US legislators drive accountability measures

In comparison to Canada, the level of transparency and ease of use seem nothing short of astonishing. While Canadians must often dig through a maze of confusing links to find the performance records of their doctors (*CMAJ* 2008;178[1]:14-6), Americans can investigate a physician's disciplinary history by simply logging onto a national website, typing in the physician's name and paying a US$9.95 fee by credit card. A profile appears within seconds.

The website (docinfo.org) is operated by the Federation of State Medical Boards, a Dallas-based national nonprofit group that represents 70 state medical boards. Besides disciplinary history, DocInfo also provides educational background, medical specialty and licensure status, pulling the information from the Federation's national database of 750 000 licensed physicians.

Another site — docfinder.org — provides free profiles of doctors in 20 states that house physician information in the DocFinder database. Launched in 1996 by Administrators in Medicine, a professional organization of state medical board executives, the site allows multistate searches and, depending upon the state, sometimes provides more disciplinary information than DocInfo.

The information on both sites is provided by state medical boards, which receive and investigate complaints about physicians practising within their states. A growing number of boards allow complaints to be filed online.

Unlike Canada, where provincial governments have essentially allowed provincial colleges to establish their own standards for overseeing the complaints process and disclosing the outcomes, the American system is largely driven by legislatively mandated disclosure requirements.

Like provincial medical boards in Canada, state boards are empowered by each state's Medical Practices Act to discipline physicians found to be incompetent or acting unlawfully or unprofessionally. Offences can include substance abuse, insurance fraud, sexual abuse, controlled substance violations, physical or mental impairment and violations of professional or moral conduct. Possible board actions can range from licence revocation, suspension or probation to fines, reprimands and restitution payments.

diane39 / iStockphoto.com

Nearly 5600 disciplinary actions were reported by state medical boards in the United States in 2006. Two-thirds of US states have now passed legislation requiring medical boards to publish disciplinary findings online.

Medical boards are structured differently from state to state. They exercise varying authority and operate under different budgetary constraints. Some are supervised or controlled by larger state regulatory agencies or state departments of health, while others operate autonomously. Funding comes from state governments or directly from physician licensing fees. Most boards are composed of volunteer physicians and members of the public, appointed by the governor, with support from an administrative staff.

Although methods for complaint intake and dispensing of sanctions are similar for all boards, the processing of complaints differs, says Tim Miller, the Federation of State Medical Board's senior director of government relations and public policy. "Some are streamlined and have delegated a lot of decision-making to the executive director and staff."

Others have more convoluted processes, with decision-making handled by committees. Although no objective surveys have compared board effectiveness, streamlined boards that delegate authority to staff seem more able to act quickly on complaints and bring them to a speedy conclusion, Miller says.

The system is far from perfect, but has been significantly bolstered by the legislative requirements over the past decade. There needs to be more standardization, says David Swankin, president of the Washington, DC-based Citizen Advocacy Center, which supports public members who serve on state health boards.

No national standards exist for offences or punishments; sexual abuse, for example, is defined differently in different states. Leering at a patient can constitute an offence in some states but in others, offences are limited to physical acts, he says. Punishments vary, too. Some states may require offenders to be chaperoned when treating female patients. Others may suspend a doctor's licence. "There's no national standard for anything," says Swankin, an expert in physician discipline.

In 2006, the Federation of State Medical Boards issued an updated "Essentials of a Modern Medical Practice Act" to encourage the adoption of national standards for medical boards. It also published a report defining physician sexual misconduct and making recommendations for investigating and disciplining doctors who contravene the law.

Obtaining information about physician discipline has become much easier as state legislatures and medical boards moved to make information available on the Internet. In 1996, Massachusetts passed the first law stipulating that information about the state's physicians be published online. Two-thirds of states have now passed similar laws.

Miller says legislatively mandated sites are usually more comprehensive, but virtually all state medical boards provide at least some measure of information. Some are very basic — name, licence number, licence status and indication of a disciplinary history, leaving it to consumers to contact boards for details.

