

Part I

Medical Licensure, Credentialing and Privileging, Profiling, and Impairment

Chapter 2

Medical Practice: Education and Licensure

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The “Right” to Be a Physician
Medical School Admission Criteria
Medical School Retention and Graduation

Medical Licensure
Conclusion

Medical education—from admission to medical school to completion of postgraduate training—occurs in a definite legal framework. Both the student and the state enjoy certain legal rights and duties.

State licensure to practice medicine and surgery is also basic. The requirements for licensure and the ways in which that medical licensure may be lost or curtailed are many.

More than 400 years ago Shakespeare observed, “Oh, how full of briers is this working-day world.”¹ This observation is still true for medicine today. This chapter points out the briers.

THE “RIGHT” TO BE A PHYSICIAN

There is no vested property or constitutional right to attend medical school. However, acceptance to a medical school class may not be based on any violation of the applicant’s general civil rights nor may requirements be arbitrary or capricious. A medical school may not employ quotas but may employ some affirmative action in selecting students.

The relationship of the medical student and the school is an enforceable contractual one. Some courts have

held that a student admitted to medical school has a “liberty right or interest” mandating procedural due process necessary for administrative problems and substantive due process for disciplinary situations. The general rule is one of fair play in making rules regarding information, discipline, and punishment.

MEDICAL SCHOOL ADMISSION CRITERIA

Each medical school, public or private, can establish its own admission standards. The admission criteria must be uniformly applied to each candidate. The primary area of legal interest in medical school admissions is that of affirmative action admissions programs, which make race, gender, or ethnic origin a factor of greater or lesser degree in the acceptance decision.

Early medical school admission cases focused on a variety of legal theories. The courts have allowed the return of entrance application fees under a theory of false pretenses when the standards used for admission were not in keeping with those advertised in the medical school’s bulletin.² Professional schools have been ordered to award degrees to students who were denied admission or retention on an arbitrary or unreasonable basis.³

8 Medical Practice: Education and Licensure

Judicial Review

Judicial review of the medical school admissions process on constitutional equal protection grounds requires the existence of “state action” sufficient to trigger the provisions of the applicable constitutional provision or federal statute. In *Cannon v. University of Chicago* a female student’s suit under the federal gender and age discrimination statutes was denied as failing to state a cause of action due to a failure to prove the existence of state action.⁴

In a decision foreshadowing the *Bakke* decision, the Court of Appeals of New York held that a strict scrutiny standard of review applied to racial reverse discrimination in medical school admissions. The New York court did not discuss less restrictive alternatives available to the university because the cessation of the minority admissions program still would not have entitled the plaintiff to a place in the incoming class.⁵

The Bakke Decision

The seminal court decision involving medical school admission requirements is that of *University of California Regents v. Bakke*.⁶ In that case Mr. Bakke was denied admission to the University of California, Davis Medical School because his credentials failed to meet the standards required for admission as a nonminority applicant. School policy established a quota-based affirmative action program, setting aside 16% of the available places in the entering medical class for minority applicants, defined as “Blacks, Chicanos, and Asian Americans.” Bakke’s entrance scores were higher than those of certain persons accepted under the minority entry program. Thus, but for Bakke’s race and ethnic origin, he most likely would have been accepted for entry into medical school.

Bakke sued, claiming a violation of the Equal Protection Clause of the U.S. Constitution and Title VI of the 1964 Civil Rights Act. No clear majority opinion developed from the U.S. Supreme Court’s review of the case. Six separate opinions were written, with no more than four justices agreeing on any one chain of reasoning behind their decision. Evaluation of the *Bakke* decisions is thus somewhat difficult.

Four justices of the Court held that the university’s plan was completely constitutional. Four held that the quota plan was in violation of Title VI but failed to reach the constitutional equal protection issue.

Justice Powell cast the swing vote. He considered Title VI primarily a codification of the constitutional equal protection standard, and thus the applicable standard of review was identical under either a constitutional or statutory evaluation. Powell, applying a strict scrutiny standard of review, considered race to be a valid factor in the evaluation of potential medical school candidates but stressed that the quota system was not necessary to achieve the university’s desired goal and thus was not permissible. The four-justice group led by Justice Brennan agreed with Powell’s approach (allowing the use of race as a factor in the admissions process) but considered the applicable standard of review

to be an intermediate level of scrutiny, as is applied in gender discrimination cases, such as *Craig v. Boren*.⁷

The *Bakke* decision did not answer all questions. The decision established that affirmative action programs in a medical school admissions process could be structured to avoid constitutional legal protection violations and further that certain types of affirmative admissions programs, such as quota-based systems, were a violation of equal protection rights. The difficulty of *Bakke* was that the court failed to articulate a definitive standard of review for affirmative action admissions programs.

Reaction to Bakke

Reaction to the *Bakke* decision was mixed both during the case and after the decision was rendered. The National Conference of Black Lawyers and the National Lawyers Guild, for example, urged that the Supreme Court refuse to hear the case at all on the grounds of inadequate records regarding possible past racial discrimination by the university.⁸

The U.S. Supreme Court had previously refused to decide a similar case on the merits, declaring the matter moot because the student in question was about to complete his legal education.⁹ On remand the Supreme Court of Washington upheld its earlier decision holding the minority admissions policy of the university to be valid.¹⁰

General Rule

Generally, affirmative action minority placement programs for medical schools are permissible, as long as race is not used as the sole determining factor in the evaluation process. State action requirements must be established before a standard of review is applicable.

The Americans with Disabilities Act

The 1990 Americans with Disabilities Act (ADA) provides that “no qualified individual with a disability shall by reason of such disability be excluded from participating in or be denied the benefits of the services, programs, or activities of a public entity.”¹¹ This mandate requires medical schools, both public and private, to make “reasonable accommodations” in evaluating applicants.¹² Case law on the ADA is still unsettled.¹³ Requirements for accommodation may include granting candidates additional time to take entrance examinations, providing a reader for the sight-impaired or dyslexic candidate, and perhaps instituting a different standard of review for a disabled candidate’s undergraduate transcript and grades.

