An Evaluation of Clinicians with Subsequent Disciplinary Actions: Washington Medical Commission

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ABSTRACT: In an effort to better understand levels of recidivism among physicians and physician assistants in the state of Washington, the Washington Medical Commission (WMC) assessed 12 years of disciplinary information, drawing on sanctions delivered in the state during the period 2008-2020. The WMC identified the frequency and severity of disciplinary actions, the offenses leading to actions and the degree to which sanctioned physicians were subsequently sanctioned again. The most significant finding of the study is that there are common timelines and complaint instances among recidivist providers in Washington. This finding suggests that proactive interventions by medical boards, aimed at reducing the incidence of recidivism, may merit further study and consideration.

Introduction

Physician misconduct adversely affects patient safety and is therefore of societal importance. Little work has specifically examined re-disciplined physicians. WMC members and staff do not currently have any clear assessment standards by which to predict whether a given physician or physician assistant is likely to reoffend. An environmental scan of medical boards in the United States was conducted to determine if there were established procedures for reducing the instances of recidivism.[1] The WMC conducted retrospective research to study the characteristics of re-disciplined allopathic physicians (MDs) and physician assistants (PAs) along with a national scan of processes and procedures used by state medical boards to address recidivism up until 2020. A national standard for intervention and resolution of clinicians with multiple instances of subsequent discipline was not evident.

Definition of Terms Used in this Summary

"Respondent": In this summary of the WMC's research, we use the term "respondent" to indicate allopathic physicians or physician assistants who have had a complaint filed against them. Discipline does not have to occur to be considered a respondent.

"Providers": We use this nomenclature to describe either an allopathic physician or physician assistant. The term "licensee" is not used, since not all respondents in our study had active licenses.

"Disciplinary Event": We refer to disciplinary events as all complaints or reports that ultimately led to discipline.

"Discipline": The WMC invokes three main levels of discipline:

1. Informal Disposition (Stipulation to Informal Disposition/STID): a document stating that allegations have been made and containing an agreement by the provider to take some type of remedial action to resolve the concerns raised by the allegations. In these instances, the respondent does not admit wrongdoing.
2. Statement of Charges (SOC): a document formally charging a respondent with either unprofessional conduct or impairment. The respondent will have an opportunity to defend against the allegations at a hearing.
3. Suspension: an order summarily suspending a respondent's license to practice. The respondent will have an opportunity to defend against the summary action.

Methods

Respondents were divided into those disciplined once and those disciplined more than once. Differences in demographics, timeframes, transgressions and penalties were evaluated. The data examined included the original disciplinary action and subsequent disciplinary action of 60 physicians and six physician assistants. There were 1,011 disciplinary events for 975 disciplined physicians, with 6.8% being re-disciplined between the years 2008 and 2020.

Results

Among those re-disciplined, 50 (76%) identified as male and 19 (29%) were international medical graduates. Fifty-three percent of recidivists were solo practitioners. Through previous research, the WMC has determined that solo practitioners or those in single specialty groups in the state tend

to have higher rates of burnout due to a lack of feedback and interaction with colleagues. This research revealed that solo practitioners reoffend at a disproportionate rate (Figure 2: Recidivist Practice Type) compared to the general population, in which only 7% of providers practice in a solo setting.

The proportion of family medicine specialty providers was higher among re-disciplined physicians (29%) compared to the total physician population (15%). Other predominate specialties included internal medicine (11%), emergency medicine (6%) and obstetrics/gynecology (5%).

The most frequent causes for discipline were negligence (16%), violation of or failure to comply with a licensing board order (14%), incompetence (9%), substandard or inadequate care (8%) and license disciplinary action taken by a federal, state or local licensing authority (8%). Discipline imposed was revocation of medical license (7.5%), stayed suspension of license (21%) and reprimand (71.5%).

Re-disciplined providers had up to 18 disciplinary events in the study period. We found that the initial five years (Time Period A) after being disciplined by the WMC is a problematic time for respondents. Eighty-nine percent of the recidivists had complaints filed against them. Seventy-five percent of those complaints subsequently resulted in another disciplinary action. In the six to 10 years after initial discipline (Time Period B) 64 complaints were filed against 27 respondents and 55% resulted in subsequent discipline action (Figure 1: Complaints Received that Resulted in Discipline). It took an average of 1.5 years (565 days) for the subsequent discipline action to be issued after the complaint was received. In the case of 11 respondents, a third disciplinary action was issued, which on average took 1.7 years (632 days) from when the complaint was received to issuance.

