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It is not enough that you should understand about applied science in order that your work may increase man's blessings. Concern for man himself and his fate must always form the chief interest of all technical endeavors. . . .

albert einstein
1879—1955

Contributors for Spring

THE INDIVIDUALS BELOW MADE THIS NUMBER OF THE FEDERATION BULLETIN *POSSIBLE.*

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PRESIDENT'S MESSAGE

Dr Sigel

Moving on from Here

MELVIN E. SIGEL, MD

As I leave the presidency of the Federation and move farther and farther away from involvement on my own state's medical licensing board, it becomes easier, retrospectively, to evaluate a decade of personal association with licensing at state and national levels. The first blush of enthusiastic activity in medical board service tends to fade and the experience gains focus, assumes clearer lines and sharper dimensions, as you move on. It becomes easier to appreciate just what you have been through.

Medical board service is an activity requiring sacrifice and commitment

Medical board service is an activity requiring sacrifice and commitment. It requires perseverance despite pressures that would surely tax even the most dedicated (essentially unpaid) volunteer. I need not remind this journal's readers of the restraints and pressures under which boards operate and the personal sacrifices that each board member must make. However, it is the rare board member who does not get caught up in the goal of public protection, the goal that drives us to continue despite forces that ofttimes seem to interfere with, thwart and frustrate our efforts. Certainly in the last ten years, the role and effectiveness of medical boards has been subject to criticisms that we may consider unfair. Despite what we may self-righteously see as our effective and responsible licensing and discipline activities, there are many who view us in a different light. If you read newspapers or watch television news specials regularly, you will soon discover exactly how the public feels about medical boards. In all candor, taking away the sensationalism and the rhetoric, there is truth, unfortunately, in some of the accusations. For many good reasons you know as well as I, we will probably never be good enough to escape all criticism, but we can avoid much of it by identifying and dealing with those problems that are in our power to correct.

If you read newspapers or watch television news specials regularly, you will soon discover how the public feels about medical boards

In that vein, let me stress the Federation's ongoing activities aimed at helping medical boards help themselves. Over the years, it has been my good fortune to have been a member of Federation committees and ad hoc groups that have developed and revised several important documents: (1) *A Guide to the Essentials of a Modern Medical Practice Act;* (2) *A Model for the Preparation of a Guidebook on Medical Discipline;* (3) *Elements of a Modern State Medical Board: A Proposal;* and (4) the *Self-Assessment Instrument for State Medical Boards (SAI).* These documents in themselves are of no value unless used. If every

board each year set as a goal using the guidance provided in the above documents to correct a deficiency identified through the *SAI,* we would ensure more responsive boards better able to assure public protection at the state level, where we all want licensure to remain.

Of all the projects I have been involved with at the Federation level, I am most excited about the potential of the *SAI.* We are just beginning to see the value of this instrument as the preliminary data come in. Over the next months and years, the tremendous amount of information available to boards in the *SAI* will be obvious to us all. It is a Federation goal to continue to support boards in their *SAI* evaluations and help them wherever and whenever possible.

I am most excited about the potential of the SAI

Also, the Federation is positioning itself to be more proactive in the near future by adding a fourth executive, enabling all boards to have representation at the annual meeting of the House of Delegates, and extending efforts to visit with and help boards whenever requested.

The Federation's licensing examination future is bright as we begin the United States Medical Licensing Examination (USMLE) in partnership with the National Board of Medical Examiners (NBME). The Federation's partnership with the NBME provides medical boards with acceptable examinations such as the USMLE and the Special Purpose Examination, fulfilling a major obligation of the Federation. The Federation's Board Action Data Bank, excellent to start with, is getting even better, more responsive and easier to use. We are also trying to strengthen our visibility with the federal government as we go into the years of "health system reform."

The Federation's partnership with the NBME provides medical boards with acceptable examinations that fulfill a major obligation of the Federation

No matter what we have done in the past, we must do more in the future. Complacency and inattentiveness to the public's perception of insufficient disciplinary activities and avoidance of tough quality-of-care issues will certainly bring federal licensure if we do not persevere. Use the *SAI!* Work on your deficiencies. Pester your state government to help you. Use public opinion in a positive fashion. Be proactive and change with the times. Our constituency, the public, demands and deserves no less.

I leave the presidency with a sense of personal gratification. However, I am left with the nagging realization that there is much more to do. The Federation and its member boards must work together, helping one another and changing with the times.

There is much more to do

I wish to thank the Board of Directors, all of those who labored on committees and boards this past year, and especially the dedicated and able staff of the Federation office in Fort Worth. It has been my pleasure and honor to serve the Federation. In the best of all possible worlds, it is my hope to stick around and continue to prod and probe whenever and wherever I can to strengthen medical boards. We must all do that.

It has been my pleasure and honor to serve the Federation

EDITORIALS

The Next Seven Generations: Reflections on the Context of Change and Health Care Reform

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In November 1992, a plurality of the American people chose a new President who spoke the language of change and reform. And a clear majority voted for an end to the political status quo. This turn toward a new vision was driven, in part, by a perceived failure of the nation's political leadership to face critical social and economic problems. It seemed time to move.

Early on, a number of observers suggested the results of November might prove as dramatic as those that sprang from the political sea change brought on by the Great Depression. Many remain sanguine. Others, not surprisingly in view of past experience, were and are rather skeptical about the possibilities.

On the side of the hopeful is that today much of the world is changing with a speed that would have been thought impossible only a few years ago. In Europe and much of Asia, tyranny, in the guise of communism, has collapsed. Its fall could prove temporary, of course, but it provides a heartening reassurance to the spirit. A striving toward change for the better appears to have become the way of the world for these latter days of the second millennium and it would be naive to expect the impulse for change to be limited to any one people or region.

That a growing number of Americans should be examining the failures of their own society and demanding they be addressed would seem a natural development in this post-Cold War era. The abatement of old tensions brings more than relief and thankfulness. It frees us at last to admit the flaws in ourselves. It breaks through the insularity of our defensive fixations.

In looking at ourselves in the sometimes painful light of this new day, there is a sad shock of recognition shared with that eternal youth in the heart of us all who sees in the mirror each day the face of passing time staring back. And we suspect we must dramatically change some fundamental elements of our lives and our society to fulfill the promise of who we were before we became who we are.

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In this context, we are focused now on the need for dramatic reform of this country's health care system. Staggering costs and limited access have denied

millions of Americans, largely women and children, adequate medical care. The facts and figures may be debated, but the social and human problem is vividly real. No society, least of all ours, can justify such a situation. And as we move to correct it, we would do well to recall these words from the Great Law of the Haudenosaunee (People of the Longhouse, the Six Nations Iroquois Confederacy): "In our every deliberation, we must consider the impact of our decisions on the next seven generations." With so complex an issue, expediency, politics, and vested interest could blind many to the simple truth of that precept.

The shape of the health care reform proposal is slowly becoming a bit clearer as the President's special task force approaches the end of its work. It has been reported that, among other things, the focus will be on providing basic coverage to every legal resident, creating a competition-based managed health care system, setting up powerful Health Alliances to represent the interests of large groups of consumers, and establishing a National Health Board to oversee and regulate the system. It could take two or three years, possibly longer, to put the system in place. New taxes and cost controls would be inevitable. It appears the effort, for now, will be to combine several elements of nationalized and market-driven health care systems. Problems still being studied involve how broad coverage should be, what taxes should be increased, and how swiftly the system can be put in place.

The President's proposals, which will probably not be released before mid-June, will not pass unscathed through Congress, of course. The final shape of the new program cannot be accurately predicted, but whatever emerges, it is safe to say it will be only the first step in the journey of health care reform. Public expectations and the now established social and political commitment will make further change inevitable.

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For now, however, amidst all the recent discussion about access and cost, we have noted a distinct and disturbing lack of emphasis on the issue of quality. As we have noted before (June 1992), the state medical boards are an essential component of quality assurance in this country. They play a key role through their evaluation of the qualifications of physicians for licensure. This is essential to all that follows. Add to their initial licensing function the state boards' regulatory authority, with all that implies, and their power to discipline physicians who are incompetent, unfit, or impaired, and you have a fundamental part of any serious quality assurance effort.

At some point as the reform effort progresses, the work and responsibility of the state medical boards must be recognized in relation to the issue of quality. Certainly, the federal government, as appropriate, should move to enhance the role of the boards within any evolving health care system.

In this number of the *Bulletin* are three items that can contribute to and widen the context of any discussion of the role of the state medical boards in this changing environment. The information provided in the article by Jost (Medical Education, Licensure and Discipline in Four European Countries) offers interesting comparisons and contrasts when considered from the perspective of state medical boards in the United States. Equally interesting, though less

than reassuring, are the challenging views concerning state medical boards presented in the article by Svorny (Advances in Economic Theories of Medical Licensure). The potential of boards in the area of quality assurance is reflected in recent reports from the Office of the Inspector General reviewed in this number by Rodecker (Two New Reports from the OIG/HHS).

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Clearly, the debate on health care reform is far from over. Numerous issues, including quality assurance, will be addressed for months and even years to come. But when all is said and done, if we know, as a nation, that we have considered the next seven generations in our deliberations, we shall have kept faith with the future. It is time we did.

DGB

On a Milestone: The Bulletin Enters Its Eightieth Year

The Federation's official publication enters its eightieth year with this number, and we venture to say it is not doing too badly for an octogenarian. It has put a touch of paint on its face, adopted a new style of dress, and begun to get about a bit more. But not forgetful of its past, it has reverted to its original quarterly publication schedule, allowing itself time to gather and prepare its materials with a mite more care. At the same time, it is presenting more material each quarter than was the case in its previous monthly incarnation. Thus, it approaches its ninth decade and moves toward the millennium with what we hope is a lively step.

As our editor emeritus, Dr Ray Casterline, pointed out in his comments on the *Bulletin's* seventieth birthday, this publication is a significant part of the Federation's heritage. When the organization was founded in 1912, it was formed by the coming together of two national groups: the National Confederation of State Medical Examining and Licensing Boards and the American Confederation of Reciprocating Examining and Licensing Boards. The latter group, the younger parent, was established in 1902 largely to promote interstate reciprocity and endorsement, and issues related to that agenda were regularly debated by the Federation over many years. In the 1960s, at long last, the major breakthrough came with development of the FLEX. That examination and its successor, the USMLE, are an outgrowth of the purposes of the American Confederation.

On the other hand, the Federation's commitment to enhancing the interchange of information about medical licensure and discipline can be traced to its elder parent, the National Confederation, which was founded in 1891 to improve communication among the boards. The *Bulletin* sprang from the work and goals of that organization. It was virtually inevitable that a Federation journal would be created almost as soon as the Federation was established. And so it was, in 1913, when the *Federation Quarterly* was begun one year following the birth of the organization. By 1915, the *Quarterly* had become the *Monthly Bulletin*. In 1920, it would become the *Federation Bulletin*. In 1992, it became

the *Federation Bulletin: The Journal of Medical Licensure and Discipline,* a title that reflects both its history and its purpose.

We find wandering through the pages of past numbers, long past and somewhat faded, a remarkable and enlightening experience. Our fragile world, the field of licensure, and the publication itself have undergone dramatic changes over these eight decades of the human comedy. No surprise there, of course; but how fascinating to see those changes appear and develop year by year, volume by volume. And how fascinating to see the Federation address those changes as effectively as the times allowed. It instills a sense of obligation to those who came before. We only hope the modifications we have worked and will continue to work while moving the *Bulletin* forward will do credit to the Federation's past and to those who gave it substance.

To share with our readers a bit of this publication's history, we intend to publish over the coming year several articles that appeared in the *Monthly Bulletin* in 1915. Unfortunately, all copies of the original *Federation Quarterly* were lost many, many years ago. The volume for 1915 is the oldest now surviving. Therefore, we have drawn on it for the Paging Through Our Past section of this and the following numbers of Volume 80 to offer you a look back at yesterday. You may find it remarkably familiar territory at times.

We begin with an "article" that was actually a record of the earliest discussion on the development of a model medical practice act. Participating were several key founders and leaders of the organization. Articles scheduled for later numbers include: Hindrances to Progress in Medical Education, The Present Non-Conformity of Medical Licensure, A National Entrance Examination Board, and Registration Under the Canada Medical Act.

Glancing back can be instructive and helps us keep our sense of proportion. It also reminds us that we owe a debt to the past that we can repay only by serving the future. As the *Bulletin* enters its eightieth year, it is very much a part of the future and it will do what it can to pay the debt.

DGB

Medical Education, Licensure and Discipline in Four European Countries

TIMOTHY STOLTZFUS JOST, JD

Overview: *The author examines medical licensure and discipline in four European countries and concludes the agencies studied are not primarily concerned with competence or quality of care. Their main focus is on professional issues as traditionally defined. They rely largely on patient complaints to identify problems, their investigative techniques are weak, and they lack sanctions appropriate for addressing quality issues. However, they do have some deterrent and educative effect and they do encourage the strong professional values that support quality assurance.*

INTRODUCTION

This article is derived from a study conducted in 1989 of efforts to assure the quality of medical care in four European countries: Belgium, England,[1] the Federal Republic of Germany,[2] and Sweden. While the final report of this study, published by the King's Fund in London in 1990 (Jost, 1990), discussed a broad range of approaches to quality assurance, this article focuses on medical education, licensure and discipline, the topics of most interest to American licensure boards. The four European countries considered were chosen, in large part, because they represent a range of approaches to health care system organization. To simplify great complexities, in Sweden and England, health care is both provided and paid for by the government; in Belgium and Germany, health care is privately provided (though many hospitals are publicly owned) and financed through mandatory quasi-public insurance. These countries illustrate, therefore, a range of possible approaches to the organization and regulation of health care, including some that might be considered in the United States in the coming years.

THE FOUNDATIONS OF PROFESSIONAL COMPETENCE: EDUCATION AND LICENSURE

If one were to ask the average citizen of one of these four countries, "what guarantees the quality of the care you receive when you seek medical treatment?" it is likely that the respondent would mention professional educa-

Under the EEC Treaty, licensing requirements of these countries look increasingly alike

tion and licensure. Each of the countries licenses, and thus establishes educational and examination requirements for, a variety of medical professionals. Because the EEC Treaty (which covers all of the countries here under consideration except Sweden) guarantees mutual recognition of "medical and allied professions," these requirements look increasingly alike. But to what extent do these professional entry requirements actually assure the competence of physicians?[3]

All four countries draw each year from a pool of aspirants to the medical profession far larger than the profession could accommodate. The high income levels, intellectually stimulating work, and opportunities to help others that characterize the medical profession, at least in the popular imagination, continue to attract a large number of intelligent and ambitious young men and, increasingly, women. Medical schools or national placement boards can thus afford to be very selective in choosing candidates. Germany, Sweden, and England narrow the field at the point of admission to medical school, relying heavily on intellectual ability as demonstrated through examination scores and prior academic performance (Allen 1984, Borgenhammer 1984, Eichhorn 1985, Walton and Binns 1984). Germany also relies in part on a combination lottery/waiting list, and Sweden considers life experience as well as academic performance for older students. As most matriculated students in these countries finish the course and go on to practice medicine, this selection process plays a vital role in assuring the quality of medical practice. Belgium takes a different approach, permitting anyone who desires admission to medical school to have a go at it, by relying on a high attrition rate, about 60 percent, to assure the quality of the final product (Albert et al 1989).

Except in Belgium, most matriculated students in these countries finish the course and go into practice

European Community (EC) directives require that doctors complete a university course of training of six years or 5,500 hours, including education in the basic sciences and clinical disciplines and supervised clinical experience (EC Council Directive 75/363 art. 1). In England, medical instruction is supervised by the General Medical Council, and consists of five years of undergraduate medical instruction (including two years of basic sciences and three years of clinical education) followed by one year of general clinical training (GMC 1980, GMC 1987). Germany has a very similar six year educational program, including two years of basic science education, three years of clinical training, and one year of clinical experience. During this course of instruction, German students take four multiple-choice examinations, which are uniform throughout Germany, and at the end, an oral examination (BAO § 3, subs. (4), Arnold et al 1982, Halbeck 1982, Renschler 1979). In Belgium, the normal course of medical instruction takes seven years, including three years of basic science education leading to a "candidature" and four years of clinical training leading to a "doctorate" (Nys and Quaethoven, 1984, Albert 1989). Two examinations are given per year, and at each stage students may not advance until they have successfully passed the examination. Finally, Sweden, the one non-EC country studied, currently has a five and a half year program leading to an MD degree, followed by a 21 month internship leading to medical licensure (Borgenhammer 1984). Plans are currently underway in Sweden, however, to change to a task-oriented (as opposed to a time-limited) medical curriculum, which could take a longer or shorter period of time to complete

Doctors must complete six years or 5,500 hours of training

than the current program.

Possession of a license to practice medicine does not, of course, necessarily mean that one can make a living at it, particularly in countries with a national health insurance program. In Germany, for example, a doctor possessing an "Approbation," or license, must practice for an additional year under the tutelage of an OID physician before obtaining a "Zulassung," or right to be reimbursed for outpatient care by the insurance system (SGB B § 95). In England, general practitioners must complete three years of training beyond licensure, including normally two years in hospital and one year with a practicing general practitioner, before they can obtain a contract to provide services for the National Health Service (Allen 1984).

In any event, most physicians currently pursue postgraduate education to obtain certification in general practice or in one of the other specialties. The broad outlines of specialist training are again governed by EC regulations in EC countries and are in many respects similar in all four countries (EC Council Directive 75/363, arts. 4, 5). There are noteworthy differences, however. Specialist training is shortest in Sweden, where it lasts from four to five and a half years, and longest in England, where most specialties require from six to seven years of postgraduate training (WHO Regional Office for Europe 1983). In Belgium, a doctor seeking specialist certification must find a specialist trainer willing to accept him, and then get his individual training program approved by the appropriate Flemish or French specialty chamber (Nys and Quaethoven, 1984). The entire Belgian program is run by the specialist societies and universities, with only broad guidance from the government. In Sweden, specialist education is governed by the National Board of Health; in Germany, by the state physician chambers, and, in England, by the Royal Colleges subject to coordination by the General Medical Council (Smith 1989b). In Belgium, there is no examination following specialist training, Germany requires an oral examination, and in England, candidates must endure oral, written, and practical examinations (WHO Regional Office for Europe 1983).

The broad outlines of specialist training are governed by EC regulations

Can these educational programs be relied on to produce doctors who will consistently and reliably provide medical care of adequate quality? Certainly, there is much to be said for systems that first select the best and brightest, then impart to them a great deal of information under the pressure of repeated examinations, and finally provide supervised experience delivering care to actual patients, with increasing responsibility as the course progresses. But the process is not above criticism.

First, the educational programs of the individual countries have their own peculiar weaknesses. The German program has been criticized for its large class sizes and few undergraduate patient contact hours, and, above all, for its reliance on multiple choice examinations, which encourage rote learning (Halbeck 1982, Renschler 1979). The short specialist training periods required in Sweden, coupled with the 40 hour work-week and 35 to 40 week work-year in Sweden, has the potential for producing specialists with remarkably little experience in caring for patients (Smith 1981). On the other hand, the heavy reliance on junior doctors for patient care in England raises the specter of service obligations crowding out education (Styles 1988).

The educational programs of the individual countries have their own peculiar weaknesses

Other criticisms apply more generally (WCME 1988, Ellis, 1987, Horder et

al 1984). First, fault is found with programs for emphasizing intellectual skills at the expense of interpersonal skills and, more narrowly, for stressing memorization rather than critical and analytical skills. Medical training programs, it is asserted, tend to rely on passive education rather than teach active learning skills. Doctors are not trained adequately to be sensitive to the needs of their patients or aware of the larger context of health and disease. Training in primary care is generally neglected in favor of a focus on specialist training (Walton 1985). Educational programs are criticized for being too short, crowded, and fragmented; covering more information than in fact can be assimilated; and leaving inadequate time for reflection, integration, and maturation (Smith 1989b). Residency programs are criticized for not being diligent in filtering out incompetent candidates who make it through undergraduate programs (Rhodes 1986).

Doctors are not trained to be sensitive to the needs of their patients

Even if the basic and specialization process does produce doctors competent to enter the medical profession, it certainly cannot assure that they will be competent 20, 10 or even 5 years later, given the rapid advance of medical knowledge, and, therefore, the rapid obsolescence of knowledge gained in medical school. Keeping doctors up to date is the task of continuing education. But only in Germany is continuing education mandatory (Bundesärztekammer 1988, § 7), and even there the obligation is so vague as to be unenforceable. A Belgian general practitioner is entitled to charge higher insurance fees upon the completion of 200 hours of continuing education, but there is no obligation or inducement to continue beyond this point (Nys and Quaethoven 1984). England required GPs to participate in continuing education at one time as a condition of receiving merit bonuses, but dropped the requirement in 1978.

Only in Germany is continuing education mandatory

Opportunities for continuing education do exist throughout Europe for those inclined to pursue it. Current continuing education programs no doubt make good doctors better. In the absence of enforceable obligations to compel or financial incentives to encourage attendance, however, it is unlikely that inadequate doctors will pursue the opportunities continuing education offers them to make their practice acceptable.

In the final analysis, it is impossible to judge the extent to which professional education and licensure assures the quality of medical care. Certainly, there is no movement afoot to abolish the current approach or to replace it with something else. It is safe to say, however, that it is risky to rely on education and licensure as the sole guarantees of quality, particularly as the educational experience of professionals recedes further and further into the past as they age. Once physicians are licensed, therefore, mechanisms must be in place to remove or limit licensure if a physician ceases to be competent.

It is risky to rely on education and licensure as the sole guarantees of quality

POLICING THE BOUNDARIES: PROFESSIONAL DISCIPLINE

Each of the countries here studied has a medical disciplinary board which has the power to sanction doctors in various ways, including revocation (or recommendation of revocation) of medical licenses. Historically, these processes have been the primary mechanism available for policing professional performance. This section will assess the contribution of these bodies to medical quality assurance.

Belgium

All physicians in Belgium must be members of the Order of Physicians (Les Ordres des Medecins or de Orde der Geneesheren).[4] The Order is composed of a National Council and ten provincial councils. Each of the provinces has one provincial council except for Brabant (Brussels), which has two, a French and a Flemish. Half of the provincial councils are Flemish and half French.[5] The National Council (which is divided into a Flemish and French speaking section) is headed by a judge from the Court of Cassation assisted by the Flemish and French vice presidents, both doctors. Ten of its delegates represent the provincial councils and six are proposed by medical faculties and appointed by the King (Anrys 1971). Its primary responsibility is to formulate professional rules governing doctors, including the ethical code (Anrys 1971). The provincial councils are composed primarily of doctors elected from the membership, but each also includes one judge and a delegate from the National Council. The principal function of the provincial councils is to handle medical discipline (Anrys 1971).

