciplinary functions.[103] If individuals appointed as public members also serve as diverse members, the benefits of diversity for the SMB as a group may not be fully realized.

95. *Id.*
96. *Id.*
97. Broome & Conley, *supra* note 85, at 148.
98. *Id.*
99. MD. CODE ANN., HEALTH OCC. § 1-214 (West 2010).
100. *Id.*
101. Nili, *supra* note 75, at 164.
102. U.S. MEDICAL REGULATORY TRENDS AND ACTIONS, *supra* note 14, at 6.
103. *See* David A. Johnson et al., *The Role and Value of Public Members in Health Care Regulatory Governance*, 94 ACAD. MED. 182, 184 (2019); HOROWITZ, *supra* note 80, at 18.

3. Authorize Effective Penalties against Hospitals and Other Entities for Failure to Report

Model Language

Section 102. Penalties for Failure to Report

(1) A willful failure to file the report described in [section(s) addressing reporting requirements] shall be punishable by a fine, not to exceed one hundred thousand dollars ($100,000) per violation, that shall be paid by the health care facility or other entity subject to the reporting requirements addressed in [section(s)]. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the licensee regarding whom the report was or should have been filed. The fine shall be paid to that agency, but not expended until appropriated by the legislature. A violation of this subdivision may constitute reportable unprofessional conduct by the licensee. As used in this subdivision, "willful" means a voluntary and intentional violation of a known legal duty.

(2) Except as provided in section (1), any failure to file the report described in [section(s) addressing reporting requirements] is punishable by a fine, not to exceed fifty thousand dollars ($50,000) per violation, that shall be paid by the health care facility or other entity subject to [section(s)]. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. The fine shall be paid to that agency, but not expended until appropriated by the legislature.

Existing Approaches

As shown in Table 2, twenty-four states have statutory language authorizing fines against hospitals and other institutions for failure to report unprofessional conduct by physicians. The amount of the fines authorized varies from $500 to $100,000 per initial failure to report. At least three states authorize higher fines for subsequent failures to report (Delaware, Florida, and Nebraska), and one state imposes a fine per day that the event is not reported (Kansas).

Fines may also vary based on the size of the reporting entity. In Vermont, for example, required reporters, including hospitals where licensees provide professional services, must report any "reportable disciplinary action" to the state board.[104] A violation of the statute triggers "a civil penalty of not more than $5,000.00, provided that a reporter who employs or grants privileges to five or more board licensees and who violates this section shall be subject to a civil penalty of not more than $10,000.00."[105]

104. VT. STAT. ANN. tit. 26, § 1317(a) (2020).
105. VT. STAT. ANN. tit. 26, § 1317(f) (2020).

In most states, the fine is triggered by any failure to report, and several states specifically include entities that "neglect" to report.[106] The model language is patterned in part on California's statute, which provides higher fines for "willful" violations.[107]

Commentary

Nearly all states require hospitals and other health care organizations within the state to report possible violation(s) of the state medical practice act or SMB rules and regulations by a licensed physician.[108] These legal requirements reflect the critical importance of information about possible violations of the state medical practice act to the ability of SMBs to take action and protect the public.[109] The requirements also reflect the fact that hospitals and other health care organizations have access to critical information such as hospital disciplinary actions and peer review actions that are often unavailable to SMBs unless reported.[110]

Despite mandatory reporting laws, failure to detect and report physician wrongdoing on the part of hospitals and other health care entities is a longstanding problem.[111] The FSMB has repeatedly identified underreporting as a serious obstacle to effective SMB oversight of physicians that severely limits the ability of SMBs to protect patients. The FSMB's 2016 *Position Statement on Duty to Report* notes that hospitals and health organizations "regularly ignore reporting requirements, find ways to circumvent them, or provide reports that are too brief and general to equip the board with relevant information."[112] In some instances, failures to report have resulted in avoidable harms to patients.[113]

There are practical and organizational reasons that hospitals and other health care entities fail to report wrongdoing by affiliated physicians.[114] Risks to public

106. *See, e.g.*, NEB. REV. STAT. § 38-1,127(3) (2011) ("[F]ails or neglects to make a report or provide information as required under this section[.]").

107. CAL. BUS. & PROF. CODE § 805(k) (West 2021); CAL. BUS. & PROF. CODE § 805.8(d) (West 2021).

108. U.S. MEDICAL REGULATORY TRENDS AND ACTIONS, *supra* note 14, at 8, 61.

109. FED'N OF STATE MED. BDS., POSITION STATEMENT ON DUTY TO REPORT 1 (2016), https://www.fsmb.org/siteassets/advocacy/policies/position-statement-on-duty-to-report.pdf.

110. ALAN LEVINE ET AL., STATE MEDICAL BOARDS FAIL TO DISCIPLINE DOCTORS WITH HOSPITAL ACTIONS AGAINST THEM 2, 15 (PUB. CITIZEN, 2011), https://www.citizen.org/wp-content/uploads/1937.pdf ("Hospital disciplinary reports are peer review actions that are one of the most important sources of information for [SMB] oversight.").

111. POSITION STATEMENT ON DUTY TO REPORT, *supra* note 109, at 2; LEVINE ET AL., *supra* note 110, at 3; HOROWITZ, *supra* note 80, at 123.

112. POSITION STATEMENT ON DUTY TO REPORT, *supra* note 109, at 2.

113. *Id.*

114. FED'N OF STATE MED. BDS., DUTY TO REPORT: PROTECTING PATIENTS BY IMPROVING THE REPORTING AND SHARING OF INFORMATION ABOUT HEALTH CARE PRACTITIONERS (2017),

reputation and financial standing are frequently cited as disincentives to reporting,[115] and there is often a lack of consequences for failure to report. Authorization of fines for failure to report is a way to change these incentives, especially if the fines are substantial and made public. Professional organizations and experts have called for fines against hospitals and other health care entities for failure to report.[116] The FSMB's 2016 *Position Statement on Duty to Report*, for example, has recommended that civil penalties be authorized and imposed in cases of institutional failure to report physician wrongdoing.[117]

Review of state statutory language authorizing penalties for failure to report is also an opportunity to assess other elements of the reporting requirement. The law should include an inclusive definition of the individuals and entities that are required to report.[118] The FSMB provides sample language that identifies a broad range of individuals and entities, including: all licensees; the state medical associations and their components; all hospitals and other health care organizations in the state, including hospitals, medical centers, long-term care facilities, managed care organizations, ambulatory surgery centers, clinics, group practices, and coroners; all chiefs of staff, medical directors, department administrators, service directors, attending physicians, and residency directors; all local medical/osteopathic societies and local professional societies; all state agencies; all peer review bodies in the state; and resident training program directors.[119] California's law identifies a similarly broad range of required reporters, as does the District of Columbia.[120] In addition to any licensed or exempt clinic or health facility and any postsecondary educational institutions, D.C.'s law includes:

https://www.fsmb.org/siteassets/advocacy/publications/duty-to-report-summary.pdf; *Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 77.