MEDICAL SCHOOL RETENTION AND GRADUATION

The primary concern of most medical students is successful graduation. Numerous suits have occurred as a result of student dismissals on academic or disciplinary grounds.

The nature of legal challenges raised in an attempt to prevent academic dismissals is quite varied.

Academic Dismissal

Once accepted into the medical school program at a public institution, students are deemed to have a liberty or property interest in the continuation of their medical school education and in eventually receiving their medical degrees. Private medical schools, although not subject to Fourteenth Amendment due process itself, are subject to the standards set by accreditation requirements and any standard or procedures that have been internally adopted.

It is essential that the medical school administration pay attention to the due process requirement during an academic dismissal proceeding. Strict adherence to due process protects the student's rights and helps reduce the risk of future litigation by the student.

Academic dismissals (i.e., those based on poor academic performance or failure to complete the requirements for graduation) are evaluated differently than are disciplinary dismissals. The institution must give the student notice of the potential dismissal, but traditional legal procedures for fact-finding, such as for a hearing, are not legally required. Academic dismissals may arise from strict academic performance or clinical performance standards.

A key case on academic dismissals is *Board of Curators of the University of Missouri v. Horowitz*.¹⁴ Therein the U.S. Supreme Court ruled that in the case of academic dismissals notice of the impending dismissal was required to be given to the student, but a formal hearing was not mandatory. The Supreme Court based its decision on the long tradition of judicial deference to academic discretion and the belief that the academic evaluation of a student is more properly placed in the academic setting rather than the courtroom.

Post-*Horowitz* decisions have tended to uphold medical schools' decisions for academic dismissal over procedural due process challenges of medical students. In most cases medical schools have provided procedural protections far beyond the scope required by *Horowitz*, including multiple forms of notice and multiple opportunities for academic hearings and inquiry before final dismissal on academic grounds. In *Sanders v. Ajir*, for example, the court held that a student going through the dismissal process on two separate occasions, with two levels of hearing on each occasion, had been afforded a level of procedural protection in excess of the requirements set by *Horowitz*.¹⁵

When academic hearings have been offered to a student before academic dismissal, court decisions have not required the same degree of formal procedural protection that has been required in other Fourteenth Amendment property or liberty settings. Most academic procedures do not provide for the presence of an attorney during hearings or for a formal transcript of the proceedings. Records consisting of the initial notice of dismissal and a summary of the final decision of the academic hearing committee are sufficient. The dismissal panel often questions witnesses, including faculty members, outside the presence of the student. Hearings are thus informal and nonadversarial. The hearings

normally consist of the student making a statement to the appeals board and then answering questions.

Even in the post-*Horowitz* cases that have required a hearing, the court has required only that the student be given the opportunity to explain his or her poor scholarship and to provide any additional information that might lead to an expectation of future satisfactory performances.¹⁶

Disciplinary Dismissal

In contrast to academic dismissal, disciplinary dismissal entitles the student to a greater standard of procedural protection. Disciplinary dismissal of students occurs on the basis of nonacademic considerations, usually specified in a formal academic code of conduct by the medical school. Reasons for disciplinary dismissal include plagiarism, cheating, and disruptive behavior. The legal requirements for due process in disciplinary dismissal cases include provision of notice to the student of the intended dismissal, an opportunity to be heard, and an opportunity to rebut the school's grounds for dismissal.

Disciplinary dismissal due process directly parallels protection afforded individuals before the deprivation of a liberty or a property interest. An example is *Goss v. Lopez*.¹⁷ In *Goss* the U.S. Supreme Court held that a high school student could not be suspended for improper behavior without being given notice of the charges against him or her, an explanation of the evidence, and an opportunity to present his or her side. The standard for procedural process is the *Matthews v. Eldridge* test, which weighs the strength of the private interest, the strength of the state interest, the risk of error under the current procedures used, and the probable value of additional or substitute procedural safeguards.¹⁸

Substantive Due Process Claims

Substantive due process consists of the concept that the individual is entitled to a decision that is not arbitrary or capricious, when a liberty or property interest exists. Educational institutions cannot act in an arbitrary way or in a capricious manner. In a dismissal case the burden of proof is on the student to demonstrate that the decision was arbitrary or capricious, that is, that no real basis for dismissal existed or malice, bad faith, or ill-will existed on the part of the medical school or its acting employees. Exercise of discretion by the medical school in terms of retention based on academic failure has not been considered to be arbitrary or capricious action by the courts.

In contrast, the mandatory dismissal of a student for first-year academic failure, when three other students with an equal or greater number of failures were allowed to repeat the first year, was judged arbitrary by a New York court at the trial level, but the decision was reversed on an appeal.¹⁹ In Michigan a court ruled against the medical school when a student was singled out on the basis of his initial score on the National Board of Nursing Examination (NBNE) and was deprived of his opportunity to retake the test along with 40 other students from the same school who had failed the same part of the examination.

10 Medical Practice: Education and Licensure

Mere general allegations by a student that a particular grade or dismissal was improper usually fail to meet the requirements of proof to establish arbitrary, capricious action by the medical school. In contrast, if the student can demonstrate by objective evidence how he or she was singled out for disparate treatment from fellow students, the chances of proving arbitrary and capricious behavior on the part of the medical school are considerably enhanced.

