



California Research Bureau Briefly Stated

Physician Misconduct and Public Disclosure Practices at the Medical Board of California

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Academic studies estimate that 44,000 to 98,000 Americans die each year from the consequences of “injuries caused by medical management” in hospitals, including negligent and incompetent care.¹ Extrapolated to the four million hospital admissions each year in California, this implies that between 10,000 and 36,000 hospitalizations in California each year are marred by negligent care, including 3,000 to 10,000 deaths.

These figures far exceed the 220 to 324 accusations filed per year against physicians by the Medical Board of California during 2000-07, most of which resulted in major disciplinary actions. The MBC licenses and regulates the 125,000 physicians and surgeons licensed in California.

The MBC faces the difficult task of identifying and disciplining “problem doctors” in order to protect the public. But regulators such as the MBC depend heavily on patient complaints in order to identify those physicians. The MBC receives fewer than 4,000 “Quality of Care” complaints each year, most of which it dismisses at early stages of investigation due to a lack of evidence against the physician.

These data imply that patients who have been harmed by negligent care rarely file formal complaints.

This poses a significant challenge for the MBC. In order to protect the public from negligent and/or incompetent physicians, the MBC must first identify

those physicians. The key strategies required for doing so are, first, an aggressive program of public outreach and education and second, a strong analytical program for identifying risk factors associated with negligent-care events in physician’s care of patients.

Our study asks two key questions. First, are the MBC’s public outreach and education efforts adequate to fulfill the Board’s public protection mandate? If not, what else could it be doing?

Second, does the MBC disclose to the public sufficient information about physicians to adequately protect the public? If not, what additional information should the MBC disclose?

We address these two concerns in turn in this research brief. First, we examine some aspects of public outreach and public education policies at the MBC and other state medical boards. Second, we present and discuss a statistical model of MBC disciplinary actions.

Public Outreach and Education

The goals of public outreach and education should be to make patients aware of the MBC’s regulatory role and to help patients better understand what they should expect from their physicians. Do patients know who the MBC is and what it does? Do they know where to go to file a complaint about the quality

of their healthcare? Do they know what constitutes negligent or incompetent care by a physician?

These questions can be addressed in a variety of ways, including public opinion surveys and analysis of complaints filed with the MBC.

We lack survey evidence specific to California about the degree to which the public is well-informed about the Medical Board's regulatory role. The MBC has sponsored no survey-based market research to measure public knowledge about the Board recently.

A 2006 national survey found that only 21 percent of respondents reported being "extremely confident" or "very confident" that they "could get information about the number of disciplinary actions taken against a doctor or hospital." Conversely, 45 percent replied they were "not too confident" or "not at all confident" that they could obtain this information.² These data raise questions about public awareness of state medical boards generally, but cannot address how well Californians know the MBC.

One policy option highlighted in our full report that could increase public awareness of the MBC would be to require physicians to provide patients with information about the Board.

The Medical Board receives complaints filed by members of the public as well as a variety of governmental agencies and other statutorily-mandated reporters, such as malpractice insurers. During the January 2000-March 2008 period, the MBC received 68,310 complaints against licensed physicians. Since 2000, 78.6 percent of physicians in our data have zero complaints on record, while 1.4 percent have five or more complaints filed against them in the period.

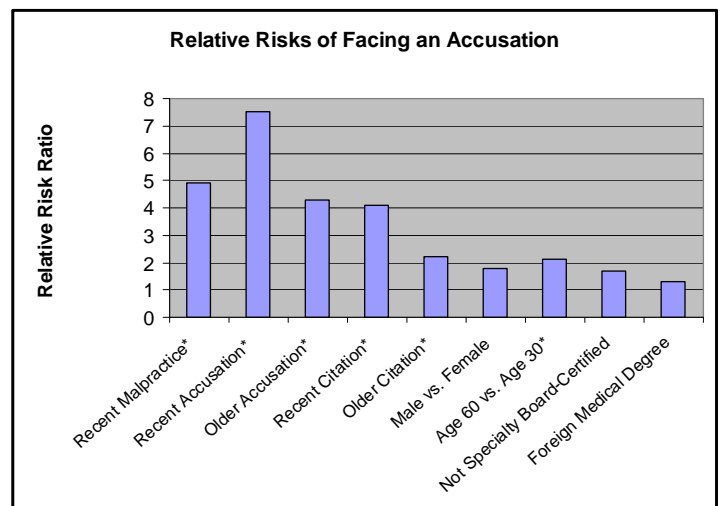
On average, more than 80 percent of all complaint cases received each year by the MBC were terminated in the MBC's Central Complaint Unit without disciplinary or administrative action (e.g., a citation, fine or educational letter), including more than 90 percent of complaints filed by patients and their families. Between 24 and 33 percent of complaints filed since 2000 were closed after a CCU staff finding of "No Violation," while another 17-35 percent were closed due to "Insufficient Evidence" or because the complaint lacked critical, required information (often because the complaint was anonymous).