115. DUTY TO REPORT: PROTECTING PATIENTS BY IMPROVING THE REPORTING AND SHARING OF INFORMATION ABOUT HEALTH CARE PRACTITIONERS, *supra* note 114, at 5; *Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 77; FED'N OF STATE MED. BDS., ESSENTIALS OF A STATE MEDICAL AND OSTEOPATHIC PRACTICE ACT 21 (2015), https://www.fsmb.org/siteassets/advocacy/policies/essentials-of-a-state-medical-and-osteopathic-practice-act.pdf.

116. *Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 77; ESSENTIALS OF A STATE MEDICAL AND OSTEOPATHIC PRACTICE ACT, *supra* note 115, at 28; ALAN LEVINE & SIDNEY WOLFE, HOSPITALS DROP THE BALL ON PHYSICIAN OVERSIGHT: FAILURE OF HOSPITALS TO DISCIPLINE AND REPORT DOCTORS ENDANGERS PATIENTS 17 (Pub. Citizen eds., 2009), https://www.citizen.org/wp-content/uploads/migration/18731.pdf.

117. POSITION STATEMENT ON DUTY TO REPORT, *supra* note 109, at 2; *Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, *supra* note 77.

118. *See* ESSENTIALS OF A STATE MEDICAL AND OSTEOPATHIC PRACTICE ACT, *supra* note 115, at 26–27.

119. *Id.*

120. CAL. BUS. & PROF. CODE § 805 (West 2021).

> . . . an individual or entity licensed or otherwise authorized under District law to provide healthcare service, including a hospital, nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, renal dialysis facility, ambulatory surgical center, pharmacy, physician or health care practitioner's office, long-term care facility, behavior health residential treatment facility, health clinic, clinical laboratory, health center, physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, psychologist, certified social worker, registered dietitian or nutrition professional, physical or occupational therapist, pharmacist, or other individual health care practitioner.[121]

State statutes should also clearly define the information that must be reported promptly in writing, which should include: any possible violation of the state medical practice act or the SMB's rules and regulations; any restriction, limitation, loss, or denial of a licensee's staff privileges or membership that involves patient care; any voluntary resignation from the staff of a health care organization or any voluntary limitation of staff privileges; and a report of each final judgment, settlement, arbitration award, or any form of payment made by the licensee or on the licensee's behalf by any source upon any demand, claim, or case alleging medical malpractice, battery, incompetence, or failure of informed consent.[122]

Some states establish a threshold for reporting, such as "actual knowledge" of misconduct or "reasonable cause" to believe misconduct has occurred.[123] However, circumvention of reporting requirements by hospitals and academic medical centers suggest that all reports of misconduct, and all disciplinary actions or arrangements should be reported. State statutes may also include language providing immunity from civil or criminal liability or disciplinary action for reports made in good faith.[124]

Statutes could specify the factors to be considered in determining the amount of the fine imposed in the statute, regulations, or board rule. California, for

121. D.C. CODE § 7-161(a)(2)–(3) (2009).

122. ESSENTIALS OF A STATE MEDICAL AND OSTEOPATHIC PRACTICE ACT, *supra* note 115, at 26–27; *see also* ALA. CODE § 34-24-59 (2002) ("The chief administrative officer of each hospital shall report to the Alabama State Board of Medical Examiners any disciplinary action taken concerning any physician when the action is related to professional ethics, negligence, or incompetence in the practice of medicine, moral turpitude, sexual misconduct, abusive or disruptive behavior, or drug or alcohol abuse. Disciplinary action shall include termination, revocation, probation, restriction, denial, failure to renew, suspension, reduction, or resignation of hospital privileges for any of the above reasons. The report shall be in writing and be made within 30 days of the date of the initial action.").

123. *See* Kristopher T. Starr, *Reporting a Physician Colleague for Unsafe Practice: What's the Law?*, 46 NURSING 14, 14 (2016).

124. ESSENTIALS OF A STATE MEDICAL AND OSTEOPATHIC PRACTICE ACT, *supra* note 115, at 28.

example, provides that the amount of the fine shall be proportional to the severity of the failure to report and differ based upon these factors:

> . . . written findings, including whether the failure to file caused harm to a patient or created a risk to patient safety; whether any person who is designated or otherwise required by law to file the report required under this section exercised due diligence despite the failure to file or whether the person knew or should have known that a report required under this section would not be filed; whether there has been a prior failure to file a report required under this section; and whether a report was filed with another state agency or law enforcement.[125]

Some states may want to consider alternative approaches instead of or in addition to the authorization of fines. For example, organizational accreditation and licensing processes are focused on patient safety and quality of care and may be leveraged to encourage hospitals, academic medical centers, and other health care organizations to report unprofessional physician conduct.[126] The Centers for Medicare and Medicaid Services (CMS) mandates accreditation by an approved accrediting organization or state agency as a requirement for participation in its programs.[127] The Joint Commission is the most prevalent accreditation organization,[128] and states could encourage regular review of reporting practices and records as part of private Joint Commission accreditation. Similarly, states could require review of reporting by hospitals and other health care institutions as part of the state licensing process.[129] States could work with the accreditation authorities to apply a similar requirement to universities and medical schools that would apply to conduct by affiliated physicians who practice outside of an academic medical center (e.g., an athletic department).

125. CAL. BUS. & PROF. CODE § 805.8(e) (West 2021).

126. Hema N. Viswanathan & J. Warren Salmon, *Accrediting Organizations and Quality Improvement*, 6 AM. J. MANAGED CARE 1117, 1120, 1122 (2000); *see also* Nadia N. Sawicki, *State Peer Review Laws as a Tool To Incentivize Reporting to Medical Boards*, 15 ST. LOUIS U. J. HEALTH L. & POL'Y 97, 117 (2022) (arguing that states could make peer review immunity contingent on compliance with state medical practice act reporting requirements).

127. *Conditions for Coverage (CfCs) & Conditions of Participation (CoP*s), CTRS. FOR MEDICARE & MEDICAID, https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCs AndCoPs (last visited Aug. 28, 2021).

