DOCTORS PLAYING LAWYERS: LESSONS FOR PROFESSIONAL REGULATION IN CRISIS

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Abstract:

When someone gets in legal trouble in America, their case is almost invariably decided by a lawyer (a judge), lay people (a jury), or a combination of the two. Professional discipline, however, is a giant unexplained exception. In professional discipline matters, accusations of dangerous or incompetent practice are decided, usually in the first instance but always in the last, by state licensing boards composed of other members of the accused's profession. These licensing boards wield immense power as labor regulatory institutions, covering ten times as many American workers as the minimum wage and more workers than private and public sector unions combined.

Given how unusual this setup is, there has been surprisingly little study of professional discipline within any academic field—and virtually none within law. This inattention is troubling not only because of professional discipline's immense footprint, but also because of the potential for widespread social harm. That potential is most obvious in health care, which accounts for approximately two-thirds of licensed professionals. But even in professions outside of health care, like engineering and accountancy, unethical or incompetent practice can cause wide-spread social harm. The decision-makers controlling whether bad actors can continue to practice have no experience in policy, regulation, or adjudication. They are playing lawyers without really knowing how.

This article is the first comprehensive assessment of professional discipline's regulatory design. It argues that the busy volunteer professionals who handle disciplinary matters lack the regulatory expertise, training, and standards necessary to ensure public safety and provider competence. Fortunately, other jurisdictions offer promising models for reform. We compare the American system

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to that in the United Kingdom, which demands more legal expertise, decision guidance, and non-professional perspectives. To add rigor to the comparison, we provide two new hand-coded datasets—one from a US state and one for the UK, showing that disciplinary outcomes are more appropriately harsh in the UK. We argue, in conclusion, that a similar model in the United States would be promising step forward.

Keywords: Health Care; Professional Licensing; Professional Discipline; Opioid Crisis; Physician Sexual Abuse; Licensing Board; Medical Board

INTRODUCTION

When someone gets in legal trouble in America, their case is almost invariably decided by a lawyer (a judge), lay people (a jury) or a combination of the two. The exception to this is when the accused is a professional– whose practice is so dangerous or unethical that his or her professional license is at stake. In these cases, the accused's right to practice is decided, usually in the first instance but always in the last, by other members of the accused's profession sitting on a state licensing board. How well does this system work?

Reports in the media suggest that it does not work very well. Wondery's 2018 "Dr. Death" podcast revealed that even after receiving multiple credible complaints, the Texas Medical Board failed to halt the bloody career of neurosurgeon Dr. Christopher Duntsch, who maimed and killed dozens of his spinal surgery patients out of ineptitude or something more sinister.[1] In 2021, the Atlantic ran a long-form piece that included a discussion of the Tennessee Board of Nursing's feeble response to the "Rock Doc"—a nurse practitioner who prescribed large-dose opioids without exams, made violent threats against patients and colleagues on social media, and had sex with patients (apparently in exchange for prescriptions).[2] And a multi-year investigation by the Atlanta Journal-Constitution (AJC) found that two thirds of physicians disciplined by the Georgia Composite Medical Board for sexual misconduct were allowed to remain in practice.[3]

Structural features of the American professional disciplinary system suggest that these high-profile examples are the tip of a very large iceberg of misconduct that is ignored or tolerated by licensing boards. Yet legal academic attention to this problem has been scant.[4] That is a problematic omission, given that about thirty

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1 *See* Dr. Death, *Season 1: Dr. Duntsch, Episode 3: Occam's Razor*, WONDERY (Sept. 4, 2018), https://wondery.com/shows/dr-death/season/1 [https://perma.cc/6LCN-ZYTG].

2 *See* Olga Khazan, *The Hard-Partying, Rock-Obsessed Nurse at the Center of a Massive Opioid Bust*, THE ATLANTIC (Jan. 28, 2021, 10:28 PM), https://www.theatlantic.com/health/archive/2021/01/rock-doc-opioids/617405 [https://perma.cc/4XNK-Q2L8].

3 Carrie Teegardin et al., *Doctors & Sex Abuse; Part 1: License to Betray*, ATLANTA J.-CONST. (July 6, 2016), https://doctors.ajc.com/doctors_sex_abuse/?ecmp=doctorssexabuse_microsite_nav [https://perma.cc/5GUP-E83F].

4 Most of the legal academic work on professional discipline focuses only on one profession at a time (mostly on law and some on medicine), and none of these treatments deeply address regulatory design. For legal academic pieces on lawyer discipline, see Leslie C.

Levin, *The Emperor's Clothes and Other Tales About the Standards for Imposing Lawyer Discipline Standards*, 48 AM. U. L. REV. 1 (1994) [hereinafter Levin, *Emperor's Clothes*] (describing the inadequate outcomes of legal professional discipline, with little attention to the regulatory structure behind them); Leslie C. Levin, *The Case for Less Secrecy in Lawyer Discipline*, 20 GEO. J. LEGAL ETHICS 1 (2007) [hereinafter Levin, *Less Secrecy*] (focusing on one aspect of regulatory design for lawyer discipline: secrecy); Stephen Gillers, *Lowering the Bar: How Lawyer Discipline in New York Fails to Protect the Public*, 17 N.Y.U. J. LEGIS. & PUB. POL'Y 485 (2014) (presenting a qualitative empirical study of legal disciplinary cases from one state); Michael S. Frisch, *No Stone Left Unturned: The Failure of Attorney Self-Regulation in the District of Columbia*, 18 GEO. J. LEGAL ETHICS 325 (2005) (same). Deborah L. Rhode, who dedicated her career to studying the legal profession, has some discussion of legal discipline in two of her books, but it is not the focus of either. *See* DEBORAH L. RHODE, IN THE INTERESTS OF JUSTICE: REFORMING THE LEGAL PROFESSION 158–68 (2000); DEBORAH L. RHODE, THE TROUBLE WITH LAWYERS 87–120 (2015). Likewise, in his seminal article on the regulation of lawyers, David B. Wilkins discusses the failures of the legal disciplinary system in passing. David B. Wilkins, *Who Should Regulate Lawyers?* 105 HARV. L. REV. 799, 822–24 (1992). Outside of law, medicine is the profession with the most legal academic attention; several articles address discipline, but none addresses the regulatory design question head-on. *See* Nadia N. Sawicki, *Character, Competence, and the Principles of Medical Discipline*, 13 J. HEALTH CARE L. & POL'Y 285, 307–14 (2010) (arguing that disciplining doctors for crimes and misbehavior outside of practice does not protect the public) (arguing that disciplining doctors for crimes and misbehavior outside of practice does not protect the public); Jing Liu & David A. Hyman, *Physician Licensing and Discipline: Lessons from Indiana*, 18 J. EMPIRICAL LEGAL STUD. 629 (2021) (presenting an empirical study of physician discipline outcomes); Elizabeth Chiarello, *Barriers to Medical Board Discipline: Cultural and Organizational Constraints*, 15 ST. LOUIS U. J. HEALTH L. & POL'Y 55 (2021) (offering a sociological perspective on medical board behavior); Marc T. Law & Zeynep K. Hansen, *Medical Licensing Board Characteristics and Physician Discipline: An Empirical Analysis*, 35 J. HEALTH POL. POL'Y & L. 63 (2010) (presenting an empirical study of medical board outcomes).

million professionals[5]—or about a fifth of all American workers and about twice as many workers as are unionized[6]—are subject to this system of self-regulatory discipline. It is problematic, too, because of the power wielded by professionals and the public risk posed by their misconduct. The danger of bad practice is most obvious in health care, which accounts for approximately two-thirds of licensed professionals.[7] But even professionals outside of health care, like lawyers and engineers, hold lives in the balance.

One might think that having a reasonable system for removing manifestly unsafe and unethical providers from these professions is a given, and indeed the lack of scholarly attention to the question implies that many assume its existence. But the American professional disciplinary system described in this article falls dramatically short of what is needed to protect the public. The root of its dysfunction lies in the identity of those who hear the cases. In every profession, the accused is tried by a jury truly made up of his peers who take a few days out of their busy professional lives to moonlight as their own regulators. In nearly every instance, the decision-makers are given very little in the way of standards or law to apply, other than to do discipline in the name of the "health, safety and welfare" of

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5 This estimate is from original empirical research, based on public records requests from several states, by Rebecca Haw Allensworth for her book THE LICENSING RACKET: HOW WE DECIDE WHO IS ALLOWED TO WORK AND WHY IT GOES WRONG (2025). This estimate is conservative when compared to other academic accounts of the percentage of the workforce that is licensed. *See, e.g.,* Morris M. Kleiner & Evgeny Vorotnikov, *Analyzing Occupational Licensing Among the States*, 52 J. REGUL. ECON. 132, 134 (2017) ("As of 2015, about 25% of the U.S. workforce had attained an occupational license, with the vast majority doing so at the state level.") (citing *2016 Data on Certifications and Licenses (Current Population Survey)*, U.S. BUREAU OF LAB. STAT. (last modified Feb. 9, 2018), https://www.bls.gov/cps/certifications-and-licenses-2016.htm [https://perma.cc/CCY6-XRNG]); Beth Redbird, *The New Closed Shop? The Economic and Structural Effects of Occupational Licensure*, 82 AM. SOC. REV. 600, 600 (2017) ("As of 2012, over 32 percent of workers were required to hold a license to work in their chosen occupation.").

6 The Bureau of Labor Statistics estimates that about 10.0% of American workers belong to a union; most work in the public sector. U.S. BUREAU OF LAB. STAT., U.S. DEP'T OF LAB., USDL REP. NO. 24-0096, UNION MEMBERS — 2023, at 1 (2024), https://www.bls.gov/news.release/pdf/union2.pdf. The number of licensed workers is more than thirty times as many workers as are subject to the prevailing federal minimum wage or less. U.S. BUREAU OF LAB. STAT., BLS REP. NO. 1109, CHARACTERISTICS OF MINIMUM WAGE WORKERS, 2023 (2024), https://www.bls.gov/opub/reports/minimum-wage/2023/home.htm [https://perma.cc/7WS5-N6HV].

7 This estimate is based on public records requests made in May 2019 for licenses issued by the states of Tennessee, California, and Illinois, where approximately two thirds of licensees are for medical and healthcare professions. Data on file with authors.

the people of their state.[8] And in every profession except law, these decision-makers have no experience in policy, regulation, or adjudication. They are doctors (and nurses and engineers) playing lawyers.

This Article undertakes the first comprehensive legal-academic account of professional discipline in the United States. Our subject is the state licensing board, the only entity with the authority to say who can practice in a profession and how, and the only body with the ability to remove someone from the profession or put conditions on his practice in response to misconduct. These boards are creatures of state statutes, yet they are governmental in name only. In previous work, one of us (Rebecca Haw Allensworth) identified the 1,790 state licensing boards in the United States and coded their statutory composition.[9] Nearly every medical licensing board in the United States is dominated by physicians.[10] The duties of these poorly-understood regulators are roughly divided into three tasks: admitting people into the profession; deciding what constitutes appropriate professional practice; and disciplining noncompliant providers.[11] Each task is performed in the name of protecting patients and the public, but it is the last task—disciplining and de-licensing dangerous or unethical providers—that can feel most urgent in terms of public protection.[12]

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8 *See, e.g.*, Sawicki, *supra* note 4, at 317 ("[L]egislatures grant medical boards disciplinary authority pursuant to broadly worded medical practice acts authorizing discipline for, among other things, 'unprofessional conduct.'"); Levin, *Emperor's Clothes*, *supra* note 4, at 5 (observing the "vague, often unarticulated standards used by state decision-makers when imposing discipline" and arguing that they "raise[] serious questions about whether sanctions could be imposed fairly").

9 Rebecca Haw Allensworth, *Foxes at the Henhouse: Occupational Licensing Boards Up Close*, 105 CAL. L. REV. 1567, 1570, 1572–74 (2017).

10 Only one medical practice act in the United States (Rhode Island) creates a licensing board that is not dominated by medical professionals. In almost every case (60/62) that majority is made up of physicians alone; in two states (Montana and Delaware), the medical professional majority can be comprised of physicians and other providers like Advanced Practice Registered Nurses (APRNs) or Physician Assistants. *See* Medical Licensing Boards Composition Fifty-State Survey (on file with authors); *Id.* at 1574; *see also* Aaron Edlin & Rebecca Haw, *Cartels by Another Name: Should Licensed Occupations Face Antitrust Scrutiny?*, 162 U. PA. L. REV. 1093, 1139–40 (2014) (arguing that because most state licensing boards are dominated by active practitioners in the profession, they are not immune to antitrust suits under the Sherman Act).

11 *See* MORRIS M. KLEINER, LICENSING OCCUPATIONS: ENSURING QUALITY OR RESTRICTING COMPETITION? 29 (2006).

12 Although the imperative of public protections may *feel* most acute in discipline, the public is even more imperiled by poor licensing policy at the level of setting entry requirements,

To meaningfully assess how well licensing boards are performing their disciplinary function, this Article must first fill a gap left not only by scholarship but also by professional regulation itself, neither of which advances a theory for why and how to discipline a professional for misconduct.[13] Our theory defines the goals of discipline (client and patient protection) and explains when and how to use each of the four tools available in the disciplinary case: reprimand, probation with conditions, suspension, and license revocation.[14]

As measured by this public protection theory of discipline, the American licensing board system is in a state of crisis. Boards systematically fail to identify and stop dangerous professional practice. To the few published empirical studies of board discipline, we offer our own contribution: a hand-coded study of five years of disciplinary decisions by the Tennessee Board of Medical Examiners.[15] We find that in a high percentage of cases, the board kept in practice doctors who have engaged in egregious misconduct, including trading drugs for sex, selling forged prescriptions, or engaging in fraud.[16] We also present a case study in too-light

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practice restrictions, ethical codes, and scopes of practice. These restrictions each carry the possibility of reducing the supply of critical professional services—like medicine and law—and raising their cost, leading to wider-spread social harm than bad actors not removed by the disciplinary system. In this arena, too, professionals regulating themselves strike the wrong balance because of self-regulation. *See* HAW ALLENSWORTH, *supra* note 5; Rebecca Haw Allensworth, *The Hypocrisy of Attorney Licensing*, *in* RETHINKING THE LAWYER'S MONOPOLY (forthcoming 2025) (on file with authors).

13 Nadia Sawicki's article on medical boards' misplaced disciplinary focus on addiction, mental health, or illegal or immoral behavior outside of practice uses "public protection" as a theory of discipline, without elaboration. Nor does she attempt to match sanction to offense as we do in this article. *See* Sawicki, *supra* note 4, at 302–05. Likewise, professional groups describe the goals of discipline vaguely. They fail to explain when which sanction is appropriate and when second or third chances should be granted. *See, e.g.*, *About Physician Discipline*, FED'N OF STATE MED. BDS. [hereinafter *About Physician Discipline*, FSMB], https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/guide-to-medical-regulation-in-the-united-states/about-physician-discipline/ [https://perma.cc/P2B4-ZM29] (last visited Aug. 7, 2024) (explaining that "[b]oards safeguard the public by disciplining physicians who engage in unprofessional, improper, or incompetent medical practice" and describing the disciplinary tools boards have to do so).

