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A THEORY OF DISCIPLINE FOR PROFESSIONAL MISCONDUCT

Nadia N. Sawicki*

The current system of physician discipline is in disarray. Critics in recent years have denounced state medical boards for inappropriately screening applicants for medical licensure, failing to discipline dangerous physicians, and generally being lax in their oversight duties at the expense of a vulnerable public. At the same time, however, there are few meaningful limitations on the scope of medical board authority in matters of professional discipline, and the disciplinary actions boards do take often seem to bear only a tangential relationship to the competent practice of medicine.

This Article maintains that if medical boards want to avoid charges of ineffectiveness – or worse, irrelevance – in achieving public goals, they must undertake a systematic review of their priorities with respect to professional discipline. Specifically, boards should recognize that disciplining character-related misconduct or criminal behavior occurring outside the scope of medical practice may not be consistent with the foundational principles underlying the legislative delegation of disciplinary authority – namely, concern for public protection tempered by constitutional fitness to practice requirements. This Article proposes that boards concerned about character and professionalism instead consider whether a physician’s conduct implicates any of the core professional values of medicine (among them, respect for fiduciary principles), and explains why a theory of discipline grounded in core values is preferable to a few proposed alternatives.

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I. INTRODUCTION

The current system of medical discipline is in disarray. Since the 1970's, state medical boards have faced criticism from a variety of sources for inappropriately screening applicants for medical licensure, failing to discipline dangerous physicians, and generally being lax in their oversight duties at the expense of a vulnerable public. At the same time, however, few constraints exist to limit medical board authority in matters of professional discipline, and the disciplinary actions boards do take often seem to bear only a tangential relation to the competent practice of medicine. As the rate of medical malpractice claims continues to rise,¹ and media reports publicize cases of physician misbehavior going unpunished,² some scholars have gone so far as to question whether the American system of professional discipline offers any real-world benefits at all.³

This Article argues that it does. Those who challenge the relevance of professional discipline in American medicine on the basis of its failures of implementation miss the point. That the modern system of medical board discipline has been unsuccessful in achieving public goals is no reason to abandon the system altogether. Instead, health law scholars ought to clearly identify the goals of professional discipline, identify how and why medical boards have failed to achieve these goals, and propose solutions for

¹ Claudia H. Williams and Michelle M. Mello, "Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms," Robert Wood Johnson Foundation Policy Brief No. 10 (May 2006).

² See, e.g., Cheryl W. Thompson, *D.C. Board Rarely Punishes Physicians*, Washington Post (April 11, 2005) at A01; Doug J. Swanson, *Drug Past, Discipline, Didn't Stop Doctor*, Dallas Morning News (July 1, 2001), at 1A.

³ See, e.g., C. H. Baron, Licensure of Health Care Professionals: The Consumer's Case for Abolition, 9 Am. J. L. & Med. 335, (1983); Walter Gellhorn, The Abuse of Occupational Licensing, 44 U. Chicago L. Rev. 6 (1976); Anthony Ogus, Rethinking Self-Regulation, 15 Oxford J. Legal Studies, 97 (1995); Shirley V. Svorny, *Physician Licensure: a New Approach to Examining the Role of Professional Interests*, 25 Econ. Inquiry 497 (July 1987). Economists, in particular, have long made similar arguments, questioning the value of licensure and self-regulation in highly insulated and self-protective professions, like medicine. These authors and others suggest that medical quality and patient safety could be better safeguarded through market-based solutions that close the information gap between physicians and consumers. While some steps have been taken in this direction (see, for example, the website of the Massachusetts Board of Registration in Medicine, <http://profiles.massmedboard.org>, which allows patients to search for physician profiles, including malpractice payments made in the past ten years), it is highly unlikely that the current system of medical licensure would be abandoned in the foreseeable future. Accordingly, this Article does not pursue alternatives to medical licensure and discipline as a means to protecting patient health, but rather evaluates realistic improvements that might be made to the existing system.

remediating these failures.

This Article approaches this challenge by focusing on one context in which medical board actions seem ill-attuned to the legal principles underlying professional discipline: discipline for character-related misconduct occurring outside the clinical sphere. Consider, for example, a Nevada board's recent decision to discipline a chiropractor for unprofessional conduct after he was convicted of involuntary manslaughter for shoving a man at a car wash. In recent years, physicians have been disciplined on grounds as varied as tax fraud,⁴ failure to facilitate review of child support obligations,⁵ soliciting sex in a public restroom,⁶ possession of marijuana for personal use,⁷ and reckless driving involving alcohol,⁸ as well as other conduct that allegedly brings the medical profession into disrepute. While exact figures are hard to come by, best estimates suggest that less than thirty percent of medical disciplinary actions are taken on the basis of negligent medical practice.⁹ Moreover, because actions taken on the basis of character-related misconduct are representative of many of the overarching problems that plague the medical disciplinary system, crafting a theory that explains why and when boards can discipline for character-related misconduct will help boards better exercise their disciplinary discretion in all contexts.

Part II of this Article traces the development of the modern American medical disciplinary system, and looks to the constitutional underpinnings of medical board authority to identify its underlying goals. Part III demonstrates that medical boards often fail to achieve these goals when they pursue disciplinary action against physicians who misbehave

⁴ See, e.g., *In re Kindschi*, 52 Wn.2d 8, 12 (Wash. 1958); *Windham v. Board of Medical Quality Assurance*, 104 Cal. App. 3d 461 (Cal. App. 2d Dist. 1980).

⁵ See, e.g., *Dittman v. California*, 191 F.3d 1020 (9th Cir. Cal. 1999) (holding that California's requirement that professional licensees disclose their social security numbers so that the state can determine if they failed to pay child support does not violate due process because being current in child support and tax obligations is an element of moral character and therefore related to fitness to practice).

⁶ See, e.g., *McLaughlin v. Board of Medical Examiners*, 35 Cal. App. 3d 1010, 1012 (Cal. App. 2d Dist. 1973)

⁷ See, e.g., *Weissbuch v. Board of Medical Examiners*, 41 Cal. App. 3d 924 (Cal. App. 2d Dist. 1974).

⁸ See, e.g., *Griffiths v. Superior Court*, 96 Cal. App. 4th 757 (Cal. App. 2d Dist. 2002).

⁹ See Darren Grant & Kelly C. Alfred, *Sanctions and Recidivism: An Evaluation of Physician Discipline by State Medical Boards*, 32 *Journal of Health Politics Policy and Law* 867 (October 1, 2007), compiling data from the Federation of State Medical Boards identifying negligence-related disciplinary codes as follows: Negligence (14.5%); Failure to Conform to Minimal Standards of Medical Practice (12.2%); Gross Negligence (7%). Grant and Alfred also cite data compiled by Public Citizen Research Group identifying 18.8% of sanctions as relating to "substandard care, incompetence, negligence."

outside the clinical sphere, and posits a few possible explanations for why this is the case. Part IV offers a proposal for tying character-related discipline to fitness to practice, and explains the implications of this approach for professional discipline more broadly. Finally, Part V identifies weaknesses in three traditional arguments in support of boards' broad exercise of disciplinary discretion.

II. PROFESSIONAL DISCIPLINE IN AMERICAN LAW

This Section describes the legal underpinnings of the current American system of medical licensure and discipline, traces its historical development, and briefly describes how the system currently operates in practice. Drawing on the constitutional justifications for professional licensure and discipline, this Section identifies two fundamental principles of the medical disciplinary system in American law – first, an emphasis on public protection (rather than punishment or compensation); and second, a recognition that the scope of professional discipline is not all-encompassing.

A. Medical Board Authority: History and Practice

Among the unenumerated powers reserved to each state under the Tenth Amendment is the power to protect the health, safety, and welfare of its citizenry, commonly known as the police power.¹⁰ As explained by the Supreme Court in *Dent v. West Virginia*, it is the “power of the state to provide for the general welfare of its people [that] authorizes it to prescribe all such regulations as, in its judgment, will secure or tend to secure them against the consequences of ignorance and incapacity, as well as of deception and fraud.”¹¹ It is pursuant to their police powers that states are authorized to regulate law, medicine, and other professions, which they typically do by delegating authority to professional licensing boards.

As a constitutional grant of authority, this story is a relatively simple one. But for those familiar with the history of medical licensure, it is much more complex. The first state medical boards were created in the late 1800s when private medical associations pushed state legislators to adopt laws regulating the practice of medicine.¹² These efforts were driven by

¹⁰ U.S. Const. Amend. X; *Slaughter-House Cases*, 83 U.S. 36, 62 (1872) (describing the police power as extending “to the protection of the lives, limbs, health, comfort, and quiet of all persons, and the protection of all property within the State”).

¹¹ *Dent v. W.Va.*, 129 U.S. 114, 122 (1889).

¹² Paul Starr, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE*, 102-06 (1984); Ronald L. Akers, *The Professional Association and the Legal Regulation of Practice*, 2 *Law & Soc'y Rev.* 463, at 465-67 (1967).

physicians who, fearful of incursions on their territory by “irregulars” and “quacks,” were convinced that well-drafted legislation – far from being self-defeating – could serve an important role in protecting their professional interests.¹³ Though some historians suggest that professional self-protection, rather than concern for patient safety, was the driving force behind these lobbying efforts,¹⁴ the medical practice acts that resulted were, as a matter of law, clearly adopted pursuant to the legislative authority to protect public health and safety.

At a minimum, the modern medical practice act defines the practice of medicine, establishes the requirements for medical licensure, and sets forth procedures for disciplinary action against licensees.¹⁵ The medical practice act also establishes the composition of the state board of medicine, the administrative agency responsible for implementing and enforcing the act’s provisions through its rulemaking and adjudicative powers.¹⁶ Modern medical boards generally include some public members, but are dominated by physicians appointed by the governor.¹⁷

Modern American licensure laws are exclusive; that is, they grant qualified individuals the right to engage in the lawful practice of medicine, and prohibit the practice of medicine by unlicensed persons.¹⁸ The

¹³ Akers, at 465-67.

¹⁴ See, e.g., Stanley J. Gross, *The Myth of Professional Licensing*, 33 *American Psychologist* 1109 (1978).

¹⁵ See, e.g., N.Y. C.L.S. Educ. § 6521 (Definition of the Practice of Medicine), § 6524 (Requirements for a Professional License), § 6530 (Definitions of Professional Misconduct). See generally, Federation of State Medical Boards, *ESSENTIALS OF A MODERN MEDICAL PRACTICE ACT* (2006).

¹⁶ See, e.g., N.Y. C.L.S. Educ. § 6523 (State Board for Medicine). See also *Douglas v. Noble*, 261 U.S. 165, 170 (1923) (holding that the delegation of professional regulatory powers to an administrative board is consistent with the U.S. Constitution). See generally, Federation of State Medical Boards, *ESSENTIALS OF A MODERN MEDICAL PRACTICE ACT* (2006); Federation of State Medical Boards, *ELEMENTS OF A MODERN STATE MEDICAL BOARD* (2006).

¹⁷ See Carl F. Ameringer, *STATE MEDICAL BOARDS AND THE POLITICS OF PUBLIC PROTECTION*, 48-51 (1999); M. Christine Cagle, J. Michael Martinez & William D. Richardson, *Privatizing Professional Licensing Boards: Self-Governance or Self-Interest?*, 30 *Administration Society* 734, 750-51 (1999); Eleanor Kinney, *Administrative Law Issues in Professional Regulation*, in Timothy S. Jost ed., *REGULATION OF THE HEALTHCARE PROFESSIONS*, 106 (1997).