The principal function of the provincial councils is to handle medical discipline

The professional obligations of Belgian physicians are set out comprehensively in a royal decree and in the Deontological Code of the Order.[6] If a doctor violates these obligations, a complaint can be made to the relevant provincial council. Most of these complaints originate from patients, but they also come from insurance companies, hospitals, employers, the public prosecutor, or other doctors (AR 79 (1967), art. 20, § 1). Upon receipt, a complaint is sent to the doctor for a response. The complaint and response are then screened by the board of the provincial council. The board is composed of the provincial council's president, vice president, and secretary, its National Council representative, and its judicial member (AR 79 (1967), art. 20, § 1). This panel can decide that investigation should be initiated or propose to the council that it reject the complaint. The council alone can decide whether or not to reject a complaint. If the council or its board orders an investigation, it will be conducted by one or two medical members and the judicial member of the council. The investigation may involve interrogating the doctor or patients and reviewing relevant medical records. Where necessary, assistance in the investigation may be obtained from inspectors from the Ministry of Health or INAMI (the national entity that coordinates the health insurance system).

Most complaints originate from patients

If the investigation substantiates the complaint, a hearing will be held before the provincial council. At the hearing, the doctor will be present and may be represented by counsel. A complaining patient who effectively initiates a proceeding will not be informed of the hearing and may not be present, as the hearings are not public.[7] At the hearing, the judicial member is responsible for assuring that proper procedures are followed and that the decision is made without bias. If the council decides that a sanction is appropriate, it may issue a warning, censure, or reprimand, suspend the doctor for up to two years, or revoke the doctor's license (AR 79 (1967), art. 16). The sanction of revocation must be voted by a two-thirds majority.

Hearings are not public

A doctor dissatisfied with the decision of the provincial council may appeal to the French or Flemish National Appeal Council (AR 79 (1967), art. 21, Van Lil 1987). An appeal can also be brought by the judicial member of the provincial council or concurrently by the president and one vice president of

the National Council (which is informed of all provincial decisions, AR 79 (1967), art. 21). The appeal councils are composed of five members named by the provincial councils, five named by the King, a clerk and a representative of the National Council (Anrys 1971). They conduct in public a de novo review of the entire case (AR 79 (1967), art. 25, § 4). The appeal councils may not only affirm or reverse a decision of a provincial council, but by a two-thirds vote, may also increase the penalty assessed by it (Van Lil 1987). The decision of the appeal council can be appealed to the Court of Cassation, but only on issues of law (AR 79 (1967), art. 23). A final decision resulting in suspension or erasure is reported to the relevant provincial medical commission, INAMI, the Attorney General, and the Minister of Health.

Cases involving mental or physical disability are handled separately

Cases involving mental or physical disability are handled separately from disciplinary cases by provincial medical committees, which are composed of representatives of a variety of medical and paramedical professions, and have responsibility for a variety of public health concerns (AT 78 (1967), arts. 36, 37; Anrys 1971). This body has the power to retake a physician's "viser," or permission to practice (which is normally granted as a matter of course by the provincial ministry to a doctor who has qualified for licensure), until the doctor regains capacity to practice (AR 78 (1967), art. 37, § 1(2)(b)). It may also limit or condition the physician's right to practice. The decisions of this body are not considered disciplinary sanctions, but can be appealed to a national committee of appeal and from there to the Council of State (AR 78 (1967), art. 37, § 4).

It is difficult to determine the extent to which the disciplinary actions of the Order affect quality of care. The Deontological Code imposes on each physician obligations to deliver high quality care and to improve the quality of care in the setting in which he works (Deontological Code (1975), § § 34, 35, 100). For 1984 and 1985, the most common ground for discipline was neglect of duties to patients (122 cases). This category is referenced to articles 6 and 113 of the Deontological Code, however, which refer respectively to the duty to render assistance in emergencies and to abandonment, rather than directly to competence and quality. The next most numerous categories of disciplined offenses include having too many offices (the number of offices a doctor may maintain being regulated by the Order); neglect of collegial duties; and disrepute in private life. None of the reported disciplinary categories are explicitly related to quality of care or to competence, though several, such as causing drug addiction or misuse of therapeutic freedom, may involve quality issues.

None of the reported disciplinary categories are explicitly related to quality of care

Recently, the Ministry of Public Health has proposed legislation that would bring about a number of changes in the Order of Physicians (MSP 1989). Membership of the Order's Councils at all levels would be modified, adding a representative of INAMI to the provincial councils; reducing the terms of office and minimum experience and maximum age requirements for members of the Councils to bring in younger members; adding delegates of the Royal Academies and senior civil servants to the National Council, and adding a magistrate from the labor courts to the provincial and appeal councils. Disciplinary procedures would be elaborated to separate prosecutorial and judicial functions, and all hearings would be held in public, to comply with European

Court of Human Rights concerns. All complaints would have to be heard, and complainants would be given the right of appeal. If these changes were to be adopted, they would go some distance towards making medical discipline in Belgium less a matter of internal self-regulation and bringing it more under external control. The changes are being resisted by the medical profession, which believes that they will result in wasting much time and energy on invalid complaints. The author could not determine whether they have been implemented.

Changes are being resisted by the medical profession

Germany

Medical discipline in Germany is governed by the Ärztekammer or physician chambers (PCs), which are also responsible for specialist training, continuing education, and regulation of ancillary outpatient personnel (Anrys 1971, Arnold et al 1982). There is one PC in each of the lands and two in North Rhein-Westphalia (Stobrawa 1989).[8] A national Bundesärztekammer coordinates the work of the PCs, but has no disciplinary authority.

A general licensing law is administered by the states

A general licensing law, the Bundesärzteordnung, exists at the federal level, but is administered by the states. Each state also has a professional code (Berufsordnung) enacted by the PC on the authority of the state laws with the consent of the relevant state ministry. These are modeled after a national Berufsordnung, adopted by the national medical association, which itself has no independent legal authority (Bundesärztekammer 1988).

The procedures of the PCs vary somewhat from state to state. The procedures of the PC of North Rhein, which are typical, are described here.[9] Proceedings against a doctor before the PC must be initiated by complaint. Complaints most commonly come from patients, though they could come from other sources, such as doctors or from the criminal courts. A copy of the complaint will normally be sent to the doctor for a response, which will be reviewed, with the complaint, by the president of the PC. The president may in the case of technical violations send a letter of admonition to the doctor. He may also advise a patient complainant to consider initiating a case for compensation in a civil court or before a Gutachterkommission, entities that are established for settling malpractice cases. More serious cases (about 10 percent of all complaints) will be reviewed by the executive committee of the PC.[10] This committee of 18 members meets once a month. The director of the PC presents reports on medical complaints, a lawyer for the PC presents cases involving primarily legal issues. The PC proceeds to discuss the case in private session. It may hold hearings, but rarely does. The dispositions available to the committee at the close of its deliberations are to dismiss the complaint, admonish the doctor, proceed to prosecute the case before the professional court (Berufsgericht) of the state, or advise the health minister of the state (Regierungsprasident) to revoke the doctor's license.

The PC may hold hearings, but rarely does

The professional court of the state is composed of a judge and two doctors. It holds a public hearing, in which the PC acts as the prosecutor. This court may warn or admonish the doctor, fine him to 100,000 DM, or find him unworthy to practice his profession (HeilBerG NRh § 49). Only the Minister of Health of the Land has the power to revoke a license, and under federal law, an otherwise unqualified doctor can only lose his license if he is found guilty

of behavior that demonstrates his unworthiness or unreliability to practice his profession, or for mental or physical incapacity (BAO § § 3,5). As a practical matter, this means that a doctor will lose his license only if he is convicted of a crime or becomes disabled. A referral from the PC or professional court is not a prerequisite to the Minister of Health revoking a physician's license, and in North Rhein it is not uncommon for the Minister to do so on his own motion, most commonly for conviction of fraud against the sickness funds. This may not be typical, however.

A doctor will lose his license only if he is convicted of a crime or becomes disabled

There are no nationally available statistics on medical disciplinary matters, thus it is difficult to judge the extent to which discipline addresses quality of care issues. The Bundesberufsordnung (Budesärztekammer 1988) devotes a good deal of space to traditional professional issues such as advertising and collegiality and ethical issues such as abortion and sterilization, but also includes obligations for doctors to pursue continuing education (§ 7); to keep patient records (§ 11); to carry malpractice insurance (§ 8); and (recently added) to participate in quality assurance activities (§ 7a). The director of the North Rhein PC estimated that about one quarter of the cases before his PC deal with quality of care issues (including alcohol and drug abuse issues), one quarter deal with advertising, and the other half address miscellaneous ethical and professional issues. In response to a questionnaire sent out by the author, one PC wrote that disciplinary proceedings involving quality of care issues were so rare that no statistics existed with respect to them. Another PC sent an annual report for 1988, which indicated that out of 37 disciplinary proceedings the previous year, 27 dealt with fraud against the insurance funds, and the remaining 10 addressed a variety of professional disciplinary matters, few of which seemed related to quality of care. Finally, a third PC indicated that disciplinary proceedings most frequently were concerned with general professional obligations, fee matters, and poor medical notes. In sum, though quality issues are addressed by the Berufsordnung, they do not seem to constitute a large proportion of the disciplinary activities of the PCs.

Quality issues do not seem to constitute a large proportion of the disciplinary activities of the PCs

England

The medical profession in the United Kingdom, including England, is governed by the General Medical Council (GMC).[11] Although the GMC is fundamentally a mechanism of professional self-regulation, it varies somewhat from the medical chambers of Belgium and Germany. Only 50 of its 97 members are elected by the medical profession, with the remainder appointed by the Royal Colleges or universities or nominated by the Queen. It has long had some lay members, and, currently, 11 members are non-physicians (Med. Act of 1983, sched. 1, pt. I, GMC 1988b). Historically, the GMC has been most representative of elite and specialist medicine, and elected representatives of the profession have only had a majority of the GMC since 1978 (Rosenthal 1987, Smith 1989a, Stacey 1992, Walton 1988a). The GMC has come in for a good deal of criticism of late, and proposals for its reform are being mooted (Brazier 1985, Cook 1987, Robinson 1988, Smith 1988a, 1989, Stacey 1992).

The GMC has come in for a good deal of criticism of late

The authority of the GMC resides in its maintenance of the register of medical doctors in the United Kingdom. A person need not be registered to practice

medicine in the UK, but only registered doctors are entitled to certain legal privileges, including the right to sue for collection of fees for medical services (Medical Act of 1983, § 46(1)). Moreover, the National Health Service (NHS) may only employ registered doctors. The GMC can remove a doctor from the register (or suspend his registration for up to one year or make it conditional on compliance with specified requirements for up to three years) if it finds that the doctor has been convicted of a criminal offense or is guilty of serious professional misconduct (Medical Act 1983, § 36). "Serious professional misconduct" is defined as conduct "reasonably regarded as disgraceful or dishonorable by his professional brethren of good repute and competency..." (GMC 1989b, p. 2). A doctor's registration can also be suspended for up to one year or be made conditional for up to three years if his fitness to practice is seriously impaired by his mental or physical condition (Medical Act 1983, § 37).

The GMC can remove a doctor from the register if it finds the doctor has been convicted of a crime or is guilty of serious professional misconduct

The disciplinary functions of the GMC are exercised by its Preliminary Proceedings and Professional Conduct Committees. The Preliminary Proceedings Committee is composed of 11 members, including 2 lay members. The Professional Conduct Committee has 32 members, 11 of which sit on any one case. A panel will usually include 2 lay members. Impairment decisions are made by the GMC's Health Committee.

Cases are initiated by the GMC when it receives a report of a conviction by a criminal court or a complaint or information suggesting professional misconduct from a patient, the Health Department (based on Medical Service Committee proceedings disciplining general practitioners) or from the NHS (regarding doctors employed in its hospitals) (GMC 1989a, Merrison 1985, Smith 1989c). The GMC obligates doctors to report serious professional misconduct when they are aware of it, but relatively few do (GMC 1989b).[12] Complaints are screened by the GMC's staff, and in the majority of cases referred to a member of the GMC appointed as "preliminary screener."

The GMC obligates doctors to report serious professional misconduct when they are aware of it, but few do

Where a complaint involves an NHS doctor, as most undoubtedly do, the GMC will often suggest that the complainant consider pursuing the NHS or Family Practitioner Committee complaint mechanisms rather than proceeding in the first instance before the GMC. The GMC argues that these referrals assure that complainants will not miss the short (eight week) limit for using these procedures, that dual investigations are impractical, and that individuals who do not choose to pursue NHS procedures or are unsatisfied with the result they obtain there, may proceed before the GMC. These referrals have been criticized, however, as sloughing off serious charges to ineffective procedures rather than dealing with them directly, adding substantial delay to the review of consumer concerns, and unnecessarily discouraging complainants who are often intimidated by the whole process to begin with (Robinson 1988, Smith 1989c).

In 1988, 66 of the 967 complaints received by the GMC were redirected to the NHS and 760 were dismissed (GMC 1989a). Eighty cases were dealt with informally by the preliminary screener in consultation with two members of the preliminary screening committee (GMC 1988a, Smith 1989d). Where appropriate, this involved a letter of advice. One hundred forty-three cases, involving the remaining 127 doctors, were referred to the Preliminary Proceed-

ings Committee.

Before a case can proceed at this point, a complaining member of the public must hire an attorney and draft a sworn declaration.[13] The doctor will be notified of the charges against him and invited to respond. The GMC has no independent investigative staff, but may, if necessary, ask its solicitors to further investigate complaints.[14] The complaint and response are then considered by the Preliminary Proceedings Committee (PPC).

The GMC has no independent investigative staff

The cases received by the PPC in 1988 involved a nearly equal number of criminal cases and serious professional misconduct cases. The PPC meets in private, and can refer a case on to the Professional Conduct Committee (PCC) for hearing, send a warning letter or letter of advice to the doctor, refer the case for investigation into mental or physical fitness to practice, or dispose of the case without further action (Smith 1989e). The PPC has statutory power to impose an emergency suspension following a hearing if necessary to protect the public, but rarely does so (Medical Act 1983, § 42 (3),(4)). In 1988, the PPC dealt with 64 doctors through letters of advice, and referred 33 doctors on to the PCC.

Hearings before the PCC are formal and quasi-judicial in nature (Bayliss 1987, Rosenthal 1987, Smith 1989e, Stacey 1992). The case is presented by attorneys representing the GMC or the complainant.The doctor is represented by his own attorney. The committee considers sequentially the facts proved, whether they constitute serious professional misconduct, and what sanction is appropriate, deliberating and announcing a decision on each issue before proceeding to the next. Proceedings are normally public and deliberation in private, but the entire proceeding may be conducted in private in sensitive cases. The committee is advised by a legal assessor, who may, for example, allow admission of evidence not admissable in court if the assessor considers it necessary. Allegations must be "strictly proved by the evidence" (GMC 1989b, p. 5), essentially proved beyond a reasonable doubt.

Allegations must be "strictly proved by the evidence"

Sanctions available to the PCC include erasure from the register, suspension for up to 12 months, conditional registration for up to three years, or postponement of consideration (effectively putting the doctor on probation, Medical Act 1983, § 36, GMC 1989b). In 1988, the PCC heard 52 cases involving 40 doctors, resulting in 6 erasures,11 suspensions, 2 conditional registrations, 1 adjournment, 1 referral to the Health Committee, and 19 cases where no action was taken that would affect the doctor's registration (including 6 adjudged guilty and admonished) (GMC 1989a). A doctor whose registration is affected by a sanction may appeal to the Privy Council or seek judicial review (Medical Act 1983, § 40), but few do and even fewer do so successfully. A doctor whose registration is erased can apply for reinstatement after ten months (Medical Act 1983, § 41).

A doctor may appeal to the Privy Council or seek judicial review, but few do

Since 1980, cases involving mentally or physically ill doctors, including substance abusers, have been handled through different channels (Smith 1989f, Walton 1989). Where such cases come to the attention of the GMC, the preliminary screener can ask the impaired physician to submit to examinations by two independent consultants and to submit any other relevant medical evidence. If these examinations establish impairment, the physician may submit voluntarily to a supervised treatment program. If he refuses to do so, the case

may be referred to the PPC and from thence to the Health Committee. The Health Committee may impose a suspension or conditional registration on the doctor (Medical Act 19183, § 37). From 1980 through 1988, about 400 impaired physicians have come under the supervision of the GMC, but all but 61 of these have been dealt with voluntarily without the intervention of the Health Committee (GMC 1989a).

From 1980 through 1988, 400 impaired physicians came under the supervision of the GMC

The GMC is also currently in the process of implementing performance review procedures for addressing alleged cases of incompetence (Smith 1992, Stacey 1992b). The procedure would provide, in response to complaints of incompetence, for an informal investigation and interventions to retrain the doctor or otherwise help the doctor improve. The most serious sanction would be indefinite suspension.

It is difficult to judge the impact of the GMC on the quality of medical care in England. The GMC's Blue Book on Professional Conduct admonishes doctors to maintain "a good standard of medical care," (GMC 1989b p. 10) and, in 1988, 26 of the 143 cases considered by the PPC and 14 of the 52 cases considered by the PCC involved disregard of patient responsibilities (GMC 1989a). Only five of these resulted in action affecting licensure, however. Moreover, because the GMC relies heavily on the NHS for screening patient complaints, and because the NHS hospital complaint screening mechanism rarely results in case referrals to the GMC, the GMC's review of physician incompetency is limited almost solely to GPs (24 of the 26 cases considered by the PPCs). Critics of the GMC claim that it places nearly insurmountable barriers in the way of policing medical competence (Robinson 1988), [15] and its leaders candidly admit that the "serious professional misconduct" standard fails to address all but the most egregious quality problems (Walton 1988a, 1988b). It is possible, however, that the new performance review procedure will result in more competency based cases coming before the GMC, even if the sanctions imposed for incompetence are less severe than those imposed for other forms of misconduct.

It is possible that the new performance review procedure will result in more competency based cases coming before the GMC

Sweden

Sweden has opted for a form of professional regulation very different from the professional self-governance model adopted by the other nations in this study. Since 1980, doctors in Sweden have been disciplined by the Hälso–och Sjukvårdens Ansvarsnämnd or Medical Responsibility Board (MRP), an independent authority that functions like an administrative court.[16] The MRB is composed of a chairman, who is a judge, and eight members: three representatives of health care unions, a representative of the county councils, and four public representatives (usually members of parliament) (HoSP (1980), § 20). Of these, only one, the representative of the physicians' union, is likely to be a doctor. The MRB has jurisdiction over everyone concerned with the care of patients in hospitals or in independent practice, not just over doctors. In fact, however, about 80-90 percent of the cases that appear before the MRB concern doctors, with most of the remaining cases concerning nurses or dentists (Rosenthal 1987). The MRB is not primarily concerned with licensure actions, but rather with investigating complaints and reprimanding or warning health and medical personnel who have intentionally or negligently failed in a profes-

The MRB has jurisdiction over everyone concerned with the care of patients

sional duty (HoSP (1980), § 12). It thus functions more as a complaint board than like a licensure board.

The vast majority of complaints originate from patients or their representatives

The vast majority of complaints before the MRB originate from patients (56 percent) or their representatives (29.7 percent), with a much smaller number coming from the National Board of Health and Social Welfare (Socialstyrelsen) (14.3 percent), the Parliamentary Ombudsman, or the Office of the Chancellor of Justice (Carlsson and Issacsson 1989). In some cases, patients initially approach the National Board, which may conduct its own inquiry before referring the case on to the MRB. Under law, county councils must report to the National Board any instance where a patient has suffered or risked suffering severe illness or injury because of treatment (SOSFS (1988): 16). The National Board will investigate these cases and report back to the county council. While the primary purpose of this procedure is to improve patient treatment, in about one fifth of the cases the National Board will decide that disciplinary intervention is appropriate and refer the case to the MRB.

Complaints received by the National Board are sent to the professional complained of, who responds in writing (HoSP (1980), § 30). This response is then submitted to the complainant, who may comment on the response (HoSP (1980), § 31). The complainant's comments are then returned to the professional, and this exchange of documents may continue until both parties have had their say. The MRB can also conduct its own investigation, but rarely does. The exchange of correspondence and relevant patient records are then reviewed by an appropriate specialist consultant of the MRB, who, together with one of the MRB's lawyers, prepares a record and report to be submitted to the MRB. Until 1989, the MRB had to consider all complaints within its jurisdiction filed within two years of the incident complained of (about 75 percent of the total number of complaints received), but the law now allows the chairman to reject frivolous complaints.

The MRB can conduct its own investigations, but rarely does

The MRB meets in private each week for from two to four hours to consider about 20 cases. The report on each case is presented by the expert who prepared it. Most proceedings are conducted based on the written evidence, but the MRB can, and occasionally does, hold oral proceedings at which the parties may be present (HoSP (1980), § § 38, 34). The MRB normally accepts the report of the investigating expert, though it is not uncommon for the report to be modified. In about 80 percent of the cases concerning doctors no disciplinary action is taken, though the report may be critical of the doctor (Nygren 1985, Rosenthal 1987). In most of the remaining cases, the doctor is either warned or admonished. Disciplinary action is much more likely in cases initiated by the National Board (62 percent) than in cases initiated by patients or their relatives (8-9 percent) (Carrlsson and Isacsson 1989).

In about 80 percent of cases concerning doctors, no disciplinary action is taken

The MRB can revoke a doctor's license or limit his prescribing privileges only in cases initiated by the National Board of Health and Social Welfare. The National Board initiates delicensure cases based on the mandatory report it receives from hospitals, criminal convictions of professionals, or egregious cases referred to the National Board by the MRB. Licenses can only be revoked involuntarily if the professional "has been grossly incompetent in the practice of his profession or has otherwise shown himself to be manifestly unsuitable to practice the same," or is physically or mentally incapacitated (HoSP (1980),

§ 15). License revocation is rare and most commonly based on substance abuse.

Decisions of the MRB can be appealed by the disciplined professional, the complainant, or the National Board to an administrative court, and in fact often are. Sweden is the only country in this study that allows patients to appeal decisions not to discipline a professional.

It is again difficult to judge the impact that the MRB has on the quality of medical care in Sweden. It certainly seems more focused on patient care issues than the boards of the other countries studied. Rosenthal's analysis of a sample of MRB files found that virtually all of the complaints reviewed dealt with patient care, including about 40 percent with therapeutic error, 25 percent with diagnostic error, and 25 percent with general poor treatment and behavior of staff (Rosenthal 1987). The analysis of Carlsson and Issacson of 1,019 complaints processed between 1980 and 1985 found that 52 percent of the complaints concerned bad treatment, 36.7 percent concerned professional-patient interaction problems (Carlsson and Isacsson 1989).