14 *See* Melissa McPheeters & Mary K. Bratton, *The Right Hammer for the Right Nail: Public Health Tools in the Struggle Between Pain and Addiction*, 48 U. MEM. L. REV. 1299, 1332 (2018) (listing the common tools available for disciplining doctors).

15 *See infra* Part V.

16 *See infra* Section V.B.

discipline, that of Dr. Michael Lapaglia, who recently served a federal prison sentence for deeds enabled by the Tennessee Board of Medical examiners.[17]

The reasons for this regulatory failure are structural to the disciplinary system. Professionals fail as self-disciplinarians for two sets of reasons, one more recognized than the other. First, and more familiarly, they fail to be clear-eyed about professional dangerousness or incompetence because of who they *are*—colleagues of the accused, trained in the same manner and holding similar hopes, fears and professional pressures. Less recognized, and just as important, is what professionals sitting in judgment of their peers *are not*. They are not trained regulators. Not only are professionals regulating themselves not lawyers naturally conversant in policy and procedure, but even as lay regulators they get far less than what a jury receives in deciding a case—instructions on the law and detailed elements for each offense.

Defenders of self-regulation say that whatever risk of bias comes with self-regulation is offset by the professional expertise that these board members bring to the cases they hear.[18] But it would seem that a critical kind of expertise—in regulatory goals and methods—is traded off in the bargain. The result is a casual, collegial system for deciding professional disciplinary cases, which is refracted back through the disciplinary process to its inception at the complaint and investigation phase.

America is not the first jurisdiction to experiment with and ultimately learn about the perils of a self-regulatory disciplinary model for the professions. Until the early 2000s, the United Kingdom used a very similar system of professionals-judging-professionals to police the profession of medicine, until scandals led to a crisis of confidence and ultimately to regulatory reform. Today, the UK decides medical disciplinary cases using a tribunal that is formally separate from the authority that sets the entry and practice standards for medicine. This system more closely resembles the adjudicatory systems seen as fair in every other area of American law where one's case is heard by a combination of legal and lay decision-makers guided by transparent standards, not a true jury of one's peers given too little information and asked to go with their gut.

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17 *See infra* Part II; Rebecca Haw Allensworth, *Licensed to Pill*, N.Y. REV. BOOKS (July 21, 2020), https://www.nybooks.com/online/2020/07/21/licensed-to-pill/.

18 *See, e.g.,* Sylvia R. Cruess & Richard L. Cruess, Op-Ed, *The Medical Profession and Self-Regulation: A Current Challenge*, 7 VIRTUAL MENTOR 320, 322–23 (2005) (justifying self-regulation as necessary due to the discrepancy of knowledge between members of the profession and the general public).

Does the UK system work any better? To help answer this question, we also hand-coded two years of disciplinary decisions by the UK's medical disciplinary tribunal to facilitate a comparison to American professional disciplinary outcomes. Despite the obvious challenges that come with comparing cases against professionals working in very different health care systems, our data suggests that the UK is more appropriately harsh on physicians found to have engaged in major misconduct than the United States, where second chances are abound. We also offer a case study for comparison to Dr. Lapaglia's—that of Dr. Katie McAllister, who was ultimately removed from the register of physicians in the UK for providing a fatal overdose of prescription drugs to a friend.[19] We conclude that the United States should take some lessons from across the pond and overhaul professional discipline not only for medicine but for all the professions to be at least as well-informed, transparent, and procedurally fair as the system for physicians in the UK.

Offering an account of the failures of 1,740 licensing boards across fifty states, governing dozens of unique professions,[20] presents a challenge, to say the least. Indeed, the difficulty of making generalizable claims about board behavior is a likely reason for the lack of scholarship on the topic. To tackle this challenge, we rely on as many studies as we were able to find that cut across states or professions. And although our article applies broadly to the professional board disciplinary system, much of our evidence and examples comes from medicine. We focus on medicine for two reasons. First, although all professional systems of discipline are under-studied, physician discipline has received relatively more academic attention than others, most notably from within medicine itself.[21] Second, lessons from

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19 *See infra* Part V; McAllister, No. 7042366 (Med. Pracs. Tribunal Serv. Sept. 8, 2020) (record of determination), https://www.gmc-uk.org/ (select "Search the register" under "check a doctor's registration status," then search for "7042366," navigate to the "Registrant history" tab, and look for the Sept. 8, 2020 entry under the heading "Hearings").

20 *See* Haw Allensworth, *supra* note 9, at 1572–74.

21 *See, e.g.,* James M. DuBois et al., *Serious Ethical Violations in Medicine: A Statistical and Ethical Analysis of 280 Cases in the United States from 2008–2016*, 19 AM. J. BIOETHICS 16 (2019) [hereinafter DuBois et al., *Serious Ethical Violations*]; James M. DuBois et al., *Preventing Egregious Ethical Violations in Medical Practice: Evidence-Informed Recommendations from a Multidisciplinary Working Group*, J. MED. REGUL., No. 4, 2018, at 23 [hereinafter DuBois et al., *Preventing Egregious Ethical Violations*]; Tristan McIntosh et al., *Protecting Patients from Egregious Wrongdoing by Physicians: Consensus Recommendations from State Medical Board Members and Staff*, J. MED. REGUL., No. 3, 2021, at 5; James M. DuBois et al., *A Mixed-Method Analysis of Reports on 100 Cases of Improper Prescribing of Controlled Substances*, 46 J. DRUG ISSUES 457 (2016) [hereinafter DuBois et al., *100 Cases of Improper Prescribing*].

medicine are generalizable to other professions using self-regulatory systems of discipline. Medicine is the prototypical American (and British) profession, and its governance structure has served as the model for all other professional licensing boards.[22] Inadequate discipline is a function of regulatory design, and therefore we see the same results in other professions such as nursing,[23] massage therapy,[24] and others.[25]

The one licensed profession that presents a more complicated comparison to medicine is law. On the one hand, the legal disciplinary system is even more likely to lead to lax discipline than medicine, because the entities handling it are even more self-regulatory than medical boards.[26] On the other hand, lawyers-

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22 *See* Cynthia L. Krom, *Disciplinary Actions by State Professional Licensing Boards: Are They Fair?*, 158 J. BUS. ETHICS 567, 568 (2019).

23 *See* Azza AbuDagga et al., *Crossing the Line: Sexual Misconduct by Nurses Reported to the National Practitioner Data Bank*, 36 PUB. HEALTH NURSING 109, 112–13 (2019) (finding that almost half of the nurses studied with sexual-misconduct-related malpractice-payment reports were not disciplined by the state licensing board); Khazan, *supra* note 2 (telling the story of a Jackson, TN nurse practitioner who wrote prescriptions in exchange for sexual favors).

24 *See, e.g.*, LA. LEGIS. AUDITOR, AUDIT CONTROL NO. 40190023, REGULATION OF THE MASSAGE THERAPY PROFESSION LOUISIANA BOARD OF MASSAGE THERAPISTS 4 (2021) [hereinafter LOUISIANA MASSAGE BOARD AUDIT] (finding that the state massage licensing board needs to "better identify unlicensed and illicit establishments that threaten the integrity of the profession"); ARIZ. AUDITOR GEN., REP. NO. 22-106, A PERFORMANCE AUDIT AND SUNSET REVIEW OF THE ARIZONA STATE BOARD OF MASSAGE THERAPY 5 (2022) (finding that the "[b]oard did not investigate or timely investigate, document, or review all complaints it received, increasing public safety risk").

25 *See* Andrea Estes, *Audit: State Licensing Agency May Have Failed to Perform Required Criminal Record Checks on Thousands of License-Holders*, BOS. GLOBE, (Sept. 15, 2021, 11:22 AM) (reporting that Massachusetts' state licensing boards, covering various professions including electricians, massage therapists and veterinarians, failed to perform criminal background checks for two-thirds of applicants, including one electrician who is a registered sex offender), https://www.bostonglobe.com/2021/09/15/metro/audit-state-licensing-agency-may-have-failed-perform-required-criminal-record-checks-thousands-licenseholders/; *see also* COMMONWEALTH OF MASS. OFF. OF THE STATE AUDITOR, AUDIT NO. 2020-0105-3S, DIVISION OF PROFESSIONAL LICENSURE FOR THE PERIOD JULY 1, 2017 THROUGH MARCH 31, 2020, at 2 (2021) (reporting that Massachusetts' home inspection, accounting, psychology, and cosmetology boards inadequately identify sex offenders among their licensees).

26 States regulate lawyers not through acts of the legislature that create agencies subject to sunshine laws, but through their supreme courts, which in turn delegate discipline to either the state bar association or a board with even less lay representation and transparency than the typical medical board. *See* Jennifer M. Kraus, *Attorney Discipline Systems: Improving Public Perception and Increasing Efficacy*, 84 MARQ. L. REV. 273, 281–82 (2000)

judging-lawyers bring a fluency in policy and procedure to their cases that other professionals cannot. They have been told, in law school, that the regulatory line is drawn not for the well-meaning lawyers just like them, but for the bad man who would walk up to it.[27] And there is some evidence that lawyers are harsher on their own than other professionals, even if not sufficiently.[28] Thus, the difficulty of extrapolating our findings in medicine to law is not only a bug but a feature—it supports our thesis that lack of regulatory expertise contributes to the crisis of self-discipline in the professions.

Just as our data from medicine are generalizable to other professions, so too is our data from Tennessee generalizable to disciplinary systems of other American states. Tennessee is an average-sized American state with typical board procedures[29] that ranks near the middle of the very few comparative measure of licensing board structure and performance.[30] Another indication that our findings in Tennessee are typical comes from comparing our data to other state-specific analyses of professional discipline, where researchers and investigative journalists

("Attorney discipline boards are controversial in part because members of the legal profession handle all of the functions in the regulatory systems."); Judith L. Maute, *Bar Associations, Self-Regulation and Consumer Protection: Whither Thou Goest?,* 2008 J. PRO. LAW. 53, 58 (discussing the self-regulatory nature of bar associations).

27 Oliver Wendell Holmes, Jr., *The Path of the Law*, 10 HARV. L. REV. 457, 459 (1897) (positing that while morality guides most people, the law exists to impose consequences on the "bad man" who "cares nothing for an ethical rule").

28 *See* Krom, *supra* note 22, at 582 (finding that attorneys often face harsher punishments for misconduct directly relating to their professional practice in comparison to CPAs and Physicians in each jurisdiction surveyed).

29 For a comparative account of medical board disciplinary procedure, for example, see FED'N OF STATE MED. BDS., U.S. MEDICAL REGULATORY TRENDS AND ACTIONS 10–11 (2018) [hereinafter FSMB, REGULATORY TRENDS], https://www.fsmb.org/SysSiteAssets/advocacy/publications/us-medical-regulatory-trends-actions.pdf.

30 *See, e.g.,* Carrie Teegardin & Saurabh Datar, *Doctors & Sex Abuse; Part 4: How Well Does Your State Protect Patients?*, ATLANTA J.-CONST. (Nov. 17, 2016), https://doctors.ajc.com/states/?ecmp=doctorssexabuse_microsite_stories [https://perma.cc/N7N2-PETE] (ranking Tennessee 30th out of 51 in terms of how well it protects patients); CAROL CRONIN & LISA MCGIFFERT, LOOKING FOR DOCTOR INFORMATION ONLINE: A SURVEY AND RANKING OF STATE MEDICAL AND OSTEOPATHIC BOARD WEBSITES IN 2021, at 22 (2022), https://www.patientsafetyaction.org/wp-content/uploads/2022/03/Looking-for-Doctor-Information-Online-1-7-22.pdf [https://perma.cc/B524-VH9V] (ranking Tennessee's medical board just above the 50th percentile among the states for the transparency and usefulness of its website in providing information about discipline to patients).

have found serious problems with professional discipline in New York,[31] the District of Columbia,[32] Georgia,[33] Illinois,[34] Indiana,[35] New Jersey,[36] and Texas.[37]

This article proceeds in five parts: Part I defines the stakes of licensing board discipline, explaining the role that boards play in holding the line against unethical and incompetent providers and the wider social consequences that result from a dysfunctional disciplinary system. It then develops a theory of professional discipline that foregrounds public safety and provider quality. Part II describes the current crisis of the board disciplinary system and uses a case study to illustrate its misplaced focused on rehabilitation and second (and third or fourth) chances. Part III then explains why the American system fails at its professed goal: the state medical board is designed to be biased and low-information, and its case outcomes reflect those flaws.

Part IV turns to the UK, identifying the crisis of confidence that led to reforms two decades ago, the nature of those reforms, and the current state of play in professional discipline. Part V then compares the disciplinary outcomes of the two jurisdictions, first through a case study and then through our empirical findings. Part VI outlines how the lessons from the UK might be applied in the United States, and a short section concludes.

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31 Gillers, *supra* note 4, at 490 (describing the failures of attorney discipline in New York).

32 *See* Frisch, *supra* note 4, at 362 (finding legal discipline in the District of Columbia lacking).

33 *See* Teegardin & Datar, *supra* note 30. *See also* GA. DEP'T OF AUDITS & ACCTS., PERF. AUDIT DIV., REP. NO. 19-14, GEORGIA COMPOSITE MEDICAL BOARD – PHYSICIAN OVERSIGHT 25–30 (2020) [hereinafter GEORGIA AUDIT] (finding that Georgia has a relatively low rate of physician discipline and identifying possible structural causes).

34 *See* David Hyman, Mohammad Rahmati & Bernard Black, *Medical Malpractice and Physician Discipline: The Good, the Bad, and the Ugly*, 18 J. EMPIRICAL LEGAL STUD. 131, 153–160 (2021).

35 *See* Liu & Hyman, *supra* note 4, at 267, 272.

36 *See Hearing on Disciplinary Actions by the N.J. Bd. of Med. Examiners Before the S. Comm. on Health, Hum. Servs. & Senior Citizens*, 2010 Leg., 214th Sess. (N.J. 2010) (testimony of Sidney M. Wolfe, Dir., Pub. Citizen's Health Rsch. Grp.), [https://web.archive.org/web/20190717134208/https://www.citizen.org/wp-content/uploads/migration/1941.pdf] (reporting that New Jersey Board of Medical Examiners consistently failed to take any disciplinary action against physicians even where performance was of such concern that hospitals took serious admitting privilege actions against them).

