

Disciplining doctors for misconduct: character matters, but so does competence

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Consider the cases of two physicians. One of them had consensual sexual relations with an adult patient. The other demonstrated repeated lapses in clinical judgment, technical skills and knowledge, leading to poor outcomes, even deaths, in multiple patients.

If you were seated on a medical board or tribunal, charged with protecting the public from bad physicians, how would you judge these two cases? If you could only remove one of these doctors from practice, which one would you choose?

Of course, this is a false choice, since boards can severely sanction anyone they choose. But their actual decisions, guided by both statute and precedent, illustrate that they do not see these transgressions in the same light. The interesting study by Elkin and colleagues [please update ref to *bmjqs-2012-000941* shown as Ref. 1] in this issue of *BMJ Quality and Safety* suggests that they are far more likely to 'throw the book' at physicians who engage in sexual relationships with patients than at others who fail to meet professional standards, including those who provide unsafe care.¹

Elkin and her colleagues examined 485 cases in which disciplinary tribunals in the most populace areas of Australia and all of New Zealand found doctors guilty of professional misconduct during the decade that began in 2000. The sanctions meted

out were serious: the offending doctor was removed from clinical practice nearly half the time. Guilty physicians were overwhelmingly male and two-thirds were general practitioners.

In perhaps the study's most striking finding, tribunals removed physicians from practice in 81% of cases in which misconduct involved sexual encounters with patients. In a multivariate analysis, the authors found that the odds of removal from practice were 22 times higher in such cases than in all others. Given the widespread knowledge among physicians that having a sexual relationship with a patient crosses ethical boundaries²—largely because of the power differential between the parties—these transgressions are rightly considered wilful violations of professional standards, and it is appropriate that they result in severe reprobation.

In contrast with the harsh sanctions for physicians engaging in inappropriate sexual relationships, the study found far fewer severe penalties for clinical incompetence. We are not given sufficient detail to pass judgment ourselves on the magnitude of the clinical problems, nor are we told about cases in which the boards let physicians off with no penalties at all, but even with the limited data, the weakness of the sanctions for clinical care issues is striking.

Because problems with clinical care may be every bit as damaging to patients as those involving ethical lapses, understanding the reason for this disparity is important. The authors offer one plausible explanation;

namely that the boards judge character defects more harshly than problems in clinical care because they consider the former to be less remediable. Whether this formulation is correct is not clear (I can think of cases in which physicians were successfully rehabilitated for problems that appeared to be characterological, and others in which attempts to remediate problems in clinical skills and judgment were unsuccessful), but it makes sense that board members would believe it to be true.

I would suggest there are other equally plausible explanations for this disparity. First, licensing boards may not consider themselves to be sufficiently expert in care standards within given clinical specialties to pass judgment on competence. Most disciplinary boards and tribunals are standing committees, comprised of a mixture of physicians (both generalists and specialists) and non-clinicians (lawyers, human resources experts, and the like), groups that are unlikely to be able to determine whether a physician has violated standards of care in a highly specialised area. For this reason, they may believe that such care needs to be judged within an institution's peer review system. Unfortunately, most such systems—in which peers are asked to judge the actions of fellow specialists who may be either professional colleagues or outright competitors—are deeply flawed.

Second, although the malpractice system is far less hypertrophied in Australia and New Zealand than it is in the USA, boards and tribunals may see this system as the appropriate place for judgments on clinical care. This would be especially so if cases were felt to require review of substantial amounts of expert testimony, which is typically gathered more fully in the malpractice arena than in many board disciplinary hearings.

Third, judgments about the quality of care are more challenging than judgments about ethical lapses.

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Studies of malpractice cases have demonstrated that both lawsuits and settlements are far more tightly related to a physician's communication skills than to his or her clinical quality.³ Moreover, in judging the care of individual physicians, we also rapidly confront the usual problems of small numbers of patients and inadequate case-mix adjustment.⁴ At the risk of oversimplifying, just consider a physician who has been charged with having sexual relationships with two patients. A regulatory body needs to know nothing more than the veracity of the charges to pass judgment. Alternatively, consider a surgeon who has had two terrible clinical outcomes in the past year. The committee trying to determine whether to sanction this physician has a far more difficult job, since it must take into account the physician's case selection, the patients' underlying risk factors, the contributions of other parties to the outcomes, and matters of statistical certainty. Given all of this, it is easy to see why boards would find that rendering judgment on character is far easier than on clinical competence.