The MRB seems more focused on patient care issues than the boards of the other countries studied

The opinions of the MRB are public. It also publishes and circulates widely both annual and monthly summaries of its decisions, which must have an educational effect. Further, about four to five percent of Swedish doctors are complained of each year, so many doctors have had personal experience with the MRB (Rosenthal 1987). Several prominent Swedish doctors with whom I spoke, however, noted that the MRB disciplines only a fraction of the doctors whom it investigates, and opined that it has little impact on the care provided by most doctors.

The Impact of Professional Discipline on Quality of Care

This section began with the proposition that professional disciplinary proceedings might improve the overall quality of medical care by ridding the professions of incompetents. This hope seems on the whole futile for the countries under review. Over the eight year period from 1973 to 1980, studied by Rosenthal, only 1 in 5,553 doctors in Britain and 1 in 3,180 doctors in Sweden had their licenses revoked per year (Rosenthal 1987). While comparable statistics are not available from Germany and Belgium, there is no reason to believe they are radically different. When one considers that many of these actions were taken for reasons having little to do with quality, and that revoked doctors often can regain their licenses relatively quickly, there is little ground for believing that license revocation has a serious impact on the pool of incompetent practitioners.

There is little ground for believing license revocation has a serious impact on the pool of incompetent practitioners

There is slightly more reason for hoping that disciplinary actions short of license revocation may have some effect on the quality of care. Though license revocation is the function of licensure boards that draws most public attention, a public warning or reprimand by an august official body, or even involvement in a disciplinary proceeding regardless of the result, is surely no small thing, and must have a deterrent effect both directly on the doctor affected by it and indirectly on those who become aware of it. Nonetheless, the total number of disciplinary actions is also quite small—1 per 483 doctors in Britain in 1980 (Rosenthal 1987).[17] And, again, in most of the countries under review, discipline is usually not directly related to quality issues.

Discipline is usually not directly related to quality issues

Moreover, an examination of the aspirations and workings of disciplinary boards gives one little reason for hoping that they will have a significant impact on the quality of medical care. For one thing, in all of the countries under review but Sweden the vast majority of members of medical licensure boards are physicians. Indeed, in Germany and in the provincial councils of Belgium all voting members are doctors. Too much has probably been made of this fact. As Rosenthal has pointed out, the consumer-dominated Swedish Medical Responsibility Board is, if anything, less severe than the medically-dominated General Medical Council (Rosenthal 1987). Ultimately, lay members of medical boards must rely on the advice of medical professionals for identifying lapses in the technical aspects of medical care and lay members may be easily intimidated, persuaded or socialized into taking on the views and values of medical board members or experts. Nonetheless, assertive lay members can play an important role in advocating protection of the public in situations where some medical members might be too quick to understand and forgive serious lapses in care.[18]

Assertive lay members can play an important role in advocating protection of the public

Other factors, however, probably play a greater role in restricting the effectiveness of the disciplinary bodies under review. First, and most importantly, most licensure boards are not primarily concerned with the competence of practitioners or with the quality of the care they deliver. Professional boards exist historically to police the boundaries of the professions: to keep non-members from poaching the privileges of members and to make sure that members behave themselves so as not to bring the profession into public disrepute. Though the boards in the countries here under review have come a long way toward seeing their role as protecting the public from incompetent professionals as well as from advertising, in all countries except Sweden the bulk of their work is still focused on "professional" issues as traditionally defined. Indeed, the more candid of those interviewed admitted that their role in policing competence did not go beyond dealing with the most egregious situations.

Most licensure boards are not primarily concerned with the competence of practitioners or with the quality of care

Second, the problem identification methods of the boards greatly limit their effectiveness. All of them depend primarily on patient complaints for initiating actions. While consumer complaints may help to identify some dramatically bad outcomes of care, which may or may not have been caused by quality lapses, and may identify some professionals wholly deficient in interpersonal skills, they will in many cases fail to identify practitioners whose technical skills are substandard. None of the bodies relies on audit or professional reporting requirements, which might be much more effective in identifying poor quality practitioners.[19]

Third, the fact finding techniques of the disciplinary boards under consideration here are very weak. None of the bodies routinely investigates complaints beyond obtaining the doctor's response and perhaps reviewing the records. None seemed to have investigative staff trained in police techniques, and those with access to outside investigators seldom used them. None interviews a doctor's other patients or goes to his office to inspect files to determine if a lapse of care is unique or part of a larger pattern of poor care. Hearings seldom go beyond the testimony of the patient and the doctor, perhaps supplemented by a review of the records or expert commentary on the doctor's performance.

None of the bodies routinely investigates complaints

If there is a factual dispute and the testimony of the patient and doctor are equally credible, the doctor must usually win, since the burden of proof for discipline will not be carried. Patient complaints of problematic interactions with professionals are particularly likely to end in a conflict between the patient's and the professional's version of events, with no independent verification of either version possible, even from the medical records.

Fourth, most of the boards lack sanctions appropriate for addressing quality issues. Ideally, a range of sanctions including requiring additional education, re-examination, supervision by another doctor, limitation of practice to certain types of practice or practice settings, withdrawal of prescribing privileges, or monitoring by the licensure board, could surgically address specific problems. Only England, however, has the power generally to impose conditions on licensure, and this power was only used twice in 1988 (GMC 1989a). Revocation is such a serious sanction as to be warranted only in the most egregious cases. Sanctions less stringent than revocation but more directive than a general admonishment are needed.

Sanctions less stringent than revocation but more directive than a general admonishment are needed

This is not to say that licensure boards have no role in quality assurance. First, they do have some deterrent and educative effect, as has already been mentioned. Much more could be achieved in this area, however, by a board dedicated to education. The regular publication of decisions by the Medical Responsibility Board in Sweden has provoked discussion as to the appropriate treatment in various kinds of cases (Hellner 1985). Other boards could be much more public about their activities and decisions.

Moreover, by maintaining professional standards the boards also contribute to the maintenance of quality standards. An anecdote concerning a junior doctor related by the Registrar of the GMC illustrates this relationship. After an exhausting 22 hour day, the junior doctor had just lapsed into a deep sleep when she was awakened and told that an attempted suicide victim had just been brought into the emergency room, still alive but completely covered with severe burns. The junior doctor, whose own competence was still limited, knew objectively that in this particular case there was nothing that even the most competent doctor could do to save the victim's life, but that professional obligations, as enforced by the GMC, necessitated attending the patient. Such a sense of professionalism, still quite strong in the countries visited, inspires a doctor to practice high quality medicine. To the extent that medical boards encourage and maintain such professional values, therefore, they do make a contribution to quality assurance. Having said this, however, it must also be said that disciplinary boards alone fall far short of the complete task of assuring the quality of medical care in these countries, as is also true in the United States.

To the extent that medical boards encourage and maintain professional values, they do make a contribution to quality assurance

Notes

The author wishes to thank the King Edward's Hospital Fund for London for permission to reprint this material from *Assuring the Quality of Medical Practice: An International Comparative Study,* to which it holds the copyright.

1. This paper focuses primarily on England rather than on the entire United Kingdom because health care delivery structures and quality assurance systems vary somewhat among the countries of the UK. Where data are available only for the entire UK or for Great Britain or where one system applies throughout the UK (as is true with the General Medical Council) the paper will make clear that the UK or Britain is the basis of reference, rather than England.
2. At the time the research on which this article is based was done, Germany had not yet been reunited. The report is based, therefore, on the system as it existed in West Germany immediately prior to reunification. It is my understanding, however, that in most matters of health care organization, the system in the eastern Länder is being modified to conform to the situation in the West rather than the contrary, so the situation described in this article has probably changed little.
3. This section is based in part on interviews with V. Nathanson, P. Towers, and Sir J. Walton, England; M. Döhler and R. Schaffer, Germany; and E. Borgenhammer and M. Timelin, Sweden.
4. Mandatory membership in the Order was challenged as violating the right of freedom of association, guaranteed by Article 11 of the European Convention on Human Rights in LeCompte, Van Leuven & De Meyere v. Belgium, 43 Eur.Ct.H.R., Series A (1981) and Albert and LeCompte v. Belgium, 58 Eur.Ct.H.R., Series A (1983). The challenge was rejected because the Order is a public law association (and thus not within the purview of the Convention), and because mandatory membership in the Order does not preclude membership in other associations. The discussion of the Order which follows in the text is based on Anrys (1971) and interviews with H. Nys and H. Ector.
5. If a French doctor practices in a Flemish province, or vice versa, he can either be disciplined by his own province, with proceedings conducted through an interpreter, or transferred to the nearest provincial council that uses his language.
6. The Deontological Code, promulgated in 1975, has never been approved by the King and thus lacks official status. It is, by and large, an explication of the royal decree, however, and has been treated as such by the courts.
7. The private nature of these hearings was challenged as violating the Article 6 of the European Convention on Human Rights in LeCompte, Van Leuven & De Meyere v. Belgium, 43 Eur.Ct.H.R., series A (1981) and Albert & LeCompte v. Belgium, 58 Eur.Ct.H.R., Series A (1983). The challenge was rejected because the possibility of an appeal to the Council of Appeal, which does hold its meetings in public and has jurisdiction to review all questions of fact and law, cures the lack of a public hearing in the first instance.
8. Several of the PCs also have constituent regional or local PCs, which are also public law bodies.
9. These procedures were described to me by R. Schäfer. Further information regarding the physician chambers in Germany was obtained from H. P. Brauer and F. Stobrawa.
10. Doctors informally admonished by the director may also appeal to the disciplinary committee. In an emergency, the president of the PC may notify the Minister of Health of the Land immediately, advising him to suspend a doctor's license.
11. The discussion of the GMC which follows is based, in part, on discussions with P. Towers, J. Walton, J. Robinson, M. Stacey, R. Smith, A. Simanowitz. For a history of the GMC, see Smith (1989a); Stacey (1992).
12. This obligation is found in a section of the GMC's bluebook, however, entitled "Disparagement of professional colleagues," and follows a preceding section threatening doctors who disparage a colleague with discipline.
13. The GMC will help with the expense of this exercise if the complainant cannot affort it. Nevertheless, critics of the GMC procedures see this as a substantial barrier for many complainants.
14. The Merrison Committee, which comprehensively reviewed the GMC and its procedures in 1975, recommended that investigative staff be retained, but this recommendation was not implemented (see Merrison 1975).
15. See, however, responding to these charges, Towers 1988.
16. The most complete description of the MRB in English is found in Rosenthal (1987). See also Hellner (1985) and Tillinger (1985) discussing the MRB. The description which follows is also based on interviews with I. Nygren and N. Blum.
17. The German state of Hesse reported 55 disciplinary actions in 1987 and 51 in 1988, during which approximately 20,000 doctors were practicing in the state, a ratio of about 1 action per 375 doctors.
18. The author makes this assertion from his own experience as a lay member of a physican licensure board in the United States.
19. The Deontological Code of Belgium, for example, not only does not require doctors to report professional misconduct of other doctors, but provides "Doctors always owe each other moral support; they are obliged to come to the defense of a colleague who has been unjustly attacked. It is forbidden to slander a colleague, to speak ill of him, or to repeat anything liable to harm him in the exercise of his practice. A professional disagreement must not give rise to a public exchange." Art. 136. Article 137 goes on to forbid a doctor from replacing another who has been dismissed or suspended from a public or private institution until he has had contact with the disciplined doctor and the Provincial Order, to "ensure that the rules of ethics are respected." Thus, the ethical code stands in the way of other institutions disciplining doctors as well.

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Advances in Economic Theories of Medical Licensure

SHIRLEY SVORNY, PhD

Overview: *The author suggests the changing nature of the market for physician services may create a new interest in the debate over the value of medical licensure. She believes licensure has served a purpose in encouraging ethical professional behavior but that the need for government intervention is declining as the monitoring of physicians shifts to hospitals, insurers, and employers.*

INTRODUCTION

The support for medical licensure expressed by health professionals has not been mirrored by economists. The concern of economists has been that restrictions on entry benefit physicians at the public's expense. Recent theoretical work, however, has provided some basis for reassessing the value of medical licensure to society.

THE PUBLIC INTEREST APPROACH

The most cited work by economists on medical licensure is by Kenneth Arrow, Milton Friedman and Reuben Kessel.[1] Arrow's work provides the traditional public interest rationale for government intervention in the market for physician services. Writing in 1963, Arrow noted that patients have less information than physicians as to the "consequences and possibilities of treatment." (p. 951) In his view, rigid entry requirements to the medical profession are "designed to reduce the uncertainty in the mind of the consumer as to the quality of product insofar as this is possible." (p. 966)

In addition to the information rationale, Leffler (1978) mentions two other justifications for minimum quality standards. He notes that individuals who consume services from less skilled physicians hurt not only themselves, but others through the spread of disease. In the vernacular of economists, this is an "externality" problem. Leffler also notes that minimum standards may be desirable if some individuals underestimate the risks associated with consuming low quality services. He terms this justification for medical licensure "society knows best."

Arrow noted rigid entry requirements to the medical profession "reduce the uncertainty in the mind of the consumer as to the quality of product"

CRITICISMS OF THE PUBLIC INTEREST APPROACH

Writing about the same time as Arrow, Milton Friedman (1962) took a very

different approach. He suggested that medical licensure does not benefit consumers but, instead, serves the interests of physicians by restricting supply. When supply is restricted, physicians benefit from higher prices and consumers are worse off. In a 1970 article, Reuben Kessel explained how control over medical school accreditation by the American Medical Association, teamed with state laws requiring physicians to be trained in accredited schools, effectively gave the AMA control over the physician supply.

For consumers, certification of practitioners would be better than licensure, said Friedman

An important point that Friedman and others have made is that simple certification of practitioners would deal with the information problem Arrow described, and that certification would be better than licensure for consumers.[2] Under certification, according to Friedman, "the government agency may certify that an individual has certain skills but may not prevent, in any way, the practice of any occupation using these skills by people who do not have such a certificate." (p. 145) The preference for certification over licensure is based on the assumption that consumers are competent to make choices for themselves. If, with all the relevant information available to them, consumers choose to purchase services from uncertified individuals, then, this argument goes, restricting such exchanges would make consumers worse off.

The case against licensure has grown over time. The (intellectual) followers of Friedman and Kessel, who view the state medical boards as influenced by special interests and having no inherent ability or advantage in selecting physicians, have done much to discredit the existing regulatory approach.[3]

Critics of licensure emphasize it does not limit physicians to areas of demonstrated competence

To make the point that licensure offers little protection to consumers, critics of licensure emphasize that licensure does not limit physicians to areas of practice in which they have demonstrated competence. Critics add that minimum quality standards cannot protect consumers from fraudulent behavior, nor can a licensing examination assure quality years later as medical technology changes.

The relevance of some medical licensure entry restrictions has been questioned. Basic science requirements have been labeled "an anachronistic stumbling block to medical licensure" (Derbyshire, 1969, p. 118, see also Kessel, 1970). Citizenship requirements, imposed for many years prior to their being declared unconstitutional, seem clearly exclusionary.

To emphasize the lack of protection for consumers, critics have pointed to the narrowness of disciplinary actions by state medical boards. Citing the need to show gross malpractice or gross incompetence as a basis for discipline, critics have labeled the medical disciplinary process ineffective (see, for example, Goodman, 1980). Because the majority of disciplinary actions are for drug-related offenses, critics complain that issues of physician competence are ignored by state disciplinary boards.

Critics complain that issues of physician competence are ignored by state disciplinary boards

Given the irrelevance of some entry restrictions, the difficulty in assuring continued physician competence and deterring fraud over time through minimum quality standards, and perceptions of weak enforcement by state medical boards, many observers conclude that licensure does little or nothing to protect consumers.

A second, very different approach to discrediting licensure questions whether the lack of consumer information in the market for physician services is sufficient to justify government intervention. Havighurst (1982), for example, notes that

"Consumers are also ignorant about many other things that they buy," adding that "it is easy to overstate the problem as it arises in health care." (p. 78) In assessing physician quality, he writes that individuals will use "past experience in repeated dealings with that physician and others, a physician's general reputation, the advice and direct experience of others, and a variety of professional credentials that may serve to distinguish the more competent and reliable. . ." Friedman argues that "licensure is not now the main or even a major source of assurance of at least minimum quality. . .people do not now choose physicians by picking names at random from a list of licensed physicians." (p. 158)

State licensure arrangements, say critics, exist to benefit physicians

Those that reject the need to provide information to consumers, or conclude that licensure provides little assurance of quality to consumers, conclude that state licensure arrangements exist to benefit physicians at consumers' expense.

NEWER THEORIES IN SUPPORT OF LICENSURE: SHAPIRO, LELAND

Since licensure has persisted over time and exists in many societies, there is something disturbing about dismissing it as an arrangement that benefits physicians, without benefits to consumers. The argument that licensure cannot provide valuable information directly to consumers has forced some economists to come up with creative suggestions as to how licensure might actually work to assure quality.

Shapiro argues that the need for costly monitoring of physician actions by consumers is reduced when physicians have met minimum training requirements

In a 1986 article, Carl Shapiro argues that the need for costly monitoring of physician actions by consumers is reduced when employing physicians who have fulfilled minimum training requirements. The underlying premise for this conclusion is that it is relatively easy for highly trained physicians to produce high quality services; that there is a connection between training levels and the quality that results. Shapiro suggests that standardization of training requirements for physicians (such as that which accompanies licensure in the United States) is desirable because it allows physicians to reveal their training level to consumers relatively cheaply. On the merits of certification over licensure, however, Shapiro agrees with most economists: "If sellers' training levels are observable, perhaps due to certification, no consumer is better off due to licensing." (p. 854)

By limiting entry through licensing, said Leland, physician income can be raised, providing an incentive for more talented individuals

Leland (1980, 1979) suggests a different theory for why medical licensure is of value to society. He notes that, if consumer information costs are significant, high quality physicians cannot be recognized and, as a result, their superior skills go uncompensated. This discourages their entry, reducing the average quality of physician services offered. By limiting entry through licensing, either randomly or by setting minimum quality standards, average physician income can be increased, thus providing an incentive for more talented individuals to seek medical training. The increase in average quality that results benefits consumers.

Leland is careful to say that his work does not show that there are positive benefits to minimum quality standards or random-entry restrictions, but instead that there *may* be positive benefits. He looks at the case of professional self-regulation (as is the case with medical licensing), and concludes that standards will be set too high, "perhaps resulting in lower welfare than when

no standards are imposed." (p. 282) In addition, he notes that the costs of implementing minimum standards must be considered, as they may outweigh any benefits.

Leland's work does not support licensure over certification

Leland's work provides an interesting justification for government intervention, suggesting how positive benefits may result from medical licensure. It does not, however, support licensure over certification. He notes that certification provides information similar to that provided by minimum-quality standards (licensure) and that, under certification, "Buyers have a wider range of choice. . .because they can buy low-quality goods or services if they wish." (p. 283) He concludes that, because certification would lead to higher welfare, it is the preferred alternative.

The models presented by Shapiro and Leland suggest that there may be benefits to society from medical licensure. But they both come to the same conclusion with respect to certification—that it is preferred—as it offers consumers more options from which to choose.

INCENTIVES FOR PERFORMANCE

My own work (Svorny 1987, 1992) is unusual in that it not only provides support for licensure, but also for licensure over certification. I argue that the value of medical licensure is in adding to existing penalties or establishing penalties where none exist for inappropriate behavior by physicians.

Svorny argues for the value of medical licensure based on the higher earnings it permits physicians and, therefore, the greater losses it imposes on them for inappropriate behavior

By increasing profitability in the market for physician services (a result of barriers to entry and required investments in education and training), licensure arrangements increase the loss associated with physician malpractice. Malfeasant physicians lose both the present value of the profits physicians earn (Kessel described the entry restrictions which raise earnings) and the return on their investment in training. A very important point is that this financial loss or penalty may occur as a result of license revocation, but does not require it. Even if a malfeasant physician's license is not revoked, the physician will bear costs as patients, referring physicians, and hospitals seek services elsewhere, reducing the physicians' earnings over time. Because of licensure, the loss of earnings is greater than it would be otherwise. Specifically, because entry restrictions reduce competition and increase physician earnings, physicians have more to lose than they would in a world with unlimited entry. In this way, licensure adds to existing civil and criminal penalties for iiillegal acts (fines, jail, etc) and strengthens incentives to deter physician malfeasance.

It may make sense for state boards to stay away from making difficult decisions about physician competence

This view of licensure can be used to justify the often-criticized, narrow focus of state medical board disciplinary actions on drug-related problems. One could take the position that it makes sense for state medical boards to stay away from making *difficult decisions* about physician competence. This allows individuals familiar with the situation to be the judge. Marginal incompetence, which may be very difficult to prove, will be penalized as clients seek services elsewhere (fewer referrals, loss of hospital privileges, expulsion from group practice, etc). On the other hand, state revocation of a medical license is of value in penalizing physicians in cases of drug abuse (and where incompetence is straightforward).

As with Leland's work, this view of licensure does not *guarantee* net gains to consumers, it just suggests that there *may* be net gains. Whether or not licensure is desirable depends on whether the incentives for quality care generated by

licensure provide benefits to consumers which outweigh the losses associated with limiting the supply of physicians from which consumers may choose. With this view of licensure, certification is not a perfect substitute. A switch to certification would not only reduce physician earnings (due to the increase in competition in the sale of physician services), but it also would provide medical avenues for physicians whose licenses have been revoked. Both reduce the penalty associated with malfeasance.

Certification would reduce the penalty associated with malfeasance

EMPIRICAL EVIDENCE

There is little evidence to support or refute a public interest model of licensure. One attempt to support a public interest model of licensure is in Leffler (1978). Leffler used data from the 1960s (just prior to the initial adoption of the standardized Federation Licensing Examination). Making the assumption that, where state examinations are harder, a larger percentage of physicians will take the national examination, he uses the percent taking the national examination as a measure of state medical board licensing quality standards. Using this measure, he finds some empirical support for the consumer-demand hypothesis for licensure.

In contrast, in Svorny (1987), empirical results are presented that suggest restrictions on physician supply have been more severe than would maximize consumer well-being. Looking across states, it appears that physician interests dominate the regulatory process. This result, however, cannot rule out the value of licensure in assuring consumers of physician quality, as it still may be better than other methods, all of which have their own attendant problems (see Svorny, 1992).