¹⁸ See, e.g., N.Y. C.L.S. Educ. § 6512 (Unauthorized Practice a Crime), § 6513 (Unauthorized Use of Professional Title a Crime). Contrast exclusive licensing laws with certification laws, which grant qualified individuals the right to use the title of physician in connection with their practice of medicine, and are exclusive only with respect to the use of that title, not with respect to medical practice generally. Also contrast this with registration laws, which require that medical practitioners register their names with a state agency, but impose no qualification requirements or restrictions on practice. See generally, Robert L. Hollings & Christal Pike-Nase, *PROFESSIONAL AND OCCUPATIONAL LICENSURE IN THE*

requirements for obtaining a medical license are relatively consistent from state to state – generally, the applicant must be a graduate of an approved medical school, have completed at least one year of an approved graduate medical education program (residency or fellowship), and have passed the United States Medical Licensing Examination (USMLE).¹⁹ Beyond imposing educational and training requirements, many medical practice acts also require that applicants for medical licensure demonstrate good moral character.²⁰ Some states also impose additional requirements, such as proof of malpractice insurance coverage;²¹ a clear criminal background check;²² or age,²³ citizenship,²⁴ or residency requirements.

Medical boards' ongoing duties include periodic re-registration of licensees, which is typically contingent on their completion of specified hours of CME.²⁵ However, medical boards rarely impose additional requirements intended to ensure the quality of care, such as mandatory recertification or random practice audits, upon physicians who have already received their licenses.²⁶ Arguably, then, the most important of state medical boards' oversight responsibilities with respect to medical quality is the discipline of professional licensees.

The medical disciplinary process is generally reactive, rather than proactive. It begins when a member of the public files a complaint, or, in the case of discipline on the grounds of criminal or civil liability, when a

UNITED STATES: AN ANNOTATED BIBLIOGRAPHY AND PROFESSIONAL RESOURCE, xvii-xix (1997). For scholarly criticisms of exclusive licensure, see *supra* note 3. See also Harris S. Cohen, *On Professional Power and Conflict of Interest: State Licensing Boards on Trial*, 5 J. of Health Politics, Policy and Law 291 (1980); Walter Gellhorn, *The Abuse of Occupational Licensing*, 44 U. Chicago L. Rev. 6 (Autumn 1976); Stanley J. Gross, *The Myth of Professional Licensing*, 33 Am. Psych. 1109 (1978); Eliot Freidson, *PROFESSION OF MEDICINE*, 23-24 (1988).

¹⁹ See, e.g., N.Y. C.L.S. Educ. § 6524 (Requirements for a Professional License). See generally, American Medical Association, *State Medical Licensure Requirements and Statistics 2007* (2007) [hereinafter, "AMA Licensure Requirements"].

²⁰ See, e.g., N.Y. C.L.S. Educ. § 6524(7). See generally, *Hawker v. N.Y.*, 170 U.S. 189 (1898).

²¹ See *Jones v. State Bd. of Medicine*, 97 Id. 859 (1976).

²² See, e.g., S.C. Code Ann. § 40-47-36 (2007)

²³ See, e.g., N.Y. C.L.S. Educ. § 6524(5).

²⁴ See, e.g., N.Y. C.L.S. Educ. § 6524(6); *but see In Re Griffiths*, 413 U.S. 717 (1973) (finding unconstitutional a Connecticut bar rule requiring bar applicants to be United States citizens).

²⁵ See *AMA Licensure Requirements*, at 48.

²⁶ Department of Health and Human Services Office of Inspector General, *FEDERAL INITIATIVES TO IMPROVE STATE MEDICAL BOARDS' PERFORMANCE*, OEI-01-93-00020, at 5 (Feb. 1993) (hereinafter, February 1993 OIG Report) (proposing that state medical boards take a more proactive role in assessing and assuring the quality of medical care after initial licensure examinations).

court or law enforcement agency files a report with the medical board.²⁷ The board screens, and, if appropriate, investigates the complaint; if the board finds the complaint is valid, it may exercise its discretion to pursue disciplinary action against the physician. Subject to procedural due process requirements, discipline can range from oral or written reprimand to license revocation or suspension.²⁸

In addition to procedural due process, medical board proceedings are also constrained by principles of substantive due process, which limit the grounds upon which professional discipline can legitimately be imposed.²⁹ The criteria for licensure and discipline may not be vague, arbitrary, or unattainable,³⁰ and must have a “rational connection with the applicant's fitness or capacity to practice” his profession.³¹ Though the substantive grounds for professional discipline vary from state to state, most state medical practice acts authorize discipline for gross incompetence, physical or mental impairment, alcohol or drug abuse, practicing without a license or aiding the unlicensed practice of medicine, as well reciprocal discipline against those providers who have been subject to disciplinary action in other states. Moreover, most states authorize discipline under a broad category of “unprofessional conduct,” which may include violations of codes of medical ethics, conduct that brings the medical profession into disrepute, or other unspecified forms of “dishonorable conduct,” including

²⁷ See Timothy Jost *et al.*, *Consumers, Complaints, and Professional Discipline: A Look at Medical Licensure Boards*, 3 Health Matrix: Journal of Law-Medicine 309, 310-11 (1993); Department of Health and Human Services Office of Inspector General, STATE MEDICAL BOARDS AND MEDICAL DISCIPLINE, OEI-01-89-00560 (Aug. 1990) (hereinafter, 1990 OIG Report). Many of these reports are also filed with the National Practitioner Data Bank, a resource maintained by the Department of Health and Human Services that provides medical boards, hospitals, and other health care entities with “information relating to the professional competence and conduct” of licensed medical professionals. Department of Health and Human Services Office of Inspector General, NATIONAL PRACTITIONER DATA BANK: USEFULNESS AND IMPACT OF REPORTS TO STATE LICENSING BOARDS, OEI-01-90-00523, at i (Mar. 1993) (hereinafter, March 1993 OIG Report).

²⁸ *Id.* at 113, notes 76-78.

²⁹ The liberty component of the due process clause includes a right to choose one's field of employment, and a medical licensure is thus considered a kind of property right. *Dent v. West Virginia*, 129 U.S. 114, 121-22 (1889); see also *Conn v. Gabbert*, 526 U.S. 286, 291 (1999) (citing *Dent*).

³⁰ *Id.*

³¹ *Schwartz v. Board of Bar Examiners*, 353 U.S. 232, 239 (1959). See also *Dent* at 122 (“The nature and extent of the qualifications required must depend primarily upon the judgment of the State as to their necessity. If they are appropriate to the calling or profession, and attainable by reasonable study or application, no objection to their validity can be raised because of their stringency or difficulty. It is only when they have no relation to such calling or profession, or are unattainable by such reasonable study and application, that they can operate to deprive one of his right to pursue a lawful vocation..”).

criminal acts (typically felonies or “crimes of moral turpitude”).³²

Because states have broad latitude in determining how best to exercise their police powers, and because the loss of a medical license does not implicate a fundamental right, rational basis review is applied when evaluating the constitutionality of legislation in the realm of medical licensure and discipline.³³ Medical board disciplinary determinations are reviewed under a similarly deferential standard³⁴

B. Fundamental Principles of Professional Discipline in American Law

The history and structure described above highlight three fundamental principles grounding medical boards’ disciplinary authority. Although, as demonstrated in Section III, these principles are not always reflected in practice, they serve as normative foundations for the delegation of professional regulatory powers under American law.

First, the primary goal of and justification for professional discipline is public protection. As an extension of the state’s police power, the medical board’s disciplinary authority is aimed at protecting medical consumers from the harms they may incur at the hands of incompetent or dishonest physicians. This is reflected in the sanctions that may be imposed on physicians, which range from alerting the medical board and community of a potential for harm (via a public letter of reprimand) to withdrawing the physician’s right to practice (delicensure). In other words, the goals of professional discipline are incapacitation and public protection; professional discipline does not serve to compensate victims, like civil law; or punish wrongdoers, like criminal law.³⁵

Secondly, while medical boards’ licensure and disciplinary authority is grounded in the state’s broad powers to protect public health, safety, and welfare, this authority is not all-encompassing. It is limited in two ways – by substance and by degree.

First, substantive due process demands that the grounds for licensure and discipline be rationally related to the practice of medicine. In other words, if it is to serve as a meaningful limitation on medical board

³² See, e.g., N.Y. C.L.S. Educ. § 6530(20) (“Conduct in the practice of medicine which evidences moral unfitness to practice medicine”); § 6530(9).

³³ See generally, *Williamson v. Lee Optical of Oklahoma*, 348 U.S. 483, 487-88 (1955) (holding that a law “need not be in every respect logically consistent with its aims 488 to be constitutional. It is enough that there is an evil at hand for correction, and that it might be thought that the particular legislative measure was a rational way to correct it.”)

³⁴ See *Kinney in Jost*, at 114; *Barsky v. Board of Regents*, 327 U.S. 442, 470 (1954); *Bettencourt v. Board of Registration in Medicine*, 904 F.2d 772, 774 (1st Cir. 1990).

³⁵ See *Deborah L. Rhode, Moral Character as a Professional Credential*, 94 *Yale Law Journal* 491, 546 (1985) (noting that the rationale for attorney discipline is not to punish, but rather to protect the public).

authority, the substantive due process requirement implies that there are some criteria that do *not* satisfy this standard. For example, while requiring that physicians counsel their patients about the importance of voting in local and national elections would likely further the public good, it would not be a proper subject for medical licensure or discipline. As a matter of practice, the dominance of physicians in the composition of state medical boards tends to support this understanding. That is, in relying on administrative boards dominated by physicians for the implementation and enforcement of licensure and discipline laws, the American system implicitly recognizes that professional members are better situated to evaluate the unique question of fitness to practice; a board composed of laypeople would have much greater difficulty evaluating, for example, whether a licensed physician's practice is consistent with the standard of care in his medical community.

Furthermore, as a matter of degree, professional licensure and discipline standards are established to ensure a minimal level of competence, rather than to identify aspirational standards of professional conduct. That is, the criteria for professional licensure establish a floor beyond which practitioners may not drop, rather than an ideal towards which they must strive. In other words, though we view a medical license as evidence that a physician possesses the basic tools necessary to practice medicine safely, the license does not ensure that he will actually use these tools correctly, and does not distinguish the merely competent provider from the excellent provider – that level of distinction takes place at the marketplace level. This principle is reflected in fact that our jurisprudence identifies the professional license as a property right requiring due process protections, and requires that the standards for licensure and discipline be reasonably attainable. Though licensure requirements were implemented in an effort to improve the quality of medical care (and, in turn, public health), they were bounded by the recognition that imposing excessive regulations would severely limit the number of licensed physicians available to serve the community. Enacting overly aspirational or stringent licensure laws, scholars often note, may have the counterintuitive effect of actually decreasing public health as compared with a purely free market system.