37 *See* Letter from Sidney M. Wolfe, Dir., Pub. Citizen's Health Rsch. Grp., to Rick Perry, Governor of Tex. (Aug. 22, 2012), https://www.citizen.org/article/letter-to-governor-perry-regarding-serious-deficiencies-of-the-texas-medical-board/ [https://perma.cc/6274-ZALU] (reporting evidence and identifying causes of "dangerously inadequate discipline by the Texas Medical Board").

I. WHY DISCIPLINE PROFESSIONALS?

States regulate the professions—from doctors to nurses to auctioneers—through statutes called "practice acts," which define the scope of a professional's practice, set the basic entry requirements, and broadly define ethical and competent practice.[38] If a practice act requires a government-granted license as a matter of law for any aspect of professional practice and requires a significant investment in human capital to obtain a license, we call that a "licensed profession."[39] A rough back-of-the-envelope calculation suggests that as many as thirty million American workers are subject to licensing requirements as defined, making up about a fifth of the American workforce.[40] Licensed professionals make up more workers than are members of unions, and about more than thirty times as many workers as are subject to the minimum wage.[41]

If licensing is to be justified as protecting the public by limiting practice to those who have demonstrated competence and ethicality, then it needs to have a disciplinary system that can *remove* practitioners who have shown themselves to lack these qualities. The American state licensing board is the only entity that can remove or restrict a professional's legal right to practice in the name of public protection.[42]

A. *The stakes: Why state professional board discipline matters*

For better or worse, state licensing boards do not concern themselves with ordinary cases of ineptitude or even malpractice.[43] If licensing board discipline is aimed primarily at removing outliers, how much does it matter that they do a poor job? After all, one imagines that the vast majority of professionals are

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38 S. DAVID YOUNG, THE RULE OF EXPERTS: OCCUPATIONAL LICENSING IN AMERICA 81 (1987) (defining a "practice act"); KARA SCHMITT, DEMYSTIFYING OCCUPATIONAL AND PROFESSIONAL REGULATION 59 (Professional Testing Inc., 2015) ("[L]icensing laws are often referred to as *practice acts* because they define which aspects of practice are regulated.").

39 *See* Haw Allensworth, *supra* note 9, at 1572–73 (defining "occupational licensing" as "the imposition of educational, experiential, or examination requirements as a precondition of lawful provision of a service").

40 *See supra* note 5 and accompanying text.

41 *See supra* note 6.

42 Sawicki, *supra* note 4, at 292–93.

43 *Id.* at 302–03 (presenting evidence showing that state boards do not prioritize "competency-related issues").

conscientious, dependable, and ethical. And there are many other regulators of professionals—from private certifying bodies to firms to insurance companies—that may provide another layer of public protection, reducing the need for state boards to act as disciplinarians.

In fact, it matters a great deal that licensing boards are failing to remove dangerous providers from the professions—both because they inflict outsized harm and because the other systems in place to catch them are inadequate.

1. Bad apples

How much harm do bad professionals really inflict? Examples from medicine suggest that dangerous and predatory professionals are more common than one might think.[44] In Tennessee alone, the Board publicly disciplined hundreds of doctors in the five-year period of our study, with offenses ranging from drug trafficking to sex with patients. And what limited data we have about how often a board responds to an allegation suggests that these numbers are far smaller than the true amount of professional misconduct. These worst-of-the-worst providers have an outsized impact on the public welfare.[45] For example, unethical doctors prescribing through pill mills, accounted for a disproportionate share of opioids dispensed in the United States during the peak prescribing period.[46] And in Illinois, for example, the 2.37% of doctors with two or more paid medical malpractice claims accounted for fifty-three percent of total payouts.[47]

The devastation caused by professional misconduct is perhaps most striking when it comes to sexual abuse. The most famous example is Larry Nassar, whose

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44 *See* Elizabeth Pendo et al., *Protecting Patients from Physicians Who Inflict Harm: New Legal Resources for State Medical Boards*, 15 ST. LOUIS U. J. HEALTH L. & POL'Y 7, 13 (2021) (noting that "sexual abuse of patients and other serious types of wrongdoing by physicians are alarmingly frequent, harmful, and under-reported").

45 Fed'n of State Med. Bds., *Report and Recommendations of the FSMB Workgroup on Physician Sexual Misconduct*, J. MED. REGUL., No. 2, 2020, at 17, 26 [hereinafter FSMB, *Recommendations of Workgroup on Sexual Misconduct*] ("In cases involving sexual misconduct, it is simply not true that unsafe or high-risk care is better than no care at all. A single instance, let alone many instances, can cause an extremely high degree of damage to individuals and communities in which they reside.").

46 *See* Terry Spencer, *Florida 'Pill Mills' Were 'Gas on the Fire' of Opioid Crisis*, AP NEWS (July 20, 2019, 1:14 PM), https://apnews.com/article/0ced46b203864d8fa6b8fda6bd97b60e, [https://perma.cc/B3XS-L5GH].

47 *See* Hyman, Rahmati & Black, *supra* note 34, at 138.

victims exceeded 100, including children.[48] But his is not an isolated case. Columbia University OB-GYN Robert Hadden has been accused by hundreds of women and girls of sexual assault during exams. He was criminally prosecuted but unlike Larry Nassar, who is serving a 175-year sentence, Dr. Hadden received no jail time on his state charges. He was later prosecuted federally and is currently serving a twenty-year sentence.[49] By the numbers, the professional that represents the most widespread social harm may be Dr. George Tyndall, who served as the OB-GYN at the University of Southern California's (USC) student health center for twenty-seven years. He abused so many women and girls during that time that their claims were resolved through a class action. Between that and other lawsuits, USC has settled with 16,000 of Dr. Tyndall's victims for a total of $1.1 billion, or about one fifth of the private school's total endowment.[50]

Evidence from other professions, such as law, suggest that a profession's bad apples can create wide-spread harm. Consider the legal and political chaos created by the relatively few lawyers who have pursued baseless claims of election

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48 People v. Nassar, No. 345699, 2020 WL 7636250, at *1 (Mich. Ct. App. Dec. 22, 2020); Tracy Connor, *Gymnastics Doctor Larry Nassar Loses License over Sex-Abuse Claims*, NBC NEWS (Jan. 25, 2017, 5:50 PM), https://www.nbcnews.com/news/us-news/gymnastics-doctor-larry-nassar-loses-license-over-sex-abuse-claims-n712241 [https://perma.cc/9E6T-F8DN].

49 Bianca Fortis & Laura Beil, *How Columbia Ignored Women, Undermined Prosecutors and Protected a Predator for More Than 20 Years*, PROPUBLICA (Sept. 12, 2023, 5AM), https://www.propublica.org/article/columbia-obgyn-sexually-assaulted-patients-for-20-years.

50 Although USC had received complaints about Dr. Tyndall's sexual abuse dating back to the 1990's, he remained at USC until the university asked him to resign quietly in 2016. *See* Harriet Ryan et al., *Must Reads: A USC Doctor Was Accused of Bad Behavior with Young Women for Years. The University Let Him Continue Treating Students*, L.A. TIMES (May 16, 2018, 06:25 AM PT), https://www.latimes.com/local/california/la-me-usc-doctor-misconduct-complaints-20180515-story.html. The L.A. Times's reporting sparked the lawsuits against USC as well as "the largest sex crimes inquiry involving a single suspect in Los Angeles Police Department History." *See* Richard Hinton & Harriet Ryan, *Former USC Gynecologist George Tyndall Charged with 29 Felonies in Sex Abuse Case*, L.A. TIMES, (June 26, 2019, 9:37 AM PT), https://www.latimes.com/local/lanow/la-me-george-tyndall-arrest-usc-sexual-abuse-20190626-story.html; Meredith Deliso, *Breaking Down University of Southern California's $1.1 Billion in Sex Abuse Settlements*, ABC NEWS (Mar. 27, 2021, 5:03 AM), https://abcnews.go.com/US/breaking-university-southern-californias-11-billion-sex-abuse/story?id=76713012; *see also* Alex Wigglesworth, *Former USC Gynecologist Who Was Accused of Abusing Patients Surrenders His Medical License,* L.A. TIMES (Sept. 9, 2019, 3:56 PM PT), https://www.latimes.com/california/story/2019-09-09/former-usc-gynecologist-accused-abuse-surrenders-medical-license.

fraud on behalf of President Trump[51] or the extremely high caseloads—in the thousands—of lawyers found to have stolen from or neglected their indigent clients' cases.[52] Recidivism rates among disciplined lawyers—at almost fifty percent—suggest that bad lawyers can have an outsized effect on the public.[53]

2. Better regulators?

The consequences of inadequate professional discipline in America are severe. Without meaningful governmental regulation that stops unethical or incompetent professionals from practicing, the private sector has layered their own standards and private governance structures on most professionals. But the example of health care, where private regulators like insurance panels, hospitals, and specialty boards layer their own standards on top of licensing board regulation, shows that these entities have their own self-interests in mind when they discipline professionals (or fail to).[54] Furthermore, they rely on state boards for information about problematic providers,[55] limiting their ability to detect patterns of bad behavior missed by these boards.

For example, hospitals each have their own credentialing system for healthcare professionals, which relies in significant part on the National Practitioner Databank (the "Databank"), a repository of information about individual healthcare providers' malpractice history and hospital discipline.[56] The

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51 *See* Bruce A. Green, *Selectively Disciplining Advocates*, 54 CONN. L. REV. 151, 180–81 (2022) (discussing the ethicality of the lawyers responsible for filing the sixty-two lawsuits on behalf of Donald Trump in state and federal courts contesting the results of the 2020 election).

52 Dru Stevenson, *Monopsony Problems with Court-Appointed Counsel*, 99 IOWA L. REV. 2273, 2286 (2014); RICHARD L. ABEL, LAWYERS IN THE DOCK: LEARNING FROM ATTORNEY DISCIPLINE, at ix (2008).

53 *See* Kyle Rozema, *Professional Discipline and the Labor Market: Evidence from Lawyers*, 67 J. L. & ECON. 371, 409 & fig.9 ("[O]f lawyers who are not disbarred after a first disciplinary action, 48 percent reoffend and 24 percent are eventually disbarred.").

54 *See* Lucian L. Leape & John A. Fromson, *Problem Doctors: Is There a System-Level Solution?*, 144 ANNALS INTERNAL MED. 107, 109 (2006) (explaining various reasons for which a hospital may fail to discipline a physician).

55 For example, the American Medical Association's Council on Ethical and Judicial Affairs ("CEJA") relies on information from state medical boards to determine an individual's membership status with the association. Barbara L. McAneny & Elliot J. Crigger, *Toward More Effective Self-Regulation in Medicine*, 19 AM. J. BIOETHICS 7, 7 (2019).

56 Teresa M. Waters et al., *The Role of the National Practitioner Data Bank in the Credentialing Process*, 21 AM. J. MED. QUALITY 30, 32 (2006).

Databank can be accessed by employers, state boards and insurance companies, but not patients or the public at large.[57] Even to those who have access to the Databank, the information there is inadequate to protect the public. Malpractice suits are a notoriously inexact measure of incompetence[58] and hospitals are infamous for either not reporting egregious behavior to the Databank or, more commonly, eluding the reporting requirement by asking a provider to clean up his act or quietly leave.[59] Both USC and Columbia knew about their predatory OB-GYNs for years before taking action.[60] And as Dr. Christopher Duntsch maimed or killed dozens of spinal patients over a fourteen-month period, three different Dallas hospitals learned about the carnage and asked him to move on.[61] As these examples make clear, asking private entities to discipline physicians is no substitute for governmental regulation through licensure. Less is known about how private regulators, like firms, operate in the market for lawyers, but recent empirical

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57 *See NPDB Reporting Requirements and Query Access*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.npdb.hrsa.gov/resources/tables/reportingQueryAccess.jsp (last visited Aug. 16, 2024).

58 *See* Joanna Shepherd, *Uncovering the Silent Victims of the American Medical Liability System*, 67 VAND. L. REV. 151, 166, 185 (2014) (explaining that high litigation costs prevent plaintiffs from bringing medical malpractice claims); Philip G. Peters, Jr., *Doctors & Juries*, 105 MICH. L. REV. 1453, 1464, 1474 (2007) (explaining that juries tend to favor physician defendants in medical malpractice cases).

59 *See* Pendo et al., *supra* note 44, at 28–29 (noting that the "failure to detect and report physician wrongdoing on the part of hospitals and other health care entities is a longstanding problem"); FED'N OF STATE MED. BDS., POSITION STATEMENT ON DUTY TO REPORT 2 (2016) [hereinafter FSMB, DUTY TO REPORT], https://www.fsmb.org/siteassets/advocacy/policies/position-statement-on-duty-to-report.pdf [https://perma.cc/QB7W-CXSD] ("FSMB has heard complaints from its member boards that hospitals and health organizations regularly ignore reporting requirements, find ways to circumvent them, or provide reports that are too brief and general to equip the board with relevant information for carrying out its regulatory functions.").

60 *See* Ryan et al., *supra* note 50; Wigglesworth, *supra* note 50; Complaint at ¶ 62, Doe v. Colum. Univ., No. 1:20-cv-01791 (S.D.N.Y. filed Feb. 28, 2020); Fortis & Beil, *supra* note 49.

61 *See* Dr. Death, *Season 1: Dr. Duntsch, Episode 5: Free Fall*, WONDERY, at 39:23–42:04 (Sept. 18, 2018), https://wondery.com/shows/dr-death/season/1/; Matt Goodman, *Dr. Death*, D MAGAZINE (Oct. 24, 2016, 1:00 PM), https://www.dmagazine.com/publications/d-magazine/2016/november/christopher-duntsch-dr-death.

evidence suggests that as in medicine, sanction by private entities like law firms does not stop bad actors from practicing.[62]

And in both medicine and law, private regulatory systems tend to push problematic providers towards underserved client and patient populations, further impugning their status as public protectors. In medicine, a bad record in the Databank may limit your professional prospects to working in institutional settings like prisons or as a cash-based solo practice.[63] In law, a recent study showed that board discipline tended to push an attorney out of firm practice and towards solo practice serving vulnerable populations like indigent criminal defendants, immigrants, and accident victims.[64] In these settings, problematic professionals are likely to encounter clients and patients most in need of quality care and least able to protect themselves from unethical or incompetent providers.

B. Towards a theory of professional discipline

In developing a theory of professional discipline, we take at face value the language in professional practice acts that identify "public protection" as the aim of licensure.[65] Public protection is paramount because patients and clients are uniquely vulnerable in the professional relationship where they cannot directly assess the quality of services, sometimes depend on them for their lives and freedom, and, especially in medicine, often must make themselves physically vulnerable to receive treatment.[66] The larger public, too, has a stake in the safety of

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62 *See* Rozema, *supra* note 53, at 398.

63 Allensworth, *supra* note 17 (explaining that medical board discipline shunts problematic providers toward vulnerable patient populations).