Contractual Relations Between Medical School and Student

Related to the concept of substantive due process is the use of contractual claims by the student to establish procedural or substantive legal rights. The trend of the courts has been to construe liberally the terms of the contract in favor of the medical school. This approach is typical in educational contract cases. However, it is at variance from the more traditional viewpoint that a contract should be construed strictly with respect to the person drafting the contract, in this case the medical school.²⁰

Handicapped Students

The ADA, originally enacted by Congress in 1990, is changing how medical schools and all other schools approach handicapped students.²¹ This act requires medical schools to make "reasonable accommodations" for students with certain physical and mental disabilities. Dyslexia, narcolepsy, drug and alcohol dependency, and mental disorders all fall within the scope of disabilities and certain protections of the law, along with the more traditional physical handicaps.²² Little case law has as yet developed.

Substance and Content of Medical School Education

Increasingly the demands to include new information in the medical school curriculum (e.g., courses on acquired immunodeficiency syndrome [AIDS]) have produced a problem of serious dimensions in medical school class scheduling. The phenomenon can be seen both within the medical school educational process and the process of health care law instruction within the legal community.²³

The AIDS crisis exemplifies the difficulty of providing education and maintaining medical ethics within the medical school process. The medical student is presented with the dilemma when assigned to a rotation that requires treatment of AIDS patients. AIDS demonstrates the potential for new requirements of specific substantive courses within medical school education by state law, a step that would be historically unique within the medical school process.²⁴

Substance of content requirements also has been increasingly dictated in a variety of other areas, on both a voluntary and an involuntary basis.²⁵ These trends point to the tendency toward further standardization of the medical school education process.

House Officers

A medical school graduate is required to complete at least one year of postgraduate training or residency, usually in a hospital. Many then go on to advanced training programs, further residency training, and fellowships certified by a variety of organizations.

In the past, house officers were considered employees and were subject to the whim of the hospital administration. California case law, noting the impact of the arbitrary cancellation of a house officer's contract on his or her career, imposed the requirement of a due process hearing, with all its protections.²⁶

Clinical training programs raise potential questions in the area of medical malpractice. There is considerable divergence among jurisdictions on the standard of care for residents in the academic medical context. Although *Rusk v. Akron General Hospital* represents the position that a special standard of care is applicable for residents within the clinical context, more recent cases suggest that the standard of care to be applied should be the standard of a general physician or the standard of the specialty in which the resident is being trained.²⁷⁻²⁹ Although there appear to be no reported cases covering the standard of care for medical students, the medical student, intern, or resident must be aware that he or she could be held to the standard of care applicable to the attending physician supervising his or her education and clinical process.³⁰

In addition, the team-teaching approach presents informed consent issues. Consent is specific to the individual physician. Thus consent given by the patient to allow the attending physician to engage in a procedure does not automatically grant consent for the procedure to be performed by proxy (e.g., by a resident or intern), even if the procedure is done at the attending physician's or senior resident's request.³¹ In the academic medical context, several possibilities for liability arise that do not normally arise within the private practice setting. The attending physician and student must be aware of the potential for liability, take steps to ensure proper consent on the part of the patients, and maintain the highest possible standards of care.³²

MEDICAL LICENSURE

Theory and Requirements

Power of the State

To exclude any incompetent practitioners, the state may require that professionals obtain a license to practice medicine and to perform surgery. The practice of medicine is viewed as a privilege granted by the state licensure board.³³ The state has a right to continue to evaluate a physician's professional practice. "The right of a physician to toil in his profession ... with all its sanctity and safeguards is not absolute. It must yield to the paramount right of government to protect the public health by any rational means."³⁴

Licensing statutes are justified under a state's sovereign power to protect the health and welfare of its citizens.

Medical practice acts create and define the composition of a state medical board, define the requirements for licensure, and vest the board with the authority to license candidates. The state medical board is mandated to regulate the practice of medicine in the public interest and to advance the medical profession. Establishing and vigilantly enforcing standards of conduct to ensure the competence and the scruples of physicians are the responsibilities of the board. This stewardship is viewed by courts as an entrustment by the state and is subject to judicial review.

Licensure statutes were originally designed to exclude the untutored, unskilled, and incompetent from the practice of medicine by certifying a minimally acceptable qualification of training, knowledge, and competence after evaluating and certifying submitted credentials. In a landmark case in 1898 the U.S. Supreme Court stated that licensure powers could be extended beyond credentialing to include standards of behavior and ethics. The case held that, in a physician, "character is as important a qualification as knowledge."³⁵ Sanctions may include denial of license, revocation of license, suspension of license, probation, oral or written reprimands, imposition of monetary fines, and censuring.

The authority of the courts to oversee the licensing of physicians also is mandated by statute. The courts, however, seldom intercede until the physician has completely exhausted his or her administrative remedies, unless the licensing board has acted wholly outside of its jurisdiction. At the conclusion of the administrative proceedings, the courts typically intervene only when the physician successfully argues that the licensing board violated the physician's constitutional rights, acted outside of its jurisdiction, or failed to follow its own rules and regulations.

Types of Licensure

Virtually all state medical licenses are unlimited (i.e., unrestricted to any particular branch of medicine or surgery). Thus the holder of a medical license may take routine histories and do physical examinations or perform specialized neurosurgery under the same license.

Some states have a restricted license for postgraduate training, such as residency. Other states issue limited or special licenses governed by specified restrictions.³⁶ In some cases the credentialing process is delegated de facto to the supervising institution. Physicians in state hospitals or correctional facilities sometimes hold licenses restricted to such institutional use. Again, the respective state legislature, medical board, or both, sets forth the specific types of licensure available in that state.

Obtaining a License

As a necessary function of its duty to protect the public interest, a state board may require physicians and related practitioners to demonstrate a certain degree of skill and learning. It may also include conditions of licensure bearing a direct, substantial, and reasonable relationship to the practice of medicine, such as a statutorily specified amount of malpractice insurance coverage, before the licensee may practice medicine. In exercising its licensing authority the

state has the inherent power to determine precisely the qualifications the applicant must possess. It may investigate educational credentials, professional competence, and moral character. The applicant bears the burden to prove his or her fulfillment of all requirements for licensure.