Looking across states, it appears physician interests dominate the regulatory process

CONCLUSION

The changing nature of the market for physician services may create new interest in the debate over the value of medical licensure to consumers. Price controls on physician fees (based on a relative value scale and some other overall control of expenditures) may preclude the use of supply restrictions to raise physician earnings. If physician earnings fall, the penalties that are imposed upon malfeasant physicians necessarily decline.[4]

It is my belief that medical licensure has been of value to society because it creates large penalties for malpractice, encouraging individual physicians to follow professional ethics. But it seems that the need for government intervention has declined as increasing numbers of physicians are involved in group practice and/or subject to serious peer review. Most important, recent shifts in court assignment of liability for physician malpractice toward hospitals, insurers, and employers (who choose health plans for their workers), have created incentives for these groups to closely monitor physician performance and to take steps to reduce patient exposure to less competent and incompetent physicians (see Svorny, 1992). This means that individuals for whom monitoring costs are relatively low (hospitals, other doctors) now have an incentive to observe physician behavior and intervene when necessary. This protects consumers and, in my opinion, reduces the value of state expenditures on medical licensing arrangements.

It seems the need for government intervention has declined

Notes

1. Friedman and Arrow have won the Nobel Prize in Economics.
2. See also Moore, 1961.
3. See, for example, Young (1987), Goodman (1980), Benham (1991), and Rayack (1982).
4. Of course, the most troublesome aspect of price controls is not what they will do to physician earnings (and penalties for malfeasance), but what they will do to incentives for smart, talented individuals to enter medical school.

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On Reforming the Regulation of Lawyers

ROBERT C. FELLMETH, JD

Overview: *The author, who was California's State Bar Discipline Monitor from 1987 to 1992, describes the reform of California's attorney discipline system. A seriously flawed process has been significantly improved and made more responsive to the public interest. Many conclusions reached and lessons learned as a result of the effort are applicable to the regulation of other professions, including medicine.*

During 1986, California State Senator Robert Presley secured passage of legislation creating the position of "State Bar Discipline Monitor." Its purpose was to investigate the attorney discipline system of the State Bar and recommend reforms to the Chief Justice of the Supreme Court and the Legislature. The law gave the Discipline Monitor the investigative powers of the Attorney General—access to all files and records. In 1987, I was appointed by the State Attorney General to that position, and held it until it sunset at the end of 1991.

We were told, "California has the nation's finest system"

The first thing we were told by the staff of the Bar as we began our inquiry was that "California has the nation's finest system." We were not surprised by this self-judgment; we had spent 20 years studying regulatory agencies and knew that most agencies are controlled by staffs who tell governing boards what they want to hear—staffs well understand that it is the messenger who usually gets shot.

What we discovered in our months of interviews, file reviews, document searches, and other research was troubling. As with most regulatory agencies, this one was controlled by the profession allegedly being constrained in the interests of a larger population. Of the 23 members of the Bar's Board of Governors, 17 are elected—by other attorneys. You read it right—the state agency exercising police power on behalf of the general public is not controlled by disinterested persons, or by persons selected by an elected public official.

The Bar is not controlled by disinterested persons

The Bar's internal discipline system consisted of a complaint intake unit, an Office of Investigations, an Office of Trial Counsel whose attorneys prosecuted discipline cases, and a two-level "State Bar Court" which presided over the hearings and made the final disciplinary decision. The entire system was pervaded by "volunteer practicing attorneys." They investigated some cases, or

assisted a staff of professional investigators. In prior years, they prosecuted the cases. Discipline cases were tried before one of hundreds of local attorneys who had volunteered to be Bar "hearing referees," and they were subject to review by a Review Department consisting of 18 persons which met two days a month to review decisions proposed by one of these hearing referees. Twelve of the 18 were volunteer practicing attorneys. All Review Department disciplinary decisions were subject to automatic review by the California Supreme Court.

The Supreme Court did not have a great deal of confidence in the product of this system, publicly excoriating the Bar for the low quality of its opinions in two published cases as we began our inquiry. Because of the inconsistency in the Bar's decision making, the Court felt constrained to review all cases itself after decision by the State Bar Court.

The attorneys working on this system were tenacious in its defense. They argued that the volunteers were important—part of the civic-minded "volunteerism" of the Bar. They argued that it was impossible to judge or understand difficult questions of professional judgment unless one is a practicing attorney; only attorneys can judge other attorneys. And they contended that the attorneys controlling this sytem were harder on their peers than would be public members or professional, independent judges—pointing to the many cases where the Review Department imposed more serious discipline than was recommended by the quasi-independent Office of Trial Counsel prosecuting them.

Involved attorneys argued only attorneys can judge attorneys

But we learned that the reality was far different than the picture carefully painted by those defending their respective roles. For example, the Bar's investigators could not *mention* the name of an accused attorney in any document produced by the Bar for fear that an accusation might reach the public domain and besmirch the reputation of counsel. Even the letters *going to the consumers who had complained* were purged of the names of the attorneys complained about. Hence, the investigator was compelled to write: "With regard to the attorney mentioned in the second paragraph of your letter. . . ." Things would get a bit confusing if the complaint accused three or four attorneys. But the Bar was concerned that even this letter—going to the person who complained—might be misplaced or intercepted and these names would then come to light on a letter with Bar stationery, resulting in reputation injury.

The Bar's investigators could not mention the name of an accused attorney in any document

The atmosphere of the Bar was not one of consumer contempt. Every person involved felt he was indeed protecting consumers. Every person felt she was contributing time and energy to the elevation of her profession to higher standards for the benefit of all. On the other hand, they were also aware of the sensitivities and concerns of their colleagues. Hence, when an investigator for the State Bar received a complaint from a client of attorney Smith, and wanted to talk to another client of Smith's to verify a fact or explore a problem, he first had to go to the Discipline Committee of the State Bar, submit documentary basis—probable cause, and receive permission just to *talk* to any other client. Again, the concern was that such a conversation may harm the attorney's reputation. The Bar should not be casting about injuring legitimate practitioners unless it had some reason to do so. Sound reasonable? Attorneys are

Every person involved felt he was indeed protecting consumers

paid to sound reasonable.

Well, what kind of system did we have? We had a room in Los Angeles where 4,000 investigative files sat for years—unworked and unread. It was referred to in-house as the "TNT room"—meaning, put one more file in there and the room will explode. Six to seven thousand cases in total were backlogged so that 12-18 months could be expected to pass before a case would be *looked at.* That is, a first look.

Six to seven thousand cases were backlogged

The Bar did not collect even public information about attorney misconduct, and did not disclose what it did collect to inquiring consumers. The much-ballyhooed statewide "hotline" number was not published in any directory in the state. Nevertheless, it was busy 60% of the time to callers.

The intake unit was receiving over 2,000 calls per month, mostly from complaining clients. Ninety-seven percent of the cases were closed prior to the filing of formal and publicly known charges. The number of cases filed was small. About 20-30 attorneys were disbarred each year—usually after multiple felony convictions; about 50-60 suffered some period of suspension. Where the case was contested, the length of time from initial complaint to final imposition of discipline exceeded five years, rarely with any interim suspension while proceedings were pending.

We issued a series of reports beginning in 1987 and continuing through 1991, suggested 35 rule and policy changes, and participated in the drafting of Senate Bill 1498 (Presley) to make 30 statutory changes to the system. The State Bar, to its credit, did not react with fear and trepidation. Perhaps because high turnover among Board of Governors' members prevented them from feeling responsible and defensive about what the previous Board had not done, perhaps because of the hostility of the State Legislature to the Bar during this period, perhaps because of widespread consumer dissatisfaction and media exposes, or perhaps because of the fortunate presence of the particular individuals then in office, the Bar moved. Most important, the Bar did something that agencies—and all groups of humans—resist mightily. It gave up territory. It admitted there was a problem. It knew a different way should be attempted. And it was willing to end the participating of "volunteer" attorneys judging their peers throughout the process.

The Bar moved—it gave up territory and admitted there was a problem

With the help of many, we were able to craft a very different system. Here are some of its elements.

We were able to craft a very different system

(1) An intake system controlled by a professional full-time prosecutor able to route cases needing interim remedies or special investigative need, and gathering substantial new information about licensee misconduct, including arrests at point of arrest, malpractice cases, cases involving allegations of fraud, criminal charges and convictions, contempt orders, reversals for incompetence, sanctions, complaints, even NSF checks written on client trust accounts. The new system includes a special track for complaints by courts about counsel. It allows the system to detect patterns of misbehavior, and to act based on an accumulation of offenses, each one of which might not warrant Bar action standing alone.

(2) A system of investigations controlled by the trial counsel responsible for litigating the case and free to inquire into all matters relevant to an attorney's performance. Where there is a question involving legal expertise,

the system does not assume that someone will decide correctly simply because he or she is an attorney; it uses outside legal expertise with knowledge *on point* to the issues in dispute.

(3) A Complainants' Grievance Panel independently reviews cases closed by the system upon request and may order a "reinvestigation."

(4) A State Bar Court consisting not of volunteer attorneys in the field, but of a six-member panel of full-time professionals, independent judges, and appointed not by the Bar, but by the Supreme Court. Bar discipline hearings are now presided over by one of these six judges.

(5) An appellate body of three judges, one of whom is a legally trained public member, to consider appeals and render the Bar's final disciplinary decision.

The result of these and many other changes has borne fruit. The massive complaint backlog is now gone. The number of attorneys disbarred or resigning with charges pending has increased fivefold. The number of attorneys suffering actual suspension has increased sevenfold. The number of attorneys subject to other informal discipline (admonitions, warnings) has increased twelvefold. The time from receipt of complaint to final imposition of discipline has been cut to one-third the previous level. Partly because of the predictability of known judges deciding cases, the settlement rate increased dramatically, further expediting imposition of discipline.

The massive complaint backlog is now gone

The Supreme Court was impressed by the quality of investigations, hearings, and opinions coming from the new system and conferred its highest blessing: it gave the State Bar Court's decisions "finality," and now reviews attorney discipline cases only by discretionary grant.

The system for Bar discipline is still flawed. The Office of Trial Counsel should be more independent from the Board of Governors, as should the Complainants' Grievance Panel. The Bar has not attacked attorney dishonesty and unfair billing adequately. Attorney advertising does not always meet legal standards prohibiting deception. Attorneys are not licensed by their specialty of practice, such as immigration, family, criminal, or bankruptcy law, in which they actually practice and are relied upon by consumers. They are never retested for competence at any point following a general examination usually taken at the age of 25. In this respect and in others, the Bar does not address issues of competence adequately. And it does not require that attorneys carry malpractice insurance, allowing 20% of licensees to practice without any remedy for redress by clients injured by gross negligence.

The Bar still does not address issues of competence adequately

There is much to be done with attorney regulation. And in California, there is a fair amount which has been done.

Do the lessons learned apply to the regulation of other professions and trades, including medicine? Not all of them, but many of the problems we found in the regulation of attorneys are replicated in the regulation of medical professionals. Whatever the trade or profession, our experience in observing and commenting upon regulatory options yields the following general conclusions:

Many of the problems we found are replicated in regulation of medical professionals

(1) the barrier to entry system should measure the skills relied upon by the public, and should include at least minimal retesting;

(2) a complaint intake system must be directed by persons able to quickly decide which cases are properly referred to other agencies, which require

immediate action, which must be specially investigated—*ie,* by the prosecutor trained to make those decisions, guided by Board policy, and consulting with experts where needed;

(3) an intake system must be broad and sensitive, receiving maximum information of facial relevance in order to detect patterns of abuse warranting early response;

(4) reliance on peers to serve as "judges" to implement the police power of the state does not work;

Reliance on peers to serve as "judges" does not work

(5) in adjudicatory decision making, it is possible to combine independence and expertise—*on point* expertise;

(6) adjudication is best handled by a panel of trained, full-time professionals who can combine independence and expertise, confer consistency and predictability to outcomes, and have the ability to decide interim restrictions to protect the public where necessary; and

(7) a high-quality due process hearing should be followed by opportunity for a thorough review by an independent appellate body, followed by a right to petition the Supreme Court.

Certainly there are some differences between the ideal systems of regulation applicable to different trades and professions. But there are also similarities. There are many similar flaws. And there are some similar solutions.

Status of the USMLE Step 3 Examination

ANTHONY LaDUCA, PhD, and DONALD E. MELNICK, MD

Overview: *The effort to develop the USMLE Step 3 examination is being guided by the Step 3 Committee, which is focusing on a new principal organizing dimension: the* clinical encounter frames. *The frames include initial workup, continued care, and emergency care. The second organizing dimension is the* physician task, *comprised of six categories of activity. The Committee's approach centers on those patient situations that will be encountered in clinical practice.*

INTRODUCTION

In some ways, designing licensing examinations calls for making predictions. This is particularly true with an examination like the United States Medical Licensing Examination (USMLE) Step 3, since its purpose emphasizes assessment of an undifferentiated physician's readiness to function in unsupervised practice. This purpose calls for evaluation that is prospective. The designers should not look to the prior experiences of the resident physicians, but *forward* to those patient situations that will be encountered in clinical practice. In addition, the designers must anticipate what those clinical encounters will be when the examination is introduced several years from now.

Designing licensing examinations calls for making predictions, a risky business in the best of times

Prediction is a risky business in the best of times, but, given the present design task, these may be the worst of times. The next ten years may bring additional changes of historic proportions to the practice of American medicine. Presently, the scope and character of these changes remain uncertain. Therefore, the design of Step 3 presents special challenges that demand care and inventiveness.

Testing experts recommend clear and direct links between the content of licensing examinations and the performance demands of the target professions (AERA et al, 1985; Cavanaugh, 1991; Kane, 1982, 1992). Often, test designers rely on "job analysis" to establish these links because it is essential that examination content be relevant to performance requirements. Physician licensing examinations should conform to these recommendations, although many approaches to job analysis are inappropriate for complex professions such as medicine.

It is essential that examination content be relevant to performance requirements

PROJECTED STEP 3 CONTENT

During the past two years, the Step 3 Committee has addressed the desirable characteristics of the examination. The Committee's discussions have addressed what the content of Step 3 should be, particularly in light of its purpose and its relationship with USMLE Steps 1 and 2. The Committee has stated its support of the following points.

The Step 3 Committee has addressed the desirable characteristics of the examination

1. Step 3 should emphasize selected physician tasks, namely, evaluating severity of patient problems and managing therapy. Within the limits of multiple choice testing, assessment of clinical judgment should be emphasized.
2. Clinical problems should be mainstream, high impact diseases. Provision should be made for less common but important clinical problems as well.
3. Test items should be patient-centered, starting with a clinical encounter (vignette), posing action-related challenges.
4. Emphasis should be on ambulatory patient encounters. Reflecting current reality, inpatient encounters of significant acuity and complexity also should be included.
5. Applied basic science concepts should be included, especially as they relate to justification for prognosis or management. Basic science fundamentals have been assessed adequately in prior Steps.

DEVELOPMENT STRATEGY

The Step 3 examination will succeed the National Board of Medical Examiners' (NBME) Part III and the Federation of State Medical Boards' Federation Licensing Examination (FLEX). Within the USMLE sequence, Step 3 will be the final examination for physician licensure and eligibility will be restricted to physicians who have passed Steps 1 and 2. These features underscore the importance of linking the content of Step 3 to the *practice* of the undifferentiated medical practitioner. The "new" FLEX met that challenge when it was introduced in 1985. Designing Step 3 is following a similar approach.

It is important to link the content of Step 3 to the practice *of medicine*

For the most part, the design of Step 3 reflects the cognitive demands posed by physicians' encounters with patients and problems that comprise a model of the practice of an undifferentiated practitioner. Surveys of physicians in selected specialties provide the raw data for the practice model and, in this manner, meet the requirements for conducting "job analysis."

Surveys of physicians in selected specialties provide the raw data for the practice model

This strategy was used in development of the new FLEX (LaDuca et al, 1984). At that time, a practice model was prepared from survey data describing patient encounters reported by physicians in six specialties: general internal medicine; general practice; general surgery; general pediatrics; family practice; and emergency medicine. Both ambulatory and hospital settings were included. The selected surveys were completed several years earlier under the direction of Robert Mendenhall and published as the *National Study of Medical and Surgical Specialties* (Robert Wood Johnson Foundation, 1981).

PRACTICE MODEL UPDATE

Developing an updated practice model has been the focus of intense activity

during the past year. Several important refinements in the concept have been made. First, the usefulness of a practice model in support of other examination developments has been recognized. The updated FLEX/Part III practice model is becoming a resource for all three USMLE Step examinations. Second, a data base of current information describing the clinical practices of physicians (allopaths and osteopaths) in a broader range of specialties is being developed. Data have been obtained through several public and private sources, reflecting differing aspects of medical practice. The NBME staff are focusing on selected specialties, including general practice, general internal medicine, general surgery, general pediatrics, family medicine, emergency medicine, and general obstetrics and gynecology.

The updated FLEX/PART III model is becoming a resource for all three USMLE Steps

The National Center for Health Statistics has supplied the 1989 National Ambulatory Medical Care Survey (NAMCS) and the 1990 National Hospital Discharge Survey (NHDS). NAMCS relies on physicians' reports of patient encounters in office settings. In addition, a third data base has been obtained that describes over 1,000,000 health claims for a large, national population of employed adults and their families in hospital and ambulatory settings.

Preliminary analyses of diagnoses reported most frequently by physicians in the selected specialties have been conducted. Comparisons with the earlier FLEX model based on the Mendenhall studies confirms the need for only modest changes.

STEP 3 DESIGN

Over the years, NBME staff and members of various FLEX and Part III test committees have contributed to refining the scheme used to organize patient encounters. A new principal organizing dimension for Step 3 design has emerged: the *clinical encounter frames.* The concept of frames retains the priority of the physician's encounter with patients. Frames capture the context and location of the encounter as (1) initial workup; (2) continued care; and (3) emergency care.

A new principal organizing dimension for Step 3 design has emerged: the clinical encounter frames

The second organizing dimension for Step 3 design is the *physician task.* It, too, has been refined by staff and committees to six categories: (1) obtaining the history and performing a physical examination; (2) using laboratory and diagnostic studies; (3) formulating the most likely diagnosis; (4) evaluating the severity of the patient's problems (prognosis); (5) managing therapy (including clinical interventions, clinical therapeutics, applying legal and ethical principles, and health promotion); and (6) applying basic science concepts (mechanisms).

The second organizing dimension is the physician task

Initial workup encounters are presentations of new, acutely-occurring problems among patients seen in ambulatory settings for the first time. Tasks emphasized include extensive data gathering and initial therapeutic intervention. *Continued care encounters* are characterized by management of previously diagnosed clinical problems among patients seen principally in ambulatory settings. Evaluating the severity of the patient's problems (prognosis), monitoring therapy, and long-term management are emphasized. *Emergency care encounters* include life or organ threatening emergencies occurring in emergency department settings. Physician tasks emphasized include rapid assessment of complex presentations and prompt therapeutic

decision making.

STEP 3 BLUEPRINT

Clinical encounter frames and physician tasks serve as the organizing dimensions for the Step 3 blueprint. The two-dimensional matrix shows content weighting *defined* by the Step 3 Committee and *endorsed* by the USMLE Composite Committee.

The process of developing the Step 3 blueprint is now complete. Given the Step 3 Committee's stated preferences, most of the test items will relate to continued care encounters. Physician tasks emphasized in this frame are prognosis and monitoring therapy, and long-term management. Therefore, it seems reasonable to anticipate that the bulk of Step 3 will pose challenges around prognosis and management of ambulatory patients with previously-diagnosed, frequently-occurring, chronic diseases and behavioral-emotional problems. For illustrative purposes, the Step 3 blueprint is shown in the Table below.

Most of the test items will relate to continued care encounters

Table. Endorsed Step 3 Blueprint

PHYSICIAN TASKS	CLINICAL ENCOUNTER FRAMES					
	Initial Workup		Continued Care		Emergency	TOTAL
	1	1A	2	2A	3	
History & Physical						9%
Diagnostic Studies						9%
Diagnosis						11%
Prognosis						12%
Managing Patients						49%
Applying Basic Concepts						10%
TOTAL	15%	10%	40%	20%	15%	100%

CURRENT PLANS

During the past few months, the Committee has been developing the library of Step 3 test questions. As a beginning, the Committee has concentrated on carefully reviewing test questions from FLEX and NBME Part III. During the summer of 1992, three specially appointed test committees have begun writing new test items for Step 3. Pretesting of items will begin in 1993, in time for the introduction of the new Step 3 examination in 1994.

Pretesting of items will begin in 1993

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The Role and Function of the Public Member

GREGORY G. ROCKWELL, JD

Overview: *The author offers a personal view of the qualifications needed by a public member of a state medical board and notes the importance of a public member's role as the "social conscience" of a board. He also points out that a public member is not a minority voice but must balance the interests of the consumer and the professional. The importance of rehabilitation is emphasized.*

The presence of the public member on medical review boards is relatively new but its importance cannot be underestimated. The numbers and participation of public members increase with each legislative session at the state level, and the Federation of State Medical Boards, in its *Elements of a Modern State Medical Board: A Proposal,* has suggested that at least a quarter of all board members be representatives of the public at large, with no economic ties to medicine. Consumers are demanding an active voice in the medical regulatory process and this trend will continue as the cost of health care regularly outdistances inflation. People want to be involved in their health care choices and public members are now an integral part of the accountability process.

Consumers are demanding an active voice in the medical regulatory process and this trend will continue

What is the role and function of the public member on regulatory boards? Each public board member brings to his or her position a different perspective, life style, educational background, and socio-economic foundation. As such, each public member will have varying prejudices and preconceived notions as to how the disciplinary and regulatory process should work. With these differing insights and expectations, the public member becomes the "social conscience" of the boards.

The public member, fully supported by the statutory mandate to protect the public health, safety and welfare, must be an open-minded guardian of this conscience. Our role is not that of the policeman; rather we must be integrally involved with board deliberations and decision making. We must have the confidence that our reasoned opinions are meaningful. Hopefully, having earned the personal and professional respect of our medical colleagues on the board, we will bring a slightly different viewpoint to disciplinary proceedings.

Our role is not that of the policeman

Physician board members tend to look toward fitness and competence within

the acceptable standards of medical practice. Agreement on the definitions of fitness and competence are relatively easy to agree upon. I submit that an agreement on what constitutes acceptable standards of medical practice is a much more difficult proposition.

Not only do standards vary from community to community, but, more importantly, the standards are invariably determined by the health care providers themselves. Thus, it is not unreasonable to expect the public member, on behalf of the community at large, both patients and doctors, to question objectively the delivery of health care services, not as a medical expert but as an informed third party observer.

Expect the public member to question objectively the delivery of health care services

I have the greatest respect for medicine and am very fortunate to have physicians as my closest friends. Nonetheless, all professionals, including those in my own field of law, are products of a particular educational and training system. As such, we are taught to accept certain ways of doing things. And this system does not by its mere existence make them right or wrong. They should be reviewed and challeeenged, and public members on the regulatory boards of all professions can enhance this evaluation. Their objective input is invaluable and, in my opinion, it must be encouraged and respected, for if peer pressure operated to encourage frank acknowledgment of honest mistakes in practice, it would become more respectable and honorable to openly admit errors and misfeasance.