64 *See* Rozema, *supra* note 53, at 371, 406–07 ("[D]isciplined lawyers are more likely to subsequently end up practicing in areas of the law with unsophisticated clients."); *see also* Leslie C. Levin, *The Ethical World of Solo and Small Firm Practitioners*, 41 HOUS. L. REV. 309, 312-14 (2004) (discussing the tendency of solo and small firm practitioners to violate ethical rules in the face of increased pressure to retain clients and the far greater discipline rates of solo and small firm practitioners as compared with other lawyers).

65 *See, e.g.*, Katherine Zheng, *Nurse Practice Acts by State: Overview and FAQ*, INTELYCARE, https://www.intelycare.com/facilities/resources/nurse-practice-acts-by-state-overview-and-faq/ [https://perma.cc/Q2A5-ZRS9] (last visited Jan. 10, 2025) (compiling nurse practice acts for all fifty states); *see also* Medical Act 1983, c. 54, § 1(1A), (UK).

66 *See, e.g.,* Zara J. Bending, *Reconceptualising the Doctor–Patient Relationship: Recognising the Role of Trust in Contemporary Health Care*, 12 J. BIOETHICAL INQUIRY 189, 195 (2015) ("[B]y virtue of their illness and need for professional opinion, patients are the more vulnerable party in the exchange.").

the professions, as illustrated by the role that over-prescribing physicians have played in the opioid crisis[67] and lawyers have played in the current lack of faith in democracy.

Mitigating these risks is one role of a state licensing board, whose obligation is to ensure that anyone holding a license meets minimum level of competency, ethics, and professional judgment.[68] These standards are especially important given the level of independence afforded to many professionals to treat, argue, advise, and design according to their professional judgment. This minimum level does not mean that every provider will be excellent, or even, as the children of Lake Wobegon, above average. But at the point of professional entry, it does mean that every licensed professional will have graduated from an accredited school, passed an exam, shown a respect for patient and client care, and demonstrated a willingness to keep up with best practices and learn from his mistakes. What it means at the disciplinary stage is less theorized. Boards and legislatures give lip service to the idea of using discipline in the name of the public,[69] yet neither kind of regulator has done much to develop a theory that breaks down how discipline, in practice, might be used to protect the public.[70]

Our theory of professional discipline recognizes that it occurs after a provider has been admitted to the profession—that is, after they have graduated from professional school, taken an exam, and generally been deemed minimally competent by their peers. At the point of a serious accusation of misconduct, a provider has allegedly engaged in some behavior (usually a pattern of behavior)

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67 *See, e.g.,* Christopher M. Jones et al., Research Letter, *Sources of Prescription Opioid Pain Relievers by Frequency of Past-Year Nonmedical Use: United States, 2008-2011*, 174 JAMA INTERNAL MED. 802, 802-03 (2014) (presenting national survey results showing that "[a]mong nonmedical users . . . opioid pain relievers were most often obtained via prescription from physicians"); *see also* Allensworth, *supra* note 17 (explaining the role that unethical prescribers have played in the opioid crisis).

68 NAT'L CONF. OF STATE LEGIS., THE STATE OF OCCUPATIONAL LICENSING: RESEARCH, STATE POLICIES AND TRENDS 4 (2017), sbp.senate.ca.gov/sites/sbp.senate.ca.gov/files/NCSL%20State%20of%20Occupational%20Licensing.pdf.

69 *See, e.g.*, *About Physician Discipline*, FSMB, *supra* note 13 ("Boards safeguard the public by disciplining physicians who engage in unprofessional, improper, or incompetent medical practice.").

70 Scholars, too, have been vague on this front. *See, e.g.*, SCHMITT, *supra* note 38, at 123; BENJAMIN SHIMBERG, OCCUPATIONAL LICENSING: A PUBLIC PERSPECTIVE 101 (1982). *Cf.* Gillers, *supra* note 4, at 494.

that raises doubts about their current competence or ethics.[71] This new information may reveal that admission to the profession was a mistake—that despite graduating and passing the tests they *never* had the requisite skills or ethics. Or perhaps something has changed since getting their license that led the professional astray. Sometimes it is the profession itself that has changed; some disciplinary cases arise from a provider's failure to stay abreast of best practices.[72] More often the thing that changed is the professional themselves.[73]

1. The Four Disciplinary Paths: Unrestricted Practice, Restricted Practice, Suspension, Revocation

If board discipline is aimed at protecting the public by ensuring minimum competence and ethics, then that suggests a specific role for using each tool wielded by a licensing board: unrestricted practice after a public reprimand or warning, probation with restrictions, temporary suspension and permanent license revocation.[74] First, if a board can determine that the provider does presently have the requisite minimum competency and ethics, the board should allow the provider to continue to practice with an unrestricted license. Second, if the board finds that a provider will meet the minimum standards if certain conditions are in place or prerequisites are met, the board should place the provider under a disciplinary order with conditions (in most states this involves placing their license on "probation"). Third, if the board determines that a professional does not currently meet the minimum standard (even in circumscribed circumstances) but that they may, through education or mental health treatment, become competent, the board should place the license on suspension, precluding practice now but leaving open a path to return to practice. Finally, a board can decide that a professional has shown such

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71 *See* DuBois et al., *Serious Ethical Violations*, *supra* note 21, at 20 (finding that almost every disciplinary case in a sample of 280 "involved repeated instances (97%) of intentional wrong-doing (99%)").

72 *See* Am. Med. Ass'n Council on Sci. Affs., *Drug Abuse Related to Prescribing Practices*, 247 J. AM. MED. ASS'N 864, 864 (1982) (attributing improper prescribing to physicians "not [keeping] abreast of new developments in pharmacology and drug therapy").

73 The frequency of mental health diagnoses among disciplined providers would suggest that a provider's mental health is often what has changed. *See* DuBois et al., *Serious Ethical Violations, supra* note 21, at 20 (collecting cases of egregious misconduct and noting that "[m]ore than half of cases involved a wrongdoer with a suspected Cluster B personality disorder (antisocial or narcissistic) or substance use disorder (51%)").

74 *Cf. About Physician Discipline*, FSMB, *supra* note 13 (discussing Board Action Categories and reflecting on importance of flexibility in applying appropriate level of discipline).

egregious lapses of skill or judgment that there is little likelihood they can *ever* be trusted to practice again. These professionals should lose their license permanently.

Crucially, these steps should be taken as swiftly as due process allows, both out of fairness to the doctor and for the protection of the public. A professional license is a property right,[75] and revoking or restricting it requires the board to provide notice and a hearing to an accused professional.[76] To the extent that the strictures of due process cannot be met before serious harm may come to the public, most boards should use their ability to summarily suspend a license on an emergency basis, pending a full administrative hearing.[77]

2. A Theory of Second (and Third) Chances

Note that three of the disciplinary moves used by boards upon finding misconduct—reprimand, probation with conditions and suspension—involve second chances for problematic providers. These are most appropriate where there is a clear underlying cause of the bad practice or lapse in judgement and there is a reliable way to treat or remove it. The most obvious example is inexpert practice, of a mild to moderate degree, that might be improved through education, supervision, or a more intensive version of supervision called "practice monitoring" where an independent monitor reviews all or some of the probated professional's work product.[78]

Second chances in the form of probation and suspension may also be appropriate in cases where drug or alcohol use disorder appears to be a direct cause of the bad practice, if the compromised decision-making does not rise to the level of predation or criminality, and if the professional appears genuinely interested in confronting their substance use problem.[79] The same is true for other mental health

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75 Schware v. Bd. of Bar Exam'rs of N.M., 353 U.S. 232, 238-39 (1957) ("A State cannot exclude a person from the practice of law or from any other occupation in a manner or for reasons that contravene the Due Process or Equal Protection Clause of the Fourteenth Amendment.").

76 *See* SCHMITT, *supra* note 38, at 130.

77 *See About Physician Discipline*, FSMB, *supra* note 13; Jacqueline Landess, *State Medical Boards, Licensure, and Discipline in the United States*, 17 FOCUS 337, 340–41 (2019).

78 *See* FSMB, *Recommendations of Workgroup on Sexual Misconduct*, *supra* note 45, at 28–30 (defining physician practice monitoring).

79 Alcoholism and other substance use disorders are seen as generally treatable conditions in physicians. *See* Robert L. DuPont et al., *Setting the Standard for Recovery: Physicians' Health Programs*, 36 J. SUBSTANCE ABUSE TREATMENT 159, 170 (2009).

issues such as depression or bipolar disorder which can be controlled by treatment.[80] Importantly, however, there must be some evidence that the addiction or other mental health issues are *causal* to the bad practice—it is possible (and the facts of many cases suggest that it's not uncommon) for incompetent or predatory providers to *also* have a drug or alcohol use disorder or another mental health diagnosis.[81]

Second chances are less appropriate when the provider has abused the public trust in a way that cannot be explained by slipping skills or poor mental health alone. The most obvious example is a professional who has used his license opportunistically—such as a pill mill prescriber or someone engaged in health care fraud.[82] A related example is the lawyer or doctor who uses his position of power to extort sex from patients. These offenses are undeserving of second chances not only because they are egregious, but because the professional has so totally abandoned the mission of patient or client care and shown a willingness to use his or her license to their own advantage that rehabilitation seems unlikely.[83] The public protection theory of board discipline also suggests that *third* chances should almost never be granted. A professional who has been through the disciplinary

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80 *See* John R. Knight et al., *Outcomes of a Monitoring Program for Physicians with Mental and Behavioral Health Problems*, 13 J. PSYCH. PRAC. 25, 29 (2007) ("While additional studies are needed, our findings suggest that physicians with MBH problems can be monitored using a strategy similar to that used for physicians with SUDs, and that most can be safely maintained in practice.").

81 *See, e.g.*, Dr. Death, *Season 1: Dr. Duntsch, Episode 3: Occam's Razor*, WONDERY, at 6:54–10:15, 18:04–20:25 (Sept. 4, 2018), https://wondery.com/shows/dr-death/season/1 (discussing Dr. Duntsch's heavy alcohol and cocaine use before and while practicing medicine).

82 *See* McAneny & Crigger, *supra* note 55, at 8 (arguing that "physicians who are using their medical degree to operate illegal enterprises like the pill mills . . . [should be] permanently removed from the profession"); Vivek Pande & Will Maas, *Physician Medicare Fraud: Characteristics and Consequences*, 7 INT'L J. PHARM. & HEALTHCARE MKTG. 8, 29 (2013) (arguing that a provider with a felony conviction for healthcare fraud should automatically lose their license).

83 Professor DuBois calls this kind of conduct "counter to the core values of medicine" and says that physicians engaging in it are undeserving of second chances. *See* James M. DuBois et al, *Preventing Egregious Ethical Violations*, *supra* note 21, at 27. A closer case is presented by a consensual sexual relationship between professional and patient or client. The Federation of State Medical Boards recently took the position that a patient *cannot* consent to sex with his or her physician. *See* FSMB, *Recommendations of Workgroup on Sexual Misconduct*, *supra* note 45, at 26. The FSMB did not, however, go as far as to recommend permanent revocation for offending physicians, a curious conclusion because defining physician-patient sex as non-consensual would suggest that the FSMB views it as rape.

process understands the seriousness of their misdeeds; they have been through the ringer, faced the fear of losing their livelihood, and been told how to get back on track. A provider who cannot or will not conform his or her practice to comply with patient or client safety after that experience is extremely unlikely to ever do so.

Finally, the public protection theory of discipline tells us that in determining a sanction or remedial measure, boards should consider all relevant facts in the professional's past, beyond the specific charges raised in the case. Just as in criminal sentencing, the decision to revoke or restrict a license involves a prediction about how this individual will behave in the future. And just like in criminal sentencing, where the rules of evidence are relaxed and both parties are allowed to paint a fuller picture of the defendant as a one-time offender or a likely recidivist, the decision about whether to revoke or restrict a license should account for a provider's full history, with a particular emphasis on his professional life.[84]

II. TOO LITTLE, TOO LATE: AMERICAN PROFESSIONAL DISCIPLINE IN CRISIS

A. Dr. Lapaglia: Too Many Chances, Too Little Information

In July of 2019, Dr. Michael Lapaglia appeared before the Tennessee Board of Medical examiners for a disciplinary hearing that would decide the fate of his

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84 *See, e.g.*, U.S. SENT'G GUIDELINES MANUAL ch. 1, pt. A, introductory cmt.1(3) (U.S. SENT'G COMM'N 2023) (describing argument that punishment should be primarily based on practical crime control considerations to lessen likelihood of future crimes); U.S. SENT'G GUIDELINES MANUAL §6A1.3 cmt. (U.S. SENT'G COMM'N 2023) (stating that sentencing judges, in determining relevant facts, are not restricted to information that would be admissible at trial and may consider reliable hearsay evidence). In the context of medical practice, researchers have identified several risk factors for recidivism. *See* Matthew C. Holtman, *Disciplinary Careers of Drug-Impaired Physicians*, 64 SOC. SCI. & MED. 543, 551 (2007) (drug and alcohol abuse); James M. DuBois et al., *Sexual Violation of Patients by Physicians: A Mixed-Methods, Exploratory Analysis of 101 Cases*, 31 SEXUAL ASSAULT 503, 516 (2017) [hereinafter DuBois et al., *Exploratory Analysis of 101 Cases*] (sexual assault); Bernard Black et al., *Physicians with Multiple Paid Medical Malpractice Claims: Are They Outliers or Just Unlucky?*, 58 INT'L REV. OF L. & ECON. 146, 156 (2019) (malpractice payments); Darren Grant & Kelly C. Alfred, *Sanctions and Recidivism: An Evaluation of Physician Discipline by State Medical Boards*, 32 J. HEALTH POL. POL'Y & L. 868, 877–78 (2007) (past state board disciplinary action).

medical license.[85] Six months before, his license had been summarily suspended because he had pled guilty to two federal felonies: one for trafficking in prescription drugs for no medical purpose, and the other for health care fraud.[86] These charges were based on his participation in a practice he called "L&B Healthcare," which had no brick and mortar operation but rather consisted of a prescription pad made up with his phone number and his partner's name and DEA number, required for prescribing controlled substances. He used the pad to write prescriptions for drugs with street value—like Suboxone and Valium—and sell them for $300 cash out of his home, in patients' homes, and at least once, in a McDonald's parking lot. Some of the prescriptions were pre-signed by his partner. When those ran out, Dr. Lapaglia forged his signature.[87]

As the facts were explained to the three-member panel hearing the case, two of whom were currently-practicing physicians, Dr. Lapaglia needed to prescribe in another doctor's name because he had lost his DEA registration in a previous round of discipline before this same board.[88] In 2014, he pled no contest to state criminal charges for dealing prescription drugs and marijuana out of his home and at that time, the board had placed the doctor's license on probation.[89] The conditions of his probation were that he attend drug treatment (he himself was evidently addicted to benzodiazepines) and relinquish his authority to prescribe controlled substances.[90] It was during this probationary period that the doctor came up with

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85 TENN. BD. OF MED. EXAM'RS, TENNESSEE BOARD OF MEDICAL EXAMINERS REGULAR BOARD MEETING JULY 30-31, 2019 MINUTES, at 14–15 (2019) [hereinafter TBME, BOARD MEETING MINUTES], https://www.tn.gov/content/dam/tn/health/healthprofboards/medicalexaminers/ME073019.pdf [https://perma.cc/3AFK-ZK97].