U.S. citizenship was once required for medical licensure, but that requirement was struck down by the U.S. Supreme Court in 1973 as unconstitutional discrimination. Another barrier to licensure was a residency requirement of a specific number of months. That requirement also was struck down as discrimination that only furthered the parochial interest of state physicians. Closely related to residency restrictions is reciprocity licensure. A state is not required to license a physician merely because he or she holds a license in another state; otherwise the state would be obligated to automatically grant a license to everyone who holds a license in every other state. Thus reciprocity is neither constitutionally discriminatory nor an infringement on a physician's rights and privilege of practice. Most states also have established a minimum age of 21 years for licensure.

Invariably, "good moral character" is required for licensure. A typical reason for denying a license on that ground is a prior criminal conviction, even if the crime on which the conviction was based has no obvious connection with the practice of medicine. Such candidates must be prepared to demonstrate total rehabilitation. The nature of the offense is a material consideration. For example, a licensing board should be prepared to differentiate between a trespass conviction arising out of a 1970s antiwar demonstration and the offense of grand larceny.

State requirements of educational achievement for licensure vary but have generally been upheld. Educational requirements cannot be arbitrary and must be rationally related to competence. Requirements of preprofessional education and professional education from "accredited schools" have been held reasonable and valid.³⁷ Experience requirements of postgraduate education are likewise considered to be rational, reasonable, and valid. If an individual's experience has provided comparable or superior education but licensure required a diploma, it has been held that the diploma requirement was not capricious or arbitrary and did not deprive one of a constitutional right of due process or equal protection.³⁸ Requiring malpractice insurance, a recent mandate in at least one state (Idaho), was upheld as reasonable because it bears a rational relationship to the welfare of citizens.

Supervision and Disciplinary Sanctions

Grounds for Discipline

Until a few years ago, licensure sanctions against physicians resulting from inadequate patient care were few and far between, in large part because of the reluctance of physicians to report or take action against colleagues. In particular, physicians feared that their colleagues who were reported would sue them for libel, slander, or restraint of trade. In addition, the boards were nearly impotent, having more restricted investigative abilities and less sanctioning authority than they enjoy today.

12 Medical Practice: Education and Licensure

Recently, however, courts have held hospitals and physicians liable for failure to “ferret out” bad physicians. Legislatures have given administrative agencies new power and have granted immunity to honorable informants and their authorized listeners. Licensing boards no longer have to wait for a formal report or complaint; they may now begin an inquiry and proceedings on their own initiative.

Grounds for discipline of the medical licensee are generally set forth in statute as “unprofessional conduct”³⁹ or violation of the Medical Practice Act.

The least precise ground for disciplinary action is the allegation of unprofessional, immoral, dishonorable, or gross misconduct.^{40–44} Such concepts are difficult to define. It is manifestly impossible to categorize all of the acts subject to discipline. Such unspecific and vague standards are enforceable because there is a common professional understanding of what the public interest requires. Precise definitions made by the state medical boards are usually left intact, but on occasion the courts reverse them and impose their own definitions. As long as a board bases its finding of unprofessional conduct or gross misconduct on expert testimony (on the record) as to the proper standard of care, the board should be upheld.

Discipline on grounds of incompetence is also somewhat vague and difficult to define. Incompetence is not established by rare and isolated instances of inadequate performance; rather, repeated defects in the exercise of everyday skills are the gist of such complaints. In rare cases a single act of gross negligence is so wanton that it sufficiently demonstrates incompetence.

Fraud and deceit in the practice of medicine are grounds for discipline; most often fraud or deceit is alleged when a physician bills a third party (Medicare or an insurance company) for work he or she did not perform. Fraud or deceit in nonprofessional activities is an offense more often in the nature of moral turpitude or immoral conduct.

A felony conviction empowers the board in most states to revoke a license.⁴⁵ In some states, revocation cannot occur until all appeals have been exhausted. Misconduct in another state also may be grounds for revocation. Fraudulently obtaining a license or aiding and assisting an unlicensed practitioner in the practice of medicine also are grounds for revocation.

Medical boards have become increasingly active in dealing with physicians who practice while impaired by alcohol or controlled substances. Some states track these physicians through the traditional disciplinary route. Other states have formally established diversion recovery programs that give physicians an opportunity to avoid formal disciplinary proceedings if they quickly agree to comprehensive treatment, supervision of their medical practice, and random testing.

Defenses to Disciplinary Charges

One of the most common practitioner defenses is that due process of law was denied by the board’s commingling of investigative and adjudicatory functions within the same administrative agency. Courts have generally rejected this argument, stating that, absent a showing of bias, there was not sufficient risk of prejudice to taint the decision.⁴⁶

Occasionally, disciplinary proceedings are brought years after the alleged improper conduct of the physician, most often because of the initial unwillingness of witnesses to come forward or because of the lengthy processes in state and federal courts. Generally a defense of inordinate delay in prosecution for an alleged offense from the too distant past, though valid in criminal and civil judicial proceedings, has been considered an invalid defense in administrative disciplinary proceedings.⁴⁷ However, some states specifically include a statute of limitations. Whether or not he or she practices in one of the few states with a statute of limitations on medical board disciplinary proceedings, the physician can defend by asserting the “equitable doctrine of laches.” This doctrine protects defendants in cases of an unexcused delay in bringing a disciplinary procedure that is inequitably prejudicial to the defendant.