128. Miranda B. Lam et al., *Association Between Patient Outcomes and Accreditation in US Hospitals: Observational Study*, 363 BMJ, 2018, at 1, 2.

129. Others have suggested that federal law should permit CMS to stop reimbursing hospitals if they failed to report disciplinary actions against physicians. LEVINE & WOLFE, *supra* note 116, at 31–34.

4. Require Criminal Background Checks at Licensure Renewal

Model Language

Section 103. Requirements for License issued by the State Medical Board

(1) All applicants for a license or renewal or reinstatement of a license issued by the [State Medical Board] shall submit to a state and national criminal history background check by providing fingerprints and executing a criminal history information release using forms provided by the Board.

(2) Fingerprints provided by each applicant shall be submitted to the [appropriate state entity], which is responsible for forwarding the fingerprints to the [appropriate state entity] for a state criminal history check and the Federal Bureau of Investigation for a national criminal history record check.

(3) Information received by the Board pursuant to a criminal history background check shall be confidential, except that such information received by and relied upon by the Board in denying the issuance of a certificate of qualification may be disclosed as may be necessary to support the denial.

Existing Approaches

As shown in Table 3, twelve states require physicians to complete a criminal background check (CBC) at the time of renewal. Two additional states require the board to regularly review CBC information independent of the renewal requirements. Delaware requires review of the criminal history of all licensed physicians at least every six months.[130] In contrast, Washington requires an annual review of a representative sample of all license holders.[131]

A majority of states with CBC requirements require both state and national CBCs, which is reflected in the model language.[132] A state-level background check generally includes infractions, misdemeanors, felony convictions, and pending criminal cases reported in databases at the state and county level within

130. DEL. CODE ANN. tit. 24, § 1723(e) (West 2011) ("The Division shall review the criminal history of all individuals licensed to practice medicine on a periodic basis, at a minimum, once every 6 months.").

131. WASH. REV. CODE § 18.130.064(5) (2008) ("The secretary shall conduct an annual review of a representative sample of all license holders who have previously obtained a background check through the department. The selection of the license holders to be reviewed must be representative of all categories of license holders and geographic locations.").

132. ARK. CODE ANN. § 17-95-306(a)(1) (2005); DEL. CODE ANN. tit. 24, § 1720(b)(6) (2017); FLA. STAT. § 456.039(4)(a)–(b) (2015); MD. CODE. ANN., HEALTH OCC. § 14-316(g)(1) (West 2020); *see also* MD. CODE. ANN., HEALTH OCC. § 14-308.1(c) (West 2015); N.J. STAT. ANN. § 45:1-29 (West 2005); N.M. CODE R. § 16.10.7.9 (LexisNexis 2009); OR. REV. STAT. § 677.265(9) (2014); VT. STAT. ANN. tit. 26, § 1353(8) (2021); WASH. REV. CODE § 18.130.064(2) (2008). *See also Criminal Background Checks: Board-by-Board Overview*, FED'N OF STATE MED. BDS., https://www.fsmb.org/siteassets/advocacy/key-issues/criminal-background-checks-by-state2.pdf (last visited Sept. 15, 2021).

a single state. A national CBC, which the FBI can conduct,[133] includes the same information reported in databases at the state and county level across the country.

Commentary

The FSMB, consumer advocacy organizations, and other entities have stated that SMBs should have greater access to reliable information from other sources, including the criminal justice system.[134] Access to this information on a timely basis is especially important considering studies finding that physicians who engage in serious ethical violations—a category that overlaps with criminal conduct under state law—often reoffend.[135] In some cases, physicians were able to relocate and continue offending,[136] underscoring the need for criminal history information from other states. CBCs are relatively inexpensive and may be added to application fees,[137] although they may impose burdens on boards with less administrative support.

Public and private entities have widely adopted CBCs as a method of regulating physicians and protecting the public. As shown in Table 3, thirty-four states require a CBC at the time of initial application for a medical license. At least seven additional SMBs require a CBC upon initial application as a matter of board practice or policy.[138] A few additional states participate in the Interstate

133. *Identity History Summary Checks*, FED. BUREAU OF INVESTIGATION, https://www.fbi.gov/services/cjis/identity-history-summary-checks (last visited Mar 29, 2021).

134. U.S. MEDICAL REGULATORY TRENDS AND ACTIONS, *supra* note 14, at 9; WOLFE ET AL., *supra* note 19.

135. Darren Grant & Kelly C. Alfred, *Sanctions and Recidivism: An Evaluation of Physician Discipline by State Medical Boards*, 32 J. HEALTH POLS., POL'Y & L. 867, 868, 882 (2007); 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*, 19 AM. J. BIOETHICS, Jan. 24, 2019, at 16, 17–18.

136. DuBois et al., *supra* note 135, at 16, 27–28; Robbins, *supra* note 18.

137. *See, e.g.*, *Background Checks*, TN. BUREAU OF INVESTIGATIONS, https://www.tn.gov/tbi/divisions/cjis-division/background-checks.html (last visited Sept. 15, 2021) (citing cost of fifty dollars for a national CBC); *Background Checks*, STATE OF R.I., OFF. ATT'Y GEN., http://www.riag.ri.gov/homeboxes/BackgroundChecks.php (last visited Sept. 15, 2021) (citing the national CBC costs thirty-five dollars); *Identity History Summary Checks*, *supra* note 133 (listing the cost to run an Identity History Summary Check at eighteen dollars).

138. *See Kansas Licensure Application Instructions Medicine & Surgery (MD) and Osteopathic Medicine & Surgery (DO)*, KAN. STATE BD. OF HEALING ARTS, http://www.ksbha.org/forms/md_do_app_nonfill.pdf (last revised May 2016); *Requirements for Medical Licensure*, ME. BD. OF LICENSURE IN MED., https://www.maine.gov/md/sites/maine.gov.md/files/inline-files/requirements2017.pdf (last revised Feb. 1, 2018); *Instructions/Application,* N.D. BD. OF MED., https://www.ndbom.org/practitioners/physicians/newapp/app-instructions.asp (last visited Sept. 15, 2021); *Medical Professional Resources: MD Application Instructions*, OKLA. BD. OF MED. LICENSURE & SUPERVISION, https://www.okmedicalboard.org/resources (last revised Aug. 2021); *Pennsylvania Licensing System*, COMMONWEALTH OF PA. DEPT. OF STATE, https://www.pals.pa.gov/# (last visited Sept. 15, 2021). To access checklist, first select "application checklist," then

Medical Licensure Compact, which requires a national CBC and excludes physicians with any criminal history from participation.[139] Finally, sixteen states require physicians to complete a CBC as a condition of license reinstatement. The model language can be adapted to amend existing requirements in these states.

