9.4.3 Discipline & Medicine

Incompetence, corruption, dishonest, or unethical conduct on the part of members of the medical profession is reprehensible. In addition to posing a real or potential threat to patients, such conduct undermines the public's confidence in the profession. The obligation to address misconduct falls on both individual physicians and on the profession as a whole.

The goal of disciplinary review is both to protect patients and to help ensure that colleagues receive appropriate assistance from a physician health program or other service to enable them to practice safely and ethically. Disciplinary review should not be undertaken falsely or maliciously.

Individually, physicians should report colleagues whose behavior is incompetent or unethical in keeping with ethical guidelines.

Collectively, medical societies have a civic and professional obligation to:

(a) Report to the appropriate governmental body or state board of medical examiners credible evidence that may come to their attention involving the alleged criminal conduct of any physician relating to the practice of medicine.

(b) Initiate disciplinary action whenever a physician is alleged to have engaged in misconduct whenever there is credible evidence tending to establish unethical conduct, regardless of the outcome of any civil or criminal proceedings relating to the alleged misconduct.

(c) Impose a penalty, up to and including expulsion from membership, on a physician who violates ethical standards.

AMA Principles of Medical Ethics: II, III, VII

Background report(s):

CEJA Report 3-A-16 Modernized *Code of Medical Ethics*

Report of the Judicial Council A-I-75 Medical discipline

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AMA Principles of Medical Ethics: II, III, VII

(Judicial Council - A)

REPORTS OF STANDING COMMITTEES OF THE HOUSE OF DELEGATES

JUDICIAL COUNCIL

The following report was presented by Henry I. Fineberg, M. D., Chairman, Judicial Council:

A. MEDICAL DISCIPLINE
(Reference Committee G, page 293)

HOUSE ACTION: FILED with commendation of the Council for initiating study on medical discipline

BACKGROUND

The American Medical Association has always been concerned with professional discipline. It is a continuing and ongoing concern of the Association that standards of professional conduct be constantly maintained and improved, if possible.

In November 1958, the Board of Trustees of the American Medical Association authorized the appointment of the Medical Disciplinary Committee to investigate medical discipline. Pursuant to its objectives, the Committee examined the disciplinary procedures of medical societies, hospital medical staffs and state medical boards; reviewed existing laws and regulations on medical discipline; and recommended certain procedures to maintain adequate standards of medical discipline. That Committee submitted its report to the Board of Trustees in 1961 and was discharged. In June 1961, the House of Delegates of the American Medical Association approved the conclusions and recommendations of the Committee, with minor amendments, and assigned the function of the Committee to the Judicial Council as one of its continuing activities.

The Medical Disciplinary Committee recommended, among other things, that medical schools acquaint students with ethical and socioeconomic principles, that state medical boards improve state disciplinary mechanisms and procedures, and that state medical associations increase their disciplinary efforts. The utilization of grievance committees of state and county medical societies to investigate patient complaints, for instance, has been an important and long-lasting recommendation of that Committee.

The Medical Disciplinary Committee concluded that physicians should "maintain an active, aggressive, and continuing interest in medical disciplinary matters..." Various segments of the American medical community have maintained this interest and made recommendations concerning medical discipline. The American Medical Association, for example, prepared model state legislation on discipline of physicians suffering from alcoholic, drug abuse, or mental problems. This statutory proposal was intended to be a paradigm that could be modified to suit the particular language of any state's legislation on medical practice.

It has been over fourteen years since the Medical Disciplinary Committee's recommendations and conclusions were disseminated. The Judicial Council is of the opinion that updated guidelines on professional discipline would benefit physicians, medical societies and the public. For this reason, the Judicial Council is again examining medical discipline and anticipates the cooperation of local and state societies and other interested parties.

THE ISSUE

Traditionally, medical disciplinary procedures have been conducted on three fronts, involving medical societies, state medical boards, and hospital medical staffs. Medical societies and hospital medical staffs have usually served a nongovernmental function in disciplining physicians. The sanction of a medical society may be to settle a dispute between a patient and a physician before its grievance committee or to expel a physician from the society for professionally irresponsible conduct. The sanction of a hospital, through its medical staff and bylaws, may be to deny a physician staff privileges and access to use of hospital facilities. A state medical board, though, may suspend, restrict or revoke a physician's license to practice.