The public member should not consider himself or herself a minority voice. All boards are constituted on a one-person, one-vote basis and must be acknowledged as such. The public member's voice is just as strong and meaningful as that of the physician member, and the mere discrepancy in numbers should not diminish the role of the public member.

The public member's voice is just as meaningful as that of the physician

I am often asked by non-medical people and by doctors if I envision myself as a consumer advocate or a physician advocate. After seven years of service, the answer is that I am neither, because I believe my responsibility as a public member is to have the social conscience that enables me to balance the interest of both patient and provider. Patients demand affordable, quality health care from physicians who have an interest in providing it. And this interest is not only the professional fulfillment of the spirit and intent of the Hippocratic oath, it is also the physician's primary source of economic well-being and self-satisfaction. Sometimes these interests come into conflict and, unfortunately too often, a judicial resolution is sought through the courts. Sometimes this is an appropriate forum; more often it is not.

If we as board members recognize that we are reviewing a process that involves the interrelationship of human beings with limited rather than unlimited resources, we will begin to recognize the need for the balancing of expectations and "finished goods." It is my belief that there are very few absolutes in medicine and its delivery to the general public. When a mistake is made, or an impaired or incompetent physician is identified, million dollar malpractice actions are not always the best solution. Of course, the injured patient must be compensated for economic loss and reasonable amounts for pain and suffering. But all this is at an eventual cost to society, and if a malpractice action becomes, per se, the grounds for discipline, we must identify the objectives of the disciplinary process and the regulations which govern.

There are very few absolutes in medicine and its delivery to the general public

One continuing issue of debate is what I call the 3 R's in the medical review process. What course of action is most appropriate: reprimand, rehabilitation, or revocation? It has recently been suggested that the small number of licenses revoked each year reflects a lack of effective medical discipline. But does revocation, in and of itself, guarantee a better qualified or more competent health care professional? I think not.

The public member must be an integral part of the identification of remedial objectives. I believe that the ultimate goal of rehabilitation, rather than punishment and revocation, is to be preferred whenever possible. Society has a tremendous investment in the training of all medical personnel, and this investment, within acceptable limits, must be protected. It does not serve our national agenda of accessible, affordable, quality health care to simply investigate, revoke and throw away the key. Such an approach and attitude is to me a statement that the system has failed. The public member must be a part of the dialogue that stresses the need for a regulatory system that permits rehabilitation where appropriate.

Society has a tremendous investment in the training of all medical personnel, and this must be protected

In the State of Washington, we do use probation and reprimand, or an assurance of discontinuance, if the board believes that the complained of conduct is not egregious, is an isolated incident, and does not involve patient harm. As in all discipline, it is an informed judgment call and the public member has a distinct role to play in passing judgment. We must be tough and firm and fair. Experience has clearly shown me that as human beings, doctors do make mistakes. When these are honestly acknowledged and a remedial plan is put into place, experience also shows a remarkably high degree of recovery or non-recurrence.

We must be tough and firm and fair

The role and function of the public board member is to be informed, involved and committed. Board work is public service that is both gratifying and essential. The public member must act as a check-and-balance mechanism to assure that licensees who sit on regulatory boards do not become self-serving. One major concern of self-regulation is the opportunity for protectionism: the "good ol' boy" syndrome. Public members are uniquely situated to prevent this scenario and we must be assertive if the public is to be protected. Our job is to assure open, fair and candid deliberations, thereby guaranteeing the reliability and accountability of the disciplinary and regulatory process.

Finally, the public member must never feel tied to the past. My own experience has been that many of my initial preconceived notions of 1985 have greatly changed. Regulatory boards are part of a dynamic and constantly changing scene. As the professions themselves mature technically and change in our information oriented society, their regulation must also change. The participation of public members is part of this change and we must strive to be accountable to our constituents: the public whom we represent.

Boards are part of a dynamic and changing scene

NEW SOUTH WALES, AUSTRALIA

Policy Statement: Medical Practitioners and Sexual Misconduct

1. It is an absolute rule that a medical practitioner who engages in sexual activity with a current patient is guilty of professional misconduct.
2. While not detracting from the fundamental impropriety of such activity, the sanction applied, as a result of a finding of misconduct, may vary according to the circumstances of each case.

From the New South Wales Medical Board's
MEDICAL BOARD NEWSLETTER,
April 1992

3. Factors to be considered include the degree of dependence in the doctor/patient relationship, evidence of exploitation, the duration of the professional relationship and the nature of the medical services provided.
4. The rule refers to current patients. The termination of the doctor/patient relationship prior to sexual activity may be raised as a defence, but its strength will be dictated by consideration of the factors referred to in paragraph 3, as well as by the time lapse after the end of the professional relationship.
5. The rationale for the Board's position has been supported in many contexts by medical disciplinary authorities. Reasons for the rule include the following:
   5.1 The doctor/patient relationship depends upon the ability of the patient to have absolute confidence and trust in the doctor.
   5.2 The doctor is in a unique position regarding physical and emotional proximity. Patients are expected to disrobe and to allow doctors to examine them intimately.
   5.3 The doctor/patient relationship is not one of equality. In seeking treatment, the patient is vulnerable. Exploitation of the patient is an abuse of power.
   5.4 The doctor's role is one of authority, by virtue of the patient seeking assistance and guidance.
   5.5 Breaches of the doctor/patient relationship have often caused severe psychological damage to the patient.
   5.6 The community expectation of the medical professional is one of utmost integrity. The community must be confident that personal boundaries will be maintained and that patients are not at risk.
   5.7 Improper sexual conduct by doctors brings community censure and damages the credibility of the medical profession as a whole.
   5.8 The onus is on the doctor to behave in a professional manner. It is unacceptable to seek to blame the patient if a sexual relationship develops.
   5.9 Personal involvement with the patient will often lead to a clouding of clinical judgment.
6. The guiding principle is that there be no exploitation of the patient or abuse of the doctor's power. Each case must be examined in relation to the degree of dependency between patient and doctor and the duration and nature of the professional relationship.
7. The Board rejects the view that changing social standards require a less stringent approach. The nature of the professional doctor/patient relationship must be one of absolute confidence and trust. It transcends social values and no standard other than the highest can be acceptable.

Two Breaches of Patient Confidentiality

1. A psychiatrist, Dr A, sought information from a general practitioner, Dr B, concerning a patient of the psychiatrist and the patient's wife (Mrs X). Neither Mr nor Mrs X were patients of Dr B, but Mrs X was employed by Dr B.

Dr A had made an informal inquiry for information from Dr B over the telephone. Subsequently, he sent Dr B a copy of his report to Dr C, the referring general

practitioner.

At no point had Mrs X consented to information being sought by Dr A or conveyed to Dr B. She complained to the Board of this breach of confidentiality.

In evidence before the Professional Standards Committee (PSC), Dr A conceded that he had erred, but indicated that he was seeking important corroborative evidence. The Committee rejected his argument that public safety is an exception to the rules concerning confidentiality, as there was no evidence of significant impending harm.

The Committee expressed its concern at the contact, both by phone call and letter; at the inappropriately colloquial and metaphoric style of the letter to the referring doctor, given the serious and confidential nature of its contents; and at the fact that such important personal and marital information could have been dealt with in this way, with potentially damaging effects.

The Committee rejected an argument that it is proper for a practitioner to obtain information on patients from other persons, including employers, on the basis of implied consent. It also commented adversely on the implications that arose during the hearing that the free exchange of information, with or without the permission of patients, is acceptable through the network of medical colleagues. This implication presumes that medical practitioners automatically understand how to keep such information "in house" and that such behaviour is reasonable if doctors feel it is in the interest of patients. The Committee viewed that attitude as being out of keeping with contemporary community views. Patients are now generally better informed and able to make reasonable decisions about their own lives, health and welfare and usually demand the right to do so.

The doctor was found guilty of professional misconduct and reprimanded.

2. In another case, a patient's spouse overheard a group of doctors and their spouses discussing a patient by name in a public place. The Board viewed this as quite unacceptable.

Discussion of patients in an identifiable manner, unless for bona fide clinical purposes, is a breach of confidentiality. The breach in the second case was compounded by the fact that it was gratuitous, involved non-practitioners and was in a public place.

MANITOBA, CANADA

Civil Litigation and the Disciplinary Process of the College of Physicians and Surgeons

Background:

Recent media reports have implied that there should be some direct relationship between a finding of negligence in a civil court and disciplinary action by the College. Some reporters have even suggested that the mere filing of a civil claim alleging negligence should be sufficient grounds for suspension of a physician's licence to practise. These suggestions not only misinform the public, but also cause considerable apprehension for physicians. Many physicians have asked the College for clarification regarding the relationship between civil litigation and discipline.

Civil Litigation Compared to Discipline:

Patients are entitled to financial compensation if they are harmed by a wrongful action of a physician. It is the role of the civil courts to determine if there was such a breach of duty and, if so, then what compensation should be paid. The court's focus is restricted to the physician's care and management of the Plaintiff patient. The court is not entitled to review the physician's care of other patients. The judge's decision that a breach of duty has occurred is referred to as "negligence".

From the College of Physicians & Surgeons of Manitoba's REPORT OF DISCIPLINARY PROCEEDINGS, *August 1992—February 1993*

A finding of negligence in a civil court is not necessarily the same as a finding of professional misconduct. It is erroneous to use the terms "negligence" and "professional misconduct" synonymously. Professional misconduct is conduct committed by a physician in the course of practice which would be reasonably regarded as disgraceful or dishonourable by other physicians of good repute and competency.

Negligence is not the key to determining misconduct. An act of negligence may lead to a finding of professional misconduct against a physician where that act is found to be inexcusable and deplorable by a College Inquiry Panel. However, even where there is no negligence found, an Inquiry Panel may still conclude that a physician is guilty of professional misconduct. The College, unlike the court, can consider other aspects of the physician's work, both ethical and clinical. The College can and does examine patient care in the context of the physician's entire practice.

The courts have consistently recognized that a professional body is the best qualified to determine what is professional misconduct on the part of a member. The mandate encompasses all standards of conduct and ethics which are necessary to ensure professional honesty, integrity, and competence so as to merit the confidence of the public in the profession.

Below is a summary of some of the differences between a malpractice suit and professional discipline:

- *The court process is directed to determining a physician's specific duty to a specific patient, whether or not that duty was breached, and deciding if the proven breach caused harm to the patient. Where each of these elements is proven, the court may order compensation.*
- Like a court, the College will first determine whether or not it can be established that a physician breached a duty to a patient. Whether or not the patient suffered harm as a result of that breach need not be established. The issue is whether or not a risk exists for harm to the public.
- *The court's examination is restricted to the physician's practice in the case before it.*
- The College is entitled to examine the physician's entire practice to determine if the facts in a specific complaint indicate an isolated event, or are generally representative of the physician's practice.
- *The court's role is to determine if a patient is entitled to compensation.*
- The College's mandate is to determine whether or not restrictions on the physician's practice are necessary to protect the public at large.

The most conscientious and careful physicians can at times fail in their duty to a patient. A simple analogy is the failure of a driver to heed a stop sign. It is evident that the driver, in failing to heed a stop sign, has been negligent. If a collision occurs with injury to another driver, then damages may be awarded in a civil suit. However, it does not necessarily follow that the driver is incompetent. The court determines what damages should be paid as a result of the incident. The College must address the "driving record" to determine if restrictions on the physician's license are required to ensure public safety.

Early Intervention and Reporting:

In order for the College to work effectively, physicians, other health care providers and the public should forward concerns as soon as possible. If a physician is practising unsafely, any undue delay in reporting may lead to continued risk with respect to public safety. It is often difficult to gather evidence from witnesses when there has been a significant lapse of time. For these and other reasons, the College recommends that members of the profession and the public address concerns to the College without delay.

Physicians often have questions about their obligation to report deficient practise by a colleague to the College. *The Medical Act* requires every member who has reason to believe that a practitioner is suffering from a mental or physical disorder or illness affecting fitness to practise, to report that practitioner to the College, where that practitioner continues to practise after being counselled not to do so. *The Code of Ethics* provides that an ethical physician will report to the appropriate professional body any conduct by a colleague which might be generally considered as being unbecoming to the profession.

These issues are discussed more fully in the College guideline "When Your Colleague Has a Problem".

It is essential for every physician to recognize that the discipline process is a critical component of self-regulation. Obviously, certain behaviours or events fall in grey areas, and physicians are often unsure as to whether or not they have an obligation to report. Some judgment must be exercised in determining the difference between an **unintended and uncharacteristic fault in practise** and an incident which suggests **a wilful disregard of reasonable standards of practise or is an indication of a deficient standard of practise.** If physicians are unsure if a matter should be reported, they are invited to contact the Registrars in confidence for direction. Every physician has an obligation to ensure that the public is adequately protected and that a safe and acceptable standard of practise is maintained. One way physicians assume this responsibility is to report concerns to the College.

One of the most significant responsibilities conferred on the profession by *The Medical Act* is that of disciplining members who fail to observe proper standards of practise, conduct and/or ethics. Maintenance of these standards is essential to ensure the ethical conduct and clinical competence of members of the profession. All physicians should recognize that their cooperation is critical if the medical profession is to have the confidence of the public in its ability to regulate the profession and ensure appropriate standards of care.

ALABAMA

The Implications of Relapse for the Physician with Chemical Dependency

GERALD L. SUMMER, MD

Alabama law requires that physicians must report information on any physicians practicing in a manner to endanger the health of patients including "being unable to practice medicine or osteopathy with reasonable skill or safety to patients by reason of illness, inebriation, excessive use of drugs, narcotics, alcohol, chemicals, or any other substance." The law also provides confidentiality and protection for physicians from liability for reporting. The individual making the confidential report is immune from liability. All reports are handled confidentially within the Physicians Recovery Network (PRN). Neither the reports nor the names of any physicians are available to the Board of Medical Examiners or any other body without the consent of the individual making the report as long as the physician is compliant with the recommendations. If the physician refuses to be evaluated or seek help, the Medical Director of the Physicians Recovery Network obtains consultation with a member of the Alabama Impaired Physicians Committee. The Alabama Board of Medical Examiners may be notified and an official investigation undertaken at the Board's discretion. However, the physician is given every opportunity to be compliant to avoid exposure to the Alabama Board of Medical Examiners. The PRN's primary responsibility is advocacy for physicians who may be impaired, but patient safety must be assured.

From the ALABAMA BOARD OF MEDICAL EXAMINERS NEWSLETTER, *Spring 1993*

In order to appreciate fully the licensing implications of a relapse during recovery, it is important to know the Alabama Board of Medical Examiners may deal with the "first time offender." Legally, the Board usually takes disciplinary action relating to anyone who is unable to practice medicine with reasonable skill and safety who has not cooperated with the PRN and/or has committed an impairment-related offense, such as self-prescribing or diverting controlled substances, or engaging in unprofessional conduct with a patient.

The uncooperative practitioner may be temporarily suspended from practice by the Medical Licensure Commission until he/she demonstrates an ability to practice medicine with skill and safety to patients. This demonstration may require an evaluation and treatment recommended by a treatment provider approved by the Alabama Impaired Physicians Committee with strong PRN support for the professional's return to practice. The resumption of practice may be conditioned upon participation in the PRN and compliance with a PRN advocacy contract, as well as a lengthy period of probation with the Medical Licensure Commission. During Commission probation, random urine and body fluid screens may be routinely conducted to detect any use of alcohol or controlled substances. Periodic checks are done to assure compliance with the Board's agreement and with the PRN contract.

The practitioner whose impairment is related to controlled substances, or whose alcohol or emotional impairment has reflected itself in poor judgment regarding the prescribing of these drugs may have his controlled substances privileges suspended or monitored for a period of time. This monitoring may require the practitioner to issue duplicate or triplicate controlled substances prescriptions. One copy is sent to the recovering doctor's practice monitor and one copy is sent to the institution by which he is employed and one to the Board. The practice monitor may review a random sample of records for those patients who have received controlled substances, to look for medical justification for these medications. The practice monitor(s) send written reports to the Board

about the results of records review.

What then, is the fate of the recovering physician who slips while on the road to recovery? The Board's response to relapse varies, depending on the practitioner's recovery history, the circumstances surrounding the relapse, the way in which the case is presented to the Board, and PRN's recommendations. If the relapsed practitioner has turned quickly to the PRN for support, and if there is evidence of sincere participation with progress in the program and no patient has been harmed, the Board may give the professional another chance. However, the practice restrictions and monitoring may, in all likelihood, be increased. On the other hand, if the practitioner has not cooperated with the PRN and cannot show clearly that he is "back on track," a suspension can be recommended. In some cases involving two or more relapses, the Commission has revoked the practitioner's license. The Commission may impose a penalty even if no patient has been harmed or the relapse has not had a demonstrated negative effect on the doctor's medical practice; the threat of such an effect is sufficient for the Commission to impose a penalty.

Time is the best ally of a "relapsed" medical professional. In one case, a chemically dependent physician's license to practice medicine was temporarily suspended in Alabama. The temporary suspension by the Medical Licensure Commission was based upon an administrative complaint filed against the physician by the Alabama Board of Medical Examiners alleging that the use of self-administration of controlled substances was to the extent that the physician was unable to practice medicine with reasonable skill and safety to patients. He was subsequently compliant to the recommendation of the Commission and stipulations of the advocacy contract under the direction of the Alabama Impaired Physicians Committee. Eight months later, he successfully reapplied for reinstatement of his license to practice medicine. The Commissioner's order placed his license on probation for five (5) years subject to terms and conditions contained in the order to include his compliance to a practice plan and requirements to adhere to the advocacy contract with the Physicians Recovery Network.

Through the legal process and cooperation with the PRN, the physician was allowed to re-enter medical practice in a structured environment and under the supervision of physicians (3) in the advocacy contract and his employer. Continued documentation for his recovery program and practice parameters will allow him to safely resume practicing medicine in Alabama.

The best advice to those who have slipped along in recovery is to focus on gaining the time needed to re-evaluate and document recovery and to turn for support from the Physicians Recovery Network.

ARIZONA (M)

BOMEX Conducts SPEX Study

In 1988, the Federation of State Medical Boards introduced the Special Purpose Examination (SPEX). SPEX is offered for re-examination of selected physicians for whom a licensing board determines the need for a current demonstration of medical knowledge.

Since its inception, there have been numerous questions raised regarding the SPEX and the characteristics of those that take the test as well as those who pass or fail it. In the current study, the Board set out to make a determination, based on SPEX statistics for Arizona examinees during the 1990 and 1991 examination periods, as to the demographic characteristics of those examinees that failed the SPEX. While the complete study cannot be reported in this article, due to the length of the research, a brief overview is presented for your information.

From the Arizona Board of Medical Examiners' BOMEX BASICS, *Summer 1992*

The study was conducted using the entire population of examinees that sat for the SPEX during 1990 and 1991. This gave a research base of 273 subjects. A simple two-tailed test was used with a multivariate regression equation. The independent variables for the model included sex of the examinee, age, medical school approval by the LCME or CACMS, (yes=LCME or CACMS approved medical schools; no=all other medical schools), ABMS member board certification (yes or no), specialty, prior test (whether the examinee sat for the SPEX before or not), and degree (MD or DO). The dependent variable was the score on the SPEX.

These are partial results from the study to date.

Medical School	Approved	Unapproved
	237	36
Sex of Examinee	Male	Female
	245	28
ABMS Board Certified	Yes	No
	205	68

Initial results suggest that medical school approval, board certification and age are significant indicators of how well an examinee will perform on the SPEX.

The regression equation indicated that an individual who was not board certified and who graduated from

a medical school in the United States or Canada would have an expected score of 78 on the SPEX (passing score is 75). If the examinee was board certified, the expected score increased by 5 points. If an examinee was an unapproved medical school graduate, the expected SPEX score decreased by 6 points to 72.

According to the study results, 47.5% of graduates from unapproved medical schools failed the test. All of these results were significant to the .001 level of significance (P<.001).

Other data of interest from the study relating to self-designated specialties are listed in the table that follows.

Specialty	Freq.	Percent*	Pass	Fail
Allergy/Immunology	2	0.7	2	0
Anesthesiology	10	3.7	9	1
Colon/Rectal Surg	1	0.4	1	0
Dermatology	9	3.3	7	2
Emergency Medicine	15	5.6	15	0
Family Practice	40	14.8	28	12
General Practice	7	2.6	6	1
General Surgery	12	4.4	11	1
Internal Medicine	53	19.6	51	2
Neurology	5	1.9	5	0
Nuclear Medicine	1	0.4	1	0
Obstet/Gynecology	31	11.5	24	7
Ophthalmology	3	1.1	2	1
Orthopedic Surg	5	1.9	5	0
Psychiatry	20	7.4	14	6
Pediatrics	13	4.8	11	2
Preventive Med	9	3.3	8	1
Plastic Surgery	4	1.5	2	2
Pathology	10	3.7	8	2
Radiology	18	6.7	10	8
Thoracic Surg	1	0.4	1	0
Urology	1	0.4	0	1

*Percent of total examinees

Clearly, these results, while based on a small sampling frame, are significant enough to warrant continued study. The Board is currently leading a larger study in cooperation with other state medical boards.

MINNESOTA

Reporting Suspected Misconduct: When in Doubt, Do

Based on the reasons given by physicians who have come before the Board for failure to report knowledge of conduct that constitutes grounds for disciplinary action, some confusion remains about the obligation to report to the Board.

From the MINNESOTA BOARD OF MEDICAL EXAMINERS UPDATE, *Spring 1993*

To clarify matters, there is only one instance where a physician is relieved of the mandatory reporting obligation. This is when "in the course of a physician-patient relationship the patient is another physician and the treating physician successfully counsels the other physician to limit or withdraw from practice to the extent required by the impairment."

In all other circumstances, physicians are required to report knowledge of conduct that constitutes grounds for disciplinary action to the Board of Medical Practice even if the conduct has already been reported by others.

It is not an excuse that the non-reporting physician believed that the matter was self-reported or had been reported by another individual or entity. *The Board encourages multiple reporting of the same instances of conduct—in fact, failure to comply with the mandatory reporting obligation is itself grounds for discipline under Minn. Stat. § 147.091, subd. 1 (u).* Practically, failing to report a colleague does no service to the physician, the patients, the integrity of the profession, or the non-reporting physician. The physician's conduct will eventually be brought to the Board's attention, patient care may be needlessly jeopardized in the interim, the profession may suffer a "black eye" from negative publicity and a separate action may be opened against the non-reporting physician.

Don't Panic! Cooperate with Board Investigations

If you are being investigated by the Board of Medical Practice—don't panic! The Board receives more than 1,200 complaints each year with about 100 of them resulting in Board action. But the Board must thoroughly investigate each complaint to determine if it has merit.