Many medical students are subject to background checks in the application process and during medical school. The American Medical College Application Service (AMCAS) works with affiliated medical schools to facilitate a background check.[140] Only ten medical schools, eight of which are Texas schools affiliated with the Texas Medical and Dental Schools Application Service (TMDSAS), do not use the AMCAS service.[141] Such background checks are extensive and include records searches from county, state, and federal databases.[142] TMDSAS noted in its most recent application year handbook that universities may also impose their own background check requirements for medical and other health sciences students.[143] Physicians also may be required to complete CBCs outside of the licensing process. Residency programs, upon selection of incoming residents, may require a CBC.[144] Hospitals may also require background checks as a condition of credentialing.[145]

A CBC should be required in addition to existing self-reporting requirements. Some physicians who have engaged in criminal conduct do not

"State Board of Medicine" under Board/Commission, then "Medical Physician and Surgeon" under License Type, and then "Allopathic."; *Criminal Background Check Instructions*, TENN. DEP'T. HEALTH, https://www.tn.gov/health/health-professionals/criminal-background-check/cbc-instructions.html (last visited Sept. 15, 2021); *Fingerprinting*, TEX. MED. BD. PHYSICIAN ASSISTANT BD. STATE BD. OF ACUPUNCTURE EXAM'RS, http://www.tmb.state.tx.us/page/get-fingerprints (last visited Sept. 15, 2021).

139. *See, e.g.*, COLO. REV. STAT. § 12-240-106(3) (2019); MONT. CODE ANN. § 37-3-305(3) (2017); UTAH CODE ANN. § 58-67-302.1(1) (West 2018); *see also Information for Physicians*, INTERSTATE MED. LICENSURE COMPACT, https://www.imlcc.org/information-for-physicians/ (last visited Sept. 15, 2021) (stating that individuals with a criminal history are not eligible).

140. *Participating Medical Schools and Deadlines*, ASS'N OF AM. MED. COLLS., https://students-residents.aamc.org/applying-medical-school/article/participating-medical-schools-deadlines/ (last visited Sept. 15, 2021).

141. *Id.*

142. *Criminal Background Check: Search-by-Search Description*, ASS'N OF AM. MED. COLLS., https://students-residents.aamc.org/applying-medical-school/article/criminal-background-check-search-search-descriptio/ (last visited Sept. 15, 2021).

143. *Application Handbook: A Guide for Applicants of Dental, Medical, & Veterinary Schools in Texas*, TEX. MED. & DENTAL SCHLS. APPLICATION SERV. (Apr. 15, 2021), https://www.tmdsas.com/ApplicationHandbook.pdf/.

144. Ann Rhodes & Catherine Solow, *Implementing a Criminal Background Check Process*, 95 J. MED. REGUL., Jun. 1, 2009, at 17, 20.

145. Roshan Patel, *Credentialing*, STATPEARLS, https://www.statpearls.com/ArticleLibrary/viewarticle/20108 (last updated Oct. 30, 2021, 12:40 AM).

disclose it.[146] A CBC will enable the board to promptly discover undisclosed offenses that would put the public at risk, including those that occurred out-of-state.[147] For example, the Washington Medical Commission requires a CBC to determine eligibility for renewal of a medical license while also requiring licensees to self-report any arrests, convictions, or other determinations or findings by law enforcement agencies for a criminal offense.[148]

A CBC requirement also complements third-party arrest notification services utilized by some boards.[149] Arrest notification services allow an authorized entity to receive notification of criminal history information from the Department of Justice (DOJ) for employment, licensing, or certification purposes.[150] Generally, arrest notification services allow the DOJ to maintain fingerprints of the respective employees, and in the case of a subsequent arrest, the DOJ notifies the entity.[151]

The model language ensures that SMBs receive complete, timely, and verified information about criminal charges and actions as part of the process of license renewal. However, SMBs will still need to take appropriate action based on the information received. Several highly publicized cases suggest that physicians continue to practice after arrest, conviction, or other determination related to criminal conduct that harms patients.[152] A review of all physicians convicted of crimes and disciplined by a SMB or the federal government between 1990 and 1999 also found that SMBs often impose modest sanctions even after a criminal conviction.[153]

146. *See* Scott Dance, *Report: State Board Overlooked Doctor's Rape Conviction*, BALTIMORE SUN (Nov. 12, 2014, 10:26 PM), https://www.baltimoresun.com/health/bs-hs-dando-oig-report-20141112-story.html.

147. McIntosh et al., *supra* note 22, at 11–12.

148. WASH. REV. CODE § 18.130.064(3), (4) (2008). This self-report of a criminal offense must be made to the Board within fourteen days of the conviction.

149. McIntosh et al., *supra* note 22, at 11, 13.

150. *See Contract for Subsequent Arrest Notification Service*, CAL. DEP'T JUST., https://oag.ca.gov/sites/all/files/agweb/pdfs/fingerprints/forms/subarr.pdf (last revised Mar. 2018).

151. *See, e.g.*, CAL. PENAL CODE § 11105.2(a)(1) (West 2019).

152. *See, e.g.*, Mayfield et al., *supra* note 7; Robbins, *supra* note 18.

153. Azza AbuDagga et al., *Cross-Sectional Analysis of the 1039 U.S. Physicians Reported to the National Practitioner Data Bank for Sexual Misconduct, 2003–2013*, 11 PLOS ONE, Feb. 3, 2016, at 1, 10; Paul Jung et al., *U.S. Physicians Disciplined for Criminal Activity*, 16 HEALTH MATRIX: J. L.–MED. 335, 341, 344 (2006).

5. Establish Preponderance of the Evidence as the Standard of Proof in Disciplinary Actions

Model Language

Section 104. Burden of Proof

(1) In any disciplinary hearing, a finding of the Board must be supported by a preponderance of the evidence.

Existing Approaches

As shown in Table 4, thirty-five states provide that the standard of proof or level of evidence required for the board to find a violation has occurred is "preponderance of the evidence," either for all or a subset of violations. Of those states, only twenty-six have established the standard of proof by statute, regulation, or decision by the highest state court.

