



## The physician and the police officer

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● It's good news for physicians that a number of state licensing boards are expediting the process of reviewing complaints against physicians and clearing the backlogs of cases. According to a recent *American Medical News* article, the Florida Board of Medicine has cut the complaint resolution time from 18 months to just over 3 months.\* They accomplished this by increasing their staff by hiring 50 new employees and consultants. Although it's tough to justify the increased expenditure, it may be worth the additional funds if cases against physicians are adjudicated more rapidly.

The few surgeons that I know who have undergone serious medical licensing board scrutiny have found it an exhausting, emotional, and very expensive process. It may only take a few months from notification of an investigation to a final decision (dismissal of the charges or a disciplinary action), but to the accused physician, it can seem like a lifetime. Since even a complaint is a mortal wound, no physician can ever be convinced the process is appropriate. But other than the intense desire that their names be cleared and their reputations restored, those I have spoken to wished most for a speedy process.

While shortening the review process is an advantage, much more needs to be done. The appeals process must also be

streamlined. I know a superb orthopedist whose license was unfairly revoked for 6 months by the infamous former New York State Health Commissioner, David Axelrod, who unilaterally overruled the Board recommendation of no sanction. He appealed and was told that his appeal would be heard in 7 months, during which time he was not allowed to practice. It was bad enough that he didn't deserve the sanction, but it was inexcusable that he was denied a timely appeal.

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Another component of the process that is in desperate need of modification is reentry into clinical practice after license revocation. A surgeon in Brooklyn asked for my interaction in negotiating a reeducation process with the state licensing board. The rehabilitation was performed under my direct supervision and that of

the medical school; it took 3 years and was intense. The surgeon successfully completed all components of the multistep process, and frankly, did a terrific job. At the reapplication hearing, he was asked by the committee what was the first thing he would do if his license to practice medicine was restored. He responded that he would take his wife out to dinner to thank her for being so supportive during this difficult period. I think this was an appropriate response, but the board disagreed. The surgeon's application was denied because his answer was not remorseful enough. He was told he could reapply in 1 year, at which time he was successful. What a travesty! It is inexcusable to make a surgeon wait an additional year to practice after he fulfilled all the board's objective criteria, based on the subjective impression of a small committee. Once a rehabilitation process, including its time frame, is agreed upon, reentry to practice should be expedited and not dabbled with.

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In addition to describing the new efficiencies in complaints review, the *American Medical News* article also reported an increase in the number of physicians that have been sanctioned.\* My first concern is that efficiency and the frequency of disciplinary decisions were linked. They are clearly separate issues and must be treated as such by the licensing boards. Speeding tickets provide an adequate simile. If traffic courts shorten the time from citation to court appearance does that justify the issuance of more speeding tickets? I don't think so. If you had your choice, would you recruit more traffic court judges or

more police officers? That's not a tough decision. Police departments allege they don't have quotas for summonses. State licensing boards are not entitled to quotas for physician sanctions.

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Although I sound critical of the state licensing bureaus, and I often am, they have a tough job. It may be straightforward to restrict the license of a physician who is a sexual predator, a drug abuser, or a narcotic prescription felon, but it's far from simple to document that a physician is incompetent.

What makes a physician incompetent? Is it one error or one lapse in judgment? If that were the case, none of us would be practicing. Physicians are mortals and we all make mistakes. If the definition of incompetence is a pattern, how many bad cases constitute a series? Is it two, three, four, or more? I have reviewed a lot of charts for hospital risk management processes, attorneys, and organizations. Rarely is it perfectly clear that a decision or action represented bad care. It's also important to remember that in contrast to malpractice suits, in critical reviews, the action need not necessarily result in an injury to a patient; gross negligence alone is adequate for sanctioning.

I am certain that many of you have also reviewed charts. Retrospective reviews are not always intrinsically fair. Decisions sound very different in the isolation of a conference room, months after the event, without the influence of the family, nurses, and case managers. It's much easier to make correct clinical plans in hindsight and in a vacuum than in the wards, sur-

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gical intensive care unit, or operating room. Yet physicians are judged by their performance under fire.

How should a review board respond to clinicians who, on review, recognize that they have made an error? Should they be chastised and punished or reeducated and supported? Adverse actions are necessary, but I certainly don't think licensing boards should gloat about how many physicians they have punished. There are other viable alternatives.

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Several organizations, including the American Board of Surgery and the American College of Surgeons, are working hard to define competency and make the criteria objective. Hopefully, this will provide ammunition in the battle against physician inadequacy or ineptitude.

The public is entitled to be treated by safe and capable physicians. Physicians also have rights, one of which is efficient, fair, and objective assessment. Medical licensing boards are our police, judges, and juries. They should be proud of expediting reviews in response to patient complaints. But rather than focusing on punishing more physicians (increasing the quota of summonses), they should invest their increased resources to ensure physicians are judged using objective criteria and, to the degree possible, reeducate and rehabilitate those who don't meet the competency standard. ●●

#### **Reference**

\*Adams D. More doctors disciplined as states bolster medical boards. *American Medical News*. 2004;47(16):1.