Entrapment is a defense that asserts that law enforcement agents coerced, tricked, induced, or persuaded the defendant physician to commit an offense that would not have been committed if not for the agents’ conduct. Entrapment may be a valid defense, but in a few cases the defense has been rejected as being limited to criminal proceedings.⁴⁸

Evidence gained by unlawful search and seizure may sometimes be suppressed and may constitute a successful defense. Courts typically explore the policies underlying the exclusionary rule before automatically applying it to professional licensure proceedings.⁴⁹ However, this evidence is not always subject to the usual prohibition because of the necessity of strict supervision in certain highly regulated business activities (e.g., firearms or narcotics).⁵⁰

Double jeopardy (the risk of double punishment for a single offense), alleged in instances of multiple license revocations, has been held an invalid defense. In addition, a board may impose discipline even when the physician has prevailed in a related criminal proceeding and the principle of double jeopardy does not apply.⁵¹

A defense of recovery from an impairment (with or without monitoring from an impaired physician committee) or assertion of the right to resume practice after voluntary surrender of license is not in and of itself a defense in sanction proceedings. Typical board considerations when recovery is alleged include establishing that the impairment was the cause of misconduct, that the subject has indeed recovered, that the recovery has arrested the threat to public health and safety, and that relapse is unlikely.

Presentation by a convicted felon of a “certificate of rehabilitation” under a “Rehabilitated Convicted Offenders Act” is not a dispositive defense. Proof of a degree of rehabilitation does not preclude a license authority from disqualifying applicants.⁵²

A jurisdictional challenge based on voluntary surrender of (or failure to renew) a license depends on whether the physician retains any remaining rights to revive the license. Furthermore, the state can assert an interest in going forward with its proof at a time when evidence and witnesses’ memories are fresh.⁵³

R.P. Reeves has described the defense of winning by “intimidation.”⁵⁴ Such defenses include “tying up” board

members or assistant attorneys general and staff with repeated requests for continuances, voluminous discovery requests, subpoenas for spurious documents or witnesses, floods of character witnesses, applications for stays, and collateral attacks in federal court.

Finally, physicians facing disciplinary charges have tried to bring federal civil rights actions under 42 U.S.C. §1983. Because boards are sitting in both their prosecutorial and quasi-judicial capacities when carrying out disciplinary functions, board members and their staffs are usually granted absolute immunity from such suits.⁵⁵ Physicians who bring such suits also may be ordered to pay the attorney fees of their successful opponents.

Disciplinary Proceedings after Formal Charges Are Filed

The license to practice medicine and surgery is a right substantive enough to warrant compliance with all the requirements of due process (i.e., proper notice of charges, notice of the hearing before a properly constituted tribunal, the right to cross-examine and produce witnesses, and the right to a full consideration and fair determination based on the facts).⁵⁶

Proper notice need not be exact and formal, but it must be sufficient to permit a full opportunity to prepare an adequate defense.⁵⁷ Hearings, which are usually required by statute to be public, are typically held before a hearing officer or, because of financial constraints, the board en banc without a hearing officer. The structure of the hearings is controlled by statute or agency rules. Some boards employ a hearing officer who reviews the records of the investigative officers and makes findings of fact, conclusions of law, and recommendations. Other boards employ a hearing officer to sit only as a judge who rules on motions and the admissibility of evidentiary documents while the board sits as a jury. Other board cases are tried by a subcommittee of the entire board, and the subcommittee then reports its findings and recommendations to the board en banc.

In whatever process is devised under state law, full opportunity must be given to challenge the testimony of adverse witnesses and other evidence in a proceeding before the full board.⁵⁸ The right to appear with counsel is uniform. During the pendency of the formal adjudicatory hearing, the board, as the decision-maker, must be sufficiently separated from its own investigative agents so that it may be free from bias and prejudice.⁵⁹

The rules of evidence in a board hearing are not identical to courthouse rules of evidence. Hearsay testimony, both written and oral, is commonly admissible as long as it goes to prove an issue and sustain a finding. The evidence must be substantive. Whether the evidence must be sufficient to establish a "preponderance," a "clear preponderance," "clear and satisfactory proof," or "clear and convincing proof" varies by state.⁶⁰

The final decision, rendered by a hearing officer or a board en banc, must adopt specific findings of fact, which is a concise and explicit statement of the events supporting the decision. It also must contain conclusions of law in a

form that permits judicial review. Appeals to the judicial process generally are limited to reviews, not retrials. Stays pending further appeal are within the discretion of the court.⁶¹ Courts are sometimes prohibited by statute from granting such stays, but even then a court can intervene with a stay if the physician successfully asserts that he or she is likely to prevail on a procedural due process claim. When a board has determined its sanction, courts are generally reluctant to interfere unless persuaded that there has been a clear abuse of discretion.

Discovery

Efforts to determine the nature and extent of witnesses against a defendant physician before the time of hearing are termed *discovery*. The administrative law process does not normally offer opportunity for full use of normal pretrial discovery. Depositions, interrogatories, requests to produce, requests for admission, and inspection of site usually may not be used to determine the strength and intensity of the state board's case.

Recusal of Board Members

Generally, state administrative law provides a mechanism to request the recusal of any board member who "cannot accord a fair and impartial hearing or consideration."⁶² Usually that request must be accompanied by an affidavit and must be promptly filed upon discovery of the alleged disqualification, stating with particularity the grounds on which it is claimed that a fair and impartial hearing cannot be accorded. This threshold issue must be determined quickly by the board.

This pretrial remedy must be exercised with care. An unsuccessful or frivolous attempt to disqualify a board member may ignite other board members' passions against the defendant physician. Historically this remedy is rarely sought in the administrative law process and is rarely granted. There is a strong presumption that the administrative tribunal is unbiased.⁶³ However, if evaluation of the case and the board's process indicates substantial grounds that make recusal necessary, it should be strongly considered.

Attorney Fees

Some states' statutes provide that, when an administrative proceeding is brought without reasonable basis or is frivolous, the board may become liable for the licensee's attorney fees.⁶⁴ This statute is powerful. Under the proper circumstances it can be an "equalizer" to help the defendant physician retain his or her rights. Making aggressive demands for attorney fees and putting the agency on notice may give a defendant physician leverage in settlement negotiations or may result in the dismissal of charges.