Figure 1
Complaints Received that Resulted in Discipline

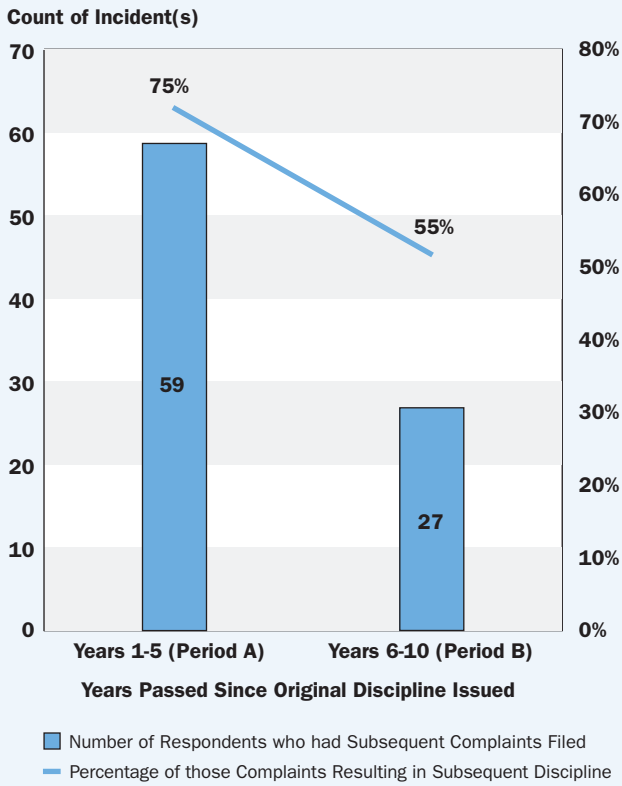
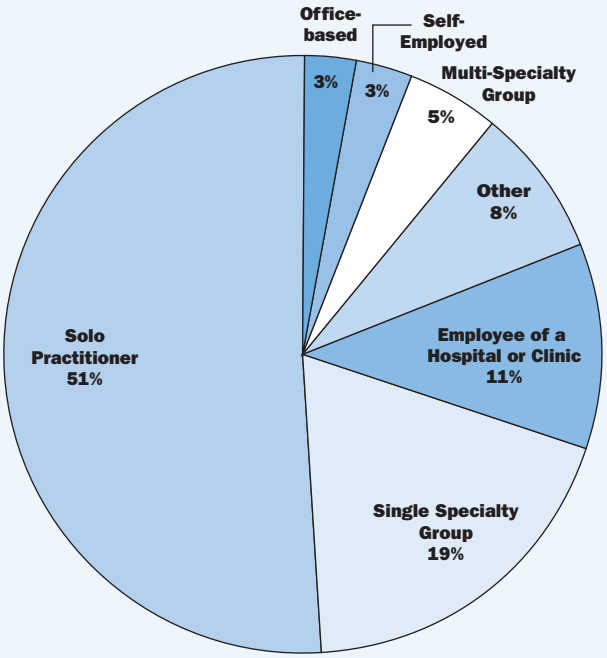


Figure 2
Recidivist Practice Type



Of the 66 recidivists examined; almost half (48%) of subsequent discipline issued stemmed from their failure to comply with a previous discipline order. In most cases, failure to comply is a preventable action and this data should indicate to state medical boards that open and clear communication needs to be established in a compliance program.

Recidivism and Sexual Misconduct

In our study, sexual misconduct accounted for 6% of cases. Although several rehabilitation programs have recently been developed for health professionals with a history of sexual misconduct, it is not clear whether these new programs have had a positive effect on recidivism cases in which sexual misconduct is the primary allegation. Currently there are no

controlled outcome studies with regards to long term rehabilitation for physicians or physician assistants after being disciplined for conduct that is sexual in nature.[1,2,3] The long-term effectiveness may be limited, either because providers are deterred from openness by the prospect of presenting a progress report to the regulatory body or because they feel coerced into treatment. Some authors, such as Pope, argue that physicians with a known history of sexual[4,5] misconduct should never be allowed to practice again because they pose too great a risk to the public even after receiving treatment.[4,5] However, regulatory bodies should consider the appeals of offending providers and decide on a case-by-case basis whether rehabilitation has been effective. Among the Washington recidivists who were initially disciplined for allegations of sexual misconduct, none reoffended with the same offense. This highlights how important it is for the WMC to address each allegation on a case-by-case basis. It should be noted that ultimately, three respondents had their licenses suspended and two voluntarily surrendered their licenses.