Accordingly, for the purposes of this Article, I propose a relatively uncontroversial definition of fitness to practice that is specific enough to be constructive but does not incorporate too many normative assumptions or prejudices about appropriate grounds for professional discipline.³⁶ The definition provides that an individual will be deemed fit to practice medicine if he possesses the basic qualities needed to practice medicine in a

³⁶ [Consider how thoroughly to address potential challenges to this notion of fitness to practice, despite its being relatively uncontroversial.]

manner that does not cause harm to his patients. At a minimum, he must possess: (a) scientific knowledge of the human body and its functions, obtained by way of education; (b) the practical skill to implement this knowledge safely, obtained by way of a residency, fellowship, or other hands-on experience, as well as the physical ability to do so; and (c) the moral reasoning needed to understand that his medical knowledge and experience should not be used to harm patients. In effect, fitness to practice is best understood as a “toolkit” of basic skills that each professional must have before he begins practicing. Although the state will grant licenses only to those who demonstrate that they have the right “tools,” state licensure cannot ensure that the licensed professionals will always use these “tools” in the right way.

These guiding principles for professional discipline in American law should be relatively uncontroversial. While critics of the current disciplinary system may question whether these principles accurately describe the system as it has been implemented in practice, as a matter of theory, these principles are not only sound, but desirable.

III. PROFESSIONAL DISCIPLINE BY MEDICAL LICENSING BOARDS: CHALLENGES AND CONCERNS

Despite the fact that the theoretical underpinnings of the American medical disciplinary regime are sound, the system as practically implemented boasts few supporters. Both physicians and critics outside the professional sphere routinely question medical boards’ disciplinary priorities and challenge their exercise of disciplinary discretion. Indeed, many disciplinary actions, particularly those taken in response to physician misconduct outside the clinical realm, seem to stray from the fundamental principles of public protection and fitness to practice described previously. This Section offers a few likely explanations of why medical boards act in this manner, and concludes that it may be because boards lack clear guidance as to the proper goals of professional discipline, and are often pressured by political and public interests to address “noisy” cases of physician misconduct.

A. Challenging the Frequency and Quality of Medical Board Discipline

The criticisms that have been levied against medical boards generally fall into two categories. On the one hand, medical professionals and others concerned with prioritization of board resources criticize boards for being less responsive to issues of medical safety than to public outcry in setting disciplinary priorities. Consumer advocates, on the other hand, charge that as a quantitative matter, boards do not discipline physicians

often enough to have a substantial impact on patient safety and public health.³⁷ This Section considers each challenge in turn.

As a historical matter, low rates of professional discipline have been the primary drivers of public discontent with medical boards.³⁸ Since the 1970's, critics have argued that medical licensing boards are simply not doing enough to protect patients. While these challenges have resulted in some cyclical variation in the frequency of professional discipline³⁹ as well as legislative broadenings of medical board authority,⁴⁰ recent estimates suggest that less than one-half of one percent of licensed physicians face serious discipline annually.⁴¹ Moreover, critics continue to cite high rates of medical malpractice to support their arguments that professional discipline is ineffective in protecting the public and improving the quality of medical care.⁴² In sum, these criticisms challenge whether boards are effectively accomplishing the public protection goals of professional discipline.

On the other hand, boards also face qualitative challenges, primarily from practicing physicians who have been disciplined for unprofessional conduct but who contend that their behavior, while possibly indicative of poor personal judgment or character, is not relevant to their fitness to practice medicine. Challenged categories of misconduct include tax fraud,⁴³

³⁷ These competing complaints call to mind the old joke memorialized by Woody Allen in his film, *Annie Hall*. As his character, Alvy Singer, tells it, "Two elderly women are at a Catskill mountain resort, and one of them says, "Boy, the food at this place is really terrible." The other one says, "Yeah, I know; and such small portions.""

³⁸ See Timothy S. Jost, *Oversight of the Competence of Healthcare Professionals*, in REGULATION OF THE HEALTHCARE PROFESSIONS (Timothy S. Jost ed. 1997), at 21-22; Carl F. Ameringer, STATE MEDICAL BOARDS AND THE POLITICS OF PUBLIC PROTECTION (1999), at 5.

³⁹ See Jost, *supra* note 38, at 21-22; Ameringer, *supra* note 38, at 5.

⁴⁰ See Kevin B. O'Reilly, *Doctor Disciplinary Actions Down for Third Year*, AM. MED. NEWS (May 12, 2008) (reporting that Indiana, New Mexico, and Washington enacted legislation in 2008 to "beef[] up board authority," and that nine other states are considering similar changes).

⁴¹ See Public Citizen Health Research Group, *Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2005-2007* (HRG Publication #1837) (2008), available at <http://www.citizen.org/documents/medicalboardtable.pdf>; see also Ameringer, *supra* note 38, at vi, 2; Jost, *supra* note 38, at 25 (noting that medical boards are no worse than other professional licensing boards in addressing disciplinary problems).

⁴² This sentiment is shared by even some medical board members. See Randall R. Bovbjerg, Pablo Aliaga & Josephine Gittler, STATE DISCIPLINE OF PHYSICIANS: ASSESSING STATE MEDICAL BOARDS THROUGH CASE STUDIES (2006), at 33 [hereinafter, *State Discipline of Physicians*].

⁴³ See *In re Kindschi*, 52 Wn.2d 8, 12 (Wash. 1958); *Windham v. Board of Medical Quality Assurance*, 104 Cal. App. 3d 461 (Cal. App. 2d Dist. 1980) (finding it "difficult to compartmentalize dishonesty" in such a way that a person who is willing to evade his federal income taxed would nevertheless be "considered honest in his dealings with his

soliciting sex in a public restroom,⁴⁴ possession of marijuana for personal use,⁴⁵ reckless driving involving alcohol,⁴⁶ and witness intimidation.⁴⁷ Consider, for example, the case of Dr. Ansar, a physician practicing at a veterans' hospital who, in the midst of a bitter divorce and custody dispute, called the police to report that his wife had attacked him with a knife.⁴⁸ In fact, Dr. Ansar's injury was self-inflicted, a feeble attempt to gain advantage in the legal proceedings.⁴⁹ When the police arrived and Dr. Ansar realized that his wife would be handcuffed and taken into custody, he immediately recanted his statement, but was nevertheless charged and convicted of filing a false police report.⁵⁰ Subsequently, the state medical board suspended his license to practice medicine for a full year on the grounds that Dr. Ansar had committed a "misdemeanor involving moral turpitude."⁵¹ The board's decision was upheld on appeal.⁵²

These cases extend beyond the realm of anecdote, however. Federal studies by the Office of the Inspector General conducted in the 1980's and 1990's concluded that medical boards rarely take action on the basis of incompetence or poor quality of care, choosing to concentrate instead on cases of drug diversion, drug or alcohol abuse, and criminal convictions.⁵³ "[W]e've never had a disciplinary action based on malpractice," reported one medical board director. "[W]hen there is a malpractice case, we tend to

patients.")

⁴⁴ See *McLaughlin v. Board of Medical Examiners*, 35 Cal. App. 3d 1010, 1012 (Cal. App. 2d Dist. 1973).

⁴⁵ See *Weissbuch v. Board of Medical Examiners*, 41 Cal. App. 3d 924 (Cal. App. 2d Dist. 1974).

⁴⁶ See *Griffiths v. Superior Court*, 96 Cal. App. 4th 757 (Cal. App. 2d Dist. 2002).

⁴⁷ See *McDonnell v. Commission on Medical Discipline*, 483 A.2d 76 (Md. 1984) (reversing a medical board's decision to discipline a physician who was being sued by a former patient for medical malpractice where the physician allegedly engaged in the intimidation of expert witnesses); *In re Lustgarten*, 629 S.E.2d 886, 892 (N.C. Ct. App. 2006) (reversing the North Carolina Medical Board's decision to discipline a physician testifying as an expert witness for allegedly testifying that another physician was testifying falsely).

⁴⁸ *Ansar v. State Medical Board of Ohio*, 2008 Ohio 3102 (2008).

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.* See Ohio Rev. Code 4731.22(B)(13) (providing that the state medical board "shall, to the extent permitted by law, limit, revoke, or suspend an individual's certificate to practice, refuse to register an individual, refuse to reinstate a certificate, or reprimand or place on probation" a physician who pleads guilty to or is convicted of "a misdemeanor involving moral turpitude").

⁵² *Id.*

⁵³ Department of Health and Human Services Office of Inspector General, *MEDICAL LICENSURE AND DISCIPLINE: AN OVERVIEW*, P-01-86-00064, at 13-14 (June 1986) (hereinafter, 1986 OIG Report); 1990 OIG Report, at 15.

look for another basis for disciplinary action.” Furthermore, a more recent study based on data compiled by the Federation of State Medical Boards concluded that 25% of all serious medical disciplinary actions taken on the basis of a physician’s criminal conduct involve conduct that impacts neither patient care nor the medical system more broadly defined.⁵⁴ And while precise figures are hard to come by, recent analyses of the frequency of various substantive grounds for discipline identify a significant portion that are not clearly linked to medical care or patient safety.⁵⁵ Critics contend that disciplining physicians for these kinds of misconduct emphasizes aspirational standards, rather than standards that are clearly linked to public protection in the medical sphere.

While both the qualitative and quantitative challenges are important to recognize, this Article focuses primarily on the qualitative challenges for three reasons. First, because an unmediated focus on the rate of medical discipline alone is unlikely to tell us much about boards’ overall effectiveness in protecting public interests.⁵⁶ The rate at which medical professionals face serious discipline is comparable to the rate of discipline in other professions⁵⁷ as well as the rate of felony convictions among the American public.⁵⁸ Giving these quantitative similarities, it is surprising that medical discipline alone would be subject to such criticism.⁵⁹ Secondly, given that the frequency of board discipline is significantly resource-driven,⁶⁰ modifying boards’ disciplinary priorities is likely to be more effective than pushing for increased rates of discipline when resources are scarce. Imagine the potential impact if all the resources spent by

⁵⁴ P. Jung, P. Lurie & S. M. Wolfe, *US Physicians Disciplined for Criminal Activity*, 16 *Health Matrix: Journal of Law-Medicine* 335 (2006).

⁵⁵ Grant and Alfred, at 875 [insert parenthetical with data from Table 2]

⁵⁶ See, e.g., Grant and Alfred at 872 (“[I]t would be preferable not to assess board effectiveness by the rate of discipline alone.”); Timothy Jost *et al.*, *Consumers, Complaints, and Professional Discipline: A Look at Medical Licensure Boards*, 3 *Health Matrix: Journal of Law-Medicine* 309, 310 ([C]ounts of disciplinary actions ... do not give us a full picture of board activity.”), 336 (“[E]valuating board success solely on the basis of formal disciplinary actions is inadequate because boards may be more active at the informal level than is commonly supposed.”).

⁵⁷ See Jost, *supra* note 38, at 25.

⁵⁸ According to the U.S. Department of Justice, nearly 1,145,000 adults were convicted of felonies in 2004. U.S. Department of Justice, Bureau of Justice Statistics, *Criminal Sentencing Statistics*, available at <http://www.ojp.usdoj.gov/bjs/sent.htm>. This represents less than one half of one percent of the United States population.

⁵⁹ Moreover, consider these data in terms of numbers rather than percentages. If each of the 3,000 physicians seriously disciplined each year sees an average of 3,000 patients annually, then at least 9 million patient interactions are at risk annually. See David Goodman, *Twenty-Year Trends in Regional Variations in the U.S. Physician Workforce*, *Health Affairs* (Oct. 7, 2004).