Fourth, the patient safety field has taught us that most poor quality and unsafe care is due to problems with systems rather than people. If a physician's order is misread because of poor handwriting, or a physician fails to catch a dangerous drug interaction, is that a personal failing, or one that can be blamed on the absence of computerised order entry and decision support, respectively? Boards may feel that physicians should not be held solely responsible when their errors can partly be attributed to dysfunctional or absent safety systems.

Finally, there is the diffusion of responsibility between licensing boards and certifying boards. In the USA, physicians receive their license to practice medicine from each state, whose requirements vary. Licenses are not specialty-specific: one simply

has a license to practice medicine in, say, California, but the license does not speak of one's ability to practice as a dermatologist or a otolaryngologist. Renewing one's license has historically been a perfunctory process: one needs only to meet a modest continuing education requirement, and there is little scrutiny of the quality of care. When a physician loses his or her license (a rare event), it is usually for problems similar to the ones described by Elkin and colleagues. Poor clinical care is an infrequent culprit. The US Federation of State Medical Boards is in the process of tightening up its process for renewing one's license ('Maintenance of Licensure,' MOL), but this initiative will take years to roll out and its final shape is as yet unknown.⁵

In the USA and some other countries, there is an additional layer of professional authority: the certifying boards. These boards (such as the American Board of Internal Medicine (ABIM, of which I am chair) or the American Board of Surgery) are specialty-specific, and board members are drawn from the specialty itself. One becomes 'board certified' by completing an accredited training programme in a field and passing a rigorous, specialty-specific examination. Physicians in the USA are not required to be board certified (one can practice with a state-issued license without being certified in a specialty), but patients value this certification and many hospitals and payers require it.^{6 7}

The standards for board certification have been substantially elevated in the past few decades. Whereas 30 years ago, 'passing the boards' at the end of training rendered a physician board certified for life, today all US boards require participation in Maintenance of Certification (MOC) programmes. Under MOC, physicians must periodically (approximately every 10 years) retake a rigorous 'closed book' secure examination, as

well as participate in self-directed learning exercises and collect and analyse their own practice-specific data.⁷ Beginning soon, all the member boards of the American Board of Medical Specialties, including ABIM, will require evidence of ongoing (every 2 years) activities, such as patient or peer surveys and participation in quality improvement activities ('continuous MOC'). While the certifying boards rarely discipline physicians or withdraw board certification (when they do, it is usually for ethical lapses such as cheating on tests or falsifying documents), their ongoing scrutiny and periodic requirements allows the public to be assured that a physician meeting the requirements of MOC is in good standing with his or her board. As computerisation facilitates better access to real-time clinical data, one can expect that board certification will become an even more authentic, real-time representation of each physician's quality of care.

The results seen by Elkin *et al* are comforting in a way, in that they demonstrate that licensing boards and tribunals are taking their responsibility to the public seriously, with zero tolerance for transgressions that reflect substantial character flaws. However, and more troubling, the study also illustrates that these boards are passive in policing the profession for substandard care. Assuring the public that its physicians possess not only high moral standards but also the requisite knowledge and skills for safe and effective practice is a key regulatory duty. Personally, I doubt that the licensing authorities, at least the ones I'm familiar with in the USA, have sufficient domain-specific knowledge, or are sufficiently insulated from the political fray to handle this charge. To serve the public's interest, it will be important for some combination of local care delivery organisations—through more robust peer review processes—and specialty-specific accrediting bodies to do so. When it comes to assessing the fitness of

physicians to practice, character matters, but so does competence.

Competing interests Dr Wachter reported serving as the chair of the American Board of Internal Medicine (for which he receives a stipend); receipt of a grant to his institution from the Agency for Healthcare Research and Quality; receipt of honoraria from more than 100 health care organizations for lectures on patient safety, health care quality, and hospitalists; royalties from Lippincott Williams & Wilkins and McGraw-Hill; receipt of fees for development of educational presentations from QuantiaMD and also from IPC—The Hospitalist Company; reported serving on the scientific advisory boards of PatientSafe Solutions, EarlySense, and CRISI (for which he receives stock options); compensation from John Wiley & Sons for blog writing; holding the Benioff endowed chair in hospital medicine from Marc and Lynne Benioff; and receipt of funding for sabbatical

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