Sanctions

All state boards have laws authorizing sanctions, some more detailed than others.⁶⁵ License revocation is the most severe sanction available because its term is indefinite, usually "forever placing the offender beyond the pale."⁶⁶ Other sanctions include suspension, probation,

14 Medical Practice: Education and Licensure

written or oral reprimand, censure, curtailment of professional activities, oral or written competency exam, community service, re-education, and monetary fines.

Restoration of a revoked license requires a petition and review process that could take years to complete. If the cause was physician impairment and if a board so chooses, a surrendered license may be restored without protracted and formalized procedures if and when demonstrated recovery can be established. Suspension of a license is similar to a revocation, except that it is for a limited period of time.

Probation is a formalized sanction in which a formal surveillance procedure is initiated. Terms and conditions of probation must be set forth in the board order. Systematic and periodic reviews are implemented, typically for years, especially when related to mental illness or substance abuse/dependence, because relapse remains a valid concern years later.⁶⁷

Reprimand (a formal and sharp rebuke of record) and censure (a judgment of fault and blame of record) are intended to induce a mending of ways. They are lenient sanctions when other sanctions are deemed too severe. In practice, such actions are more effective as a means of defining minimal acceptable levels of conduct than as a means of disciplinary enforcement. Licenses may be restricted to prohibit writing any prescriptions, to prohibit writing Schedule II controlled drugs, to limit hospital practice, or to limit all practice beyond supervised positions in state hospitals or teaching centers. In the past, restricted licensure has been used to provide supervision of the wayward, but this practice has fallen from favor because of an insufficient emphasis on the rehabilitation of restricted physicians.

Sanctions are generally imposed only after the physician has received notice and an opportunity to be heard in the adversary proceeding, with witnesses, cross-examination, and the like as set forth earlier. However, if a board determines that there is an imminent and material danger to patients or public health, safety, and welfare, a summary suspension, and later hearing, can be imposed. However, the physician is entitled to a prompt, postsuspension hearing that concludes without appreciable delay.⁶⁸ Summary suspension is the single exception to the rule that sanctions are imposed only after a full hearing.

Sanctions to protect the public are the primary responsibility of the medical board. Public opinion has become increasingly critical of the paucity of revocations, inadequate supervision, and investigative impotence.⁶⁹ A perception persists that professional compassion for a colleague can sacrifice public protection and that some sanctions are inconsistent, lenient, and seemingly ineffective. Contributing factors to the inadequacy of the boards include court-issued stay orders, injunctions, appeals, new trials granted on technical grounds, inadequate financing, and resistance by defense attorneys, hospital administrators, and district attorneys.

National Collectors of Disciplinary Data

Three national clearinghouses currently collect disciplinary data on physicians. These data are retained and made

available to other boards in states where a physician may hold a license, principally in response to reports of physicians “jumping jurisdictions” after disciplinary action is taken in one state of licensure.

The Federation of State Medical Boards in Fort Worth, Texas, has maintained a national clearinghouse on physician discipline for several years.⁷⁰ The federation collects information about disciplinary actions taken by the 65 member jurisdictions and then transmits a summary of those actions to each of the other jurisdictions on a monthly basis. State medical boards can then contact a sister state and obtain details of disciplinary action taken against a physician who is also licensed in their state.

A part of the 1986 Health Care Quality Improvement Act (Pub. L. 99-660) established the National Practitioner Data Bank.⁷¹ Like many federal projects, the data bank was initially slow to receive adequate funding and slow to get under way. The legislation included a requirement that hospitals must query the data bank at least every 2 years about all physicians on their staff. Medical boards and certain others also may query the data bank. Federal law requires medical boards and hospital staffs that impose a curtailment on a license of more than 30 days to report that incident to the data bank.

The third national clearinghouse will be under the Health Insurance Portability and Accountability Act (HIPAA) (see Chapter 16).

Appeals

Judicial review of an administrative decision usually is limited to determining whether the administrative agency acted arbitrarily, capriciously, or fraudulently; whether the order was substantially supported by the evidence presented; or whether the administrative agency's actions were within the scope of its legal authority as created by the statute. Although courts review a decision of law made by the administrative agency, decisions regarding the credibility of evidence and witnesses ordinarily are a matter for the administrative agency itself and are overturned only if they are clearly contrary to the weight of the evidence. Courts seldom intervene to substitute their judgment in determining a sanction or an assessment of mitigating circumstances.

Although there is no fundamental right to appeal an administrative decision, virtually all jurisdictions grant appeal by state statute. Licensees have fought any limitation of the appeals process by arguing that such limits would compromise access to the judicial process and limit board accountability.

Typically, courts restrict appeals to the appeals process specified by statute. This restriction could result in denying judicial access until the board has had a rehearing or the petitioner has exhausted all other administrative remedies. Some statutes typically limit judicial appeals to those approved by the board, known as *by leave appeals*, as opposed to those allowed by right. Courts typically limit their scope of review to the issues of law. Rarely, however, courts have granted a new trial as part of the appeals process, as if no administrative proceeding had occurred.

As a practical matter, some state courts may choose to review cases however they like, accepting limits that suit their convenience or needs. On one hand, they may choose to protect a licensee from administrative arbitrariness with strict scrutiny.⁷² On the other hand, they may choose to accept virtually all board findings with routine affirmance.

Restoration of a License

Restoration of a license after revocation or suspension is a matter of serious concern for the public, the profession, and the physician. The odds of restoration are against the physician. And the physician clearly bears the burden of proof to demonstrate that there has been a substantial change of conditions in his or her qualifications, practice methods, or both since the discipline was originally imposed. The process of reinstatement has no due process entitlements, supposedly because reinstatement fights are not substantive enough property rights to warrant such protection.⁷³

A surrendered license cannot be used to avoid a restoration process and consequent hearing and sanction. Licenses so surrendered are deemed final. In suspension, as compared with revocation, resumption of practice is automatic. There also is an early automatic reinstatement for a licensee who has failed to pay a routine renewal fee.