These data indicate that many patients may lack understanding of the MBC's regulatory authority and/or what the law requires before the MBC may discipline a physician for providing negligent care. Complaint disposition data is not generally available for other state medical boards. However, according to a 2006 study of six state boards (including the MBC), "Investigation closes almost two-thirds of cases, typically because there is too little evidence to support formal charges but sometimes with an informal notice of concern or similar communication with the respondent physician."³ These data suggest that the MBC's rate of early-stage case closure is not unusual.

Disciplinary Risk Factors and Disclosure

The primary justification for public disclosure of state medical board disciplinary actions is to help patients make informed choices when choosing caregivers. The MBC discloses various information about physicians on its Physician License Lookup website, accessible at www.medbd.ca.gov/lookup.html.

State medical boards vary in what they disclose about physicians and for how long. As few published studies have addressed the correlates of state medical board disciplinary actions, the disclosure standards may have little relationship with the risks patients face when choosing between physicians.



We estimated a statistical model of MBC "accusations" (filings of formal charges, most of which result in major disciplinary actions) in order to better identify disciplinary risk factors. Our model draws on prior studies that found that older, male

physicians who lacked Specialty Board certifications, and physicians previously disciplined, were most likely to face disciplinary actions.⁴

Accusations are very rare. About 0.23 percent of the physicians in our sample of physicians actively engaged in patient care faced one or more accusations in a given year. The table above reports the key *relative risks* of accusation estimated in our model. We found that physicians with prior histories of malpractice payouts (judgments, arbitration awards and settlements reported to the MBC), accusations, or citations/fines were significantly more likely to face new accusations, with relative risk ratios ranging from just over two-to-one for citations six to ten years old, to nearly five-to-one for malpractice payouts in the preceding five years, to over seven-to-one for an accusation in the preceding five years.

These statistical results support expanded public disclosure of past malpractice settlements, which currently are highly restricted. Additionally, they support lengthened disclosure of past citations and fines, which currently are disclosed only for five years. For a more detailed discussion of these issues, see the full CRB report at

<http://www.library.ca.gov/crb/CRBSearch.aspx>

Notes

¹ See, e.g., Kohn, Linda T.; Janet M. Corrigan; and Molla S. Donaldson; eds. 2000. *To Err Is Human: Building a Safer Health System*. Washington, D.C.: National Academy Press. www.nap.edu/openbook.php?isbn=0309068371.

² Matthew Greenwald & Associates. 2006. *Health Confidence Survey*. Survey. Sponsor: Employee Benefit Research Institute, May 16-June 3, 2006.

³ Bovbjerg, Randall R.; Pablo Aliaga; and Josephine Gittler. 2006. *State Discipline of Physicians: Assessing State Medical Boards Through Case Studies*. Washington: Office of Disability, Aging and Long-Term Care Policy Office of the Assistant Secretary for Planning and Evaluation U.S., Department of Health and Human Services. <http://aspe.hhs.gov/daltcp/reports/2006/stdiscp.pdf>.

⁴ Kohatsu, Neal D.; Dawn Gould; Leslie K. Ross; and Patrick J. Fox. 2004. Characteristics Associated With Physician Discipline: A Case-Control Study. *Archives of Internal Medicine* 164(6): 653-658. Morrison, James, and Peter Wickersham. 1998. Physicians Disciplined by a State Medical Board. *Journal of the American Medical Association* 279(23): 1889-1893. Grant, Darren, and Kelly C. Alfred. 2007. Sanctions and Recidivism: An Evaluation of Physician Discipline by State Medical Boards. *Journal of Health Politics Policy and Law* 32(5): 867-885.