In contrast, thirteen states require "clear and convincing evidence" to find that a violation has occurred for at least some types of violations. A few states have more than one standard of proof for physician disciplinary matters. For example, Arizona requires its medical board prove a disciplinary violation with "clear and convincing evidence," except for proceedings involving sexual misconduct.[154] In Florida, proceedings are generally subject to a preponderance of the evidence standard, but revocation of a license requires clear and convincing evidence.[155]

Commentary

A standard of proof is the level of evidence required for the board or other decisionmakers to find that a violation has occurred.[156] Professional organizations and experts have recommended that SMBs use preponderance of the evidence as the standard of proof in disciplinary actions.[157] This would mean, for example, that a board could base its finding on evidence indicating it was "more likely than not" that a violation took place, or evidence "sufficient to incline a fair and impartial mind to one side of the issue rather than the other."[158] Physician disciplinary actions are civil proceedings, and the preponderance of the evidence standard is used in most civil cases, where a typical jury instruction

154. ARIZ. REV. STAT. ANN. § 32-1451.04 (2018); ARIZ. REV. STAT. ANN. § 32-1401(27)(aa) (2021).

155. FLA. STAT. § 458.331(3) (2020).

156. *Standard of Proof*, BLACK'S LAW DICTIONARY (11th ed. 2019).

157. GUIDELINES FOR THE STRUCTURE AND FUNCTION OF A STATE MEDICAL AND OSTEOPATHIC BOARD, *supra* note 42, at 11, 13, 39; WOLFE ET AL., *supra* note 19.

158. *Preponderance of the Evidence*, BLACK'S LAW DICTIONARY (11th ed. 2019); Colorado v. New Mexico, 467 U.S. 310, 316 (1984).

is to find for a party that has stronger evidence, "however slight the edge may be."[159]

In contrast, clear and convincing proof generally means evidence that is sufficient to find the allegations "highly probable or reasonably certain."[160] The clear and convincing standard is typically used in claims involving fraud or "some other *quasi-criminal* wrongdoing."[161] Clear and convincing is a higher standard of proof than preponderance of the evidence, but both require less certainty than the more familiar standard in criminal cases, "beyond a reasonable doubt."[162]

The standard of proof used must satisfy due process requirements. Most courts to examine the issue have held that use of the preponderance of the evidence standard in medical disciplinary actions satisfies due process requirements.[163] However, some courts have held otherwise. For example, in *Painter v. Abels*, the Supreme Court of Wyoming found the "preponderance standard fails to protect" the plaintiff because they could lose their livelihood, reputation, medical license, and protected property right.[164] Further, the court found the risk of error is high because the agency takes part in all steps, acting as the investigator, prosecutor, and decision maker.[165] The court held that the board should apply the clear and convincing standard rather than preponderance of the evidence standard to decrease the chance of error.[166]

Adherence to an unnecessarily high standard of proof may impair a SMB's ability to protect the public from egregious wrongdoing by physicians. Inconsistent application of the standard of proof may expose the SMB to

159. *Preponderance of the Evidence*, BLACK'S LAW DICTIONARY (11th ed. 2019); *Colorado*, 467 U.S. at 316.

160. *Clear and Convincing Evidence*, BLACK'S LAW DICTIONARY (11th ed. 2019); *Colorado*, 467 U.S. at 316.

161. *Nguyen v. State Dep't Health Med. Quality Assurance Comm'n*, 29 P.3d 689, 694 (Wash. 2001); *see also* Foster v. Bd. of Dentistry, 1986-NMSC-009, ¶ 10, 103 N.M. 776 (board of dentistry not required to use clear and convincing evidence standard rather than preponderance of evidence in determining that dentist's license should be suspended).

162. *Clear and Convincing Evidence*, BLACK'S LAW DICTIONARY (11th ed. 2019).

163. *See* Eaves v. Bd. of Med. Exam'rs, 467 N.W.2d 234, 237 (Iowa 1991); Rucker v. Mich, Bd. of Med., 360 N.W.2d 154, 155 (Mich. Ct. App. 1984); In re Grimm, 635 A.2d 456, 461 (N.H. 1993); In re Polk, 449 A.2d 7, 16–17 (N.J. 1982); Anonymous (M–156–90) v. State Bd. of Med. Exam'rs, 496 S.E.2d 17, 19–20 (S.C. 1998); Gandhi v. State Med. Examining Bd., 483 N.W.2d 295, 298 (Wis. Ct. App. 1992); N.D. State Bd. of Med. Exam'rs—Investigative Panel B v. Hsu, 2007 ND 9, ¶ 27, 726 N.W.2d 216, 230.

164. Painter v. Abels, 998 P.2d 931, 941 (Wyo. 2000); *see* Nguyen, 29 P.3d at 697 (holding it is much more than just loss of a job, but the physician's "substantial interest to practice within his profession, his reputation, his livelihood, and his financial and emotional future" to show the minimum standard of proof for physician disciplinary action must be higher than mere preponderance, thus clear and convincing was selected).

165. *Painter*, 998 P.2d at 941.

166. *Id.*

physician claims of unequal treatment. Consideration of legal requirements, like the standard of proof, should be coupled with education for SMB members to understand and consistently apply the standard of proof and other legal requirements.[167]

It is also important to distinguish the board's standard of proof in disciplinary proceedings from the judicial standard of review in state court. If a physician pursues an appeal in state court, the court reviews the administrative agency's decision to determine if it is supported by substantial evidence.[168] As stated above, substantial evidence means there is adequate evidence to support the conclusion.[169] When the courts review agency interpretations, the Supreme Court directs them to defer to an agency's interpretation of its own regulations unless the agency's position is "plainly erroneous."[170]

V. CONCLUSION

SMBs play an important role in protecting the public from harmful physicians. More public, professional, and scholarly attention is needed to identify and assess legal policy tools that would make SMBs more effective at protecting patients in egregious cases. This Article offers specific, expert-informed, and actionable legal and policy tools in the form of model language with commentary for five high-impact statutory provisions that address board composition and function, reporting to the board, and adjudication of disciplinary matters. The model provisions and commentary are intended to serve as a new resource for SMBs, state legislatures, and other policymakers to encourage and support examination of existing medical practice acts in order to improve SMB function and better protect patients from harmful physicians.

167. HOROWITZ, *supra* note 80, at 187–88 (recommending increased training for SMB members on the statutory requirements governing the disciplinary process and the need to provide justifications for decisions and to "understand the elementary rules of evidence and due-process requirements").

168. *See* sources cited *supra* note 73.

169. *Substantial Evidence*, BLACK'S LAW DICTIONARY (11th ed. 2019); Consol. Edison Co. of N.Y. v. N.L.R.B., 305 U.S. 197, 229 (1938).