In the restoration process, a petition must be submitted (usually after at least one year) to initiate a preliminary investigative process. The investigation might involve an interview of the petitioner, review of character references, and contacts with other law enforcement agencies. The board might take steps to ensure that those providing character references are fully familiar with the facts the board found that led to the initial loss of license. Board concern focuses on rehabilitation and maintenance of skills, and it always keeps the public interest in mind. If a restoration petition is denied, reconsideration, future resubmission, or court challenges are available as alternative appeals. A court appeal of a denied reinstatement petition has virtually no chance of success because the decision is left to the board's discretion. A board may require a minimum waiting period before resubmission of a reinstatement petition.

CONCLUSION

Physicians and the medical services they provide greatly affect public health, safety, and welfare. Because of that impact and the historically high-profile nature of the medical profession, state government has the authority to regulate medical education and to erect a medical licensure process. The state also exercises a continuing jurisdiction over the professional activities of licensed physicians and may impose sanctions thereon. Currently the pendulum of public opinion is swinging to favor more oversight and accountability of physicians, rather than less.

Endnotes

1. Shakespeare, *As You Like It*, Act 1, Scene 3.
2. *Steinberg v. Chicago Medical School*, 354 N.E. 2d 586 (Ill. App. 1976).
3. *DeMarco v. Chicago Medical School*, 352 N.E. 2d 356 (Ill. App. 1976); *In re Florida Board of Bar Examiners*, 339 So. 2d 637 (Fla. 1970).
4. *Cannon v. University of Chicago*, 559 F. 2d 1063 (7th Cir. 1977).
5. *Alevy v. Down State Medical Center* 384 N.Y.S. 2d 82 (1976).
6. *University of California Regents v. Bakke*, 438 U.S. 265 (1978).
7. *Craig v. Boren*, 429 U.S. 190 (1976).
8. Smith, *A Third Rate Case Shouldn't Make Hard Law*, Jurisdoctor 31 (Feb. 1978).
9. *DeFunis v. Odegaard*, 416 U.S. 312, 94 S.Ct. 1704, 40 L.Ed. 2d 164 (1974).
10. *DeFunis v. Odegaard*, 529 P. 2d 438 (Wash. 1974).
11. Pub. L. 101-336, 104 Stat. 327 (codified at 42 U.S.C. §12101 *et seq.*). An excellent discussion of the ADA is found at Jones, *Overview and Essential Requirements of the Americans with Disabilities Act*, 64 Temple L. R. 471 (Summer 1991).
12. 42 U.S.C. §12181.
13. As examples, see *Kaltenberger v. Ohio College of Podiatric Medicine*, 162 F. 3d 432 (6th Cir. 1998); and *El Kouni v. Trustees of Boston University*, 169 F. Supp. 211 (D. Mass. 2001).
14. *Board of Curators of the University of Missouri v. Horowitz*, 96 S.Ct. 948 (1978).
15. *Sanders v. Ajir*, 555 F. Supp. 240 (W.D. Wis. 1983).
16. *Ross v. Pennsylvania State University*, 445 F. Supp. 147 (M.D. Penn. 1978).
17. *Goss v. Lopez*, 95 S.Ct. 729 (1975).
18. *Matthews v. Eldridge*, 424 U.S. 319 (1976).
19. *Ewing v. Board of Regents University of Michigan*, 742 F. 2d 913 (6th Cir. 1984), *cert. granted* 53 U.S.L.W. 3687 (U.S. Mar. 25, 1985).
20. *Lions v. Salva Regina College*, 568 F. 2d 200 (1st Cir. 1977).
21. 42 U.S.C. §12101 *et seq.*
22. S. Rep. No. 116, 101st Cong., 1st Sess. 22 (1989); H.R. Rep. No. 485, 101st Cong., 2d Sess. 56 (1990).
23. *Teaching Health Law, A Symposium*, 38 J. Legal Educ. 489-497, 505-509, 545-554, 567-576 (Dec. 1988).
24. J.W. Burnside, *AIDS and Medical Education*, 10 J. Legal Med. 19 (Nov. 1, 1989).
25. Allen R. Felhous & Robert D. Miller, *Health Law and Mental Health Law Courses in U.S. Medical Schools*, 15 Bull. Am. Acad. Psychiatric Law 319 (Dec. 1987).
26. *Enehiol v. Winkler*, 20 Cal. 3d 267, 142 Cal. Rptr. 418, 572 P. 2d 32 (1977).
27. *Rusk v. Akron General Hospital*, 84 Ohio App. 2d 292, 171 N.E. 2d 378 (1987).
28. *McBride v. United States*, 462 F. 2d 72 (9th Cir. 1972).
29. *Pratt v. Stein*, 298 Pa. Super. 92, 444 A. 2d 674 (1982).
30. Ben A. Rich, *Malpractice Issues in the Academic Medical Center*, 36 Del. Law J. 641-646 (Dec. 1987).
31. *Id.* at 652.
32. Harold I. Hirsch, *The Evils of Admitting Private Patients to Hospitals with Teaching Programs: A View from Outside the Ivory Tower*, 16 Legal Aspects Med. Prac. (Nov. 1988).
33. See, e.g., 59 O.S. 2001, §620.
34. *Lawrence v. Board of Registration in Medicine*, 239 Mass. 424, 428, 132 N.E. 174 (1921).
35. *Hawke v. New York*, 170 U.S. 189, 194 (1898).
36. See, e.g., 59 O.S. 2001, §493.4.
37. *Dent v. West Virginia*, 129 U.S. 114, 123 (1888).
38. *In re Hansen*, 275 N.W. 2d 700 (Minn. 1978).