86 Plea Agreement at 1–2, United States v. Lapaglia, No. 3:18-CR-172 (E.D. Tenn. Oct. 25, 2018); Lapaglia, No. 201802040, at 3-5 (Tenn. Bd. of Med. Exam'rs Jan. 2, 2019) (order of summary suspension). To access this order or any of the subsequently-referenced orders from both the Tennessee Board of Medical Examiners and Tennessee Board of Nursing, go to https://apps.health.tn.gov/licensure/Default.aspx, search for the relevant license-holder (here Michael Anthony Lapaglia), and select "Adverse Licensure Actions."

87 Lapaglia, No. 201802040, at 2–5.

88 *See* TBME, BOARD MEETING MINUTES, *supra* note 85, at 14–15.

89 Criminal Judgment, Tennessee v. Lapaglia, Case No. 103051 (Feb. 5, 2014); Lapaglia, Nos. 2013015321, 2013019391, at 4 (Tenn. Bd. of Med. Exam'rs Mar. 19, 2014) (consent order) (on file with authors).

90 *See* Lapaglia, Nos. 2013015321, 2013019391, at 3–5.

the idea for L&B, which resulted in the federal convictions and the hearing in 2019 that determined the status of his Tennessee medical license.[91]

Dr. Lapaglia and his lawyer presented a defense that did not contest the basic facts—he admitted to the forged prescriptions, the cash appointments without exams and the McDonald's parking lot. Rather, he argued that his heart was in the right place, that he genuinely believed he was prescribing for therapeutic purposes, even if he cut a few corners and did not do things by the book. He also emphasized his own struggles with substance use and his compliance with the board's previous condition that he get clean.[92] And despite his role as an ostensible adversary, the lawyer prosecuting the case against Dr. Lapaglia essentially concurred, beginning his closing argument by saying "Dr. Lapaglia did something that was dumb."[93] And he failed to confront or correct the doctor when Dr. Lapaglia claimed he had never even been accused of trafficking in Suboxone.[94] The panel was given copies of the two criminal judgments—one state and one federal—for that very crime, but the panel members did not appear to read them.[95]

The newest board member, Dr. Stephen Loyd, lead deliberations after hearing the proof.[96] It was his second day on the job, after a two-hour orientation on the basics of board service.[97] He had not been briefed on or even given a copy of the rules or statutes that he was now in charge of interpreting and applying. He had not been given guidance about how to decide contested cases or even about the goals of physician discipline. He had not even been told what remedial and punitive measures the board had at its disposal.[98]

"My job is to protect the health, safety and welfare of the citizens of Tennessee," Dr. Loyd began. "Do I think taking [Dr. Lapaglia's] license protects

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91 *See* Lapaglia. No. 17.18-157362A, at 2 (Tenn. Bd. of Med. Exam'rs Aug. 13, 2019) (final order).

92 *See* Hearing Before the Tenn. Bd. of Med. Exam'rs at 2:23:30–2:33:00, Lapaglia, No. 17.18-157362A (Tenn. Bd. of Med. Exam'rs July 31, 2019), https://tdh.streamingvideo.tn.gov/Mediasite/Channel/98fe21d561e9489487745f0c7da678b25f/watch/ee17b74a7fa640d994571f4a5fee42261d.

93 *Id.* at 3:25:45.

94 *Id.* at 3:09:35.

95 [Add cite – what is the evidence that the panel members did not appear to read the judgments?]

96 *Id.* at 4:17:05.

97 Interview with Stephen Loyd, Member, Tenn. Bd. of Med. Exam'rs, in Brentwood, Tenn. (Aug. 11, 2021).

98 *Id.*

the people of Tennessee? I do not," he said. "I hope I'm a good judge of a heart. I saw someone who has a good heart."[99]

Even on the facts presented to the board, at least as viewed by a regulator more clear-eyed about the possibility of a professional lying under oath or otherwise acting opportunistically, this was a questionable proposition. But there were other facts, easily verified and in the public domain, yet not presented to the panel at all, that were relevant to Dr. Lapaglia's chances of rehabilitation. Although it appeared to the panel that he was asking for a third chance to practice medicine, having twice been convicted of using his license to deal drugs (the second time while on probation for the first offense), he was asking, essentially, for his *fifth* chance to practice.

As revealed in North Carolina's public and easily searchable records of physician discipline,[100] Dr. Lapaglia had faced board discipline because his residency supervisors said he engaged a hospitalized sixteen-year-old in an inappropriate personal relationship.[101] He ignored the North Carolina board's requests to tell his side of the story, and his medical license lapsed.[102] Then, in 2010, while working as an ER physician, he faced legal troubles for medically paralyzing suspected drug dealers at the behest of law enforcement so they could perform warrantless, nonconsensual rectal searches for evidence.[103] The practice led to two civil suits, which he apparently settled, and a federal case where the Sixth Circuit found that Dr. Lapaglia's search violated the Fourth Amendment, calling it "so unreasonable as to shock the conscience."[104] Neither the inappropriate relationship nor the forced paralyses were mentioned in his Tennessee disciplinary cases.

In the end, Dr. Lapaglia got that third (or fifth) chance to practice medicine. In the July 2019 hearing, the Tennessee Board of Medical Examiners reinstated Dr.

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99 Hearing Before the Tenn. Bd. of Med. Exam'rs at 4:17:10, Lapaglia, No. 17.18-157362A.

100 The database can be found at *Licensee Search*, N.C. MED. BD., https://portal.ncmedboard.org/verification/search.aspx (after searching for Michael Anthony Lapaglia and selecting the result, navigate to "Actions – Adverse & Administrative").

101 Lapaglia, at 2 (N.C. Med. Bd. Feb. 25, 2002) (notice of charges & allegations).

102 *See* Lapaglia (N.C. Med. Bd. Sept. 21, 2005) (notice of dismissal).

103 *See* Booker v. Lapaglia, No. 3:11-CV-126, 2014 WL 4259474, at *3–5 (E.D. Tenn. Aug. 28, 2014), *vacated*, 617 F. App'x 520 (6th Cir. 2015).

104 United States v. Booker, 728 F.3d 535, 540, 548 (6th Cir. 2013).

Lapaglia's license with fewer restrictions than when he formed L&B in the first place.[105]

B. *A System that Fails the Public*

Measured against our theory of professional discipline, the decision in Dr. Lapaglia's case falls short. Dr. Lapaglia was an unsafe provider—both for his own patients and for the broader population of Tennessee that was and remains in the grips of a pill addiction crisis—not because of his own problems with Benzodiazepines or because he did not know the correct procedure for prescribing controlled substances, but rather because he viewed his medical license as a tool to be used (illegally, according to two different criminal systems) for his own financial gain rather than for patient care. More chances were inappropriate especially because board orders had no apparent deterrent effect on him; instead he saw the board's regulation as something to be worked around.

The Lapaglia case is not an aberration in the United States. It stands for a larger, more systemic problem: the American licensing system disciplines professionals too infrequently, too late, and too leniently to adequately protect the public.

1. Inaction & Delay

Perhaps the most troubling feature of professional board discipline is its failure to react to bad conduct in the first place. Cases like Dr. Duntsch, whose license was not revoked until well after the criminal case against him was in progress,[106] or Dr. Tyndall, whose conduct went undetected by the Medical Board of California for almost three decades,[107] suggest that boards simply do not discipline nearly enough professional providers. A national study of nursing board cases alleging sexual abuse found that states only discipline an average of one or two nurses a year for this offense despite the likelihood that abuse is relatively

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105 *See* Lapaglia, No. 17.18-157362A, at 6–7 (Tenn. Bd. of Med. Exam'rs Aug. 13, 2019) (final order) (detailing Lapaglia's probation); TBME, BOARD MEETING MINUTES, *supra* note 85.

106 The Texas Medical Board had reliable information about Dr. Duntsch's dangerousness yet failed to act. *See* Dr. Death, *Season 1: Dr. Duntsch, Episode 4: Spineless*, WONDERY, at 15:02–23:24 (Sept. 11, 2018), https://wondery.com/shows/dr-death/season/1.

107 Ryan et al., *supra* note 50.

common.[108] Inaction at massage boards is likewise a documented problem. The Louisiana Board of Massage Therapy was recently criticized by the state legislature for failing to pursue disciplinary against providers working at establishments easily identified on the internet as brothels,[109] and the town of Oxford, Massachusetts, became so frustrated by the state licensing board's inaction against sex traffickers that it created its own licensing scheme by ordinance.[110]

Boards' failure to pursue discipline is difficult to study systematically, as it requires knowing the base rate of professional misconduct. As some researchers have done, one way of establishing a base rate is to examine complaint data. Only about two percent of complaints against physicians, for example, result in any public disciplinary action.[111] The data from law reveal a slightly higher number, although still in the single digits.[112] Of course, not all patient and client complaints are credible enough to merit an investigation, let alone a finding that discipline is in order. But the prevalence of "private discipline," in the form of a letter sent to a practitioner without any license restrictions or public information, suggests that boards do consider many complaints that they reject for public discipline to be nevertheless credible and troubling. In law there are twice as many private actions as public.[113] In medicine, private discipline exceeds public action by a factor of eight.[114] A more objective measure of base rates of misconduct comes from malpractice data. Researchers have shown that doctors paying out major malpractice settlements and jury awards are still unlikely to face board discipline. Nationally, a physician that pays out on ten malpractice claims still only faces a

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108 AbuDagga et al., *supra*, note 23, at 113.

109 According to the massage board, they do not use the sites because "establishments do not have control over what is posted on these websites and there are so many of these websites it would be hard to know which ones to search." LOUISIANA MASSAGE BOARD AUDIT, *supra* note 24.

110 Andrea Estes, *FBI Investigating State's Licensing of Massage Therapists with Fake Credentials*, BOS. GLOBE (Feb. 26, 2020, 1:11 PM), https://www.bostonglobe.com/2020/02/26/metro/fbi-investigating-states-licensing-massage-therapists/.

111 *See, e.g.*, GEORGIA AUDIT, *supra* note 33, at 25.

112 Levin*, Emperor's Clothes*, *supra* note 4, at 8–9 ("Only about five percent of all complaints result in any sanctions against lawyers.").

113 *Id.* at 9.

114 *See* GEORGIA AUDIT, *supra* note 33, at 25.

thirty-three percent chance of board discipline.[115] The same is true of doctors who face disciplinary actions by their hospitals: more than half face no subsequent board sanction.[116]

In the unlikely event a board does pursue discipline, it does so very slowly. Again, empirical studies are few, but one, by a law professor reading five year's worth of disciplinary decisions against lawyers in New York, found the length of time between when misconduct came to light and when the board acted "unconscionably long." He said, "it mocks the professed goal of protecting the public and the administration of justice if a lawyer who will be (and should be) suspended or disbarred is left to practice for years until the day of sanction."[117] And an investigative journalist in Florida found that it took the medical board an average of 434 days to resolve a case.[118]

Case studies we gathered from Tennessee suggest long delays between when the board learns of misconduct and when it takes action against a license. It took the licensing board three years to act against an over-prescriber whose misconduct likely led to the overdose deaths of five of his patients in a single year.[119] During that time he practiced medicine on a clean license. The same board learned in 2013 about an OB-GYN with significant malpractice history who apparently traded drugs for sex with eleven of his patients. They eventually revoked his license in 2017, before reinstating him in 2018.[120]

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115 SETH OLDMIXON, PUB. CITIZEN, THE GREAT MEDICAL MALPRACTICE HOAX: NPDB DATA CONTINUES TO SHOW MEDICAL LIABILITY SYSTEM PRODUCES RATIONAL OUTCOMES 13 (2007), https://www.citizen.org/wp-content/uploads/npdb_report_final.pdf [https://perma.cc/E8B8-MTM7]; *see also* Hyman, Rahmati & Black, *supra* note 34, at 141–42 (finding that a physician in Illinois paying out on five or more malpractice claims had a 31% chance of facing disciplinary action).

116 *See* ALAN LEVINE, ROBERT OSHEL & SIDNEY WOLFE, PUB. CITIZEN, STATE MEDICAL BOARDS FAIL TO DISCIPLINE DOCTORS WITH HOSPITAL ACTIONS AGAINST THEM (2011) https://www.citizen.org/article/state-medical-boards-fail-to-discipline-doctors-with-hospital-actions-against-them/ [https://perma.cc/ED7D-K58Q].

117 Gillers, *supra* note 4, at 496.

118 *See* Steve Miller, *Questionable Doctors Keep Licenses Because of Drawn-Out Investigative Process*, FLA. TIMES-UNION (Oct. 24, 2013, 1:38 PM), https://www.jacksonville.com/story/news/2013/10/24/questionable-doctors-keep-licenses-because-drawn-out-investigative-process/15811782007/.

119 *See* Rinehart, No. 17.18-146184A (Tenn. Dep't of Health Nov. 27, 2018) (final order).

120 Hodges, No. 17.18-138745A, at 8 (Tenn. Dep't of Health Sept. 26, 2017) (final order) (revoking licensure); TENN. BD. OF MED. EXAM'RS, REGULAR BOARD MEETING TUESDAY, MARCH 20, 2018 & WEDNESDAY, MARCH 21, 2018 MINUTES, at 5–6 (2018) (documenting reinstating of Dr. Hodges' license subject to condition that all patients be chaperoned).

2. Wrist-slaps

When boards decide disciplinary cases, they are too forgiving and too generous with subsequent chances. Journalists at the Atlanta Journal-Constitution conducted a nationwide study of medical board disciplinary cases and found that of the approximately 2,400 doctors who had received board discipline for sexual misconduct during the period they studied, half were still in practice.[121] Likewise, empirical evidence of professional recidivism suggests that licensing board disciplinary orders fail to protect the public. Researchers conducting a nationwide empirical study of medical board sanctions found that doctors who receive moderate to severe sanctions who were permitted to return to practice were over twenty times more likely to be disciplined again than doctors without a disciplinary history.[122] Similar data is found in law, where lawyers having faced previous board sanction are thirty times more likely to receive board discipline than those who have not been in trouble with their licensing board.[123]

To the very few studies of board sanction severity, we add our findings from Tennessee. Our empirical analysis of five year's worth of medical board disciplinary decisions[124] supports the conclusion suggested by the AJC investigation and the evidence about professional recidivism: boards do not discipline professionals in a way that protects the public. Even when a board makes findings of fact that suggest very serious lapses of ethics and competency—often on a repeat basis—they tend to impose sanctions that either keep the provider in practice or articulate a path back to licensure. According to our data, between 2016 and 2020, temporary or permanent revocation of a doctor's licensure was the outcome in just thirty-three percent of cases involving sexual misconduct. And during that five-year period, when over 10,000 Tennesseans died of drug overdoses mostly driven by the opioid crisis, the board kept in practice almost two thirds of the doctors they found to have improperly prescribed.[125]

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121 Teegardin et al., *supra* note 3, at 11.