170. Auer v. Robbins, 519 U.S. 452, 461 (1997).

TABLE 1. STATE LAWS THAT ADDRESS GENDER DIVERSITY AND RACIAL AND ETHNIC DIVERSITY OF SMB MEMBERSHIP[171]

State	Gender Diversity	Racial/ Ethnic Diversity	Requirement
Alabama	X	X	"Each member of the commission shall be a citizen of this state and the membership of the commission shall be inclusive and reflect the racial, gender, geographic, urban/rural, and economic diversity of the state." ALA CODE § 34-24-310(a) (2009).
Arkansas	X	X	"The purposes of this subchapter are to: (1) Provide appointment recommendations for Arkansas state boards and commissions that license or otherwise regulate health-related professions to ensure board and commission compositions that reflect the diversity of the State of Arkansas" ARK. CODE ANN. § 17-80-301(1) (2009). "The appointing authorities for state health-related agencies, boards, and commissions shall consider appointment recommendations submitted by minority health-related professional associations." ARK. CODE ANN. § 17-80-302(a) (2009).
Iowa	X		"All appointive boards, commissions, committees, and councils of the state established by the Code, if not otherwise provided by law, shall be gender balanced." IOWA CODE § 69.16A(1) (2009).

171. As of July 1, 2021.

Louisiana		X	"At least every other member appointed from a list provided for in this Paragraph shall be a minority appointee. Nothing in this Paragraph shall preclude consecutive minority appointments from lists provided for in this Paragraph." LA. STAT. ANN. § 37:1263(B) (2018).
Maryland	X	X	"To the extent practicable, the members appointed to each health occupations board authorized to issue a license or certificate under this article shall reasonably reflect the geographic, racial, ethnic, cultural, and gender diversity of the State." MD. CODE ANN., HEALTH OCC. § 1-214 (West 2010).
Missouri	X	X	"When making appointments to the boards . . . the governor shall take affirmative action to appoint women and members of minority groups." MO. REV. STAT. § 324.021 (2008).
North Carolina	X	X	"Each appointing and nominating authority shall endeavor to see, insofar as possible, that its appointees and nominees to the Board reflect the composition of the State with regard to gender, ethnic, racial, and age composition." N.C. GEN. STAT. § 90-2(a1) (2019).

North Dakota	X		"Appointments to boards, commissions, committees, and councils of the state established by this code, if not otherwise provided by law, should be gender balanced to the extent possible and to the extent that appointees are qualified to serve on those boards, commissions, committees, and councils. Any appointment in accordance with this section should be made in a manner that strives to seek gender balance based on the numbers of each gender belonging to the group from which appointments are made." N.D. CENT. CODE § 54-06-19 (1989).
Oregon		X	"In selecting the members of the board, the Governor shall strive to balance the representation on the board according to geographic areas of this state and ethnicity." OR. REV. STAT. § 677.235(2)(d)(A) (2019).[172]
Tennessee	X	X	"In making appointments to the board, the governor shall, to the extent feasible, strive to ensure the full twelve-member board is composed of at least one (1) person who is sixty (60) years of age or older, one (1) person who is female and one (1) person who is an African-American." TENN. CODE ANN. § 63-6-102(c) (2012).

172. An updated version of the section took effect January 1, 2022. There is no change to the language addressing diversity.

TABLE 2. STATE LAWS THAT AUTHORIZE PENALTIES AGAINST HEALTH CARE ENTITIES FOR FAILURE TO REPORT UNPROFESSIONAL CONDUCT BY PHYSICIANS[173]

State	Amount per violation	Requirement
Alabama	≤$2,500	ALA. CODE § 34-24-59(a) (2002) (for failure on the part of a chief administrative officer of a hospital to file a report).
California	$10,001-$50,000	CAL. BUS. & PROF. CODE § 805(l) (West 2021); CAL. BUS. & PROF. CODE § 805.8(e) (West 2021); CAL. BUS. & PROF. CODE § 805.01(g) (West 2018) (up to $100,000 per willful violation).
Delaware	$10,001-$50,000	DEL. CODE ANN. tit. 24, § 1731A(i) (2010) ($10,000 for the first violation, and $50,000 for each subsequent violation).
D.C.	≤$2,500	D.C. CODE § 7-161(d)(2) (2009).
Florida	≤$2,500	FLA. STAT. § 459.016(2) (1998) (not to exceed $1,000 for the first offense, and not exceed $5,000 for subsequent offenses; FLA. STAT. § 458.337(2) (1998) (required to report to the Division of Health Quality Assurance).
Indiana	$5,001-$10,000	IND. CODE § 16-21-3-1 (1993).
Kansas	*	KAN. STAT. ANN. § 65-28,121(c) (2001) (not to exceed $1,000 per day for each day thereafter that the incident is not reported).
Maine	$2,501-$5,000	ME. STAT. tit. 24, § 2506 (2013).
Maryland	$2,501-$5,000	MD. CODE ANN., HEALTH OCC. § 14-413(e)(1) (West 2020).

173. As of July 1, 2021.

Massachusetts	$5,001-$10,000	MASS. GEN. LAWS ch. 111, § 53B (1996).
Minnesota	Not specified	MINN. STAT. § 147.111 (2019).
Nebraska	≤$2,500	NEB. REV. STAT. § 38-1,127(3) (2011) (up to $500 per violation for the first offense, up to $1,000 per violation for subsequent offenses).
Nevada	$5,001-$10,000	NEV. REV. STAT. § 630.307(5) (2015).
New Jersey	$2,501-$5,000	N.J. REV. STAT. § 26:2H-12.2b(f) (2012); N.J. REV. STAT. § 26:2H-14 (2003) (not more than $5,000 for each day in violation of reporting requirement).
New Mexico	$5,001-$10,000	N.M. CODE R. § 16.10.10.11 (LexisNexis 2018).
North Carolina	≤$2,500	N.C. GEN. STAT. § 90-14.13(a2) (2019) (up to $250 for the first violation, and up to $500 for each subsequent violation).
Oregon	$5,001-$10,000	OR. REV. STAT. § 677.415(10)(a) (2010).
Pennsylvania	≤$2,500	63 PA. STAT. AND CONS. STAT. ANN. § 422.4(f) (West 1986).
Rhode Island	≤$2,500	5 R.I. GEN. LAWS § 5-37-25 (1986); 5 R.I. GEN. LAWS § 5-37-9 (1998).
Vermont	$5,001-$10,000	VT. STAT. ANN. tit. 26, § 1317(f) (2020) (a hospital that employs from one to four physicians is subject to a penalty of up to $5,000, while a hospital that employs five or more physicians is subject to a penalty of $10,000).