⁶⁰ See *infra*, Section III-B.

medical boards in disciplining character-related misconduct occurring outside the clinical sphere were instead redirected to address behavior with a more direct impact on patient health and welfare (for example, substandard care).⁶¹ Finally, evaluating boards on the basis of specific disciplinary actions is easier and likely to be more productive than considering the many actions that medical boards fail to take. Because many of the “noisy” cases relating to character and professionalism test constitutional boundaries and ultimately face judicial scrutiny, they offer unique opportunities for clarifying the boundaries of permissible board discipline. The lessons learned in these cases can then be used to provide guidance for professional discipline in other contexts as well.

B. Underlying Issues: Finance and Structural Independence

If medical boards are failing to achieve the public goals with which they’ve been tasked, it is imperative to understand why this is the case before proposing any solutions. While at least one prominent legal scholar has explored the motivations of state bar examiners in investigating attorney character,⁶² no similar studies have been done of state medical boards.⁶³ Accordingly, there is little consensus as to why medical boards choose to pursue discipline against certain kinds of physician misconduct but not others. That said, at least a few potential explanations have been proposed.

According to a 2006 report prepared for the U.S. Department of Health and Human Services, high costs and limited financial and human resources are among the major obstacles to effective disciplinary enforcement by medical boards.⁶⁴ Because of these resource limitations, boards generally take a reactive rather than proactive approach to medical discipline, and are often unable to investigate all the complaints that are made against physicians, necessarily triaging those of highest priority while leaving others unexamined.⁶⁵ A recent empirical study seemed to confirm this finding, noting a correlation between the extent of a board’s financial

⁶¹ [Consider counterargument about relative cost of pursuing discipline against criminal conduct vs. negligent practice]

⁶² Deborah L. Rhode, *Moral Character as a Professional Credential*, 94 *Yale Law Journal* 491 (1985).

⁶³ The only study that addresses similar themes in the medical context is Randall R. Bovbjerg, Pablo Aliaga & Josephine Gittler, *State Discipline of Physicians: Assessing State Medical Boards Through Case Studies* (U.S. Department of Health and Human Services 2006), <http://aspe.hhs.gov/daltcp/reports/2006/stdiscp.pdf>.

⁶⁴ Bovbjerg at 15-17, 38-41. See also Robert C. Derbyshire, *How Effective is Medical Self-Regulation?*, 7 *Law and Human Behavior* 193, 199 (1983); 1990 OIG Report, 6-8; 1986 OIG Report, 2.

⁶⁴ Bovbjerg at 9, 14-15.

⁶⁵ Bovbjerg at 21, 35.

resources and its rate of discipline.⁶⁶ These reports suggest that increasing medical boards' budgets would go a long way towards increasing the frequency of medical discipline. Moreover, to the extent that boards choose to pursue certain substantive categories of discipline rather than others on the basis of financial limitations – relying on court reports to identify physicians who have been convicted of criminal activity, for example, is likely to be less costly and labor-intensive than actively investigating physicians who provide medical care that consistently falls short of professional standards⁶⁷ – perhaps increasing board resources might have an impact on the quality, not just the quantity, of professional discipline.

Another common explanation for medical boards' lax approach to professional discipline is that the boards are “captured” by professional interests or otherwise lack meaningful public oversight.⁶⁸ Indeed, one of the most prominent criticisms of the medical profession in the 20th century has been that it is self-protective, monopolistic, and more attuned to the economic security of its members than to the welfare of the public at large.⁶⁹ In the context of medical discipline, some have argued that the boards' approaches to various substantive grounds for discipline are likewise driven by internal constraints within the medical community – for example, the push to improve the public standing of physicians by emphasizing their moral superiority (which, compared to their technical skill, is much easier for laypersons to judge).

While there can be no denying that the history of American medicine is replete with examples of professional self-protection by the AMA and other private professional associations (as well as by individual physicians),⁷⁰ it is not clear that these problems affect the physicians

⁶⁶ M. T. Law & Z. K. Hansen, *Medical Licensing Board Characteristics and Physician Discipline: An Empirical Analysis*. See also Andis Robeznieks, Am. Med. News (quoting NY Health Department spokeswoman saying that increase in NY discipline was partly due to a double in licensing fees). *Possibly add note about source of medical board funding*.

⁶⁷ See Bovbjerg; 1990 OIG Report, 10, 15 (noting that because quality of care inquiries tend to be time-consuming, “boards tend to look for another basis to take action.”); 1986 OIG Report, 14. Moreover, financial limitations mean that boards are often reactive rather than proactive, responding to consumer complaints or criminal reports, rather than initiating investigation on their own.

⁶⁸ See Bovbjerg at 45; Harris S. Cohen, *On Professional Power and Conflict of Interest: State Licensing Boards on Trial*, 5 *Journal of Health Politics, Policy and Law* 291 (1980). See also Robert C. Derbyshire, *How Effective is Medical Self-Regulation?*, 7 *Law and Human Behavior* 193, 199-200 (1983) (citing Harris Cohen, Milton Friedman).

⁶⁹ See generally, PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE*, 223 (1984) (discussing medicine's historical opposition to the establishment of independent regulatory schemes for professionals such as midwives, chiropractors, and osteopaths).

⁷⁰ See, e.g., *Matter of the Am. Med. Ass'n.*, 94 F.T.C. 701 (1979) (prohibiting medical

serving on state medical boards. Arguably, the attitude of a physician appointed by the governor to sit as a member of the state agency responsible for interpreting and enforcing the state's medical practice act is likely to be very different than that of the average practicing physician.⁷¹ Indeed, the 2006 Health and Human Services report posited that medical boards may actually be able to act more effectively if they maintain statutory and structural independence from both political and professional interests.⁷² And a similar report dated 1990 identified state limitations on board authority as one of the most significant obstacles to expeditious and effective disciplinary review.⁷³ A recent empirical study of the frequency of medical board discipline across various states agreed, finding that boards were more likely to take disciplinary action when they were more structurally independent from state government;⁷⁴ boards with a higher proportion of public (that is, non-professional) members were found to be no more likely to engage in vigorous disciplinary enforcement.⁷⁵ These data ultimately led the authors of the study to conclude that claims that "the medical profession has captured the regulatory apparatus" have been "overstated."⁷⁶

C. Lack of Legislative or Judicial Guidance

The three issues described above – financial constraints, professional self-protection, and lack of independence, are unlikely to be resolved without significant political and professional buy-in.⁷⁷ However, the boards responsible for professional discipline also face another significant challenge that can be more easily resolved – namely, a lack of

associations and state medical boards from enforcing their ethical guidelines regarding advertisement and price fixing); *Wilk v. Am. Med. Ass'n*, 895 F.2d 352, 360 (7th Cir. 1990) (upholding district court's finding that the AMA violated federal antitrust laws by conspiring to eliminate the chiropractic profession). [Add references to *Tuskegee*, *Nuremberg*, etc.]

⁷¹ See Bovbjerg at 34; Derbyshire at 198-99.

⁷² Bovbjerg at 9, 12-14, 14-15.

⁷³ 1990 OIG Report, 8-9.

⁷⁴ Law and Hansen.

⁷⁵ Law and Hansen. See also Andis Robeznieks, *Public Active on Medical Boards, But Not Always Tougher on Doctors*. Am. Med. News Nov. 11, 2002 (noting that the Alabama, Mississippi, and Louisiana medical boards have physician-only membership, and have "some of the most aggressive disciplinary rates.")

⁷⁶ Law and Hansen at 5.

⁷⁷ Increasing funding and structural independence, for example, would require strong support from state legislatures and executives. Reducing the profession's self-protective instincts, on the other hand, would take a significant amount of buy-in from the profession that is, quite frankly, unlikely to happen. See Robert C. Derbyshire, *How Effective is Medical Self-Regulation?*, 7 Law and Human Behavior 193, 199 (1983).

clear direction in setting disciplinary priorities. Existing legal doctrine has neither adequately defined fitness to practice nor resolved the question of why personal character is relevant to safe and effective medical practice, so it is no wonder that boards face challenges in exercising their disciplinary discretion in a principled manner.

As noted in Section II, legislatures grant medical boards disciplinary authority pursuant to broadly worded medical practice acts authorizing discipline for, among other things, “unprofessional conduct.”⁷⁸ Although such language seems to provide little guidance for medical boards engaged in concrete disciplinary decisionmaking, courts have consistently upheld such broad categories of discipline, finding that they provide boards with the flexibility and discretion necessary to effectuate public goals.⁷⁹ The North Carolina Supreme Court, for example, has consistently upheld unprofessional conduct statutes against challenges of vagueness and overbreadth.⁸⁰ While acknowledging that there may be “room for difference of opinion” as to the outer edges of the concepts of “unprofessional” or “dishonorable” conduct, the court stated that “there is at and around the central core of these concepts much conduct which so clearly constitutes improper practice that few, if any, members of the profession would seriously claim to be unaware that such conduct is not consistent with these concepts.”⁸¹ Rather than impose upon states the burden of cataloging “every conceivable improper practice in which the licensee is forbidden to engage,” the court held that unprofessional conduct statutes be evaluated by reference to the test of “whether a reasonably intelligent member of the profession would understand that the conduct in question is forbidden.”⁸² Similarly, the Washington Supreme Court upheld a statute authorizing professional discipline for “moral turpitude” against a

⁷⁸ See *supra*, Section II.

⁷⁹ As Justice Frankfurter wrote in *Schwabe*, the fact that the definition of moral character “has shadowy rather than precise bounds” and its determination “involves an exercise of delicate judgment” does not imply that a state may not require it as a condition of practice. *Schwabe v. Board of Bar Examiners*, 353 U.S. 232, 248-49 (1959). For state court decisions rejecting vagueness challenges to professional discipline statutes, see, e.g., *Brody v. Barasch*, 155 Vt. 103 (1990) (“moral unfitness”); *Ketring v. Sturges*, 372 S.W.2d 104, 111 (Mo. 1963) (“dishonorable conduct”); *Haley v. Medical Disciplinary Bd.*, 818 P.2d 1062, 1072-74 (Wash. 1991) (“moral turpitude”); *Abrahamson v. Department of Professional Regulation*, 568 N.E.2d 1319, 1324 (Ill. App. Ct. 1st Dist. 1991) (“good moral character”), rev’d on other grounds, 606 N.E.2d 111 (Ill. 1992); *Sanchick v. Michigan State Board of Examiners*, 342 Mich. 555 (Mich. 1955) (“unprofessional, unethical and dishonest conduct of a character likely to deceive the public”).

⁸⁰ See, e.g., *In re Wilkins*, 294 N.C. 528, 548 (N.C. 1978); *In re Guess*, 327 N.C. 46, 56 (1990)

⁸¹ *In re Wilkins*, 294 N.C. 528, 548 (N.C. 1978).