For example, Utah consumers are

directed to an on-line summary report, while a detailed report is available for US$12. Other states provide full details online. Some also post disciplinary sanctions from hospitals, the federal government, and civil or criminal courts. "One of them even tells you if they take MasterCard," says Swankin. "It's just chock full of information."

10 operated under a mandate. Some 18 of 20 top-scoring states provided information about malpractice settlements, while 15 included information about criminal convictions and 13 provided hospital discipline information. The survey urged state lawmakers to adopt steps to make disciplinary information more comprehensible and searchable.

The system is far from perfect, but has been significantly bolstered by legislative requirements.

Information on malpractice claims and settlements are handled carefully, if at all. Some have a financial threshold above which settlements are reported. Others provide no settlement figures. Some remove malpractice information after 5 or 10 years; others leave it up permanently. "It's a tough sell to put up malpractice information," says Swankin. "Physicians and medical societies don't like to see it. They say it's totally deceptive."

Massachusetts is the model, Swankin says. Recognizing that physicians in some specialties are more likely to be sued than others, the state's board compares doctors only to others in their speciality, and offers guidance before providing details about malpractice suits. With studies showing no correlation between malpractice history and a doctor's competence, the site states: "you could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history." Information about the malpractice history of the physician's speciality is then provided, along with the individual physician's history of malpractice payments, expressed as "below average," "average," or "above average."

A 2006 survey of doctor disciplinary information on state board websites by Washington, DC–based Public Citizen found that New Jersey, Virginia and Massachusetts ranked highest, with North Dakota scoring lowest. The top 10 states were all required by legislation to display profiles. Only 1 of the bottom

Until the public site was launched in 2001, Federation disciplinary information was only available to hospitals, insurance companies and state medical boards. Now, if disciplinary action has been taken, the physician profile — which costs US$9.95 per physician — specifies the state medical board involved, the date and type of action, and the reasons for it. But information on malpractice claims or settlements isn't included.

Loopholes that previously allowed physicians with revoked licenses in 1 state to practise in other states have been closed. Since 2002, the Federation's Disciplinary Alert Service has notified boards by e-mail within 48 hours when a licensed physician has been disciplined in another state. Before issuing new licenses, state boards can query the database. They can also search the National Practitioner Data Bank, an electronic repository of information on disciplinary actions, hospital privilege restrictions and medical malpractice payments, which is not open to the public. Many states have also changed confidentiality laws to allow medical boards to share information about investigations. Thus a doctor under investigation in one state loses any window of opportunity to obtain a license in another state before disciplinary action is taken.

Even in the litigious United States, boards are seen to serve an important role in protecting the public, with their power to set and enforce minimal standards of expected practice, and to impose sanctions for actions that don't rise to the level of malpractice. "They [boards] can look at things you just can't sue over," Miller says. "For example, violation of privacy. It's very difficult to sue over violation of privacy, but you can get disciplined for it very easily."

The number of complaints received and rectified each year by state boards, Miller notes, greatly outnumbers the number of malpractice suits. In 2006, state boards reported 5574 disciplinary actions. Yet only a fraction of injured patients advance their case to lawsuit stage: roughly 2%–10%, according to several studies. A US Bureau of Justice report that looked at malpractice insurance claims in 7 states between 2000 and 2004 found that most malpractice suits ended without a settlement. — Janet Rae Brooks, Salt Lake City, Utah

DOI:10.1503/cmaj.080209

More bang for the taxpayer's buck

Consider it a milestone for public access to the findings of publicly funded research. Commencing this April, researchers funded by the US National Institutes of Health will be required to send copies of their final manuscripts to the National Library of Medicine's PubMed Central database, where they will be made available to the general public 1 year after publication in peer-reviewed journals.

A National Institutes of Health directive issued Jan. 11, 2008, mandated that researchers comply with the federal agency's public-access policy, which was initially implemented as a voluntary measure in 2005. But a provision of a $940-billion spending bill signed into law by President George W. Bush in December 2007 moved the bar from requesting to requiring.

Researchers, libraries, citizens and patient advocacy groups pushed lawmakers for the change after less than 5% of researchers voluntarily submitted copies of their manuscripts to PubMed Central.

Proponents say the change will speed medical progress, improve hu-