122 Grant & Alfred, *supra* note 84, at 877.

123 *See* Rozema, *supra* note 53, at 382.

124 *See infra* Section V.B.

125 Out of 79 Tennessee cases where the board found facts amounting to "[d]ispensing, prescribing or otherwise distributing any controlled substance not in the course of professional practice, or not in good faith to relieve pain and suffering, or not to cure an

III. PERSONNEL IS POLICY: SELF-REGULATORY DISCIPLINE

Why do boards act so infrequently, so slowly, and with such forbearance when confronted with professional misconduct? The answer lies with the regulatory design used in American professional licensing, most especially the choice of who decides board disciplinary cases. In the typical state, discipline is decided by busy, working professionals, inexpert in regulation, who are given too little information to do much else than go with their instinct to try to rehabilitate respondent professionals. This part shows how these regulatory problems contribute to a professional disciplinary system that is too forgiving to be safe.

A. *Agency Structure: Maximum Discretion with Minimal Resources*

States regulate the professions through "practice acts," statutes that define the scope of a profession, outline basic entry requirements like testing and education, and establish ethics rules to define good practice.[126] Practice acts also create boards to oversee the administration of this statutory scheme, which involves making more fine-grained rules about entry and practice requirements, deciding individual cases for licensure, and identifying professionals who have violated the practice act and deciding whether that justifies a license restriction or revocation.[127]

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ailment, physician infirmity or disease, or in amounts justifiable and/or for durations not medically necessary, advisable or justified for a diagnosed condition," the board kept 52 in practice by imposing a reprimand or probation; many retained their prescribing authority. Note that this language used by the board to justify these relatively light sanctions closely tracks the language of the federal code that makes such prescribing a felony. *See* Ruan v. United States, 597 U.S. 450, 452 (2022).

126 *See* STANLEY J. GROSS, OF FOXES AND HEN HOUSES: LICENSING AND THE HEALTH PROFESSIONS 8–9 (1984) (defining a "practice act"); YOUNG, *supra* note 38, at 81 ("Licensing laws are often called 'practice acts,' because they grant authority to licensees to engage in certain practices within a profession.").

127 *See, e.g.*, McPheeters & Bratton, *supra* note 14, at 1332–33 (describing the regulatory authority of Tennessee's health-related boards); KLEINER, *supra* note 11, at 29 (describing the duties and authority of licensing boards generally); GROSS, *supra* note 126, at 97–98 (same). The interpretive power of boards is immense, especially when resolving individual disciplinary cases, because legislatures tend to be especially generous in delegating regulatory authority to boards by writing particularly vague practice acts for boards to interpret. *See id.* at 102 (observing that "[g]enerally the boards have wide latitude" in

In this sense, the typical American licensing board does both rule-making and adjudication—it creates its own rules and interprets them in individual cases.[128]

Practice acts also set the qualifications for membership of a licensing board, most often with a majority of seats going to currently-licensed professionals.[129] Public members (non-professionals) on boards typically have no experience in either the profession or regulation and thus their influence on the board is often weak.[130] Typically, board members are selected by the state governor, often in consultation with the state professional association.[131] As a result, most board members come from the ranks of their state or national professional association—groups dedicated to the betterment of the profession and its members.[132] Not much is known about how public members are selected for service, but most likely it is through a system of political patronage.[133] Board members are not paid significantly for their time; typically boards only reimburse for travel expenses or provide a modest per diem stipend.[134] The typical board member must therefore balance full-time professional work with his or her duties on the board, allowing them inadequate time to devote to the regulatory project.[135]

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setting standards for entry and defining ethical practice); *see also, e.g.*, KLEINER, *supra* note 11, at 31 ("[L]icensing appears to be responsive to political pressure from occupational associations seeking to become regulated.").

128 This structure was challenged and upheld in *Martin v. Sizemore*, 78 S.W.3d 249, 263–64 (Tenn. Ct. App. 2001).

129 Allensworth, *supra* note 9, 1572–74..

130 *See* David A. Johnson et al., *The Role and Value of Public Members in Heath Care Regulatory Governance*, 94 ACAD. MED. 182, 184 (2019) (describing how public members, over time, "begin to identify increasingly with the interests of the profession or their professional colleagues"); SCHMITT, *supra* note 38, at 79.

131 *See, e.g.*, *Guide to Medical Regulation in the United States — Introduction*, FED'N OF STATE MED. BDS. (2024) [hereinafter *Introduction*, FSMB], https://www.fsmb.org/u.s.-medical-regulatory-trends-and-actions/guide-to-medical-regulation-in-the-united-states/introduction/ [https://perma.cc/7KRH-Z46R]; GROSS, *supra* note 126, at 98.

132 *Id.* at 98–99 (discussing the power associations have in board appointment); SCHMITT, *supra* note 38, at 77 (same).

133 SCHMITT, *supra* note 38, at 77; SHIMBERG, *supra* note 70, at 165 (observing that public member vacancies "often went to those who had worked in the governor's campaign or made financial contributions").

134 *See, e.g.*, STATE OF ILL. COMM'N ON GOV'T FORECASTING AND ACCOUNTABILITY, BOARDS AND COMMISSIONS WITH SALARIES OR OTHER COMPENSATION (2023), https://www.ilga.gov/commission/lru/Salaries.pdf; *see also* OR. ADMIN. R. 847-003-0200 (2023).

135 *See* Frisch, *supra* note 4, at 356–57, 360 (arguing that Washington D.C.'s disciplinary system, comprised of volunteer practicing attorneys, results in protracted delays).

Thus, the American licensing board is an inversion of the typical agency, where bureaucrats take counsel from industry experts but make the final decision for themselves.[136] At a licensing board, the final decision-making power is given not to those with the most information about the regulatory consequences of a decision—its staff and lawyers—but to professionals who take a few days off every quarter from their busy professional lives to act as their own regulators.

B. *System Failures: Under-resourced, Unguided, and Rehabilitative*

This choice of personnel has several implications for professional disciplinary procedure. Somewhat counter-intuitively, professionals regulating themselves tend to under-fund their own work, leading to a slow, complaint-based system not equipped to discover professional misconduct when it happens. Self-regulation has also led to a lack of guidance on disciplinary issues, which exacerbates the problem of boards lacking expertise in regulatory matters. Finally, and perhaps most obviously, it leads to pro-professional bias highlighted by the disciplinary system's emphasis on rehabilitation.

To fully understand how these features of a licensing board contribute to failures of professional discipline, it is important to understand the legal procedure of discipline.[137] When boards or umbrella agencies' housing boards receive a credible complaint[138] about a professional, it is reviewed by a consulting professional to give an opinion about whether the complaint describes improper practice.[139] If the consultant gives the go-ahead, investigators for the board or the department in which the board is housed will investigate by asking for patient charts

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136 *See* MARSHALL J. BREGER & GARY J. EDLES, INDEPENDENT AGENCIES IN THE UNITED STATES: LAW, STRUCTURE, AND POLITICS 39, 57 (2015).

137 For an overview of the disciplinary procedure that tracks the description provided here, see RUTH HOROWITZ, IN THE PUBLIC INTEREST 121–22 (2013) and SCHMITT, *supra* note 38, at 123–30.

138 For the online form used for filing a complaint against a health-related professional in Tennessee, see *Filing Complaints Against Health Care Professionals*, TENN. DEP'T OF HEALTH [hereinafter *Filing Complaints*], https://www.tn.gov/content/tn/health/health-program-areas/health-professional-boards/report-a-concern.html [https://perma.cc/ZSM5-U4AB] (last visited Oct. 30, 2024). For a more detailed description of the complaint process, see RANDALL R. BOVBJERG ET AL., STATE DISCIPLINE OF PHYSICIANS: ASSESSING STATE MEDICAL BOARDS THROUGH CASE STUDIES 20 (2006).

139 Barbara A. Van Horne, *Psychology Licensing Board Disciplinary Actions: The Realities*, 35 PRO. PSYCH. 170, 172–73 (2004).

or files, interviewing witnesses, and subpoenaing documents.[140] Once the investigation is complete, another go/no-go decision is made by a member of the profession acting as a consultant or by a panel dominated by professionals.[141] If charges are recommended, then an attorney prosecuting the case will send either a private letter of warning, or a letter formally charging the professional.[142] In the latter case, the attorney and professional will begin a negotiating process to come to an agreed order, which must be approved by the board.[143]

If the parties fail to work out a deal or the board rejects it, the case proceeds to a contested case hearing, which resembles a trial,[144] where facts must be proved either by clear and convincing evidence or, more commonly, by a preponderance of the evidence.[145] In most states, the board or a smaller panel constituted from it acts as judge and jury.[146] In some states, as in Tennessee, an administrative law judge sits in on the hearing to swear in witnesses or rule on technical legal issues

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140 For a description of the investigatory powers of the health-related boards in Tennessee, see TENN. CODE ANN. § 63-1-117 (2019) and TENN. CODE ANN. § 68-1-104(2) (2011) (opioid-related investigations). *See also* Allan Barsky et al., *Licensing Complaints: Experiences of Social Workers in Investigation Processes*, INT. J. SOC. WORK VALUES & ETHICS, Autumn 2021, at 29, 30 (describing the complaint and investigation process).

141 *See, e.g.,* Jonathan Yi, *Proceed with Caution: The Effect of Disciplinary Determinations on Civil Suits Involving Engineers*, FLA. B.J., Dec. 2007, at 10, 12 (2007) (describing using a majority-engineer "probable cause" panel to decide whether to bring professional disciplinary charges against an engineer under investigation). *See also Filing Complaints*, *supra* note 138; BOVBJERG ET AL., *supra* note 138, at 26; Grant & Alfred, *supra* note 84, at 869.

142 *See* BOVBJERG ET AL., *supra* note 138, at 26.

143 This is usually a rubber stamp. *See* Grant & Alfred, *supra* note 84, at 869-70. For a general discussion of the settlement process, *see* SCHMITT, *supra* note 38, at 127-28. For a discussion of the agreed order process in other professions, *see* Barsky et al., *supra* note 140, at 29, 35 (social workers); James Luther Raper & Randall Hudspeth, *Why Boards of Nursing Disciplinary Actions Do Not Always Yield the Expected Results*, 32 NURSING ADMIN. Q. 338, 341 (2008) (nursing).

144 For a description of contested case hearings, *see* Yi, *supra* note 141, at 11, 12 (engineers) and BOVBJERG ET AL., *supra* note 138, at 26–27 (physicians).

145 For a comparison of burdens among medical boards, see FED'N OF STATE MED. BDS., STANDARDS OF PROOF REQUIRED IN BOARD DISCIPLINARY MATTERS (2021), https://www.fsmb.org/siteassets/advocacy/regulatory/discipline/standards-of-proof-required-in-board-disciplinary-matters.pdf. For the same information in nursing, see Edie Brous, *Common Misconceptions About Professional Licensure*, AM. J. NURSING, Oct. 2012, at 55, 56–57 & tbl.2.

146 SCHMITT, *supra* note 38, at 126 ("Boards or subsets of boards may act as a jury in formal hearing.").

like the admissibility of evidence.[147] But it is the board—or a panel comprised of a subset of its members—that decides everything that really matters: what happened, whether it violated their profession's practice act, and what penalties to impose.[148] In other states, the case is tried directly to an ALJ, who makes proposed findings of fact, law and sanction.[149] But here, too, the board has the final say in adopting the recommendation of the judge.[150] State law provides for an appeal process outside of the administrative proceeding, usually in a state court.[151] But judicial review is highly deferential and does not permit the court to substitute its judgment for that of the board on the facts of the case.[152]

1. Slow, reactive, nonadversarial

The choice to use volunteers from the profession to implement and oversee this process significantly impacts its design and how well it works. Most fundamentally, boards do not have enough money to adequately fund a disciplinary process that would identify bad actors, marshal the evidence against them, and impose a public-regarding sanction while adhering to the strictures of due process.[153] Boards' lack of funding is, in significant part, a function of the professional-volunteer structure of their membership. Most boards are funded primarily or entirely by licensing fees,[154] and professional board members have an

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147 *See* McPheeters & Bratton, *supra* note 14, at 1333; BOVBJERG ET AL., *supra* note 138, at 27–28.

148 SCHMITT, *supra* note 38, at 127. For profession-specific descriptions of who makes what decisions, see FSMB, REGULATORY TRENDS, *supra* note 29, at 11 (doctors) and Raper & Hudspeth, *supra* note 143, at 341–2 (nurses).

149 FSMB, REGULATORY TRENDS, *supra* note 29, at 66.

150 In California, for example, the board does not attend the hearings; however, the board votes on whether to adopt the administrative law judge's decision. FSMB, REGULATORY TRENDS, *supra* note 29, at 66 (medicine); Edie Brous, *Professional Licensure: Investigation and Disciplinary Action*, AM. J. NURSING, Nov. 2012, at 53, 55 (nursing).

151 *See, e.g.*, TENN. CODE ANN. § 4-5-322 (2024).

152 *See, e.g.*, *id.* § 4-5-322(h) (limiting power of courts to affect board decisions); *Tenn. Dep't of Health v. Collins,* No. 18-492-IV, at 6 (Tenn. Ch. Jun. 25, 2019) (final order), *aff'd*, No. M2019-01306-COA-R3-CV (Tenn. Ct. App. Nov. 25, 2020) (finding a board sanction inappropriate and remanding to the board).

153 *See* SCHMITT, *supra* note 38, at 121 (noting that a common stated reason for lack of board discipline is "inadequate funding to perform the necessary investigations"). Similar observations have been made in specific professions. *See, e.g.,* Landess, *supra* note 77, at 140 (medicine); Van Horne, *supra* note 139, at 175 (psychology).