⁸² *In re Wilkins*, 294 N.C. 528, 548 (N.C. 1978).

vagueness challenge, noting that when the statute is “construed in relation to the purposes of professional discipline, considered in the context of a specific application, and supplemented by the shared knowledge and understanding of medical practitioners,” its content is sufficiently clear to put practitioners on notice that certain conduct is prohibited.⁸³

And yet, most courts attempting to define fitness to practice or explain how a particular category of professional misconduct relates to fitness are able to offer little more than circular reasoning in support of their conclusions. As noted by Deborah Rhode in her paradigmatic 1985 article on moral character as a credential for the practice of law, what passes for legal analysis in these cases is highly conclusory and “border[s] on tautology.”⁸⁴ Even *Hawker v. New York*, the case which speaks most directly to the issue of character-related criteria for professional licensure and discipline, offers little guidance. In *Hawker*, the Supreme Court upheld a New York state law prohibiting the practice of medicine by those who have been convicted of a felony, but provided little support for its conclusion that personal character is “as important a qualification as knowledge” for professional practice and is therefore subject to discipline.⁸⁵ In two brief sentences, the Court offered the following meager explanation of its conclusion: “The physician is one whose relations to life and health are of the most intimate character. It is fitting, not merely that he should possess a knowledge of diseases and their remedies, but also that he should be one who may safely be trusted to apply those remedies.”⁸⁶ While these factors serve to emphasize the importance of disciplining physicians compared to other professionals,⁸⁷ they do not satisfactorily explain why any particular grounds for discipline are appropriate. Indeed, most state

⁸³ *Haley v. Medical Disciplinary Bd.*, 818 P.2d 1062, 1074 (Wash. 1991)

⁸⁴ Deborah L. Rhode, *Moral Character as a Professional Credential*, 94 *Yale Law Journal* 491, 552 (1985).

⁸⁵ *Hawker v. N.Y.*, 170 U.S. 189, 193 (1898). Because the Supreme Court decided *Hawker* decades before it elucidated the fitness to practice requirement in *Schwartz*, the analysis in *Hawker* does not lend itself to an easy discussion of the connection between personal character and fitness to practice medicine.

⁸⁶ *Id.* at 194, 191 (No business “so directly affect[s] the lives and health of the people” as the practice of medicine); *In re Kindschi*, 319 P.2d 824, 826 (Wash. 1958) (“The daily practice of medicine concerns life and death consequences to members of the public”).

⁸⁷ See also *Schwartz v. Board of Bar Examiners*, 353 U.S. 232, 247 (1959) (In his concurrence, Justice Frankfurter wrote that because the legal profession is charged with the important responsibilities of “defen[ding] right and ... ward[ing] off wrong,” it is particularly important that members of the profession have “a high sense of honor, [be] of granite discretion, [and] of the strictest observance of fiduciary responsibility.”); *In re Polk*, 449 A.2d 7, 18 (N.J. 1982) (describing the less stringent burden of proof in medical disciplinary proceedings compared to legal disciplinary proceedings as reflecting “society’s important interest in life and health”).

court decisions in disciplinary matters simply conclude that moral character broadly defined is a necessary component of fitness to practice without providing adequate support for this assertion.⁸⁸

Substantive due process challenges to medical board disciplinary actions taken on the basis of unprofessional conduct statutes have resulted in equally unhelpful judicial analysis. Without providing strong justifications for their decisions, courts have held that professional discipline on grounds as varied as tax fraud,⁸⁹ failure to facilitate review of child support obligations,⁹⁰ soliciting sex in a public restroom,⁹¹ possession of marijuana for personal use,⁹² and reckless driving involving alcohol⁹³ all fall within the boundaries of unprofessional conduct statutes and are reasonably related to the practice of medicine. Consider, for example, *In re Kindschi*, a Washington Supreme Court case that set the precedent for numerous cases upholding medical discipline on character-related grounds.⁹⁴ In *Kindschi*, the Washington Supreme Court upheld a medical board's decision to suspend the license of a physician who had committed tax fraud, on the basis of a statute authorizing discipline for "unprofessional conduct," including "conviction in any court of any offense involving moral turpitude."⁹⁵ Finding "a rational connection between income tax fraud and one's fitness of character or trustworthiness to practice medicine," the court held that the board's discipline for tax fraud did not violate due process.⁹⁶ In justifying its decision on the grounds that the public "has a right to expect the highest degree of trustworthiness of the members of the medical

⁸⁸ *See, e.g., Dittman v. California*, 191 F.3d 1020, 1032 (9th Cir. 1999) (citing *Schware* and concluding that "a state may require good moral character as a qualification for entry into a profession, when the practitioners of the profession come into close contact with patients or clients"); *Raymond v. Board of Registration in Medicine*, 443 N.E.2d 391, 395 (Mass. 1982) ("A physician's bad moral character may reasonably call into question his ability to practice medicine."); *Foster v. Bd. of Medical Quality Assurance*, 227 Cal. App. 3d 1606, 1610 (Cal. App. 3d Dist. 1991) (a physician's "intentional dishonesty" regarding his malpractice coverage "demonstrates a fundamental lack of moral character which is incompatible with the honesty required to properly maintain the doctor-patient relationship").

⁸⁹ *In re Kindschi*, 52 Wn.2d 8, 12 (Wash. 1958); *Windham v. Board of Medical Quality Assurance*, 104 Cal. App. 3d 461 (Cal. App. 2d Dist. 1980).

⁹⁰ *Dittman v. California*, 191 F.3d 1020 (9th Cir. Cal. 1999).

⁹¹ *McLaughlin v. Board of Medical Examiners*, 35 Cal. App. 3d 1010, 1012 (Cal. App. 2d Dist. 1973)

⁹² *Weissbuch v. Board of Medical Examiners*, 41 Cal. App. 3d 924 (Cal. App. 2d Dist. 1974).

⁹³ *Griffiths v. Superior Court*, 96 Cal. App. 4th 757 (Cal. App. 2d Dist. 2002).

⁹⁴ *See, e.g., Deatherage v. Board. of Psychology*, 948 P.2d 828 (Wash. 1997) (improper witness testimony).

⁹⁵ *In re Kindschi*, 319 P.2d 824, 825 (Wash. 1958).

⁹⁶ *Id.* at 826.

profession,”⁹⁷ the Washington Supreme Court effectively paved the way for professional discipline against physicians who engage in any conduct suggesting untrustworthiness or violating “sound standards of conduct.”⁹⁸

Of course, there are good reasons for legislatures to grant medical boards such broad authority and for courts to defer to board decisions provided they satisfy a reasonableness test. On the legislative side, given that professional expectations are likely to evolve over time and across various contexts, it would be problematic if unprofessional conduct statutes were drafted to capture specific and defined instances of misconduct, rather than offer a significant degree of flexibility. Moreover, granting medical boards broad directives and allowing them to make judgments on their own without overly stringent judicial review is consistent with the principles of professional discipline that provide for physician-dominated boards as best suited to identify and enforce professional standards.⁹⁹ While such a deferential stance may be appropriate as a matter of both law and policy, the meagerness of judicial discussion in professional discipline cases makes it difficult for boards to derive clear principles and guidelines for future action. By failing to provide a fuller analysis in substantive due process cases, courts are missing a key opportunity to explain to boards why the boundaries of constitutional action lie where they do.

Given the lack of guidance provided to boards by the legislatures in their initial grant of disciplinary authority and by the courts in their judicial review of disciplinary decisions, it is no wonder that the disciplinary actions taken by state medical boards are sometimes inconsistent with the principles of professional discipline. In the absence of legislative or judicial guidance, boards are free to take action based not on sound theories of discipline, but on the pressures imposed by public officials, private interests, and the public, none of which are necessarily the best drivers of administrative decisionmaking. This Article seeks to remedy this problem by clarifying the principles of professional discipline and proposing a theory that boards can use to prioritize action in the realm of character-related misconduct and beyond.

IV. THE CORE VALUES THEORY OF MEDICAL DISCIPLINE: CONCEPT AND APPLICATION

As described above, the modern system of medical discipline does not adequately take into account the fundamental principles of professional discipline outlined in Section II. This Section proposes an alternative

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ See *supra*, section II.

theory of discipline for professional misconduct that more appropriately accounts for these concerns – namely, one that focuses on the core professional values inherent in the most elemental understanding of fitness to practice. Medical boards that wish to operate more effectively ought to be guided by this theory in setting disciplinary priorities and exercising their disciplinary discretion.

A. Respect For Core Medical Values as an Element of Fitness to Practice

To satisfy the fundamental principles outlined in Section II-B, professional discipline must not only be aimed primarily at public protection, but must also be appropriately targeted at issues of fitness to practice narrowly defined. A theory of discipline that does not incorporate these limitations is of little value to medical boards struggling to determine what kinds of disciplinary actions they can pursue consistent with their legal directives. In contrast, a theory of discipline built to accommodate narrow character-based elements of fitness to practice can be extremely helpful to medical boards seeking disciplinary guidance.

As described in Section II, even the most elemental definitions of fitness to practice encompass not only educational and training requirements, but also some aspects of moral reasoning, character, or professionalism. However, most medical boards' interpretation of the character- or professionalism-based element of fitness to practice is so expansive that it begs the question of whether there exists any kind of physician misconduct that actually falls outside the scope of the fitness to practice inquiry. Clearly, some limitations must be imposed on disciplinary inquiries into character or professionalism.¹⁰⁰ A core values-based theory of discipline, which posits that the only relevant moral question is whether a physician demonstrates respect for the core values of medical practice, serves this function well. Pursuant to this theory, medical boards concerned with professionalism and character ought to identify these core medical values, and then pursue discipline only against those physicians whose behavior demonstrates disrespect for those values.

This approach is consistent with the reasoning that some courts have adopted in reviewing medical board disciplinary actions. While courts are reluctant to require proof of good character generally as an element of fitness to practice, they are more inclined to uphold professional discipline against physicians who demonstrate their disrespect for foundational medical values that are components of the fitness to practice inquiry.¹⁰¹

¹⁰⁰ See, *supra*, Section II-B.

¹⁰¹ *Griffiths v. Superior Court* 96 Cal.App.4th 757 (2002) (noting that driving under the influence of alcohol “threatens personal safety and places the safety of the public in jeopardy”); *In the Matter of the Revocation of the License of Irwin Jacob Polk* 90 N.J. 550

Among the key values and characteristics that judges have suggested bear a direct connection to the practice of medicine, honesty,¹⁰² compliance with the law,¹⁰³ adherence to fiduciary principles,¹⁰⁴ and respect for life, health, and bodily integrity¹⁰⁵ have all been identified as relevant to fitness to practice and, in turn, medical discipline.¹⁰⁶ Consider, for example, the thorough reasoning engaged in by a California court in upholding board discipline of a physician convicted of driving under the influence of alcohol. The court in Griffiths, rather than making a summary statement that driving under the influence is indicative of poor character and therefore a proper subject of discipline, wrote a nuanced opinion carefully identifying the various ways in which the physician's behavior demonstrated a lack of cognitive or moral skills necessary for medical practice.¹⁰⁷ Among the physician's demonstrated faults, noted the court, were disrespect for legal prohibitions against drinking and driving, the failure to apply scientific knowledge regarding the speed at which alcohol is absorbed into the bloodstream, and a lack of concern for his own bodily safety and that of

(1982) (noting that sexual abuse of patients results in psychological harm).

¹⁰² See, e.g., *Windham v. Board of Medical Quality Assurance*, 104 Cal. App. 3d 461 (Cal. App. 2d Dist. 1980) (noting that forensic medical practice involves honesty in financial dealings with the government and private insurance carriers, honesty in reporting and testifying as to medical matters, and honesty and integrity in patient dealings); *Griffiths v. Superior Court* 96 Cal.App.4th 757 (2002) (“Honesty and integrity are deeply and daily involved in various aspects of the practice of medicine”); *In Re License Issued to Zahl*, 186 N.J. 341(2006) (holding that the “panoply of dishonest acts” committed by the physician, including insurance fraud, “bespeak a fundamental disregard for truth which is ultimately inimical to the practice of medicine.”); *Krain v. Medical Board*, 71 Cal.App.4th 1416 (1999) (“the intentional solicitation to commit a crime which has as its hallmark an act of dishonesty [perjury] cannot be divorced from the obligation of utmost honesty and integrity to the patients whom the physician counsels”).