An invitation from the Board to respond in writing to a complaint should be taken seriously and responded to with thoughtfulness and accuracy. The licensee is required by the Medical Practice Act to cooperate and that means responding in a timely manner.

One of the Complaint Review Committees of the Board reviews the complaint, the licensee's response and the medical records to determine whether there may have been a violation of the Medical Practice Act.

Seven out of 10 cases are closed at this point in the

process. The remaining three cases are continued for collection of additional data and/or a field investigation.

Statistically, one of the three remaining cases will be dismissed after investigation and the other two will involve an appearance by the licensee before the Complaint Review Committee. Even an appearance before the Complaint Review Committee does not necessitate an adverse Board action.

At some time within every licensee's career, a complaint is likely to be filed and the licensee will be asked for a response.

Complaints are a part of the licensee's professional career and should be taken in stride as another responsibility in the "care and feeding" of your license.

When that letter of inquiry comes from the Board or the Attorney General's Office, don't panic—just respond—promptly and professionally!

WYOMING

Pitfalls of Prescribing Controlled Substances

DON RISKE, JD

Recent disciplinary actions of the Board of Medicine have again focused attention upon the prescribing of controlled substances by physicians and the potential for license action if statutory restrictions are violated. Due to the seriousness of the sanctions which can be imposed, drug prescription is an area of practice which deserves attention and understanding by the practitioner.

From the Wyoming Board of Medicine's
NEWSLETTER, *Spring 1993*

The Wyoming Medical Practice Act provides that the Board of Medicine may take disciplinary action against a physician for a number of different specific violations including: repeatedly prescribing or administering, selling or supplying any drug legally classified as a narcotic, addicting or scheduled drug to an addict or drug abuser except as permitted by law; repeatedly prescribing, selling, supplying or administering any drug legally classified as a narcotic, addicting or scheduled drug to a parent, spouse or child of the licensee or to himself; pre-signing blank prescription forms; willful and consistent utilization of medical service or treatment which is inappropriate or unnecessary; and unprofessional or dishonorable conduct.

In general, a prescription not for a legitimate medical purpose, is not viewed to be in the usual course of professional practice. A physician is exempt from federal and state drug distribution laws only when he or she acts within the appropriate and regular bounds of professional practice. If the written direction in a prescription is not for a substance to be used in treating illness, it is not considered as a prescription as the term is used in the controlled substances statutes and as people of common intelligence generally understand the term.

Courts have looked at numerous factors when examining a physician's prescribing practices to determine whether violations exist:

1. An inordinately large quantity of controlled substances prescribed;
2. Large numbers of prescriptions issued by a physician;
3. No physical examination given prior to issuing the prescription;
4. A warning by the physician to the patient to fill the prescription at different pharmacies;
5. A physician issuing prescriptions to a patient knowing that such drugs will be delivered to others;
6. A physician prescribing controlled substances at intervals inconsistent with legitimate medical treatment;
7. The physician's using street slang terms for drugs;
8. No logical relationship between the drugs being prescribed and the treatment of the condition allegedly existing; and
9. A physician writing a number of prescriptions on the same date but putting different dates on each prescription.

A physician should inform himself/herself of the techniques utilized by patients to acquire prescriptions for controlled substances from physicians. Important among the above stated factors is a physical examination of the patient and a prescription which relates directly to treatment of the condition diagnosed at such physical examination. While this may seem fundamental to most practitioners, the incidences of "script writers" and physicians who trade controlled substances prescriptions for sexual favors or for large amounts of cash knowing that the purpose has no legitimate medical justification are increasing.

Treatment of chronic pain patients, cancer patients and other medical conditions by prescribing large amounts of controlled substances by a Wyoming physician could trigger an investigation by the Wyoming Pharmacy Board and/or the Wyoming Board of Medicine. In any circumstance where such prescribing is to be done, the physician is well advised to inform the Wyoming Board of Pharmacy and the Wyoming Board of Medicine in writing of his or her intention to write prescriptions for large amounts of controlled substances to a particular patient, so that such an investigation might be avoided.

Physicians attempting to treat drug addicts through methadone programs should first be advised of and comply with the requirements of federal law for specific certification to administer such a program.

Physicians with particular questions about prescribing practices and possible violations of the Wyoming Medical Practice Act may contact the Board of Medicine office in Cheyenne at (307) 777-6463.

Discussion on a Model Medical Practice Act

This article was featured in the April 1915 number of the Federation's Monthly Bulletin, *which was successor to the* Federation Quarterly *of 1913-1914. The* Monthly Bulletin *became the* Federation Bulletin *in 1920. In 1992, the* Federation Bulletin *became the* Federation Bulletin: The Journal of Medical Licensure and Discipline *and returned to a quarterly schedule. Sadly, all copies of the original* Federation Quarterly *have been lost, as have several numbers of the* Monthly Bulletin. *This, therefore, is the earliest surviving feature article known to have appeared in the Federation's official publication.*

The discussion recorded here took place on the floor of the second annual meeting of the Federation, held at the Congress Hotel in Chicago on 25 February 1914. It marked the beginning of that long process that would lead, finally, to the publication of the first edition of the Guide to the Essentials of a Modern Medical Practice Act *in 1956.*

Though all the speakers were distinguished leaders of the Federation and the two organizations that merged to create it in 1912, four deserve particular notice. George H. Matson, MD, of Ohio, was the Federation's first executive officer. Otto V. Huffman, MD, of New York, was the first editor of the official publication and the second executive officer of the organization. Walter L. Bierring, MD, of Iowa, need one be told, was the second editor of the official publication and the third, and longest serving, executive officer. David A. Strickler, MD, of Colorado, holds the distinction of having served as Federation president longer than anyone else: nine years (1916-1925).

DR. WALTER P. BOWERS, Boston: The consideration of this subject, of course, is a matter of certain practical difficulties because, however well we may understand the subject, we know quite well that we cannot get in many instances what we would desire. Knowing we will be limited to a few minutes, I have a few remarks with reference to what I consider a model medical practice act, and first, I would state, it should be very brief, very clear and concise, and that there should be nothing unnecessarily technical in it.

1. It should provide for a board of examiners, preferably seven, and it should be the only board of examiners in the state in which it is created. It should consist of men of mature mind and medical experience, selected because of their natural and acquired fitness for this work.

2. The board should have full power to make regulations for the conduct of its work and should make such standards of qualifications of the applicants for licentiation as may be deemed fitting, such as requiring a degree in medicine and the determination of the quality of that degree. I think it is belittling for laws to have as an important part many restrictions which are in the state law. I am a believer in men more than in measures, and I think these matters, when men can be found qualified to deal with them, should be left so far as detailed administration is concerned to the men who have them in charge, because conditions change from time to time, and a licensing board which finds its function in the condition of today may find a different function in the future.

3. It should have power to cancel certificates and revoke licenses for cause. It should also have power to reissue certificates and to reregister physicians whose licenses have been revoked.

4. It should require every possessor of a certificate of registration to have that certificate recorded in the office of the town or city clerk where the person has a residence or where he practices.

5. Compensation should be provided for by the decision of the governor and council of the state and should be sufficient to remunerate the person for the time given. If a board should develop its work so as to require more time from its members, the governor

should be at liberty to increase the compensation.

6. The fees for examination and registration should be not less than $25 for the first, and when necessary, for more than one examination, not less than $10 for each subsequent examination. This system of providing for additional examinations for the delinquent applicants without charge, it seems to me, to be absolutely unjust.

7. There should be a penalty for practicing illegally not exceeding $100 for the first offense, and for subsequent offenses not less then $500 or imprisonment or both. The reason why I should not have the penalty of the first offense more than $100 is because some men are ignorantly evading the law, and it is unnecessary to make the penalty for the first offense a large one.

8. There should be no exemption under this law, the question simply being whether one has practiced medicine for hire for this purpose. There should be a definition of the word medicine, and a definition of the word "medicine" I should like to submit for your consideration.

Assuming an act to have been created, I would have it read as follows: The word medicine as used in this act shall be regarded as referring to that branch of science which relates to the prevention, cure or alleviation of the diseases of the human body, and any person shall be regarded as practicing medicine within the meaning of the section of this act which applies to this particular thing who shall publicly assume or advertise under title or other designation which shall show or tend to show that the person publicly assuming or advertising is a practitioner of medicine in one or more of its branches, or who shall investigate or diagnosticate physical ailments or conditions of any person whom he has to treat or modify the same by the use of instruments, or external appliances or manipulations, or by the application or administration of any remedial agent for either internal or external effect, excepting in so far as the provisions of this section do not conflict with the exemptions that are provided.

DR. B. D. HARISON, Detroit, Mich.: The subject of medical legislation and a proper medical practice act is a very extensive one, and as my time is limited I shall only take up one or two phases of the proposition.

First, about the composition of the board. There has always been a provision in the courts about the membership of the board, the membership being confined to those members of the profession who are not connected with teaching. That was very material ten or twelve years ago when we had low-grade colleges to contend with. That condition has passed away. In foreign countries where teachers and clinical men have places on boards and conduct the examinations, they can do so properly and much more efficiently than a general practitioner throughout the state who is subject to political influences. They can be well intentioned, but they have not the experience or ability to conduct a proper examination, and the experience of other countries has been that the clinical professor, the man who is in active touch as teacher, is the only proper person to conduct a real, thorough examination, and there has been no complaint of favoritism from that source.

As regards the composition of the board, it does not make much difference about the board, whether there are three or four schools represented on it or not, because the members of the board forget all about schools when they once qualify. They are all working for the same object.

In framing a medical act there should be as little in it as possible. The board should be given discretionary powers on almost anything; I would not tie them to standards and things of that kind, but the proper method in my opinion is to create a minimum standard of preliminary education and emphasize that in the act. The standard should not be less than so and so, and the minimum standard in medical education cannot be less than so and so in years and months, and further on in the act give the board authority to set medical standards both preliminary and medical. The board should be in a position to raise the standard to any reasonable extent. It has the actual authority to put on thirteen years, but such a board would not last long if it did that. But the board can do anything that is reasonable and keep up with the procession. We have put on a year; we did not have to go to the legislature. We can put on any additional preliminary education or a hospital year without legislative influence whatsoever.

In regard to the discipline clause, I think it is well to keep that thing out of the boards as much as possible. You have to define to the Supreme Court what unprofessional conduct is; you cannot say a man is guilty of unprofessional conduct and convict him without specifying what that is. You must specify that in the act.

As to the splitting of fees, you must specify that in the discipline clause and you can make that a misdemeanor under the law. He is tried in the courts first. That is up to the prosecuting attorney, and when a man is finally convicted you simply get a certified copy to file with the board and his license is cancelled automatically. Whenever we as a board had to do this business we were held up by injunctions, by exceptions, and the place was overcrowded with lawyers. Then, in addition to what I have said, you want a good definition.

DR. GEORGE H. MATSON, Columbus, Ohio: It seems to me, this discussion might have been

postponed until next year since we have a special committee to consider the subject and to bring before us at that time a model medical practice act for consideration. Some of the discussants, however, have brought out a viewpoint which I want to agree with, if nothing else. In the first place, it is my opinion the board should be a small one of prominent individuals with a paid executive officer, whose duty it is to enforce the medical practice act. In case the county prosecutors will not enforce the act, then the board ought to be charged with it, and without enforcement it is a dead letter so far as illegal practitioners are concerned. The board should be a part of the state machinery; the fees collected from the examinations should not be turned over to the state medical boards, as the officers for the medical boards should be paid by the state by an appropriation sufficient to maintain that department the same as they maintain other departments in the state. The board should be appointed by the governor. We might have a commissioner if it were not for the fact that we have revocations to deal with, and because of the charges brought before the board and because it requires medical men to pass upon them, this power of the board would be necessary. It would avoid criticism in the definition of unprofessional conduct which Dr. Harison spoke of. Unprofessional conduct and gross immorality should be well defined for the reason alluded to by Dr. Harison. Unless they are, actions of the board will be upset by an appeal from the board and an appeal from the state medical boards would make a good many of us feel we wish there had not been any appeal. It is necessary to maintain the medical boards in the communities as they are now organized. The powers of the board should be defined in a very short concise sentence. Their power should be unrestricted and unlimited.

I quite agree with Dr. Harison that the standards of both preliminary and medical education should be in the hands of the board who shall have power to change them as the medical colleges change their courses.

The practice of medicine should be clearly defined. I think there should be no exemptions.

I think the question of examinations as spoken of by one of the members, by all schools could be well arranged with reference to light, heat and cold; questions on electricity, serum therapy, and a great many of the drugs used by schools could be referred to members of the board representing the various schools.

The matter of reciprocity, which will be discussed in another paper, should be well defined in the medical practice act.

Penalties for illegal practices should be well defined, and should be so placed that the lower courts can handle the cases.

These are the only high points I can think of discussing at this time.

DR. WALTER L. BIERRING, Des Moines, Iowa: I have a few words to say about the health law. Iowa is operating under an entirely new organization. The board of health consists of four physicians who have been appointed, the appointing board consisting of the governor, the secretary of state, and the auditor of state, and those three officials are also ex-officio members of this board of health, including the treasurer of the state. The four members are appointed, so that not more than two are from the same political party, and not more than two are from the same school of medical practice. There are, I believe, two democrats and two republicans on this board, two of the regular school, one of the eclectic and one of the homeopathic school. The four physicians constitute the board of medical examiners. They are on a salary of $900 a year. They are required to meet only twice a year by law and as many other times as necessary. The secretary is appointed by the same appointing board, who is health commissioner of Iowa and executive officer while the board is not in session. He receives a salary commensurate with his entire time. There is added to the board of health a sanitary engineer who is on full salary. The board of health has five members, with the four ex-officio members, and the board of medical examiners which consists of four members.

We are hoping with this smaller board to do better than with the larger board which was more under political influence than it is now.

DR. HERBERT HARLAN, Baltimore: I agree with everything Dr. Matson has said, except the appointment of the board, and I agree with him on that except in one particular. He left out what I consider a very important point, and that is the appointment of the board by the governor. If he had added to that "From a list selected by the president of the state medical society," it would have been better. That there should be so many republicans or so many democrats, I do not approve of that. But I believe the governor in general could be depended upon to select members for the board, and if that is not out of the way the Maryland board is elected by the state medical society, and I do not believe that is the very best way. If we do not select the right people for members of the board the physicians are to blame. There is a good deal of politics among medical men, as you know, and we may get men on the board who are not desirable. If the list could be submitted to the governor, I think it would be alright. In our state we sometimes have a democratic governor and sometimes the other kind, but the list would be a good one. The president of the state society, if he is careful, might select a good list. On the other hand, he might put his friends on the list.

From that list the governor should select the board.

DR. S. L. JEPSON, Wheeling, West Virginia: In the drawing up of this medical practice act it seems to me the most important thing in it will be a proper definition of the practice of medicine. We admit osteopaths in the state of West Virginia on examination just the same as we do every other applicant, except in the principles of osteopathy, diagnostic osteopathy, and the practice of osteopathy we invite osteopathic practitioners. I want to say, I have in my possession now the most scientific set of questions, out of the whole list, that came from an osteopathic practitioner.

One other point: I would like to see incorporated in the law, if it be possible and legally right, not only the power to rescind a license, but the abrogation of the provision that now exists in our laws for an appeal to the courts. Recently we had two licensed physicians indicted in Wheeling. We revoked their licenses after trial; they appealed to the court, and the circuit judge, one of the most conscientious men I know, reversed the action of the board because of his fear he might do unnecessary damage to these two physicians. He failed to discriminate between the advertising part of that firm and the therapeutic part. He failed to hold the practitioners accountable for the advertising which he condemned most bitterly.

DR. D. P. MADDUX, Chester, Pa.: I was much impressed years ago in my surgical teaching with a remark of the late Dr. Senn who said that "The fate of a wound depends upon what you keep out of it." The fate of a medical bill depends upon what you keep out of it. You can only have a model medical practice act when executed in a model manner. You can put in matters of duty in a suggestive way that will be seriously hampering to it, and the only suggestion I would make in the creation of an act of this kind would be that it give the widest latitude in its execution.

DR. W. SCOTT NAY, Underhill, Vermont: In connection with the remarks made by the gentleman from Maryland in regard to the appointment of members of the board, the Vermont law provides that the State Medical Society shall nominate and the governor shall appoint, but at the last session of the legislature there was a bill introduced emanating from the governor himself to do away with that method of appointing members on the board, he being jealous it seems of the physicians, because he said it was only a commission in which there were nominations and he was expected to follow them. We went before the committee and discussed this matter; it was not a matter of politics. We wished to take it out of the hands of the politicians entirely, and when the matter came up before the house, it was dismissed. Our governor has been the most radical man we have ever had, but he acquiesced in this after all.

DR. P.H. TATMAN, Eureka Springs, Ark.: I think politics should be kept entirely out of this matter in selecting members for the licensing board, and I believe a better way for the purpose of making appointments is for the State Society to appoint a strong committee, members from each congressional district, to look the field carefully over and make recommendations to the governor for appointment. Our board is appointed by the governor through recommendations of the list made through the state society, but I believe this matter can be handled much better by a strong committee of intelligent physicians to look the field over because it is certainly necessary that we should have the best material. Politics should not play any part whatsoever.

DR. DAVID A. STRICKLER, Denver, Colo.: I want to agree with those who have taken the position that the medical practice act should have as little as possible in it; that is, a good definition of what the practice of medicine should consist, and a definition of the practice of medicine should be all inclusive with all those who practice the healing art irrespective of the method of practice, and the board should be given the largest possible discretionary power under which licenses should be revoked. It should be definitely stated that power should be given to the board for revoking licenses. In our state that is a rigid rule, and while the decision of the board may be reviewed by the courts, it is rare that our revocations do not hold.

DR. ARTHUR M. HUME, Owosso, Mich.: We have had experience with the political element, and our law as originally framed made the nominations by the state society necessary, although it was left to the option of the governor to appoint from the list of candidates submitted. I do not think the governor has paid much attention to that, and for several years there has been no complaint of politics entering into it. We have very little to fear from politics. The important thing is a proper, comprehensive, and legally workable definition of the practice of medicine. This was made a part of our Michigan Medical Practice Act by an amendment adopted at the last session of the legislature, and aside from that the board is given full discretion in practically all matters, so that we have very nearly a model medical practice act.

MEDICOLEGAL DECISIONS

Recent medicolegal decisions involving or of interest to medical boards.

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SECTION 1: MEDICAL BOARDS

Board Violates Physician's Due Process Rights in Suspending His License. . . . A physician's due process rights were violated by the state board of medicine in revoking his license, the Pennsylvania Supreme Court ruled.

An emergency meeting of the Board was called to consider whether to authorize the Board's prosecuting attorney to cite a physician for a formal hearing based on a complaint of sexual molestation of a female patient. The physician performed a partial craniotomy on a 17-year-old female patient. She filed a report with local police alleging that on the day after the operation, while she was in intensive care, the physician fondled her vagina and placed his penis in her mouth. Seven of the eight Board members present at the emergency meeting voted to cite the physician for a formal hearing.

Board improperly commingled its prosecutorial and adjudicative functions

The complaint was issued, and the Board appointed a neutral hearing examiner to preside over the disciplinary proceedings. The Board's hearings were stayed pending the outcome of criminal actions. After the physician was acquitted of all charges by juries in two counties, the Board resumed its hearings. Additional complaints were filed against the physician by several other patients who alleged incidents took place over a period of eight years between 1976 and 1984. The incidents generally involved patients who claimed they awoke from sedation to find the physician engaged in sex acts with them. The hearing examiner ruled the physician's license should be suspended for five years and ordered that he seek psychiatric treatment.

The physician appealed to the Board, which ordered the permanent revocation of his license. Three members of the Board who voted to authorize the formal hearing voted to revoke the physician's license permanently. A trial court reversed the decision.

On appeal, the supreme court said the Board improperly commingled its prosecutorial and adjudicative functions. The Board violated the physician's constitutional due process rights by both deciding to prosecute him and making the final judicial decision on his appeal. The court said the constitutional defect could be cured by placing the prosecution function in a group of individuals or an entity distinct from the Board and allowing the Board to render ultimate adjudication without also prosecuting the physician. —*Lyness v. Commonwealth of Pennsylvania, State Board of Medicine,* 605 A.2d 1204 (Pa. Sup. Ct., March 18, 1992; reargument denied June 30, 1992)

Amphetamine Rule Invalid. . . . A rule issued by the State Board of Registration for the Healing Arts to regulate prescribing of amphetamine and amphetamine-like drugs was void, a Missouri appellate court ruled.

The Board filed a disciplinary action against an obstetrician for violating the Board's amphetamine rule. The physician's medical practice partially involved treating patients suffering from exogenous obesity, overweight resulting primarily from overeating. Between April 1983 and July 1986, the physician prescribed oral anorectic drugs for several patients suffering from obesity. Oral anorectics act as appetite suppressants and have other central nervous system actions or metabolic effects. They are either Schedule III or Schedule IV controlled drugs. On several occasions, the physician failed to record pulse rate, weight, blood pressure, and heart and lung conditions. In some cases, the drugs were continued after prior use during which no substantial weight reduction occurred. He also prescribed the drugs for longer periods

than permitted under the amphetamine rule.

The rule, which was issued by the Board, addressed amphetamines and amphetamine-like drugs. The rule defined amphetamine-like drugs as those with pharmacologic activity similar to the prototype drugs of the amphetamine class. The rule did not specify which pharmacological activity was to be examined in defining amphetamine-like drugs. A trial court found the term "amphetamine-like" vague and indefinite and the amphetamine rule void. The court reversed the discipline by the Board.

Department of Health, not medical board, was administrative agency responsible for implementing the controlled substance law

Affirming the trial court's decision, the appellate court said the Board did not have the authority to issue the amphetamine rule to regulate prescribing of controlled substances. The court said under state law, the Department of Health was the administrative agency responsible for implementing the controlled substance law. The court said it was improbable the state legislature would have intended the agencies regulating physicians, podiatrists, pharmacists, veterinarians, and dentists each could issue their own regulations on controlled drugs that were possibly inconsistent with those issued by the Department of Health.

The court said the amphetamine rule was void and the physician was not subject to discipline for violation of the rule.—*Casey v. State Board of Registration for the Healing Arts,* 830 S.W.2d 478 (Mo. Ct. of App., April 14, 1992; rehearing and transfer denied May 12, 1992; transfer denied June 30, 1992)

Licensing Requirements for Graduates of Unaccredited Medical Schools Not Unconstitutional. . . . . There was no civil rights violation when a graduate who attended an accredited medical school and a foreign unaccredited medical school was denied a temporary license to practice medicine, a federal appellate court in Illinois ruled.