154 *See* SCHMITT, *supra* note 38, at 160–61; *Introduction*, FSMB, *supra* note 131.

obvious interest in keeping licensing fees low for themselves and their colleagues. Small budgets make for inadequate investigatory resources and necessitate a complaint-based system which is reactive and slow, a dynamic reflected in an empirical study showing a correlation between board resources and disciplinary activity.[155]

Rather, disciplinary cases are opened only when someone files a complaint to a board.[156] Typically, anyone can file a complaint—even someone who isn't a patient or a client of the provider.[157] Sometimes colleagues will turn in a provider to the board, and indeed many states impose an ethical duty on physicians to report their colleagues.[158] But feelings of loyalty and collegiality prevent this from being a large or reliable source of disciplinary complaints.[159] Law enforcement agencies may refer cases to boards, but they are not required to do so,[160] and it happens less than one might expect.[161]

Most often complaints must therefore come from patients and clients. There are major drawbacks to such a system. First, a consumer must know that he has received bad or unethical care, though the licensure system is justified in part by

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155 Law & Hansen, *supra* note 4 (finding that some of the only factors that correlated with disciplinary rates were staffing and funding).

156 *See, e.g.*, Deborah L. Rhode & Alice Woolley, *Comparative Perspectives on Lawyer Regulation: An Agenda for Reform in the United States and Canada*, 80 FORDHAM L. REV. 2761, 2766 (2012); PA. DEP'T OF STATE, 50 STATE COMPARISON REPORT: A COMPARISON OF STATE OCCUPATIONAL LICENSURE REQUIREMENTS AND PROCESSES 17–18 (2021), https://www.dos.pa.gov/ProfessionalLicensing/Documents/50-State-Licensing-Comparison/50-State-Comparison-Report-full.pdf; Grant & Alfred, *supra* note 84, at 882; Landess, *supra* note 77, at 339; BOVBJERG ET AL., *supra* note 138, at 20.

157 *See, e.g.*, HOROWITZ, *supra* note 137, at 122; Jacqueline Landess & Bryan Holoyda, *Medical Board Complaints*, *in* MALPRACTICE AND LIABILITY IN PSYCHIATRY 267, 268–69 (Peter Ash, Richard L. Frierson & Susan Hatters Friedman eds., 2022).

158 *See* FSMB, DUTY TO REPORT, *supra* note 59, at 2; Linda Thorne et al*., An Experimental Study of a Change in Professional Accountants' Code of Ethics: The Influence of NOCLAR on the Duty to Report Illegal Acts to an External Authority*, 191 J. BUS. ETHICS 535, 539, 546 (2024).

159 *Cf.* ABEL, *supra* note 52, at 502 (noting that only about ten percent of complaints against lawyers come from other lawyers, including judges).

160 *See* McPheeters & Bratton, *supra* note 14, at 1334 (emphasis added) (citing TENN. CODE. ANN. § 63-1-151(a)(2) (2016)) ("State and federal prosecuting attorneys are *encouraged* to notify the licensing agencies.").

161 *See* Timothy S. Jost et al., *Consumers, Complaints, and Professional Discipline: A Look at Medical Licensure Boards*, 3 HEALTH MATRIX 309, 315 (1993); BOVBJERG ET AL., *supra* note 138, at 20–21.

the idea that consumers do not know what they are getting.[162] Second, they must actually *feel* harmed by the conduct. For large classes of cases—Dr. Lapaglia's script-selling scheme, for example[163]—consumers will have no complaints about the unethical services they received. Third, the aggrieved consumer must know that a board exists, learn how to get in touch, and be willing to put themselves through the investigation process.[164]

The system could be designed to be more proactive. Licensing boards could use public information about controlled substance prescribing, malpractice suits or hospital discipline to initiate investigations into problematic providers.[165] Boards could access public criminal records or develop stronger relationships with local law enforcement that might encourage information sharing. But some of these proactive investigative techniques involve resources and as long as boards remain underfunded, their means of learning about bad practice is unlikely to change.

Inadequate funding also contributes to the lack of adversariality in the board disciplinary process because without enough resources to pursue contested cases, board staff feel pressure to negotiate settlements with accused professionals. Meting the due process requirements of a contested case is expensive and time-consuming. Contested cases are also costly because they involve the potential for an appeal in state court, where discipline that is "arbitrary and capricious" will be thrown out.[166] Board prosecutors are therefore encouraged to work out negotiated settlements with providers. Professionals wanting to avoid a public trial also favor negotiated orders. Board members, as unpaid volunteers, also prefer to approve negotiated settlements than to take yet more time off from their professional lives to travel to the state capital and hear a case, which can take days or weeks.[167]

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162 *Cf.* Wilkins, *supra* note 4, at 824–29 (noting that only the most sophisticated clients are likely to know they have been harmed yet are also the least likely to complain to a board).

163 *See supra* Section II.A.

164 Victims of sexual misconduct are perhaps especially unlikely to make a complaint. *See* FSMB, *Recommendations of Workgroup on Sexual Misconduct*, *supra* note 45, at 24 (noting that boards' typical requirement that disciplinary hearings be conducted in public may make patients hesitant to bring sexual misconduct cases).

165 *See* David A. Hyman, *Are We Driven by Data: The Problem of Bad Doctors*, 96 DENV. L. REV. 761, 772 (2019) (suggesting that malpractice history be used to identify problem doctors).

166 *See supra* note 151–52 and accompanying text.

167 One trial before the Tennessee Board of Medical Examiners took seventeen months from opening arguments to deliberations. TENN. BD. OF MED. EXAM'RS, REGULAR BOARD MEETING TUESDAY, NOVEMBER 28 2017 & WEDNESDAY, NOVEMBER 29, 2017 MINUTES,

Theoretically, the process of working out an agreed order could be adversarial, as are plea negotiations in the criminal system.[168] But in the licensing context, the negotiation happens in the shadow of a contested case hearing,[169] where panels constituting mostly representatives from the accused's own profession will give the provider the benefit of the doubt, removing the leverage that a criminal prosecutor has by threatening a trial before a judge or jury. Furthermore, a heavy reliance on consent orders significantly reduces the amount of public information available about a professional's misconduct. Documents charging a professional with discipline are not usually public,[170] as they are in the criminal and civil legal systems, so the full set of alleged facts is unavailable. And consent orders tend to be elliptical in their recitation of the facts underlying the discipline, because they, too, are a product of negotiation between a board prosecutor without leverage and a professional with in interest in admitting as little as possible.

2. Unguided

When it comes to discipline, boards have very little to rely on in terms of statutory guidance or concrete rules with elements. Essentially, boards must find whether a professional has violated a vaguely worded practice act and to discipline is in the interest of the citizens of its state.[171] Boards do sometimes create policy statements about discipline, but they are often too imprecise—like the statutes they interpret—to be constraining or guiding. Typically, any specificity boards do provide is about what conduct will be deemed misconduct, not about the

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at 18–19 (2017) (documenting contested case hearing of Brian S. Waggoner on September 27, 2017), https://www.tn.gov/content/dam/tn/health/healthprofboards/medicalexaminers/ME112817.pdf; Waggoner, No. 17.18-139095A (Tenn. Bd. of Med. Exam'rs Mar. 1, 2019) (final order), https://apps.health.tn.gov/DisciplinaryExclusion/boardorder/display/1606_27530_030119 [https://perma.cc/JT9D-J8H6].

168 *See, e.g.*, Gerard E. Lynch, *Screening Versus Plea Bargaining: Exactly What Are We Trading Off?*, 55 STAN. L. REV. 1399, 1403 (2003).

169 *See supra* discussion at notes 144–52.

170 *See, e.g.*, Angela Wheeler Spencer et al., *The Disclosure of CPA Disciplinary Action,* CPA J., Mar. 2015, at 60.

171 Professor Nadia Sawicki has pointed out that constitutional vagueness or overbreadth challenges to these practice acts have failed. Sawicki, *supra* note 4, at 317.

appropriate disciplinary sanction for a provider who has engaged in it.[172] Of legal discipline, Professor Leslie C. Levin has said, "even causal observation of the vague, often unarticulated standards used by state decision-makers when imposing discipline raises serious questions about whether sanctions could be imposed fairly."[173]

Professionals themselves are on record describing board decision-making as unconstrained. For example, board members interviewed for a set of case studies of state medical boards said that they struggled to determine how many instances of negligence amounted to incompetence. They confirmed that "there are no agreed upon, objective standards of competence on which they can rely."[174] And professionals on the receiving end of discipline have also said that board decisions amount to "gut reaction[s]."[175] A sign of the lack of concrete guidance for board members deciding disciplinary cases is the level of variability and inconsistency in the way that regulators react to misconduct. This is a problem not only between states[176] but also within the same state and for the same profession. For example, the qualitative study of bar decisions in New York found that lawyer discipline in that state "lacks even an approximation of consistency."[177] In psychology, an observer has called for "a lexicon for disciplinary grounds and disciplinary actions" in order to "enhance consistency within as well as across boards."[178]

Boards' extreme discretion is a function of regulatory design. In most legal systems, the legislative and adjudicative functions are separate. Sometimes the lines are quite stark— as between Congress and the courts in the federal system. But even in the administrative context, where a single agency can perform both rule-

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172 The Tennessee Board of Medical Examiners' policy on sexual misconduct is a good example: it defines sexual misconduct at some length, but then asserts that in cases involving sexual misconduct, "the board will impose such discipline as the board deems necessary to protect the public." TENN. BD. OF MED. EXAM'RS, POLICY REGARDING SEXUAL MISCONDUCT ¶ II(A)(11) (2022), https://www.tn.gov/content/dam/tn/health/healthprofboards/medicalexaminers/BME_sexual_misconduct_policy.pdf.

173 Levin*, Emperor's Clothes*, *supra* note 4, at 5.

174 BOVBJERG ET AL., *supra* note 138, at vii.

175 Barsky et al., *supra* note 140, at 31.

176 *See, e.g.*, Landess, *supra* note 77, at 340 (finding a four-fold variation between states in terms of medical board disciplinary actions); Jon J. Lee, *Catching Unfitness*, 34 GEO. J. LEGAL ETHICS 355, 393 (2021) (finding "a vast discrepancy among states" in how they apply the "fitness to practice" ethical rule).

177 Gillers, *supra* note 4, at 503.

178 Van Horne, *supra* note 139, at 170, 176.

making and adjudicative duties, there is usually more separation of personnel between who makes the rules and who adjudicates cases under them.[179] One advantage of this separation, wholly absent from the licensing board context, is that it forces the rule-makers to be specific and constraining in their guidance to the adjudicator. This makes for a more transparent process and upholds rule-of-law principles better than a system where the rule-makers give themselves maximal discretion, to be exercised with inappropriate leniency in the end. Specific, constraining guidance would also prevent the current state of affairs where boards can come across as harsh on the books while actually pursing a policy of forgiveness in individual cases.

3. Biased

The last, and perhaps most important, problem with a system that uses professionals to police their own is as obvious as it is difficult to prove. The disciplinary procedure described above is self-regulatory at almost every stage, creating an apparent risk of pro-professional bias. Professionals consult on whether to investigate a complaint, advise board staff about whether to pursue discipline to a full investigation and, in the end, have the voting power over lay members to decide the facts, law, and sanction. Judicial review works as a one-way ratchet in favor of the professional—a court can reject a board's disciplinary action but cannot make it more severe.[180]

The appearance of bias is itself a problem and threatens the system's legitimacy in the eyes of the public. Moreover, the apparent risk seems borne out in disciplinary outcomes. As discussed in Part II, professional discipline under the current board system is too inactive, too slow, and too forgiving to be safe. Scholars have asserted that self-regulation is behind this problem.[181] For example, the authors of a seven-year study of 180 medical licensing board disciplinary cases concluded that their data "suggest that the field of medicine has self-regulated in a

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179 For example, the FTC combines adjudicatory and rulemaking authorities. The independence of one from the other are assured through structural design and incentives provided to the decision-makers within the agency. *See* 32 CHARLES ALAN WRIGHT, CHARLES H. KOCH, JR. & RICHARD MURPHY, FEDERAL PRACTICE & PROCEDURE: JUDICIAL REVIEW OF ADMINISTRATIVE ACTION § 8234–35 (2d ed. 2023).

180 *See* Landess & Holoyda, *supra* note 157, at 272–73.

181 *See, e.g.,* Frisch, *supra* note 4, at 362 (blaming the "disciplinary system dominated by volunteer lawyers" for a system that produces inadequate professional discipline).

manner that protects self-interests above patient interests."[182] This conclusion is supported by analogy to studies of malpractice, where professionals are reluctant to testify against their peers.[183]

Empirically proving the link between professional board member dominance and lax discipline, however, is a difficult matter. The only empirical study of licensing board discipline and board composition was unable to show that the percentage of public (non-professional) board members had a strong effect on board disciplinary rates.[184] This non-finding, however, should not be taken as evidence that self-regulation does not lead to too-light discipline for two reasons. First, because until recently every medical board in the United States was dominated by physicians,[185] the researchers were not able to compare our system of self-regulation with one in which non-physician voices are given a more meaningful role. And second, the ethos of self-regulation enshrined in American licensing board structure may communicate to minority public members that their role is limited, and they should defer to the professionals on the board.[186]

Why, exactly, do board members go easy on their peers? Board members, knowing that their own practice is far from perfect, may identify with the accused in cases about professional competence. Relatedly, professionals sitting in judgment of their peers may feel the need to protect their profession, as a general matter, from second-guessing by outside voices. Sociologists emphasize the importance of autonomy in establishing professional identity,[187] and governmental incursions on that, in the form of a licensure action, may be viewed as encroachments on the professional domain.

Harder to understand is why board members appear to be biased in favor of the unethical or predatory members of their own profession, whose continued

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182 DuBois et al., *Serious Ethical Violations, supra* note 21, at 25.

183 Sociologist Elizabeth Chiarello makes this link between malpractice suits and licensing boards specific in her article on boards and the "white wall of silence"—the informal ethical code that prevents physicians from speaking ill of each other—that results in board members "easing their obligations. . . in favor of allying with fellow professionals." Chiarello, *supra* note 4, at 76–77.

184 *See generally* Law & Hansen, *supra* note 4.

185 FSMB, REGULATORY TRENDS, *supra* note 29, at 47–48.

186 *See* Johnson et al., *supra* note 130, at 184; SCHMITT, *supra* note 38, at 79.

187 *See, e.g.*, Adam P. Sawatsky et al., *Autonomy and Professional Identity Formation in Residency Training: A Qualitative Study*, 54 MED. EDUC. 616, 619, 624 (2020) (medical profession); Kellye Y. Testy and Zachariah J. DeMeola, *Leading the Way: The Power of Professional Identity Formation for Lawyers*, 76 BAYLOR L. REV. 115, 145–46 (2024) (legal profession).

licensure threatens the reputation and prestige of their profession. It may be that while there are more complicated and competing psychological impulses in a case involving dishonesty or abuse, board members' impulse to "circle the wagons" around their profession or applying the "golden rule"—treating the professional as they would want to be treated when facing a wrongful accusation—win out over fears of reputational harm to the profession as a whole.