¹⁰³ *Griffiths v. Superior Court* 96 Cal.App.4th 757 (2002) (noting that driving under the influence of alcohol “shows an inability or unwillingness to obey the legal prohibition against drinking and driving and constitutes a serious breach of a duty owed to society.”).

¹⁰⁴ *In re Lesansky*, 25 Cal. 4th 11, 16 (Cal. 2001) (identifying among the character traits necessary for the practice of law: trustworthiness, honesty, fairness, candor, and fidelity to fiduciary duties).

¹⁰⁵ *Griffiths v. Superior Court*, 96 Cal. App. 4th 757, 770 (Cal. App. 2d Dist. 2002). (“Alcohol consumption quickly affects normal driving ability, and driving under the influence of alcohol threatens personal safety and places the safety of the public in jeopardy.”)

¹⁰⁶ Similar values, particularly the value of compliance with and respect for the law, may be relevant in reviewing bar discipline of attorneys. While compliance with the law is arguably an even more important value for the legal profession, see Rhode at 570 (“Abolitionists, civil rights activists, suffragists and labor organizers – indeed, the architects of our constitutional framework – all were guilty of ‘disrespect for law’ in precisely the sense that bar examiners employ it.”).

¹⁰⁷ *Griffiths v. Superior Court*, 96 Cal. App. 4th 757 (Cal. App. 2d Dist. 2002).

other drivers on the roads.¹⁰⁸ The conclusion reached by this court and others is that, if a physician's conduct in his personal life demonstrates a failure to understand or respect the values essential to safe and effective medical practice, professional discipline may be appropriate. On the other hand, professional values that are non-essential or aspirational in nature may be enforced as social norms within the medical profession, but are not an appropriate subject for legal discipline.¹⁰⁹

B. Challenges in Application

The benefit of the core values theory of discipline is that it gives direction to medical boards as to the appropriate exercise of disciplinary discretion, while still offering boards significant flexibility in applying this standard. Unfortunately, this promising element of the theory is also the primary criticism against it. From defining core professional values to determining what kind of behavior implicates those values, this theory offers boards a great deal of discretion, on its face doing little to solve the problem of boards' unbridled exercise of disciplinary authority.

Under the core values theory, the strongest predictor of substantive grounds for discipline will be the value or values that are identified as essential to medical practice. Defining these values too broadly will exclude many physicians who are arguably fit to practice medicine; defining them too narrowly will allow practice by physicians who may be at a greater risk of harming patients.¹¹⁰ Unfortunately, there is little empirical research indicating which professional values are closely linked to safe medical practice and patient safety. Accordingly, boards have little but common sense to turn to in identifying and selecting professional values, citing values as diverse as honesty, compliance with the law, adherence to fiduciary principles, and respect for life, health, and bodily integrity.

Consider, for example, how disciplinary outcomes might differ if various state medical boards were to identify different core professional values as essential to medical practice. If a board were to determine that respect for physical health and welfare is a value essential to the safe practice of medicine, then professional discipline would be justified against a physician convicted of assault and battery in a bar fight, on the grounds that his violent conduct indicates a lack of respect for others' physical health and welfare. In contrast, if another board deemed honesty essential,

¹⁰⁸ *Id.*

¹⁰⁹ See generally, David Luban, *LAWYERS AND JUSTICE: AN ETHICAL STUDY* (1988), 128 (distinguishing between essential components of the professional's role and mere "side constraints").

¹¹⁰ Moreover, the choice of who defines the values – boards, legislators, or courts – will be of great normative significance.

discipline might be justified upon a showing of any dishonest behavior by a physician in his personal relationships – for example, lying about his address to get his child into a good public school. Where there is little consensus in identifying the core values essential for fitness to practice, there is also likely to be little consensus among boards as to the proper substantive grounds for professional discipline.

Moreover, even if there were widespread agreement about which values are essential components of fitness to practice, controversy would still arise in determining what kind of behavior implicates those values. Consider, for example, if medical boards, legislators, and the public alike all determined that “respect for human life” was one core value that all physicians needed to possess in demonstrating fitness to practice medicine. A decisionmaker called upon to identify prohibited behavior that indicates disrespect for life might authorize professional discipline for elective abortions, physician assisted suicide, voluntary and involuntary euthanasia, lethal injection, as well as crimes of murder and manslaughter that take place outside the clinical sphere. Although in all of these cases, as a definitional matter, a life is ended at the hands of a medical professional, it is important to note that there is widespread debate within the medical community about what it means to value life and whether activities such as physician assisted suicide and voluntary euthanasia do, in fact, indicate a lack of respect for life.¹¹¹ Similarly, identifying “respect for physical health and welfare” as a core medical value would be equally fraught with controversy. While it is clear that physical assault and sexual abuse of patients demonstrates a lack of respect for bodily integrity, what about voluntary amputation and female circumcision, which are touted by some physicians and communities as legitimate ways of respecting patient values? For any value that is identified as relevant to professional practice, decisionmakers will still likely disagree about its proper application in the disciplinary context.

C. Consensus for Fiduciary Duty as a Core Medical Value

A partial solution to these problems may be found if we can identify a relatively uncontroversial professional value that the state, the public, and the profession can agree is a core component of medical practice. While there may still be disagreement about how this value is expressed in personal conduct, any consensus that can be reached in identifying relevant

¹¹¹ For example, supporters of physician assisted suicide argue that the role of the physician is not to preserve life at all costs, but rather to value the patient’s conception of a good life, which may in some cases involve facilitating his death. Physicians who support abortions, for example, might argue that respect for human life does not require the preservation of an unwanted fetal life at the expense of an adult mother’s health or welfare.

values is likely to serve an important function in defining the boundaries of disciplinary inquiry.

The principle of fiduciary duty in professional practice serves this function well. Principles of fiduciary duty establish that fiduciaries entrusted with the care of vulnerable populations have a duty to act in the best interests of their beneficiaries, and must not use their positions of authority to benefit themselves or others at the beneficiaries' expense. Both in medicine and law, professionals and clients both recognize the importance of the fiduciary duty; indeed scholars have identified as one of the distinguishing characteristics of professions the fact that they have "a credible code of fiduciary ethics that is effectively enforced."¹¹² Moreover, courts commonly call on principles of fiduciary duty to justify professional boards' disciplinary decisions and to demonstrate why the right to practice a profession should not be granted to those who demonstrate that they are likely to abuse that right. For example, the Supreme Court in *Hawker* culled citations to state statutes and court decisions suggesting that physicians, even if technically competent, might abuse their positions of power in ways that are harmful to patients if they promise impossible cures, collect fees for ineffective treatments, or abuse patient confidences.¹¹³ One state court cited in *Hawker* expressed concern that the "unprincipled and vicious" not be given the right the right to "enter professionally the families of the worthy but unsuspecting and be admitted to the secrets which the sick chamber must often intrust to them."¹¹⁴ Later opinions cite similar concerns about potential abuses of professional power, particularly relating to issues of confidentiality and privacy.¹¹⁵

If the principle of fiduciary duty is used to narrow the scope of character-related inquiry for professional discipline, the next step is to ask

¹¹² Michael J. Polelle, *Who's on First, and What's a Professional?*, 32 U. S.F. L. Rev. 205 (1998).

¹¹³ *Hawker v. New York*, 170 U.S. 189, at 191 note 1, 194-95 (1898).

¹¹⁴ *Id.* at 194-95.

¹¹⁵ See, e.g., *Shea v. Board of Medical Examiners*, 146 Cal.Rptr. 653, 662 (Cal. Ct. App. 1978) ("[T]here is no other profession in which one passes so completely within the power and control of another as does the medical patient."); *Hughes v. State Board of Medical Examiners*, 134 S.E. 42, 47 (Ga. 1926) ("[T]he relation of physician and patient is of such a confidential and serious nature, that not only the skill but also the moral character of the physician is of great importance to the interest of the patient and the state. It is important that only men of good character should practice medicine."); *Meffert v. State Board of Medical Registration & Examination* 72 P. 247, 249 (Kan. 1903) ("The object sought is the protection of the home of the sick and distressed from the intrusion therein, in a professional character, of vicious and unprincipled men - men wholly destitute of all moral sensibilities. It was not the purpose of the lawmakers to clothe a man with a certificate of moral character, and send him out to prey upon the weak and unsuspecting - upon those who would be entirely at his mercy[.]").

how this approach would play out in practice. Generally speaking, there are three categories of physician misconduct that are likely to implicate fiduciary principles. First, where a physician uses his clinical skills to cause harm to a patient or other beneficiary – consider physician assisted suicide, voluntary and involuntary euthanasia, lethal injection, torture, or irresponsible prescription of controlled drugs.¹¹⁶ Second, where a physician uses his privileged position (but not his clinical skills) to cause harm to a patient or other beneficiary – consider sexual abuse of patients that is facilitated by the privacy of the doctor-patient encounter, and breaches of patient confidentiality. Third, where a physician uses his privileged position to benefit himself without regard for his patient or other beneficiary - consider false expert testimony, Medicaid fraud, pharmacy theft, or even exceeding the speed limit on the basis of a nonexistent medical emergency. The common factor in all three scenarios is the physician's abuse of his clinical skills or privileged position, by virtue of which he is granted unique access to vulnerable beneficiaries in the first place.¹¹⁷ Importantly, this approach categorically excludes some kinds of personal misconduct as irrelevant to questions of professional discipline – namely, those that do not implicate the physician's clinical skills or privileged status, including many crimes that take place outside of the professional sphere (such as assault, murder, and fraud against non-patients), many instances of financial mismanagement or tax fraud in the personal sphere (such as failure to make child support payments), as well as simply poor personal judgment (such as marital infidelity). If professional discipline for these kinds of misconduct is to be justified, it must be because they implicate some *other* professional value essential to the practice of medicine.

However, relying on fiduciary principles to narrow the scope of disciplinary inquiry is only a partial solution, because even the uncontroversial value of fiduciary duty suffers from conflicts in interpretation. There are normative implications as to how harm is defined and how beneficiaries are identified, and the malleability of these terms poses problems for the effective implementation of fiduciary principles as a limiting category for professional discipline. For example, much depends

¹¹⁶ In each of these cases, the physician's medical expertise is used to achieve a result that is, according to some, harmful to a fiduciary. In physician assisted suicide, for example, the physician uses his knowledge of pharmaceuticals and his right to prescribe them to assist in the death of a patient. In drug abuse cases, the physician uses those same skills in a way that arguably harms both the patient and any third parties to whom the patient diverts excess drugs. In abortion cases, the physician terminates the life of an unborn fetus by using his clinical skills.