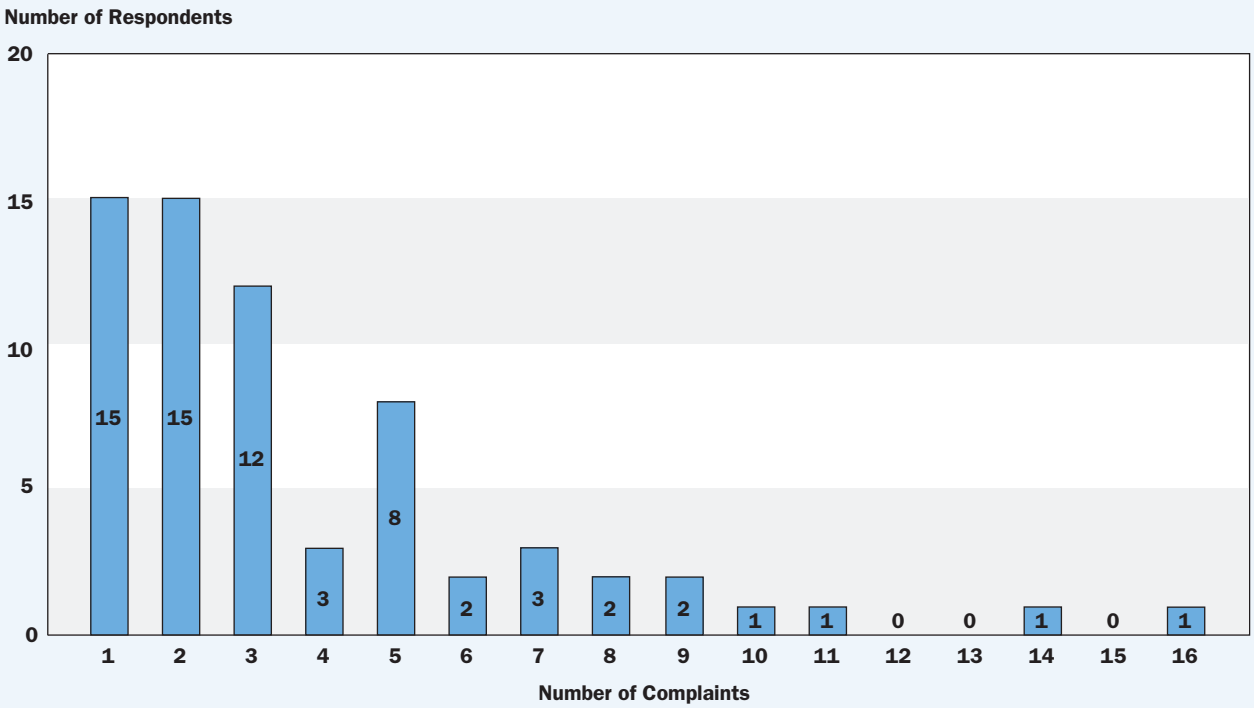
While discipline for sexual misconduct accounted for just 6% of cases in our study, the WMC believes that it is important to acknowledge and address the seriousness that sexual misconduct allegations have in impacting patient safety and the trustworthiness of the profession of medicine.

Discussion

The WMC has concluded from its research that there is an opportunity to provide intervention at certain time intervals in a provider's professional career in order to reduce the incidence of recidivism. The average time elapsed between initial licensure and the filing of a recidivist's first complaint is 8.2 years. The average number of complaints that recidivists will receive before their first disciplinary action is 3.2 (Figure 3: Number of Complaints Received before First Discipline Action) and the average number of years between the filing of a complaint to their initial disciplinary action is 7.3 years. It is not unreasonable to assume that the longer providers are in practice and the more patients they treat, the more statistically likely it is that they will have at least one complaint filed against them.

Knowing these time intervals and averages provides the opportunity for the WMC — and other state medical boards — to provide outreach and education to providers who fall within these intervals. For example, after eight years of licensure (or three renewal cycles) the WMC could proactively reach out to a provider in an effort to preemptively identify areas of concern. A simple, confidential conversation about a provider's job satisfaction or feelings of burnout, accompanied by a general discussion about the provider's struggles, could

Figure 3
Number of Complaints Received Before First Discipline Action



provide a proactive opportunity to identify potential issues and reduce the chances of future complaints being filed.

Another potential opportunity for state medical boards is the implementation of clinical support programs for providers who have multiple complaints filed against them. A clinician and/or board representative could reach out to the licensee after a threshold of complaints has been filed. In this hypothetical example, the WMC's medical consultant would be notified when providers have had three complaints filed against them. This would present an opportunity to discuss any questions the provider might have, aid with mental health concerns or offer educational resources.