16 Medical Practice: Education and Licensure

39. See, e.g., 59 O.S. 2001, §509.
40. This includes false or deceptive advertising. Many states have specific statutes and regulations providing for discipline on this ground.
41. *Brun v. Lazell*, 172 Md. 314, 191 A. 240 (1937) (revocation of license to practice dentistry based on guilty plea to criminal charges of indecent exposure).
42. *Raymond v. Board of Registration in Medicine*, 387 Mass. 708, 443 N.E. 2d 391-394 (1982) (where the board disciplined a physician upon his conviction for possession of unregistered submachine guns the court held that "lack of good moral character and conduct that undermines public confidence in the integrity of the medical profession are grounds for discipline").
43. *Urlick v. Comm. Board of Osteopath Examination*, 43 Pa. Commonw. 248, 402 A. 2d 290 (1979) (court upheld licensure revocation for committing a crime of moral turpitude where the physician was convicted of conspiracy to use the mails to defraud and conspiracy to unlawfully distribute and possess Schedule II controlled substances).
44. *Lawrence v. Board of Registration in Medicine*, 239 Mass. 424, 428, 430, 132 N.E. 174 (1921) (gross misconduct in the practice of medicine is not too indefinite as a ground for discipline).
45. Includes felonies clearly unrelated to the practice of medicine, such as income tax evasion.
46. *Withrow v. Larkin*, 421 U.S. 35 (1975).
47. Note that a statute of limitations defense was not valid to block admission into evidence in a licensure proceeding; a felony conviction more than 3 years old was admissible, even where that state required that legal actions be commenced within 3 years. *Colorado State Board of Medical Examiners v. Jorganson*, 198 Colo. 275, 599 P. 2d 869 (1979).
48. See generally R.P. Reeves, *The Law of Professional Licensing and Certification*, 255-257 (1st ed. 1984).
49. See, e.g., *Emslie v. State Bar of California*, 11 Cal. 3d 210, 520 P. 2d 991, 1000 (1974) (rule not applied to attorney disciplinary action); *Elder v. Board of Medical Examiners*, 241 Cal. App. 2d 246, 50 Cal. Rptr. 304 (1966), cert. denied 385 U.S. 101 (1967) (rule applied in disciplinary action against physician).
50. *United States v. Biswell*, 406 U.S. 311 (1972).
51. *Arthurs v. Board of Registration in Medicine*, 383 Mass. 299, 418 N.E. 2d 1236 (1981).
52. *Hyland v. Kehayas*, 157 N.J. Super. 258, 384 A. 2d 902 (1978).
53. See *Cross v. Colorado. State Bar of Dental Examiners*, 37 Colo. App. 504, 508, 552 P. 2d 38 (1976) ("It is logical and sensible that where such grave charges of... unprofessional or dishonorable conduct are alleged, the Board has the right to preserve (any) evidence... of these charges otherwise witnesses may disappear and the passage of time itself may well dim or even eradicate the memory of the witnesses and thus preclude the construction of an adequate record.")
54. R.P. Reeves, *The Law of Professional Licensing and Certification*, 258 (1st ed. 1984). But such tactics may lead to assessment of attorney fees or costs in some states, 12 O.S. 2001, §941B and 75 O.S. 2001, §318D.
55. See, e.g., *Horowitz v. State Board of Medical Examiners of Colorado*, 822 F. 2d 1508 (10th Cir.) (members of state medical board absolutely immune for actions in connection with suspension of podiatrist's licensure), cert. denied 484 U.S. 964 (1987); *Vakas v. Rodriguez*, P. 2d 1293 (10th Cir.), cert. denied 469 U.S. 981 (1984); see *Batz v. Economou*, 438 U.S. 478, 508-517 (1978).
56. *Johnson v. Board of Governors of Registered Dentists of the State of Oklahoma*, 913 P. 2d 1339 (Okla. 1996).
57. *Bloch v. Ambach*, 528 N.Y.S. 2d 204 (N.Y. App. Div. 1988).
58. *Physicians and Surgeons*, 61 Am. Jur. 2d. §105 (1981).
59. *Morrissey v. Brewer*, 408 U.S. 471, 92 S.Ct. 2593, 33 L.Ed. 2d 494 (1972).
60. See, e.g., *Johnson v. Board of Governors of Registered Dentists*, supra note 56.
61. See, e.g., 75 O.S. 2001, §319.
62. See, e.g., 75 O.S. 1991, §316.
63. *Schneider v. McClure*, 456 U.S. 188, 102 S.Ct. 1665, 72 L.Ed. 2d (1982); *National Labor Relations Board v. Ohio New & Rebuilt Parts, Inc.*, 760 F. 2d 1443 (6th Cir.), cert. denied 474 U.S. 1020 (1980).
64. See, e.g., 12 O.S. 2001, §941B, and 75 O.S. 2001, §318.
65. See, e.g., 59 O.S. 2001, §509.1.
66. Derbyshire, *Offenders and Offenses*, 19 Hosp. Prac. 981 (1984).
67. Shore, *The Impaired Physician, Four Years After*, J.A.M.A. 248: 3127 (1982).
68. See *Barry v. Barchi*, 443 U.S. 55, 66 (1979); *Ampueto v. Department of Professional Regulation*, 410 So. 2d 213 (Fla. D.C. App. 1982) (6-month delay in postsuspension hearing found unreasonable).
69. See 18 Hosp. Prac. 251 (1983) (10-year saga of a license revocation).
70. Federation of State Medical Boards, 2630 West Freeway, Suite 138, Fort Worth, TX 76102-7199.
71. Codified at 42 U.S.C. §11101 et seq.
72. R.P. Reeves, supra note 48, at 276.
73. *Hicks v. Georgia State Board of Pharmacy*, 553 F. Supp. 314 (Ga. 1982), citing *Meachum v. Fano*, 427 U.S. 215, 228 (1976).