¹¹⁷ Another line of inquiry might consider whether discipline would be appropriate against a physician who breaches his fiduciary obligations in a context unrelated to the practice of medicine (for example, as a trustee of a family trust).

on whether the patient is considered the physician's only beneficiary, or whether the physician is understood to be a fiduciary for society more broadly.¹¹⁸ Defining the fiduciary role of the physician to include parties other than the patient might justify disciplining physicians who perform abortions, those who fail to report a patient's infectious disease, and those who provide biased expert testimony, on the grounds that they are using their clinical skills or privileged positions to harm a third-party beneficiary. Likewise, the question of whether a physician's conduct results in harm depends greatly on the definition of harm. As explained above, some may argue that assisting a terminally ill patient's voluntary suicide does not constitute a harm, while others may argue that ending a person's life always constitutes a harm to that patient. Still others might take the position that even if physician assisted suicide is not harmful to the patient, it can result in harm to society or other third-party beneficiaries. Similar arguments could be made for participation in activities that are deemed harmful by some but not by others, including female circumcision, voluntary amputation, and prescription of medical marijuana.

D. Benefits of the Core Values Theory

Ultimately, then, even if there is widespread support for using the value of respect for fiduciary principles to narrow the scope of justifiable professional discipline, open questions of definition and interpretation make it an incomplete solution at best. That said, there are some very real benefits to be gained by using a professional values analysis at every level of action, whether by legislators determining grounds for professional discipline, medical boards reviewing professional misconduct, or courts reviewing board disciplinary actions.

First, using a values-based approach that emphasizes fiduciary duty will rid the disciplinary process of a significant degree of uncertainty and increase the likelihood of consistency in outcomes over time. Currently, physicians aren't being put on notice as to what kind of conduct will subject them to discipline; boards aren't getting adequate guidance from the courts about the constitutional limitations on professional discipline; and courts have very little principled jurisprudence to look to in evaluating due process challenges. Given the fact that many state legislatures are currently moving to expand the scope of medical boards' disciplinary authority in response to public concerns, it is particularly important that this authority be exercised in a principled way. Using a medical values analysis that recognizes the importance of fiduciary duty, although it won't be outcome-determinative, will help determine some categories of conduct that are relevant to

¹¹⁸ [Insert citations to articles discussing broader physician fiduciary duties, especially in the context of public health.]

disciplinary inquiries, and will categorically exclude others – for example, many non-violent felonies.

Secondly, to the extent that boards have been criticized for taking an inconsistent approach to medical discipline – imposing lesser sanctions on providers who engage in tax fraud than those who engage in Medicare fraud¹¹⁹ – applying this kind of principled analysis may help redeem them in the eyes of the public. It will set the stage for a more principled application of constitutional principles of due process in the context of professional discipline, which will help to ensure that medical boards exercise their disciplinary discretion in a manner that best serves the public interest.

Finally, and most importantly, using a professional values analysis to reprioritize medical boards' actions will free up boards' limited resources so they can focus on the things that are arguably more likely to harm patients and the public – for example, gross incompetence, sexual assault of patients, and repeated violations of the standard of the care. Given that financial problems are among the most significant systemic issues faced by modern medical boards, boards should take every effort to re-examine their disciplinary priorities and determine whether there might be a better allocation of resources that would result in more effective disciplinary enforcement. This would, in turn, help boards respond to both the qualitative and quantitative criticisms of the approach they take towards physician discipline.

V. ALTERNATIVES TO THE CORE VALUES THEORY

The core values theory of discipline, while somewhat ambiguous in its application, is nevertheless stronger than alternative theories purporting to justify the exercise of medical board disciplinary authority in cases of character-related misconduct. This Section addresses three such theories, which, though intuitively appealing, justify a wider range of disciplinary action than is permitted under American law. Whether grounded in prediction, trust, or social contract, each alternative theory arguably satisfies the state's police power goals, but fails to take into account the fundamental legal principles underlying professional discipline, particularly the constitutional limitation that professional board action bear a rational relationship to fitness to practice.

A. Prediction Theory

One of the arguments that courts have used to justify discipline for

¹¹⁹ See P. Jung, P. Lurie & S. M. Wolfe, *US Physicians Disciplined for Criminal Activity*, 16 Health Matrix: Journal of Law-Medicine 335 (2006).

character-related misconduct outside the professional sphere is that it may be predictive of misconduct or error in clinical practice. The Washington Supreme Court in *Haley*, for example, held that a physician's conviction for tax fraud indicates a "lack of trustworthiness," raising a "reasonable apprehension" that he might likewise "abuse the trust inherent in professional status."¹²⁰ Writing of the disciplined physician, the court explained its difficulty in "compartmentaliz[ing] dishonesty in such a way that a person who is willing to cheat his government out of \$65,000 in taxes may yet be considered honest in his dealings with his patients."¹²¹ In other words, if maintaining honesty in patient relations is an element of safe and effective medical practice, disciplinary action may be appropriate against a physician who engages in dishonest behavior in the personal realm on the grounds that he is likewise predisposed to dishonesty in the context of medical practice.

While this argument has intuitive appeal, its empirical validity is highly controversial. Scholars of psychology have long debated whether human behavior is primarily dispositional (that is, grounded in consistent character traits)¹²² or situational (that is, dependent on context and environment).¹²³ Most contemporary theorists conclude that behavior is generally driven by both dispositional and situational factors,¹²⁴ though the balance between the two may vary depending on context. For example, dispositional or trait-based factors often have less predictive value in "strong situations" like workplaces, where personal behavior is narrowly prescribed and often dictated by norms, scripts, and routines.¹²⁵ On the

¹²⁰ *Haley v. Medical Disciplinary Bd.*, 818 P.2d 1062, 1069 (Wash. 1991)

¹²¹ *Id.*; see also *Krain v. Medical Board* 71 Cal.App.4th 1416 (1999) (holding that "the intentional solicitation to commit a crime which has as its hallmark an act of dishonesty cannot be divorced from the obligation of utmost honesty and integrity to the patients whom the physician counsels.")

¹²² See, e.g., Robert McCrae and Paul Costa, Jr., *The Five-Factor Theory of Personality*, in HANDBOOK OF PERSONALITY: THEORY AND RESEARCH (Lawrence Pervin and Oliver John, eds., 2nd Edition, 1995).

¹²³ Situational behaviorists believe that, at heart, context matters: a tendency towards deceit in one's personal life does not necessarily predispose a person to fraud in his professional life. See, e.g., Walter Mischel, PERSONALITY AND ASSESSMENT, 146 (Lawrence Erlbaum Associates, 1996) ("[T]he concept of personality traits as broad response predispositions is ... untenable."); Hartshorne and May, STUDIES IN THE NATURE OF CHARACTER, VOL. 1: STUDIES IN DECEIT (1928) (studying the consistency of behavior among schoolchildren).

¹²⁴ [Cite *Newton and Keenan (1988)*, *David-Blake and Pfeffer (1989)*, and others.] See also Rhode at 556-559 (citing research by Hartshorn and May).

¹²⁵ [Cite research by Walter Mischel, *The Interaction of Person and Situation*, in D. Magnusson & N.S. Endler (eds) *Personality at the Crossroads: Current Issues in International Psychology*, pp. 333-352 (1977), A. Davis-Blake and J. Pfeffer, *Just a Mirage: The Search for Dispositional Effects in Organizational Research*. *Academy of*

other hand, at least some analyses suggest that conscientiousness (the character trait that is arguably most relevant to discussions of professionalism, honesty, and trustworthiness) is fairly consistent across various situations, including in employment contexts.¹²⁶

Suffice it to say that social science research on the consistency of moral behavior as a whole has reached no clear conclusion as to whether character traits are generally consistent across various domains. Moreover, little empirical research has been done on the predictors of professional misconduct and discipline either in the legal or medical realms.¹²⁷ Of course, lack of empirical support in an area where little empirical research has been done is not a reason to reject the predictive argument altogether. If a strong theoretical argument can be made in support of a connection between discrete elements of personal character and clinical harm to patients, then perhaps this hypothesis can be used to direct future empirical research about the predictive value of character-related misconduct.¹²⁸ The core values

Management Review, 14, 385-400 (1989), and others.] barrack and mount, 1993, *Autonomy as a moderator of the relations between the big five personality dimensions and job performance*. *J. Applied Psychology*. 78. 111-118]

¹²⁶ Murray R. Barrick & Michael K. Mount, *The Big Five Personality Dimensions and Job Performance: A Meta-Analysis*. 44 *Personnel Psychology* 1, at 17-18 (1991). According to this study, elements of conscientiousness include dependability, persistence, goal-directedness, and organization. *Id.* at 4.

¹²⁷ See Deborah L. Rhode, *Moral Character as a Professional Credential*, 94 *Yale Law Journal*, 491, 556 (1985) (summarizing research on predictors of attorney discipline). In the context of medical practice, most studies examining the predictors of clinical misconduct or disciplinary complaints look only at correlations with length of practice, gender, race, and other similar demographic characteristics. See, e.g., James Morrison & Peter Wickersham, *Physicians Disciplined by a State Medical Board*, 279 *JAMA* 1889 (June 17, 1998); Roberto Cardarelli, John C Licciardone & Gilbert Ramirez, *Predicting Risk for Disciplinary Action by a State Medical Board*, 100 *Texas Medicine* 84 (January 2004). Others look at medical school grades and examination scores, but not aspects of character or personality. See, e.g., H. Hamdy et al., *BEME Systematic Review: Predictive Values of Measurements Obtained in Medical Schools and Future Performance in Medical Practice*, 28 *Medical Teacher* 103 (2006); Robyn Tamblyn et al., *Physician Scores on a National Clinical Skills Examination as Predictors of Complaints to Medical Regulatory Authorities*, 298 *JAMA* 993-1001 (September 5, 2007).

The only marginally useful studies of predictors of medical misconduct reveal high rates of disciplinary recidivism, Darren Grant & Kelly C. Alfred, *Sanctions and Recidivism: An Evaluation of Physician Discipline by State Medical Boards*, 32 *Journal of Health Politics Policy and Law* 867 (October 1, 2007), or a connection between “unprofessional conduct” in medical school and board discipline. See Maxine A. Papadakis et al., *Disciplinary Action by Medical Boards and Prior Behavior in Medical School*, 353 *N Engl J Med* 2673 (December 22, 2005).

¹²⁸ Moreover, even if empirical research did demonstrate a link between personal character and safe medical practice, it is by no means clear that the existing system of medical licensure and discipline would be the most accurate or effective mechanism for evaluating personal character. See Rhode at 556.

theory, particularly its emphasis on respect for fiduciary principles, aims to serve this purpose.

These empirical questions, however, are not nearly as troubling as the fact that the prediction theory might justify disciplining physicians with any characteristics that correlate with medical misconduct or poor clinical judgment in the patient care setting, regardless of their relevance to fitness to practice. For example, imagine that a retrospective study of physician characteristics reveals that male OB/GYNs practicing in rural areas are statistically more likely to be found liable in patient malpractice suits. Would this justify preemptive discipline?¹²⁹ Or, to choose an even more problematic example, imagine that physicians who engage in extramarital affairs are found fifty times more likely to face patient malpractice suits. A prediction theorist could argue that those physicians' lack of honesty in their personal relationships is predictive of dishonesty in their professional relationships. But can it really be said that a physician who engages in extramarital affairs, or a male OB/GYN practicing in a rural area, is unfit to practice medicine, lacking the intrinsic characteristics of education, training, and character that form the foundation of competent medical practice? It seems unlikely. If we are serious about the substantive due process limitation that demands that licensure and discipline requirements be rationally related to fitness to practice, the prediction theory is a poor substitute.