The power to affect a physician's license to practice is the most serious disciplinary action that can be taken. Unfortunately, given limitations of available staff, investigatory opportunities, and funding, state medical boards may be unable to function as well as they could in disciplinary matters. Facing such limitations, a state board may have to concentrate more on licensing than on discipline.

Discipline by medical societies has, for the most part, been based on the physician's conduct in relation to his patients, his colleagues, and the public. A medical society may order the physician to take corrective measures to modify his conduct or face suspension or revocation of his membership in the medical society. Such discipline is extremely effective, for membership in the medical society is an important and valuable asset for the physician. Greater emphasis should be placed on discipline at this level, and there should be closer cooperation between the medical society and the state medical board.

Discipline by a hospital medical staff under its bylaws can and should relate primarily to the physician's professional competency. This well defined form of peer review is not widely known to the public, but it is an effective mechanism for maintaining the standard of medical care in the hospital. There should be a more direct relationship between hospital medical staff action and state medical boards.

POSSIBLE ALTERNATIVES

In some states, peer review systems combined with remedial education have been used; in other states, continuing medical education programs have been established, in part, to avoid the need to discipline underinformed physicians. Recent legislation in several states has attempted to broaden the disciplinary categories that may come before the state medical board. Other legislation has been enacted to improve the reporting of disciplinary actions and to otherwise improve the system of medical discipline. Some of these efforts may be effective. Some may be counterproductive and fail. Therefore, it is the opinion of the Judicial Council that some of the following alternative procedures may be of assistance to the state and local societies and others in dealing with this problem.

First, the peer review systems combined with remedial education and the continuing medical education programs that have been established represent a worthwhile effort that should be encouraged. Practicing physicians may be able to learn more from their fellow physicians, from the combined information that can be exchanged on the empirical results of various scientific procedures, than from any other source. Such educational programs should help to minimize the need for disciplinary procedures.

Such systems and programs, however, are not sufficient, in and of themselves, to satisfy the high requirements that the profession of medicine establishes for itself. In addition, the state and

local medical societies and the hospital medical staffs should assume a greater role in the disciplinary process. State legislation could require state and local medical societies and hospital medical staffs to report final disciplinary actions taken by them against a physician. Such legislation could also hold the reporting physician or hospital immune from liability for making such reports. The availability of such information would reinforce the state medical boards' capacity to discipline.

The expertise that is available among the membership of state and local medical societies, medical specialty societies, and hospital medical staffs should be available to assist state medical boards in investigating complaints or allegations made in disciplinary proceedings. Special committees of both medical and specialty societies could be authorized to assist the state medical board. Each hospital medical staff could be authorized and required to obtain from the state medical board a certification that each physician on its staff is duly licensed to practice medicine in the state and such other information as the hospital medical staff may require. The hospital medical staff could be further authorized and required to report the extent of practice privileges granted to each physician on its staff and any limitations or later disciplinary action taken by the hospital medical staff. Appropriate statutory immunity from liability should be provided for any activity authorized to so assist the state medical boards, thereby assuring that such valuable and competent assistance will be readily available.

The function and financing of state medical boards themselves should also be improved. A state medical board should have investigatory powers, preferably including its own investigating and legal staff. This would allow more time and effort to be devoted to professional discipline.

A state medical board should have the statutory power to allow ongoing evaluations of professional competency to be made. This might take several different forms, such as approved continuing education courses, specialty board examinations, or regular state board review of peer review committee actions.

Finally, the state boards should not be solely dependent on a general revenue budget annually authorized by the state legislature. Such a system defeats long-range planning and may emasculate governmental disciplinary functions. A better approach would be to make the state board financially self-sustaining. License and renewal fees could go directly to the state board and could be budgeted separately by the board. Fees so collected should be sufficient to cover the costs incurred by the state board in properly fulfilling its functions.

CONCLUSIONS

The foregoing alternatives are not being recommended as final and definitive solutions at this time. These alternatives and others will be studied by the Judicial Council, and the Council will report further to the House of Delegates on this matter. The Judicial Council will seek the advice, assistance and cooperation of medical societies, physicians, and other interested parties on this subject before reporting further to the House.