Virginia	$10,001-$50,000	VA. CODE ANN. § 54.1-2400.6(E) (2021).
Washington	≤$2,500	WASH. REV. CODE § 70.41.210(4) (2008)174 (up to $500 per violation).
West Virginia	$5,001-$10,000	W. VA. CODE R. § 30-3-14 (2018) (penalties range from $1,000 to $10,000).
Wyoming	≤$2,500	WYO. STAT. ANN. § 33-26-409(d) (2003) (up to $100 per violation).

174. An updated version of the section will take effect July 1, 2022. There is no change to the basis for or amount of the penalty for failure to report.

TABLE 3. STATE LAWS THAT REQUIRE CRIMINAL BACKGROUND CHECKS AT INITIAL APPLICATION, RENEWAL, OR REINSTATEMENT OF MEDICAL LICENSE[175]

State	Initial	Renewal	Reinst.	Source
Alabama	X		X	ALA. ADMIN. CODE r. 540-X-3-.05 (2008); ALA. CODE § 34-24-337(d) (2021).
Arizona	X			ARIZ. REV. STAT. ANN. § 32-1422(A)(12) (2017).
Arkansas	X	X	X	ARK. CODE ANN. § 17-95-306(a) (2005); 060.00.001 ARK. CODE R. § 39(E) (LexisNexis 2020).[176]
California	X		X	CAL. BUS. & PROF. CODE § 144(a), (b)(14) (West 2021); CAL. BUS. & PROF. CODE § 2082(g) (West 2018).
Delaware	X	X		DEL. CODE ANN. tit. 24, §§ 1720(b)(6), (h), (i), 1723(e) (2017) (ongoing review of criminal background information).
District of Columbia	X	X	X	D.C. CODE § 3-1205.22(a) (2021); D.C. Mun. Regs. tit. 17, § 8501.1, .4, .5 (2018).
Florida	X	X		FLA. STAT. § 458.311(g) (2008); FLA. STAT. § 456.039(4)(a)-(b) (2015).

175. As of July 1, 2021.

176. The Westlaw database reflects an updated version and location of this rule. 007.33.24 ARK. CODE R. § 39(E). There is no change to the requirement of criminal background checks.

Idaho	X			IDAHO CODE § 54-1810(1) (2019); IDAHO CODE § 54-1811(2) (2019).
Illinois	X			225 ILL. COMP. STAT. 60/9.7 (2011); *see also* 225 ILL. COMP. STAT. 60/9(F), 60/19(H) (2014).[177]
Indiana	X			IND. CODE § 25-1-1.1-4(c) (2014).
Iowa	X		X	IOWA ADMIN. CODE r. 653-8.4(1)(a), (f) (2017).
Kansas	X		X	KAN. STAT. ANN. § 65-28,129(a) (2008).
Kentucky	X			201 KY. ADMIN. REGS. 9:210(1) (2020).
Louisiana	X	X	X	LA. STAT. ANN. § 37:1277 (2018).
Maryland	X	X	X	MD. CODE ANN., HEALTH OCC. § 14-307(i) (West 2020); MD. CODE ANN., HEALTH OCC. § 14-308.1(b) (West 2015); MD. CODE ANN., HEALTH OCC. § 14-316(g)(1) (West 2020).[178]
Massachusetts	X	X		243 MASS. CODE REGS. 2.04(8) (2021).
Michigan	X		X	MICH. COMP. LAWS § 333.16174(3) (2013); MICH. COMP. LAWS § 333.16245(8) (2015).

177. An updated version of the section took effect January 1, 2022. There is no change to the requirement of criminal background checks.

178. An updated version of the section will take effect October 1, 2022. There is no change to the requirement of criminal background checks.

Minnesota	X		X	MINN. STAT. § 214.075(a) (2019).
Mississippi	X		X	MISS. CODE ANN. § 73-25-3 (2007); MISS. CODE ANN. § 73-25-14(9) (2008).
Nebraska	X			NEB. REV. STAT. § 38-131(1) (2018).
Nevada	X			NEV. REV. STAT. § 630.167(1) (2017); *see also* NEV. REV. STAT. § 622.530(1)(g) (2019).
New Hampshire	X		X	N.H. REV. STAT. ANN. § 329:11-a(I) (2018).
New Jersey	X	X	X	N.J. STAT. ANN. § 45:1-29 (West 2005); *see also* N.J. ADMIN. CODE § 13:35-3.13 (2011); N.J. STAT. ANN. § 45:1-30(e) (West 2005).
New Mexico	X	X	X	N.M. CODE R. § 16.10.2.18 (LexisNexis 2013); N.M. CODE R. § 16.10.7.9 (LexisNexis 2009); N.M. CODE R. § 16.10.7.18 (LexisNexis 2009).
North Carolina	X		X	N.C. GEN. STAT. § 90-11(b) (2019); 21 N.C. ADMIN. CODE 32B.1303(a)(16) (2019); 21 N.C. ADMIN. CODE 32B.1350(b)(7)–(8) (2019).
Ohio	X		X	OHIO REV. CODE ANN. § 4776.02(A) (West 2017); OHIO REV. CODE ANN. § 4731.281(C) (West 2019).

Oregon	X	X	OR. REV. STAT. § 677.265(9) (2014); OR. ADMIN. R. 847-020-0150(7) (2016).
South Carolina	X		S.C. CODE ANN. § 40-47-36(A) (2006).
South Dakota	X		S.D. CODIFIED LAWS § 36-4-11.1 (2018).
Utah	X		UTAH CODE ANN. § 58-67-302.1(1) (West 2018).
Vermont	X	X	VT. STAT. ANN. tit. 26, § 1353(8) (2021).
Washington	X	X	WASH. REV. CODE § 18.130.064(2)–(3), (6) (2008); WASH. REV. CODE § 18.130.064(5) (2008) (requires annual review of random representative sample of licensees).
West Virginia	X		W. VA. CODE R. § 11-1A-8.1 (2019).
Wyoming	X		WYO. STAT. ANN. § 33-26-202(b)(xvi) (2019).