The physician completed his core clinical rotations at an accredited medical school but graduated from a foreign medical school. He applied for a temporary medical license. He was asked to attend an interview with the state licensing board. The Board voted to deny the application based on the interview. The state required applicants who graduated from unaccredited medical schools to complete their core clinical rotations at a clinical facility affiliated with the medical school from which they graduated. There was no such requirement for graduates of accredited medical schools.

The physician filed suit against the Board and the State Department of Professional Regulation, alleging the denial of his application violated his constitutional rights. The trial court dismissed the case, stating the physician failed to state a claim upon which relief could be granted.

There was a legitimate distinction between accredited and unaccredited medical schools

Affirming the decision, the appellate court said since no suspect class or fundamental right was involved, the licensure requirements merely had to be rational. The court said there was a legitimate distinction between accredited and unaccredited medical schools and additional educational requirements may be imposed on graduates from unaccredited medical schools. In addition, the court ruled the requirements for temporary licensure did not arbitrarily discriminate between Canadian medical schools and other foreign medical schools, because many Canadian medical schools were accredited.—*DeSalle v. Wright,* 969 F.2d 273 (C.A.7, Ill., July 16, 1992)

Rule Limiting Physical Therapists Improperly Issued. . . . A rule prohibiting physical therapists from performing electromyographic examinations was not issued properly, a Virginia appellate court ruled.

A physical therapist and a state association of physical therapists filed suit to prevent the Board of Medicine from enforcing a rule that prohibited physical therapists from performing electromyographic examinations. A trial court permanently enjoined the Board from enforcing any rule prohibiting the performance of electromyographic examinations by physical therapists. The court denied a request for attorney fees by the association.

Affirming the decision, the court said the Board was empowered to regulate the practice of medicine and physical therapy. Before physical therapists were licensed by the state, they routinely conducted electromyographic tests on patients referred to them by physicians. The tests involved nerve conduction studies using external electrodes on a patient's skin over a muscle and needle electrode examinations involving insertion of a needle electrode into a patient's muscle. In 1983, the Virginia Neurological Society, whose membership consisted of physicians, announced its position that EMG testing constituted the practice of medicine and should be performed and interpreted by qualified physicians.

Board did not follow Administrative Process Act in adopting rule

It sent a resolution to the Board. The Attorney General issued two opinions in which he concluded electromyography was the practice of medicine and could only be performed by a physician. In the second

opinion, he said physical therapists could conduct the external electrode portion of the test at the direction of a physician but the invasive needle electrode portions of the test must be performed only by a physician. The Board published a summary of the Attorney General's opinion in its newsletter. In July 1988, the Board gave notice to the physical therapist to appear at an informal conference to inquire into allegations he had violated laws governing the practice of medicine by performing the needle electrode portion of EMG examinations.

The appellate court said the Board's enforcement of the Attorney General's opinions was not a proper adoption of the rule. The Board's actions were governed by the Administrative Process Act, and the Board did not follow it. Only properly issued rules or decisions of the Board could be appealed, the court said. It dismissed the action by the association and the physical therapist and said they could file a new action against the Board if it reached an adverse decision in the case against the physical therapist. Since the appeal was not proper, attorney fees could not be awarded.—*Virginia Board of Medicine v. Virginia Physical Therapy Association,* 413 S.E.2d 59 (Va. Ct. of App., Dec. 24, 1991)

Fake Physician Fined $10,000 and License Revoked. . . . The license of a physician who misrepresented her qualifications and lacked a medical degree was revoked properly, the highest court of Massachusetts ruled.

The physician swore under oath she had attended a medical school in the Dominican Republic from 1972 to 1976. She submitted a document purportedly signed by the dean of the medical school, verifying she had received her doctor of medicine degree in 1977. On the basis of that information, she was granted a limited physician license. She worked as an intern and resident at a medical center for three and a half years. In 1982, she applied for full licensure, again swearing she attended the medical school from 1972 to 1976. She also submitted a certificate from the Educational Commission for Foreign Medical Graduates in support of her application. She received a full license in 1983, which she renewed in 1985.

Dominican medical diploma and dean's letter were forgeries

On February 11, 1987, the Board of Registration in Medicine temporarily suspended her license and issued a show cause order. In support of its order, the Board referred to correspondence from the dean of the medical school stating the physician had attended, but withdrew without receiving a degree. The physician then submitted a letter allegedly from the Educational Commission stating that an error had been made and that her diploma was valid. After a hearing, the hearing officer recommended her summary suspension should remain in effect. After another hearing, the Board revoked her license permanently and fined her $10,000.

The high court affirmed the decision. The evidence supported a finding the physician misrepresented her qualifications and lacked a medical degree. The physician stipulated she did not possess the qualifications required to be a registered physician and did not possess a valid certificate from the Educational Commission for Foreign Medical Graudates. In an affidavit, the dean of the medical school stated the physician did not graduate from the medical school and her diploma and the letter purporting to be from him were forgeries.—*Benmosche v. Board of Registration in Medicine,* 588 N.E.2d 621 (Mass. Sup. Judicial Ct., March 2, 1992)

Physician Denied License for Child Pornography Conviction. . . . A trial court did not err in denying a physician a license to practice because of a federal conviction for receiving child pornography, a New York appellate court ruled.

The physician, who was licensed to practice medicine in Pennsylvania, applied for a license to practice in New York. Shortly before applying, he pleaded guilty in a federal court in Pennsylvania to knowingly receiving hardcore child pornography. He was placed on probation for two years and fined $1,500. After a hearing to assess his moral character, a board of the State Board of Medicine denied his application because he did not fulfill the moral character prerequisite for licensure sufficiently. At the time of the hearing, he was practicing medicine and teaching in Ohio. A trial court transferred the physician's action to annul the determination.

Physician failed to make a clear showing his patients would not be exposed to serious risk of harm

The appellate court said the factors required to be considered when a prospective licensee has been convicted previously of a criminal offense were sufficiently developed to determine that he had not shown clearly his patients would not be exposed to an unreasonable risk of harm if he were licensed. The physician admitted purchasing a videotape depicting nudity of persons in their teens and younger and using pornographic material for sexual stimulation. The videotape showed children engaged in sexual activity.

The physician was not involved in therapy at the time of the hearing despite the recommendations of two of three psychiatrists he saw. Only a year had elapsed

between his offense and his application for licensure. The physician planned to limit his professional activity to teaching or clinical research, but his New York license could not be so restricted. The court said the evidence supported the conclusion he had failed to make a clear showing his patients would not be exposed to a serious risk of harm.—*Bevacqua v. Sobol,* 579 N.Y.S.2d 243 (N.Y. Sup. Ct., Feb. 6, 1992)

One Year Suspension. . . . A physician's one-year suspension for sexual contact with a patient was confirmed by a New York appellate court. The physician acknowledged he removed his gloves after a gynecological examination of a patient and subjected her to sexual contact for no medical purpose. After a hearing, the physician's license was suspended for one year. The appellate court affirmed. The Office of Professional Medical Conduct did not have to prove the patient did not

Lack of consent was irrelevant

consent to the contact. Lack of consent was irrelevant to the charge against the physician, the court said. The patient's implied consent to medically appropriate contact with her sexual or intimate parts neither legally not logically extend to sexual contact of a non-medical nature.—*Kim v. Sobol,* 580 N.Y.S.2d 581 (N.Y. Sup. Ct., Feb. 27, 1992)

Assistant Surgeon Guilty of Abandonment. . . . An assistant surgeon's license to practice medicine was suspended for two years for abandoning a patient, a New York appellate court ruled. The physician assisted a surgeon to correct a perforated diverticulum. Upon opening the patient's abdomen, they were confronted with numerous adhesions that prevented them from reaching the affected areas. The surgeon decided to terminate the surgery without reconnecting the bowel. Not reconnecting the bowel placed the patient's life in immediate danger due to fecal contamination of the abdomen. The assistant surgeon advised the surgeon that he should not close the abdomen without reconnecting the bowel, suggested that another surgeon be called to do so, and offered to take over the operation himself. The surgeon rejected all the assistant's suggestions because he believed the situation was not

A physician-patient relationship existed during and after surgery

salvageable and the patient was terminal. The surgeon concluded the surgery, and the assistant surgeon left the hospital without taking steps to have a reoperation performed. A nurse told the manager of the Medical Staff Organization and Quality Assurance about the situation. He contacted the Chief of Surgery who arranged for a reoperation on the patient. On appeal from a two-year suspension of his license, the assistant surgeon said the patient was not his and there was no physician-patient relationship between him and the patient. The appellate court said there was such a relationship, and it continued after the operation was completed. The finding of guilt was supported by substantial evidence, the court said.—*Le Pointe v. Sobol,* 586 N.Y.S.2d 334 (N.Y. Sup. Ct., July 16, 1992)

Physician Monitored for Drug Abuse. . . . A physician must accept the terms of his two-year probation, including monitoring for drug abuse, for failure to maintain appropriate records, a New York appellate court ruled.

The physician petitioned to set aside penalties imposed on his license and registration to practice medicine in New York. He was placed on two years probation after admitting to the Department of Health he had failed to maintain a record of controlled substances he had administered to himself. When his application for reconsideration was denied, he appealed.

His physician stated in the hearing which followed that for three years the physician had been taking self-administered Seconal. He said he had ceased dispensing drugs to himself upon being placed on probation and now was taking only drugs prescribed by his physician for his medical problem. He maintained he should not have to undergo monitoring for continuing drug impairment since no allegations had ever been made against him for impairment but rather only for technical oversight in not keeping appropriate records of the drugs he had dispensed to himself.

Not necessary for a licensee to be charged with drug impairment in order for terms of probation to include drug use verification

The court disagreed. "It is not necessary for a licensee to be charged with drug impairment to impose upon him terms of probation which include drug use verification," the court declared. The physician had used drugs for three years without the knowledge of his personal physician. His failure to keep records of such use could not be considered entirely aside from the issue of habituation. He was still using drugs prescribed by his physician.—*Furer v. Sobol,* 576 N.Y.S.2d 632 (N.Y. Sup. Ct., Nov, 27, 1991)

Physician Appeal Successful Against Sanctions. . . . A physician in California successfully appealed an order of 60 days suspension and five years probation for unprofessional conduct in engaging in sexual activity with a patient.

A male physician who practiced family and internal medicine had been seeing a female patient for a year and a half. During an office visit, she complained of marital problems and accompanying emotional distress. Two months later, they met for lunch, the physician having initiated the date. They discussed her marital problems and his own as well. Soon thereafter, they met again for lunch. The patient asked if she should see another physician for her emotional problems, but he said it was not necessary. A few days later, she agreed to come to his home. As soon as she arrived, the physician carried her into the bedroom where they had sexual intercourse.

Sexual conduct with a patient did not, ipso facto, render physician unfit to practice

A week later, they met at a hotel room. At this time, the patient refused the physician's advances. She had decided not to see him socially anymore, though she was willing to remain his patient. She returned to the office a few days later for examination of a sore throat. A few weeks later, they met again in a hotel and engaged in intercourse. When the patient continued to see the physician often, both privately and professionally, her husband became suspicious. The social relationship was broken off approximately two months after it began. In the meantime, the patient's husband complained about the physician's conduct to the medical board.

In his defense, the physician pointed out that his assistants had never recorded any instance of emotional complaints by the patient. She had never asked for a referral to a psychiatrist or psychologist. He had told her when she visited him at his house that she should find another primary care physician. Several witnesses testified on his behalf that he was well-qualified and competent and that, in general, there was no blanket prohibition against dating and sex with a patient.

Two witnesses for the State Medical Board maintained, on the other hand, the standard of care required a physician to terminate the physician-patient relationship before entering a social relationship. Their opinions were based on AMA rules and a section of the Business and Professions Code which provided the commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer which is substantially related to the qualifications, function, or duties of the occupation for which a license was issued constitutes unprofessional conduct and grounds for disciplinary action . . ." The witnesses also invoked "experience" as a basis for their opinions.

The court found as far as the law was concerned, there was very little "experience" for judging consensual sexual conduct between a physician and patient outside of psychotherapeutic relationships. Psychotherapists were treated differently from other health professions. Cases dealing with psychiatric treatment could not be cited in this case, the court said.

The only relevant case the court of appeals could discover in which the Business and Professions Code was interpreted was one in which the court ruled "only if a physician engaged in sexual conduct on the pretext that it was a necessary part of treatment for which the patient has sought out the physician" could the physician remain liable. If the sexual activity in question was not "substantially related," per the code, to "qualifications, functions, and duties" as a physician, there was no action based on violation of the code.

The trial court's finding the physician "took advantage of a position of trust and inserted the intimate social relationship over the existing professional relationship" was insufficient to support the legal conclusion the sexual relationship had any bearing on the physician's duties and functions. Engaging in sexual activity with a patient did not, concluded the court, ipso facto render the physician unfit to practice.—*Gromis v. Medical Board of California*, 10 Cal. Rptr.2d 452 (C.A.1, July 30, 1992)

SECTION 2: OTHER HEALTH PROFESSION BOARDS

Chiropractor's License Suspension Upheld. . . . The highest court of Massachusetts upheld the decision of the Board of Registration of Chiropractors to suspend a chiropractor's license for six months, followed by a two-year period of probation.

The chiropractor challenged the constitution of the Board when it judged him. He pointed out that at the time of his hearing, the statute mandated there be at least two registered physicians on the Board. In this case there were none. However, noted the court, the statute had been amended to eliminate this requirement by the time of the Board's decision. Also, in a proceeding challenging an administrative agency's action, no collateral attack could be made on the entitlement of the agency's members to serve (rather it was the attorney general who made such determination).

Board member should have recused himself, but due process was not denied by his sitting in case

The chiropractor specifically challenged the legality of one board member serving for this case, claiming a denial of due process because this member reviewed chiropractic claims for insurance companies, including one which was the subject of the Board's action.

The chief of the legal division of the State Ethics Commission sent the Board an informal opinion during the proceedings, stating that because the board member was not an employee of the insurance com-

pany and because he had no financial interest in the chiropractor's case, he should be allowed to participate in the proceedings. The opinion added in order to comply with the Conflict of Interest Law, the board member should disclose to the governor the facts pertaining to his connection to the insurance company and his prior review of matters concerning the chiropractor. In two and a half years, the board member had reviewed 14 chiropractic cases; five of those cases had resulted in complaints being filed with the Board. None of the 14 involved the chiropractor, although the board member had reviewed claims the chiropractor had put to other insurers.

In a letter to the governor, the board member had disclosed he learned the insurance company intended to await the Board's decision before paying the chiropractor's claims. The chiropractor contended evidence of such knowledge alone was enough to establish bias. The court found this situation was not a case in which it appeared "that the probability of actual bias on the part of the (board member) is too high to be constitutionally tolerable." There was only tenuous evidence to suggest a likelihood of bias. Although "better practice suggests" the board member should have recused himself, due process was not denied by his sitting in the case.—*Varga v. Board of Regulation of Chiropractors,* 582 N.E.2d 492 (Mass., Oct. 7, 1991)

Revocation of CRNA's License Affirmed. . . . An Oregon appellate court upheld the revocation of the license of a certified registered nurse anesthetist on the grounds the Board of Nursing could deduce he likely would invade the privacy and offend the dignity of patients.

Nurse's specific conduct could be considered "derogatory to the standards of nursing" and board made a reasonable deduction he was predisposed to invading privacy of patients

The 56-year-old certified registered nurse anesthetist was licensed to practice in seven states. In 1988, while working in a mortuary, he photographed the genitalia and rectums of three corpses. He had been photographing corpses for sexual stimulation since the 1960s and had always developed the pictures himself. This time he sent the film to a commercial laboratory, and the developer called the police. After an investigation, he stopped photographing corpses, moved to California, and continued to work as a CRNA.

The police informed the Oregon Board of Nursing of its investigation. The Board then revoked the nurse's license for "conduct derogatory to the practice of nursing," specifically, "failing to respect the dignity and rights of clients, regardless of social or economic status, personal attributes, or nature of health problems."

The nurse argued in his appeal that he had violated no specific rule and the Board must promulgate a rule prohibiting the specific conduct in which he was engaged before revoking his license. The court pointed out in response that it was enough for the Board to determine the nurse's specific conduct could be considered "derogatory to the standards of nursing."

The nurse's psychiatrist had furnished evidence the nurse did not pose a threat to the community or to his patients. But, wrote the court, this argument did not support an assignment of error. The Board was not required to accept an expert witness' conclusions or opinions, and the nurse did not claim there was a lack of substantial evidence for the Board's findings.

Finally, the nurse maintained the Board did not explain how it found he was likely to invade the privacy and offend the dignity of patients. The court established a review of factual determinations that embodied inferences consisting of two stages: (1) whether the basic facts were supported by substantial evidence, and (2) whether a reasonable person could deduce the inferred fact from the basic fact. In this case, the court found the Board had made a reasonable deduction the nurse was predisposed to invading the privacy and offending the dignity of his patients due to the "significant and chronic" nature of his psychiatric disorder. The basic fact that he was predisposed to invading the privacy of patients made the inferred fact, or his misconduct as a nurse, appear likely.—*Miller v. Board of Nursing,* 836 P.2d 749 (Or. Ct. of App., Aug. 26, 1992)

SECTION 3: OTHER ISSUES OF INTEREST

Arbitration of Sexual Assault Claims Against Rheumatologist . . . . An action against a rheumatologist for sexual misconduct during the course of two medical examinations should be delayed while the matter was arbitrated, the highest court of Maryland ruled. A patient's employer sent her to the rheumatologist to evaluate her physical disability resulting from job-related chronic musculoskeletal pain. During two examinations of the patient, the physician allegedly fondled her vaginal area and her

Proceedings stayed pending outcome of malpractice arbitration

breasts. A trial court dismissed the patient's action against the physician, and the high court affirmed. The court said the patient's allegations against the physician fell within health care malpractice claims and the statutory requirement to arbitrate. The court or-

dered the legal proceedings stayed pending the outcome of the arbitration.—*Jewell v. Malamet,* 587, A.2d 474 (Md. Ct. of App., March 25, 1991)

Wrongful Death Action Against HMO for Failure to Diagnose Malignant Melanoma. . . . A trial court should not have dismissed wrongful death actions against an HMO for negligence in selecting and retaining a physician who failed to diagnose a patient's malignant melanoma, a Pennsylvania Superior Court ruled.

The patient was a school teacher whose employer contracted with an HMO for health care coverage for her and her family. The HMO was a modified IPA model HMO that contracted with independent, private physicians as independent contractors. A primary care physician was assigned to each subscriber. On October 28, 1985, the patient's primary care physician removed a mole from the patient's back. Even though she had told him the mole recently had undergone a marked change in size and color, he discarded it without obtaining a biopsy or other histological examination. As a result of his failure to submit the tissue sample for testing, the patient's malignant melanoma was not diagnosed or treated, and she died on January 1, 1988.

Claim of negligence against HMO for failure to use reasonable care in selecting physician was reinstated

Her estate filed suit against the physician and the HMO. The estate alleged the negligence of the HMO in selecting and retaining the physician as a primary care physician contributed to the patient's death. It also claimed the HMO was liable for breach of contract and misrepresentation based on the express representations made by the HMO concerning the competency of its primary care physicians and the availability of medical specialists through referrals. A trial court dismissed the complaint, and the estate appealed.

Reversing the decision, the appellate court said allegations the primary care physician was the ostensible agent of the HMO stated a claim in the malpractice suit. The physician was held out as an agent of the HMO which represented its primary care physicians were screened and fully qualified physicians who would render competent medical care. The physician allegedly was not screened properly or evaluated and was not qualified and failed to make a timely referral to a specialist.

The estate stated a claim for negligence against the HMO by alleging it had a duty to use reasonable care in selecting and retaining the primary care physician, that it breached the duty, and that the patient was not timely diagnosed, treated, and died as a result. The court said the estate stated claims for intentionally misrepresenting the qualifications of the primary care physician, for punitive damages, and for breach of contract.

The appellate court remanded and reinstated the estate's claims against the HMO.—*McClellan v. Health Maintenance Organization of Pennsylvania,* 605 A.2d 1053 (Pa. Superior Ct., March 10, 1992)

Police May Inspect Prescription Records Without Warrant. . . . A state law authorizing police officers to search prescription records of controlled drugs without obtaining a warrant was valid, the Ohio Supreme Court ruled.

State law and regulations authorized the collection of prescription data without warrant by police officers and employees of the State Board of Pharmacy. The objective of the law was to establish a system of collecting and analyzing data on the diversion of controlled substances from legitimate to illicit channels, either from patients obtaining several prescriptions of the same drug from multiple physicians, or excessive doses of the same drug being filled in multiple pharmacies in a six-community area. The program was designed to obtain data on certain target drugs, such as terpin hydrate with codeine, paregoric, Percodan, Percocet, Dilaudid, Ritalin, Xanax, Tylox, Darvon, Darvocet, and Adipex. The six communities began to collect data in July 1988 and analysis began in November 1988. The data were collected by uniformed personnel in some communities and non-uniformed officers in others. The data were collected in computers located in the police stations of the communities. Several physicians, patients and a pharmacist filed suit to enjoin enforcement of the statute. They argued the statute and regulations violated their right of privacy and the constitutional right to be free from unreasonable searches and seizures.

Administrative search, even if conducted by police, may be conducted without a search warrant if it does not interfere with any reasonable expectation of privacy

A trial court said the pharmaceutical industry was a pervasively regulated industry and the statutes and regulations fell within the established administrative search exception to the warrant requirement. An appellate court affirmed.

The supreme court said the statute authorizing police officers engaged in a specific investigation involving designated persons or drugs to inspect prescription records of pharmacies did not violate any constitutionally protected privacy rights of the patients or the physicians. The court said an administrative search may be conducted without a search warrant if it did not

interfere with any reasonable expectation of privacy. The mere fact that police officers were involved in administrative searches did not void the administrative search exception to the requirement for a search warrant. The court noted the searches were limited to specific investigations involving a designated person or drug.

The court affirmed the decision.—*Stone v. City of Stow,* 593 N.E.2d 294 (Ohio Sup. Ct., July 8, 1992)

Hospital May Impose Monitoring on Physician. . . . . A hospital and supervising physicians did not violate a physician's rights by imposing a monitoring system on his practice, a federal trial court for California ruled.

The physician practiced obstetrics and gynecology at the hospital. In 1987, he was granted privileges to perform intra-abdominal laser surgery. After he performed a few operations, concerns were raised as to possible irregularities in his handling of the cases. The supervisory committee of the hospital met with the physician, determined he had mismanaged four cases, and recommended he be subject to a monitoring system. The medical executive committee agreed and required the physician to have a second opinion on every admission to the hospital, to have a monitor present during each operation, and to share follow-up care of the patient with the monitor. Additional hearings were conducted by the judicial review committee. When the physician performed a cesarean section without obtaining a consultation required by the monitoring system, his staff membership was suspended.