Based on past WMC engagement and customer service surveys, providers are often overwhelmed with their careers and personal lives and do not have the time to be proactive in matters related to their mental health or education — which can lead to subpar patient interactions and the potential for mistakes. Providers may not be averse to assistance from a regulatory body, but they often do not know how to seek help. State medical boards have the opportunity to engage with their licensees with a simple survey that could be emailed to those who fall within similar demographics and time frames as those outlined in this study to understand more about the needs of licensees and follow up with a short phone call.

Solo Practitioners and Increased Disciplinary Risk

Providers who are professionally isolated are at increased risk for multiple occurrences of discipline.[6] They are less likely to be aware of professional norms and the consequences of violating them. It may be particularly risky to be professionally isolated within a private practice as a psychiatrist, where the WMC has seen a disproportionate amount of sexual misconduct complaints. Within the parameters of this research, we found that four solo practitioners were disciplined initially for sexual misconduct. Two (50%) were subsequently disciplined for failure to comply with the initial discipline order and the other two were subsequently disciplined for a standard-of-care issue that was not related to sexual misconduct.

Re-discipline is not uncommon with solo practitioners in the state of Washington and underscores the need for better identification of at-risk individuals and optimization of remediation. In 2017 the WMC implemented its compliance orientation program. This program assigns a respondent a compliance officer and schedules an orientation call and regular check-ins. This open line of communication aims to reduce subsequent discipline due to failure to understand or meet compliance requirements.

Recidivism Among International Medical Graduates

While Elkin et al.[7] investigated the frequency of complaints and disciplinary action against International Medical Graduates (IMGs), we found that there was little information about the specific discipline or penalties levied. Our data reveals that IMGs were less likely to be disciplined for inappropriate prescribing but more likely to be disciplined for negligent behavior.

Several potential explanations for an increased likelihood of disciplinary action in this population have been proposed. Previous discussions have revolved around the notion that IMGs may possess poorer communication skills, especially if they are from non-English-speaking nations.[8] In addition, they may not be familiar with cultural norms, which can make communicating effectively within a professional team, and with patients, difficult.[9]

After looking deeper into the allegations of neglect within the IMG population, the WMC's evaluation team concluded that 75% of the neglect complaints stemmed from communication issues. A lack of effective communication skills and familiarity with cultural nuances could increase the risk of patient complaints, leading to disciplinary action. However, it is unlikely that lack of communication and cultural differences alone explain our findings. Another explanation is that systemic discrimination may exist within the workplace setting for IMG providers, making them more likely to have a complaint filed against them. Coombs and King,[9] through a survey of 2,000 physicians in Massachusetts, reported that 44% of U.S. medical graduates believed that their IMG colleagues suffer from significant discrimination within the workplace. It is possible that a similar type of systemic discrimination permeates throughout medical regulation, ranging from initial complaint to disciplinary penalty. Confirming the presence of discrimination, defining its exact nature, and determining how it may pervade our disciplinary system will require further study.

Conclusion

As they see a trend of more complaints being filed and respondents becoming increasingly litigious, state medical boards may need to address their ability (and resolve) to help providers who commit offenses that require discipline and be proactive

Table 1
Complaints Received that Resulted in Initial Discipline

Complaint Allegations	Formal Actions	Informal Actions	Summary Suspension	Voluntary Surrender	Other	Total
Action in Another State/Jurisdiction	13	2			2	17
Criminal Conviction	2	2				4
Documentation		1				1
Failure to Comply	26	3				29
Malpractice Reporting	3					3
Mental Health, Physical Health	3	1	1			5
Misrepresentation/Fraud	1	1				2
Moral Turpitude	3					3
Patient Injury/Death		1				1
Practice Without a Valid License (Expired, Suspended, Revoked)	2					2
Sexual Misconduct	8	3				11
Standard of Care		3				3
Standard of Care/Services	18	39			1	58
Substance Abuse	4	9		1		14
Unprofessional Advertising		1				1
Unprofessional Gross Incompetence	1					1
Unprofessional Rx Distribution	4					4
Violation of Regulations or Rules	3					3

in their efforts to help them not reoffend. Definitive national data about the number of providers who could be considered recidivists per year are lacking. In addition to more research, medical boards should have a conversation regarding reciprocity. In our research, we see that many recidivists fall into the "reciprocity" loop, in which they are subsequently disciplined by another state medical board. The increase in recidivism due to reciprocity could be improved by having a discussion on how these actions are reported. State medical boards should discuss with the FSMB the monitoring and analysis of provider disciplinary actions and how that can be enhanced. Efforts to identify these providers is an important aspect of the medical profession's ongoing effort to protect patients and to ensure the delivery of quality care. ■

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