TABLE 4. STATE LAWS THAT ADDRESS STANDARD OF EVIDENCE IN SMB DISCIPLINARY PROCEEDINGS[179]

State	Preponderance of evidence	Clear and convincing evidence	Source
Alaska	X		Odom v. State Div. of Corps., 421 P.3d 1, 7 (Alaska 2018) (assumes for the purposes of the decision that the preponderance of the evidence standard applies).
Arizona	X	X	ARIZ. REV. STAT. ANN. § 32-1451.04 (2018); ARIZ. REV. STAT. ANN. § 32-1401(27)(aa) (2021) (exception for proceedings involving sexual misconduct).
Arkansas	X		C.C.B. v. Ark. Dep't of Health & Hum. Servs., 247 S.W.3d 870, 874–875 (Ark. 2007).
California		X	Ettinger v. Bd. of Med. Quality Assurance, 185 Cal. Rptr. 601, 603 (Cal. Ct. App. 1982).
Colorado	X		COLO. REV. STAT. § 13-25-127(1) (1995); COLO. REV. STAT. § 24-4-105(7) (2019).
Connecticut	X		Jones v. Conn. Med. Examining Bd., 72 A.3d 1034, 1043 (Conn. 2013).

179. As of July 1, 2021.

Delaware	X		Sokoloff v. Bd. of Med. Prac., No. N09A–11–005, 2010 WL 5550692, at *2 (Del. Super. Ct., Aug. 25, 2010).
District of Columbia	X		Sherman v. Comm'n on Licensure to Prac. Healing Art, 407 A.2d 595, 601 (D.C. 1979).
Florida	X	X	FLA. STAT. § 458.331(3) (2020) (greater weight of the evidence); FLA. STAT. § 458.331(3) (2020) (clear and convincing for license revocation).
Georgia	X		GA. COMP. R. & REGS. 616-1-2-.21(4) (2020).
Hawaii	X		HAW. CODE R. § 16-201-21(d) (LexisNexis 1990).
Idaho		X	Laurino v. Bd. of Pro. Discipline of Idaho State Bd. of Med., 51 P.3d 410, 415 (Idaho 2002).
Illinois		X	Vuagniaux v. Dep't of Pro. Regul., 802 N.E.2d 1156, 1163, 1173 (Ill. 2003).
Iowa	X		Eaves v. Bd. of Med. Exam'rs, 467 N.W.2d 234, 237 (Iowa 1991); State v. Brown, 218 Iowa 166, 170 (1934), 253 N.W. 836, 838 (Iowa 1934).
Kansas		*	KAN. STAT. ANN. § 65-2836(c) (2020) (clear and convincing by two-thirds of voting members to rebut license revocation based on conviction of a felony or class A misdemeanor).

Kentucky	X		Parrish v. Ky. Bd. of Med. Licensure, 145 S.W.3d 401, 411 (Ky. Ct. App. 2004).
Louisiana	X		LA. STAT. ANN. § 37:1285.2(C) (2018).
Maryland	X		MD. CODE ANN., HEALTH OCC. § 14-405(b)(2) (West 2017).
Michigan	X		Rucker v. Mich. Bd. of Med., 360 N.W.2d 154, 155 (Mich. Ct. App. 1984).
Minnesota	X		MINN. R. 1400.7300 (2021); *In re* Wang, 441 N.W.2d 488, 492 (Minn. 1989).
Mississippi	X		MISS. CODE ANN. § 73-25-27 (2009).
Missouri		X	MO. REV. STAT. § 334.099(1)(8) (2011).
Montana	X		MONT. CODE ANN. § 37-1-311(1) (2007).
Nebraska		X	Davis v. Wright, 503 N.W.2d 814, 819 (Neb. 1993).
Nevada	X		NEV. REV. STAT. § 630.346(2) (2017).
New Hampshire	X		N.H. CODE ADMIN. R. ANN. Med 206.10(a) (2007).
New Jersey	X		*In re* Polk, 449 A.2d 7, 12 (N.J. 1982).
New Mexico	X		Foster v. Bd. of Dentistry of State of N.M., 714 P.2d 580, 582 (N.M. 1986).

New York	X		N.Y. PUB. HEALTH LAW § 230(10)(f) (McKinney 2020).
North Carolina	X		N.C. GEN. STAT. § 150B-25.1(a) (2015).
North Dakota	X		N.D. CENT. CODE § 28-32-46(5) (2001).
Ohio		X	OHIO REV. CODE ANN. § 4731.22(G)(1) (West 2021).
Oklahoma		X	Bottles v. State ex rel. Okla. State Bd. of Med. Licensure & Supervision, 917 P.2d 471, 472 (Okla. 1996); Robinson v. State ex rel. Okla. State Bd. of Med. Licensure & Supervision, 916 P.2d 1390, 1393 (Okla. 1996).
Oregon	X		Gallant v. Bd. of Med. Examiners, 974 P.2d 814, 816, 818 (Or. Ct. App. 1999) (interpreting OR. REV. STAT. § 183.450(5) (1999)).
Pennsylvania	X		Oakes v. Bureau of Pro. & Occupational Affs., State Bd. of Osteopathic Med., No. 2416 C.D.2011, 2012 WL 8704931, at *2 (Pa. Commw. Ct. Oct. 23, 2012); Starr v. State Bd. of Med., 720 A.2d 183, 191 (Pa. Commw. Ct. 1998).

Rhode Island	X		Mills v. Nolan, No. PC 01-4153, 2003 WL 22790706, at *10 (R.I. Super Ct. Nov. 13, 2003); Miele v. Bd. of Med. Licensure & Discipline, C.A. 90-1930, 1991 WL 789899, at *2 (R.I. Super Ct. 1991).
South Carolina	X		Anonymous (M-156-90) v. State Bd. of Med. Exam'rs, 496 S.E.2d 17, 20 (S.C. 1998) (interpreting S.C. CODE ANN. § 1-23-600 (2019)).
South Dakota	X	X	S.D. CODIFIED LAWS § 36-4-29 (2013); *In re* Setliff, 2002 S.D. 58, ¶ 13, 645 N.W.2d 601, 605 (clear and convincing standard for license revocation).
Tennessee	X		TENN. COMP. R. & REGS. 1360-04-01-.02 (1990).
Texas	X		Granek v. Tex. State Bd. of Med. Exam'rs, 172 S.W.3d 761, 777 (Tex. Ct. App. 2005).
Vermont	X		VT. STAT. ANN. tit. 26, § 1354(c) (2021).
Washington		X	Nguyen v. State, Dep't of Health Med. Quality Assurance Comm'n, 29 P.3d 689, 697 (Wash. 2001).
West Virginia		X	W. VA. CODE § 30-3-14(b) (2018).
Wisconsin	X		WIS. STAT. § 440.20(3) (2018).

Wyoming	X	X	WYO. STAT. ANN. § 33-26-407(b) (2003); WYO. STAT. ANN. § 33-26-406(c) (2009) (preponderance for petition to regain license privileges).