Hospital and supervisory committee immunized by Health Care Quality Improvement Act

The physician refused to request a hearing and filed a complaint with the federal Civil Rights Office for race discrimination. A year later, the Civil Rights Office and the hospital settled the claims by the physician. The agreement provided for restoration of the physician's staff privileges with a system of monitoring restraints similar to those previously imposed. The physician was given 30 days to decide whether to seek reinstatement pursuant to the terms of the agreement. The physician refused to accept the terms of the agreement, and then filed suit against the hospital and the supervisory committee for antitrust and civil rights violations.

Granting summary judgment for the hospital and the supervisory committee, the court said the Health Care Quality Improvement Act immunized them as a professional review body in imposing the monitoring system on the physician. Their suspension of the physician was immune from liability under the Act since they acted as a professional review body.—*Fobbs v. Holy Cross Health System Corporation,* 789 F.Supp. 1054 (D.C. Cal., March 16, 1992)

Directed Verdict for Psychiatrist Reversed. . . . A court of appeals in Ohio ruled in favor of a patient who appealed a directed verdict on punitive damages for a psychiatrist and reduction of compensatory damages due to negligence on the patient's part.

The original action was brought against the psychiatrist, a professional corporation, and a hospital for negligence and intentional infliction of emotional distress. The patient sought compensatory damages against all three and punitive damages against the psychiatrist and professional corporation.

Facts of case demonstrated conscious disregard for patient's rights and safety with great probability of causing substantial harm

The patient was treated by the psychiatrist for recurrent dizziness for which her physician could find no explanation. Over the course of four years, she underwent between 141 and 171 sodium pentathol interviews, for which she was charged $75 to $100 each time. She received little or no feedback from the psychiatrist about what she revealed in the interviews. After having told him in one of the first that she had been abused sexually by her mother as a very young child, he told the patient the source of the problem had not been revealed and they would have to continue. Though she asked that a nurse remain present while she was sedated, the hospital nurses almost never stayed with her in the room. The psychiatrist instructed her to unbutton the top of her pants and sometimes suggested she massage her breasts during the interviews. Once he asked her to masturbate while under the influence of sodium pentathol.

After 16 months of treatment, the patient finally learned from the psychiatrist that she had spoken of being abused as a child, but he would not tell her by whom. He insisted she had to discover for herself in interviews who had molested her. After becoming severely distressed, she was put on psychiatric disability by the psychiatrist for several months. She was unable to work or sleep and rarely left the house. She began having psychotic episodes in which she saw visions, one of which showed her mother molesting her. She found out from the psychiatrist she had been abused by her mother, who she confronted against the advice of the psychiatrist. Upon discovering the psychiatrist had given her a suggestion to persuade her not to confront her mother, she became apprehensive about the general course of treatment. The patient went to a psychologist who consulted with two psychiatrists. They determined their colleague was deviating from

the standard of care. The patient had become addicted to sodium pentathol and suffered from post-traumatic stress disorder, a result of the trauma induced by the treatment she had undergone.

The court of appeals found a number of errors in the lower court's decision. First, it ruled that refusing to permit three physician-expert witnesses to testify for the patient as to the standard of care applicable to the hospital was an abuse of discretion. The trial judge questioned whether any of the psychiatric experts had a sufficient background in hospital administration to be able to testify in this capacity. Such a reservation, however, should not affect the admissibility of such evidence, but only its weight. Because Ohio law states any licensed doctor is competent to testify about medical issues, it need not be determined whether he is the best possible witness but merely that his testimony will add to the search for truth. Second, the decision to prevent portions of an expert-psychologist's testimony with regard to proximate cause and damages was unfounded. While it is true liability testimony can be limited to certain medical doctors (in order to prevent "non-clinicians from testifying about quality of clinical care"), no such limitations apply to causation and damages. As a qualified psychologist who had treated the patient and had witnessed her distress, his testimony was justified. The court of appeals found error in the lower court refusing to submit the question of punitive damages to the jury. In cases which evidence fraud, malice, or insult, and not mere negligence, punitive damages traditionally have been allowed. The court of appeals could not help but infer malice on the part of the psychiatrist. The facts of the case demonstrated a conscious disregard for patient's rights and safety with a great probability of causing substantial harm. Finally, the trial court's instructions to the jury on comparative negligence and assumption of risk were incorrect. The patient had used marijuana during her treatments. The record failed to show conclusively that marijuana was a contributing factor, or that the patient had neglected to demonstrate "any want of ordinary care" for her own well-being. Compared to repeated injections of sodium pentathol over a four-year period, her use of marijuana could not be taken for proximate cause even in the most remote sense. Neither could the patient have knowingly assumed the risk of hindering her treatment with its use, for the psychiatrist himself knew of it and did virtually nothing about it. In such a matter, decided the court, the patient must in large part rely upon her physician.—*Joyce-Couch v. DeSilva,* 602 N.E.2d 286 (Ohio Ct. of App., Sept. 23, 1991)

Physician Personal Health Records Not Protected by Confidentiality Rule. . . . The personal health records relating to alcohol and substance abuse, mental, physical, and emotional condition, and other subjects evaluated by medical review committees could not be protected when the physician was charged with negligently performing surgery, according to the court of appeals of Texas.

The estate of a patient claimed the physician had given treatment and performed surgery negligently during the time the physician was impaired by alcohol and other substance abuse, suffering from mental, physical, and emotional problems. These difficulties, according to the estate, resulted in an incapacity of the physician to perform safely and effectively. The estate sued the physician for both actual and punitive damages. A trial court judge ruled treatment records for the physician were subject to discovery even though they constituted documents typically covered by a physician-patient and mental health professional-patient relationship and privilege. The physician appealed, asking that his records be respected and not disclosed for use in the malpractice action.

The court of appeals heard the arguments of the physician who claimed records regarding professional conduct prepared by medical review committees and the Texas State Board of Medical Examiners were confidential and exempt from discovery. The court of appeals did not agree; it stated information about the physician's habits or customs in using alcohol or other substances was pertinent for determining punitive damages.

Information about physician's habits or customs in using alcohol or other substances was pertinent for determining punitive damages

The court recognized confidential communications between the physician and the patient typically are privileged and may not be disclosed. Further, it agreed records which establish the identity, diagnosis, evaluation, or treatment of a patient by a physician or mental health professional also typically were confidential and privileged and could not be disclosed. Unfortunately, the physician claimed this privilege of confidentiality on appeal. The issue was not raised in an objection to the original discovery request, and thus, the court determined, the physician waived his right to assert it subsequently.

In another part of the case, the physician offered to submit for court inspection documents being sought by the estate. However, this offer was not made at a hearing and was not a valid response, according to the court of appeals.

Finally, the court determined much of what was being sought by the estate did not fall within the scope of physician-patient privilege. Since the physician offered no evidence to support his claim of privilege, the

court did not consider the issue further.

The appellate court ordered the physician to issue an authorization for discovery of medical records pertinent to his prior treatment.—*Kavanaugh v. Perkins,* 828 S.W.2d 616 (Tex. Ct. of App., June 30, 1992)

HIV Information Has Special Protection. . . . The Supreme Court of New York has ruled a physician breached her statutory duty in releasing information to a Pennsylvania Worker's Compensation Board regarding a patient's HIV status.

The patient filed a claim in Pennsylvania for worker's compensation upon experiencing ear and sinus problems. The Compensation Board then subpoenaed his physician in New York to appear at a hearing, bringing with her "all medical reports or records of any kind whatsoever relating to treatment of (the patient)." Included was an authorization signed by the patient permitting the physician to "complete the medical report," to "release medical records to . . . representatives of (the employer)" and to "discuss the status of the injury with representative of (the employer)." The physician forwarded a copy of the patient's entire chart and file. Contained in these records was information the patient was HIV-positive.

The patient filed suit against the physician for breach of fiduciary duty. In her defense, the physician who practiced in New York argued that she had been complying with the subpoena and her action should be "cloaked with judicial immunity." However, under the Public Health Law that addressed disclosure of HIV-related information, only a court of competent jurisdiction could compel discovery of such information. Since the Worker's Compensation Board had no such jurisdiction, the physician remained liable. The law mandated any disclosure of a patient's HIV-related information must be authorized specifically by the patient, subpoena or no.

Physician liable for releasing HIV-related information on patient to Worker's Compensation Board without patient's specific authorization

A general authorization for release of medical or other information could not be construed as a release of confidential HIV-related information unless such authorization specifically indicated its dual purpose, according to the law. Further, any exceptions to the "ground rule of confidentiality of HIV-related information (should) be strictly construed". The physician could, however, discover all of the patient's records, including HIV material, necessary to construct a defense in the matter of damages for pain and suffering and lost earnings due to psychic trauma. The law did not intend to create a super-plaintiff completely insulated from examination by the defense into his physical and mental condition when conducting discovery for damages related to pain and suffering and lost earnings due to psychic trauma.—*Doe v. Roe,* 588 N.Y.S.2d 236 (N.Y. Sup. Ct., Sept. 11, 1992)

Dentist Discriminated Against HIV Patient. . . . A dentist discriminated against a patient who was HIV positive, according to the Court of Appeals of Minnesota. Beginning in 1986, a dentist treated a patient for routine dental needs including cleaning, preparation of a denture, and filling a tooth. Approximately one year following his initial contact with the dental practice, the patient tested positive for HIV. Two years later, the patient reported taking the drug AZT. Shortly thereafter, the patient scheduled a routine appointment for dental prophylaxis (cleaning). Instead of accepting the patient in the usual manner, he was referred to the university dental clinic where the dentist thought the patient could receive better, more appropriate care. Subsequently, the dentist was accused of an unfair discriminatory practice because he refused to provide dental services to the HIV-positive patient.

Court held HIV infected patient was "disabled" and dentist made no effort to acquaint himself with current knowledge for treatment of HIV-positive patients

The court of appeals determined the patient qualified for consideration as "disabled." The court reached this conclusion even though the patient had no apparent physical disability. Instead, the court recognized other factors such as a recommended prohibition from unprotected sexual intercourse, lack of availability of life or health insurance, shortened expected longevity, and preclusion from some career choices. Also, the court perceived a material limitation on major life activities because HIV-positive patients are stereotyped.

The dentist claimed his action in making a referral to the university clinic was in the best interest of the patient. The dentist said he lacked adequate knowledge about the risk of dental manipulations such as prophylaxis for a patient who may be immunosuppressed. At the university clinic, there were staff dentists and physicians more skilled in managing HIV-positive patients, the dentist claimed.

Expert witnesses testifying on behalf of the patient and the human rights commission said nothing more than universal precautions against contamination was necessary for treating HIV-positive patients. The dentist used these precautions routinely in his practice. The American Dental Association recommended universal precautions and consultation with an HIV-positive patient's physician while providing dental

care. The dentist made no effort to contact this patient's physician and undertook no effort to acquaint himself with current knowledge for treatment of HIV-positive patients. Instead, he simply referred the patient to the university clinic and advised dental services would no longer be available at his office.

The court of appeals concluded these actions were discriminatory, and the intent of the dentist, in spite of his claims for concern about the patient, was to discriminate against this individual.—*State By Beaulieu v. Clausen,* 491 N.W.2d 662 (Minn. Ct. of App., Oct. 20, 1992)

SECTION 4: *CITATION INDEX,* VOLUME 63

Below is an index of items on licensure and other subjects of particular interest published in *The Citation* (Volume 63) during 1992. (The index of *The Citation,* which is contained in the 31 December number of that publication, is presented by subject, keyword, and case name.)

The Citation is a medicolegal digest published by Citation Publishing Corporation, Long Grove, Illinois.

Two New Reports From the OIG/HHS

DEBORAH LEWIS RODECKER, JD

The Office of Inspector General of the Department of Health and Human Services (OIG) has published two more in a series of reports prepared from 1986 to 1992 on the quality assurance efforts of state medical boards. The just published *Federal Initiatives to Improve State Medical Boards' Performance* is enlightening reading. There is help that state medical boards could and should be getting from folks at the federal level, and not much appears to be happening. The Health Care Financing Administation (HCFA)

Federal Initiatives to Improve State Medical Boards' Performance. *Department of Health and Human Services, Office of Inspector General, February 1993 (OEI-01-93-00020).*

particularly comes across in this report as an obstacle to effective medical board functioning with regard to the pursuit of quality-of-care cases. Basic, obvious, necessary and appropriate recommendations are made by the OIG in this report. For example, professional review organizations (PROs) should report cases of medical mismanagement resulting in significant adverse effects on patients to state medical boards, says the report. This recommendation turns out to be nixed by HCFA, and HCFA has provided no assistance with the OIG recommendation to allow state Medicaid programs to share case information with medical boards. Also, the OIG seems to get no support from HCFA with regard to the OIG's recommendations that there be promotion of identification for medical boards of quality problems in nursing homes and that medical boards be encouraged to use PROs to assist on medical board quality-of-care cases.

The report does credit the Public Health Service (PHS) with assistance in the areas of medical board performance assessment. (The Federation of State Medical Boards now has the *Self-Assessment Instrument for State Medical Boards (SAI)* as a result of the financial support of the PHS.) It appears that in the future the PHS may be helpful with funding problems faced by medical boards. This report is brief and relevant reading for all of us.

State Medical Boards and Quality-of-Care Cases: Promising Approaches is an OIG report based on research with nine (9) different state medical boards and, as one would expect from the title, focuses on efforts at the state level to improve performance regarding physicians who provide poor quality medical care. This report should be required reading for every medical

State Medical Boards and Quality-of-Care Cases: Promising Approaches. *Department of Health and Human Services, Office of Inspector General, February 1993 (OEI-01-92-00050).*

board member, executive and board attorney. It is a fine one, filled with numerous sensible suggestions about identifying quality-of-care cases, investigating, negotiating and prosecuting such cases, intervening prior to pursuing formal sanctions, and, my favorite topic, preventing poor quality medical care at the outset. As always, adequate funding for state medical boards is specified at the conclusion as an "indispensable" factor in the successful pursuit of quality-of-care cases. The other indispensable factor is the will to make a "serious, ongoing commitment" to quality-of-care cases. The report makes a strong statement about state legislators, executives and medical board members remaining "firmly rooted in the conviction that the medical boards are responsible for protecting the interests of the public, not the physician community. They must recognize that a more activist medical board posture in addressing QC cases will generate some controversy and some pressures to pull back. At such times, they must provide medical boards with the support necessary to persevere in carrying out their responsibilities to the public."

This report identifies many of the specific tools that medical boards need to do the job that we all are struggling to do better—improving the quality of care for the citizens of our respective states.

Related Reports From the Office of Inspector General

Medical Licensure and Discipline: An Overview. *June 1986 (P-01-86-00064).*

Identified vulnerabilities associated with licensing of foreign medical graduates and significant problems and patterns in discipline.

State Medical Boards and Medical Discipline. *August 1990 (OEI-01-89-00560).*

Assessed disciplinary practices by, among other things, examining key changes taking place and impediments to improved performance.

State Medical Boards and Medical Discipline: A State-By-State Review. *August 1990 (OEI-01-89-00562).*

Profiled, state-by-state, the authorities and policies relating to discipline.

Quality Assurance Activities of Medical Licensure Authorities in the United States and Canada. *February 1991 (OEI-01-89-00561).*

Provided an overview of the extent and type of quality assurance activities being undertaken in the United States and Canada.

Performance Indicators, Annual Reports, and State Medical Discipline: A State-By-State Review. *July 1991 (OEI-01-89-00563).*

Profiled on a state-by-state basis the use and content of annual reports, focusing on performance indicators relating to discipline.

The Peer Review Organizations and State Medical Boards: A Vital Link (Draft). *August 1992 (OEI-01-92-00530).*

Reviewed the status of PROs' efforts to provide boards with information about substandard medical care.

National Practitioner Data Bank: Usefulness and Impact of Reports to State Licensing Boards (Draft). *October 1992 (OEI-01-90-00523).*

Assessed the utility of National Practitioner Data Bank reports to state licensing boards.

Pleaders' Digest: A Brief Look at *The Citation*

DOROTHY G. HARWOOD, JD

One of the most popular parts of the *Federation Bulletin* is the Medicolegal Decisions section. It should be. It derives from the excellent material published twice each month in *The Citation: A Medicolegal Digest. The Citation's* subtitle is apt, for it is not one of those too familiar newsletters prepared by self-styled experts in this and that. It is a careful survey and summary of recent court decisions related to health-care issues. Its publishers describe it as "a surveillance publication specializing in matters of medicolegal importance." Its quiet, cleanly designed format suits that purpose quite well.

The Citation *appears twice monthly. A one year subscription is $120. Inquiries may be made to: Citation Publishing Corporation, Box 3538 RFD, Long Grove, IL 60047. Telephone 1-800-626-5210.*

The Citation has been published for over 30 years, for most of that time by the American Medical Association. Recently, ownership changed to the Citation Publishing Corporation: Dean E. Snyder, JD, publisher; Robert K. Ausman, MD, president; and Ms Sheri Thomsen, editor.

Originally, *The Citation* focused on negligence and malpractice issues, but coverage has been widened to include such subjects as contract arrangements, employment practices in health-care settings, controlled-substance violations, reimbursement, staff privileges, and even some domestic relations matters. Particularly important to readers of the *Bulletin* is that the new owners of *The Citation* have decided to significantly increase their attention to licensing matters. Almost every number now contains at least one or two cases involving licensing board decisions that have undergone judicial scrutiny. And a recent number (15 March 1993) featured a section, titled Special Interest Topics, devoted entirely to licensing issues.

The purpose for reading *The Citation,* of course, is to learn from the trials and tribulations of others, and the members of state medical boards can certainly glean valuable information from every number. Board attorneys can widen their perspectives and identify changing trends in court opinions by reviewing the experiences of their colleagues in the health-care arena. Any reader, in fact, will gain through *The Citation* a wider understanding of the workings of the law, sometimes noting that logic and court decisions do not always go hand-in-hand.

But be warned: the 12 pages in each number of *The Citation,* in its standardized format, can be intense reading if taken in a full dose at one sitting. However, selective reading is facilitated by inclusion of a key word list on the front page of every number, enabling the busy reader to locate articles on licensure before moving to other subjects of individual interest.

Many physician readers will also be interested in a special program now in place that makes Category 1 continuing medical education credit available for study of *The Citation.* This program is a cooperative effort between the publishers and the Continuing Medical Education Office of the Medical College of Wisconsin, which is accredited by the Accreditation Council for Continuing Medical Education. Details about CME credits and registration are available from *The Citation*

office (1-800-626-5210). Up to 12 Category 1 credits can be earned each year.

Anyone interested in the licensing and regulation of the health professions will find *The Citation* a valuable addition to her or his regular reading list. Certainly, every board attorney should have ready access to it.

LETTER TO THE EDITOR

On Reviewing FMG Applications

To the Editor — I read with interest the letter from Steve Seeling in the June issue of the *Bulletin* about recruiting physician advisors for the South Carolina board and the article by Doctor Citron in the December issue about licensing applications. Those items prompt me to think you might be interested in the recent and very positive experience of the Oklahoma State Board of Medical Licensure and Supervision relating to the review of applications from foreign medical graduates.

In December 1992, I met with a subcommittee of the Oklahoma State Medical Association composed of graduates of foreign medical schools. I was on the agenda to discuss the licensing process. At this particular meeting, most of the attendees were from Middle Eastern countries. They communicated to me that the process was frustrating in its complexity and demeaning in some of its requirements. They also felt it appeared, on the surface at least, to be discriminatory because of the specificity of the questions asked of foreign graduates but not of domestic graduates. I defended the Board, explaining that the members who review applications are as unfamiliar with the education and training process in the Middle East as the committee members are with Caribbean schools. They suggested that it might be useful if they spoke for their countrymen before the Board when applications were reviewed. Instead, I invited them to become a part of the process at staff level by reviewing applications with me.

In January, we met at the Board office. We began by reviewing the computerized application process. Then we looked at applications that had been scheduled for review at the next Board meeting. These represented applicants from Iraq, India, Bolivia, and Pakistan, to name a few. They started with applications from countries they were familiar with. Their comments were very helpful and informative. They explained the educational systems available in those countries and expressed concern at some of the results on the licensing examinations and the frequency with which the examinations were taken. They also had some reservations about scores on transcripts accompanying several applications. I then asked that they review applications from other countries. They were to put themselves in the place of Board members and tell me what they found on reviewing the information before them relative to whether or not the applicant was qualified to practice medicine.

The conclusions were that the Board is not discriminatory, the Board has a monumental task in determining the qualifications of applicants, and the Board does everything it can to assure protection of the public. They agreed that there is no better way to determine competence and judge qualifications. One committee member had had concerns that the law in Oklahoma required an applicant to provide evidence that his/her education and training was equivalent to that provided by LCME approved schools. He stated that there was no way an educational program in a foreign country would likely be equivalent; but, as we discussed this, it became clear that, combined with training and other assets, the applicant could show such evidence. It was a matter of finding and organizing the information.

At the first Board meeting, four representatives of the committee and I presented our plan to the members of the Board; Lyle Kelsey, representing the State Medical Association, who had been a part of the meetings and reviews, spoke in support. We made it clear to the Board that the committee had no intention of interfering in any way with the proper role of the Board to act on applications for licensure. We offered comment on each application in a short paragraph, using supplemental information to clarify and enhance the formal review. We also noted an applicant's accomplishments relative to competence and any information that caused concern. In many instances, the applicant was present and questions suggested by the committee members were asked by the Board. The

meeting was a complete success and both sides agreed that this was valuable enough to continue. We met again in February and are scheduled to meet in May.

The success of this venture is best summed up in personal comments made by committee members and Board members. One committee member said, "There are many reasons why a doctor may not be able to pass the FLEX and those reasons should be explained by him to the Board." Another said, "Training supervisors are the best judges of an applicant's competency in practice; if a doctor can stay in a training program for two years, he is probably qualified to practice." Still another said, "There is nothing wrong with requiring doctors who are applying for licensure to show evidence that they can communicate with patients and colleagues." The Board agreed for the most part with these comments. In turn, the Board members expressed some personal comments during the proceedings, such as: "That is a very good question; we should ask it of every applicant;" "I didn't know of the routes to training programs in India; I'm glad to have that information;" and "We may need to start asking more specific information about FLEX failures from now on."

In conclusion, the experiment has been positive. The Board respects the knowledge of the FMG reviewers and appreciates their input. The reviewers appreciate the opportunity to be of assistance to the Board and feel more comfortable with the application review process. One anecdote: at the meeting, an applicant was denied licensure by the Board and accused the members of discrimination. Three of the four committee members followed him out into the hall and expressed their dismay that he should make such an accusation. They pointed out to him the deficiencies in his application and offered to assist him in organizing the information for a better presentation in the future.

Carole A. Smith
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