B. Trust Theory

Similar problems arise when trust theories are used to justify disciplinary inquiries into character-related misconduct. Trust theorists posit that misconduct outside the clinical sphere is a legitimate subject for professional discipline if it is likely to cause public distrust of medical profession. In *Kindschi*, for example, the Washington Supreme Court identified the dual goals of professional discipline as protecting the public and protecting the “standing of the medical profession in the eyes of the public.”¹³⁰ More recently, the court held that “conduct may indicate unfitness to practice medicine if it ... lowers the standing of the medical profession in the public's eyes.”¹³¹

Taking these statements at face value, it is difficult to understand

¹²⁹ [Consider including a brief discussion of criminal law's approach to prediction and preventive detention.]

¹³⁰ In re *Kindschi*, 319 P.2d 824, 826 (Wash. 1958).

¹³¹ *Haley v. Medical Disciplinary Bd.*, 818 P.2d 1062, 1069 (Wash. 1991); *See also* In re *Lesansky*, 17 P.3d 764, 767 (Cal. 2001) (“Attorney discipline is imposed when necessary ‘to protect the public, to promote confidence in the legal system, and to maintain high professional standards’”)

how inquiries into personal misconduct that lowers public opinion of the profession (but does not otherwise harm patients) relates to the state's interests in protecting public health and welfare. Indeed, few courts have ever expressly identified why the state's police powers justify disciplinary action that serves only to protect the medical profession's position in society. Perhaps the strongest defense was provided by the Washington Supreme Court in *Haley*, where it affirmed that preserving medical professionalism "is not an end in itself," but merely an "an instrumental end pursued in order to serve the State's legitimate interest in promoting and protecting the public welfare."¹³² Wrote the court, "To perform their professional duties effectively, physicians must enjoy the trust and confidence of their patients. Conduct that lowers the public's esteem for physicians erodes that trust and confidence, and so undermines a necessary condition for the profession's execution of its vital role in preserving public health through medical treatment and advice."¹³³ This link between public trust and professional efficacy has been widely recognized by legal scholars, most notably by Mark Hall, who posits that trust is a fundamental element of the healing relationship,¹³⁴ without which vulnerable patients would not be willing to seek care.¹³⁵ Without systemic medical trust, Hall argues, the medical profession would not be able to effectively achieve the state's goals in patient welfare and public health.¹³⁶ Under this view, then, any behavior that diminishes patients' confidence in the medical profession could be an appropriate subject for professional discipline.

This approach towards character-related physician misconduct is problematic for the same reasons as the predictive theory. Even accepting a connection between private misconduct and public trust in medicine, this kind of correlation alone may not be a strong enough justification for state intervention. Patients may place faith in their physicians for any number of reasons – their religion, their affiliation with a particular hospital, their personal appearance – and it is by no means clear why a state should

¹³² *Haley*, 818 P.2d at 1070.

¹³³ *Id.*

¹³⁴ Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 480 (2002).

¹³⁵ Hall, *supra* note 134, at 478; Mark A. Hall et al., *Trust in Physicians and Medical Institutions: What Is It, Can It Be Measured, and Does It Matter?*, 79 MILBANK Q. 613, 614 (2002).

¹³⁶ See also Starr, *supra* note X, at 5 (addressing the importance of clinical authority to the therapeutic process); David Mechanic, *The Functions and Limitations of Trust in the Provision of Medical Care*, 23 J. HEALTH POL. POL'Y & L. 661 (1998) (describing the effects of erosion of trust on the effectiveness of medical interventions). However, empirical evidence of whether a single physician's misconduct actually affects public trust in the profession as a whole (and whether disciplinary action taken by a state medical board actually serves to counteract this effect) is scarce and by no means conclusive. See Hall, at 496-98.

facilitate patient decisions that are based on non-clinical, irrelevant, or potentially discriminatory factors that have no clear link with fitness or competency to practice medicine.¹³⁷ In defining a physician's character by reference to public perception, courts have effectively defined it outside of the scope of fitness to practice, which under even a relatively uncontroversial definition speaks to the physician's intrinsic capabilities in the realm of education, training, and character. In contrast, when courts write about protecting the profession's standing, they are describing a change in public perception, rather than a change in qualities intrinsic to the medical professional. Defining the character element of fitness to practice by reference to public perception will not limit the scope of permissible professional discipline; rather, it has the potential to encompass even some categories of conduct that bear only the weakest connection to the state's interest in protecting the public's health and medical welfare. For example, though a physician's possession of two unregistered submachine guns may tend to "undermine public confidence in the integrity of the profession,"¹³⁸ it is difficult to see how this fact alone would call into question the physician's ability to practice medicine safely and with the best interests of patients at heart.

Accordingly, although the argument from public trust may offer one explanation of how professional discipline serves the state's police power goals, it alone is not an adequate justification for discipline that does not otherwise satisfy constitutional scrutiny.¹³⁹

C. Social Contract Theory

A final argument that can be made to justify professional discipline for character-related misconduct is grounded in social contract theory. While it may bear some similarities to the trust arguments described above,

¹³⁷ See generally, R. Gatter, Faith, *Confidence and Health Care: Fostering Trust in Medicine through Law*, 39 Wake Forest Law Review 395 (2004) (distinguishing between trust as faith and trust as confidence in competence); see also Mark A. Hall, *Caring, Curing and Trust: A Response to Gatter*, 39 Wake Forest Law Review, 2004.

¹³⁸ See *Raymond v. Board of Registration in Medicine*, 443 N.E.2d 391, 394 (Mass. 1982).

¹³⁹ Another common criticism is that that defining fitness to practice by reference to public trust is evidence of the profession's "shallow vanity," rather than any concern for public welfare. See generally, Keith Swisher, *The Troubling Rise of the Legal Profession's Good Moral Character*, 82 St. John's L. Rev. 1037, 1062 (2008) ("The bar is not concerned with reputable character in any meaningful sense. As we have seen, it routinely denies applicants of present reputable character. Such denials would be wholly arbitrary under a reputable character standard. Instead, the bar is more concerned with "reputable relational character" - that is, whether an applicant's past conduct is consistent with the bar's perceived self-image. This outlandish definition reconciles the cases - "fitness" to practice law is fitness to cohere with the bar's exalted self-image.").

it is worth discussing in its own right.

In the context of medicine, social contract theory posits that medical professionals are entitled to the privileges of exclusive licensure and self-regulation only by virtue of an (implicit or explicit) agreement to take responsibility for the provision of important social goods¹⁴⁰ and to hold themselves to higher standards of conduct than the general population.¹⁴¹ Accordingly, if a physician breaches this social contract, the state would be justified in restricting his right to practice.

The primary problem with this approach is that it not clear either that such a social contract exists, or that it binds physicians to particular standards of personal character or behavior. After all, if reasonable decisionmakers can disagree as to whether tax fraud constitutes “unprofessional conduct” subject to professional discipline, it is difficult to conclude that there is a social contract between physicians and society prohibiting this behavior. Moreover, if we think of the many kinds of obligations that could be imposed on physicians as a condition of licensure but that American law fails to recognize in that context – for example, the obligation to provide uncompensated care to indigent patients,¹⁴² or the obligation to treat patients during a public health emergency even at their own risk¹⁴³ – social contract theory seems even less relevant in justifying obligations with a more tenuous link to public health and patient safety. Indeed, social contract theory is typically used to defend professional ethical obligations, rather than legal obligations.

Moreover, even assuming that physicians enter into a clear social contract prohibiting character-related misconduct when they receive their medical licenses, social contract theory faces the same problems as prediction theory and trust theories: while requiring that licensed professionals satisfy higher standards of character may serve the state’s goals in protecting public welfare, it runs afoul of the fitness to practice

¹⁴⁰ See generally, Wilbert E. Moore, *THE PROFESSIONS: ROLES AND RULES*, 6 (1970); Michael D. Bayles, *PROFESSIONAL ETHICS*, 8-9 (1988); William M. Sullivan, *WORK AND INTEGRITY: THE CRISIS AND PROMISE OF PROFESSIONALISM IN AMERICA*, 4-5, 9-10 (2004); Corinne Lathrop Gilb, *HIDDEN HIERARCHIES: THE PROFESSIONS AND GOVERNMENT*, 53-54 (1966).

¹⁴¹ See Sullivan, *supra* note 140, at 2; William M. Sullivan, *What Is Left of Professionalism after Managed Care?*, 29 *HASTINGS CENTER REPORT* 7, at 10-11 (Apr. 13, 1999).

¹⁴² Required by EMTALA and other laws, providing for fines in the case of noncompliance, but unrelated to licensing standards.

¹⁴³ See Heidi Malm et al, *Ethics, Pandemics, and the Duty to Treat*, 8:8 *Am. J. Bioethics* 4 (Fall 2008); Nadia N. Sawicki, *Without Consent: Moral Imperatives, Special Abilities, and the Duty to Treat*, 8:8 *Am. J. Bioethics* 33 (Fall 2008). But see the highly controversial Model State Emergency Health Powers Act, which attempts to tie physician licensure requirements to obligations during emergencies (Section 608).

limitation on professional licensure and discipline. Given that our society imposes constitutional limitations on the exercise of state authority, a social contract to which the state is a party cannot violate these constitutional limitations.

CONCLUSION

If there is to be any uniformity and consistency in medical discipline, state medical boards must exercise their disciplinary discretion pursuant to some guiding theory of professional discipline. Moreover, this theory must be consistent with the guiding principles of professional discipline under American law – the primary concern of public protection, tempered by constitutional fitness to practice requirements that limit the scope of permissible disciplinary action. This Article proposes a theory that identifies the core values essential for safe and effective medical practice, and authorizes discipline where a physician’s behavior demonstrates a failure to recognize those core values. Of the key values that have been considered by medical boards and courts as relevant to professional fitness, the principle of fiduciary duty is the one most likely to garner consensus among lawmakers, patients, and medical professionals. While it clearly limits the scope of professional discipline to misconduct deriving from a physician’s privileged position or clinical skills, it offers lawmakers, medical boards, and courts significant flexibility in determining what constitutes harm to a beneficiary.

Compared to alternative theories of discipline, which threaten to encompass a wide variety of personal behavior that does not clearly implicate fitness to practice, the core values theory of discipline incorporates these constitutional limitations within its structure. Moreover, it offers significant benefits in terms of consistency, identifying some categories of conduct as relevant to professional discipline, and categorically excluding others. Finally, and most importantly, the core values theory offers a means by which boards can reevaluate their disciplinary priorities and increase their effectiveness in a budget-neutral manner.

While efforts to more clearly delineate the scope of justifiable professional discipline may be misconstrued as inappropriately limiting medical boards’ ability to protect the public, these concerns are unfounded. The issue at hand is not whether boards are disciplining physicians often enough, but rather whether boards are exercising their disciplinary powers in the most effective and efficient manner. Despite some recent expansions of authority, medical boards generally operate under significant financial and constraints, and necessarily maintain a system of triage in matters of

discipline. The active pursuit of baseless or irrelevant complaints detracts from the boards' ability to focus on professional misconduct that may have a far more direct impact on patient safety and the protection of public health. Accordingly, both the effectiveness and the continued relevance of the current system of professional board discipline depend on a clear understanding of how it can justifiably be exercised.

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