C. *Outcome Failures: Tough Love at the Boards*

System design leads to results. The American licensing system is designed to produce discipline that focuses on professionals: on their treatment, rehabilitation, and second (or fourth) chances.

In 1980, the American Medical Association came out with a "4D model" to explain physician misconduct.[188] The model was not evidence-based[189] and was ostensibly limited to physicians, but its basic logic has had a lasting and outsized impact on how licensing boards approach professional misconduct generally. Importantly, of the four explanations, three deflect blame from the professional themselves and point towards rehabilitation as the appropriate mode of discipline. The model says that doctors engage in misconduct because their education is "dated," they are "disabled" by their own substance use, they are "duped" by their patients, or they are "dishonest." All but the last "D" support continuing education or substance use disorder treatment as a path back to unrestricted practice.[190] The result is a pattern of disciplinary orders that emphasize education (even in cases where the provider could not possibly have mistaken his conduct as meeting the professional standard), addiction treatment (even for conditions very likely to relapse, and even after multiple relapses) and specific limitations on practice (even

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188 *See* Donald R. Wesson & David E. Smith, *Prescription Drug Abuse: Patient, Physician, and Cultural Responsibilities*, 152 W.J. MED. 613, 614 (1990); Am. Med. Ass'n Council on Sci. Affs., *supra* note 72, at 864.

189 *Cf.* DuBois et al., *100 Cases of Improper Prescribing, supra* note 21, at 458 (stating that "it is unclear" the extent to which the 4D Framework is "evidence based").

190 *See* Am. Med. Ass'n Council on Sci. Affs., *supra* note 72, at 864 (arguing for rehabilitation for "disabled" doctors); Wesson & Smith, *supra* note 188, at 614 (saying the 4D model was introduced to support education for "duped" and "dated" doctors).

where the facts suggest a general lack of judgment, boundaries, and competency). Boards call this "tough love."[191]

1. Education

Education as a way to remediate imperfect professional practice makes sense when there is a clear connection between a knowledge deficit and the dangerous or unprofessional conduct. Over-prescribing cases against nurses, physician assistants, and doctors from the early and middle periods of the opioid crisis may be good examples, when pharmaceutical companies downplayed the true risks of high-dose opioid use for chronic pain and doctors were deliberately misinformed.[192] Cases about competence—which are surprisingly rare at licensing boards—may also be good candidates for a rehabilitative order involving education. But the cases we read from Tennessee suggest boards are using education to rehabilitate professionals whose transgressions seem to go beyond a lack of knowledge. For example, nurse Christina K. Collins, whom prosecutors said was the top prescriber of controlled substances in the state at one time, was found by the nursing board to have prescribed one patient so many controlled substances that he would have had to take 51 pills a day and tripled another patient's morphine prescription after he was hospitalized for an overdose. The nursing board ordered her to attend continuing medical education but otherwise kept her in practice and left her prescribing unrestricted.[193]

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191 *See* Hearing Before the Tenn. Bd. of Med. Exam'rs at 4:17:05, Lapaglia, No. 17.18-157362A (Tenn. Bd. of Med. Exam'rs July 31, 2019), https://tdh.streamingvideo.tn.gov/Mediasite/Channel/98fe21d561e9489487745f0c7da678b25f/watch/ee17b74a7fa640d994571f4a5fee42261d.

192 For an excellent account of this behavior on the part of pharmaceutical companies, see generally BARRY MEIER, PAIN KILLER (2003).

193 Brett Kelman, *This Pain Clinic Nurse Gave a Patient 51 Pills a Day. And She Kept Her License*, THE TENNESSEAN, (Oct. 11, 2018), https://www.tennessean.com/story/news/2018/10/11/opioid-epidemic-tennessee-pill-mills-christina-collins/1488026002/ [https://perma.cc/H9W9-P2WS]; Collins v. Tenn. Dep't of Health, 694 S.W.3d 170, 173–74 (Tenn. Ct. App. 2023) (detailing the procedural background and 2018 board order for two years of probation plus civil penalties, costs, and additional education). The board's 2018 order was subsequently challenged by the Tennessee Department of Health and reversed on procedural grounds. Four years later, a new panel finally revoked Collins' Advanced Practice RN license, permanently prohibited her from prescribing controlled substances, and voided her "multistate privilege," although it permitted her to continue to practice as an RN in Tennessee. *Id.* at 175; Collins, No.

2. Practice restrictions

When it comes to remedial measures to rehabilitate professionals, licensing boards tend to be minimalists.[194] One example is the use of chaperones in orders following sexual misconduct, even though many people argue that chaperones are ineffective at protecting patients.[195] Other examples of minimally invasive board orders are when a board removes a pill mill prescriber's ability to prescribe controlled substances or an order limits a sexually predatory professional to working with men or the elderly.[196] These orders may prevent the precise conduct from recurring in the exact same way, but they ignore the more general danger presented by a provider who has abandoned an ethos of patient or client care to the point of graft or abuse. Indeed, Dr. Lapaglia's first board order may have removed his ability to personally prescribe controlled substances, but it allowed him to stay in practice where he found other ways to abuse the system. At least one sexually predatory doctor whose disciplinary order precluded practicing on women, then turned to victimizing men.[197]

17.19-138846A (Tenn. Bd. of Nursing Feb. 28, 2022) (final order), https://apps.health.tn.gov/DisciplinaryExclusion/boardorder/display/1702_12828_022822.

194 *See* Teegardin et al., *supra* note 3 (observing that boards often send sexually abusive doctors to treatment centers featuring art, yoga and equestrian therapy or ask them to attend "weekend 'boundary' classes at hotels or college campuses").

195 *See, e.g.*, RON PATERSON, INDEPENDENT REVIEW OF THE USE OF CHAPERONES TO PROTECT PATIENTS IN AUSTRALIA 10 (2017), https://nhpopc.gov.au/wp-content/uploads/Chaperone-review-report-WEB.pdf [https://perma.cc/H9W9-P2WS] (calling for an end to using chaperones as a remedial licensure condition). One study found that 19% of cases of physician sodomy occurred the presence of a chaperone. DuBois et al., *Exploratory Analysis of 101 Cases*, *supra* note 84, at 518. *See also* Natalie Musumeci, *How Larry Nassar Molested My Daughter Right in Front of Me*, N.Y. POST (Feb. 9, 2018, 09:46 AM), https://nypost.com/2018/02/09/nassar-victims-mom-sickos-a-wolf-in-sheeps-clothing/ [https://perma.cc/U8GV-AWXN] (explaining the guilt the parents felt after finding out their daughters were unknowingly assaulted in their presence).

196 *See, e.g.*, SCHMITT, *supra* note 38, at 122 (discussing case of a psychologist who had sex with a patient, in which a disciplinary order restricted him to treat women over 50).

197 *See* Danny Robbins, *Doctor Accused by 17 Females Loses License After Male Patient's Accusation of Sexual Impropriety*, ATLANTA J.-CONST. (July 13, 2018), https://www.ajc.com/news/public-affairs/limiting-doctor-male-patients-failed-stop-sex-abuse/lu2GbV9GxSNlkujDCI0AAN/ [https://perma.cc/9JZU-3B74].

3. Addiction treatment

Finally, and perhaps most importantly, professional board members are quick to attribute misconduct not to incompetence, criminality, or bad judgment, but to what they seem to see as sickness—usually a drug or alcohol use disorder. Here, board members are aided by the 4D model that attributes a large share of misconduct to a professional's "disability."[198] This problem may be especially acute in the health professions where board members are trained to see a substance use disorder as a sickness and to treat the patient with compassion and sympathy, even if the path to redemption puts the public at risk.

In theory, it makes sense for boards to focus on a provider's substance use. Drug and alcohol use disorders are extremely common among professionals facing discipline before a license board.[199] Substance use can lead to poor decision-making, failure to apply appropriate boundaries, and mental and physical incapacitation. If a provider's misconduct stems from a substance use disorder, treating the underlying cause of the misconduct would seem to be the most effective way to stop it at minimal cost to the provider and the public. But in practice, boards take this "illness" model too far. Disciplinary cases from Tennessee suggest that boards persisted in the view that substance use is the root cause of misconduct in the face of clear evidence of other factors not as susceptible to treatment: sexual predation, mendacity, narcissism, and gross professional incompetence.[200] Another

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198 *See* Am. Med. Ass'n Council on Sci. Affs, supra note 72, at 864 (describing the four forms that lead to prescription drug over-prescribing).

199 *See* Holtman, *supra* note 84, at 547 (identifying alcohol or drug use disorder as the largest specific category of board disciplinary actions against physicians); Martha Middleton, *Big Trouble: Experts Say Substance Abuse and Mental Health Issues Are a Growing Problem for the Legal Profession*, A.B.A. J., Dec. 2015, at 63, 64 ("Substance abuse plays a role in 40 percent to 70 percent of all disciplinary proceedings and malpractice actions against lawyers.").

200 For example, the Tennessee Board of Medical Examiners found that Dr. Kristin Dobay forged prescriptions in the names of his girlfriend and other patients for high-dosage drugs with street value (one example was for a daily dose of over thirteen times the recommended maximum), some of which he gave to his administrative assistant to resell. The board allowed the doctor to voluntarily surrender his license but articulated a path back to licensure that involved primarily completing drug recovery programs and assessments. Dobay, No. 2019007891 (Tenn. Bd. of Med. Exam'rs Sept. 18, 2019) (consent order); Brett Kelman, *Nashville Doctor Loses Medical License due to Shady Prescriptions*, TENNESSEAN (Oct. 18, 2019, 5:00 AM), https://www.tennessean.com/story/news/health/2019/10/18/nashville-doctor-kristin-dobay-shady-opioid-prescriptions/3987949002/ [https://perma.cc/3G8Q-F8TS].

flaw of the "illness" model of professional discipline is that it places the focus on the provider and their story of recovery, relapse, and redemption, rather than focusing on how relapses that result in patient and client harm undermine public safety and confidence in the professions.

IV. PHYSICIAN DISCIPLINE IN THE UK: CRISIS AND REFORM

The General Medical Council (GMC)—the body responsible for licensing and disciplining doctors in the United Kingdom—was for the 150 years following its foundation in 1858, organized and structured to reflect the collegial, self-regulating model currently applied by U.S. state professional licensing boards: a medical profession regulated by doctors for doctors.[201] Like American boards, it combined rule-making and adjudication within one professionally-dominated regulatory entity. This ended at the beginning of the twenty-first century, when a crisis of public confidence in the profession of medicine forced the regulator to review its processes[202] and, ultimately, to change the GMC's structure, decisional rules, and accountability. The GMC no longer hears disciplinary cases against doctors; these are decided by an independent tribunal whose membership includes as many lawyers and lay people as it does physicians, all of whom are merit-selected, paid a salary, and trained in medical professional regulation. They are also held to specific, detailed rules of decision in disciplinary cases.

A. *Crisis & Reform*

The GMC is like a state medical board in that it has statutory responsibility to regulate the medical profession under an act of the legislature that gives it the authority to decides who can practice medicine (maintaining a "register" of physicians), sets the rules of medical practice, and disciplines doctors whose conduct or performance is called into question— duties it performs in the name of protecting patients and promoting public confidence in the profession.[203]

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201 *See generally* Mary Dixon-Woods, Karen Yeung & Charles L. Bosk, *Why Is UK Medicine No Longer a Self-Regulating Profession? The Role of Scandals Involving "Bad Apple" Doctors*, 73 SOC. SCI. & MED. 1452 (2011).

202 *See generally* MARK DAVIES, MEDICAL SELF-REGULATION: CRISIS AND CHANGE (2007).

203 Medical Act 1983, c. 54, § 1(1A), (1B) (UK).

Beginning in the 1980s, academic and social commentators argued that the GMC's disciplinary machinery was not applied often enough, hard enough or consistently enough to those who failed to live up to the standards of public protection.[204] A series of public scandals raised doubts about whether the GMC was able to respond effectively to misconduct, from doctors whose standards of clinical competence were unacceptably poor,[205] to doctors who sexually assaulted and abused vulnerable patients.[206] The most well-known and influential inquiry from this period was into the case of Harold Shipman, a doctor who murdered hundreds of his patients.[207] Dr. Shipman was not struck from the GMC's medical register (equivalent to license revocation in the United States) until after he was sentenced to fifteen concurrent terms of life imprisonment for the murders.[208]

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204 *See* Justin Waring, Mary Dixon-Woods & Karen Yeung, *Modernising Medical Regulation: Where Are We Now?* 24 J. HEALTH ORG. & MGMT. 540, 543 (2010).

205 *See generally* JEAN RITCHIE, THE REPORT OF THE INQUIRY INTO QUALITY AND PRACTICE WITHIN THE NATIONAL HEALTH SERVICE ARISING FROM THE ACTIONS OF RODNEY LEDWARD (2000), https://chpi.org.uk/resources/the-richie-enquiry-into-the-activities-of-rodney-ledward-2000/ (describing the case of Dr. Rodney Ledward, who was accused of injuring women under his care during thirteen botched operations between 1989 and 1996); SECRETARY OF STATE FOR HEALTH, LEARNING FROM BRISTOL: THE REPORT OF THE PUBLIC INQUIRY INTO CHILDREN'S HEART SURGERY AT THE BRISTOL ROYAL INFIRMARY 1984-1995, 2001, Cm. 5207, at 133–76 (UK) (describing the case of two surgeons who persisted with substandard practice resulting in the avoidable deaths of over 30 children, despite evidence of excess mortality within an inadequate surgical program).

206 *See generally, e.g.*, ANNA PAUFFLEY, COMMITTEE OF INQUIRY, INDEPENDENT INVESTIGATION INTO HOW THE NHS HANDLED ALLEGATIONS ABOUT THE CONDUCT OF CLIFFORD AYLING, 2004, Cm. 6298 (UK) (detailing regulatory failures in the case of Dr. Clifford Ayling, an OB-GYN, who was convicted of 13 counts of indecent assault on female patients between 1991 and 1998 and was sent to prison for four years in December 2000); SECRETARY OF STATE FOR HEALTH THE KERR/HASLAM INQUIRY REPORT, 2005, Cm. 6640-I, at 83–412 (UK) (describing the cases of two psychiatrists, Dr William Kerr and Dr Michael Haslam, who sexually abused vulnerable female patients over a period of twenty years, were never disciplined by the GMC, and allowed to retire in 1988); COMMISSION FOR HEALTH IMPROVEMENT, INVESTIGATION INTO ISSUES ARISING FROM THE CASE OF LOUGHBOROUGH GP PETER GREEN (2001) (describing the case of Dr. Peter Green who was found guilty in 2000 of nine counts of indecent assault on young male patients between 1985 and 1999 and sentenced to eight years' imprisonment before being disciplined by the GMC).

207 *See generally* JANET SMITH, THE SHIPMAN ENQUIRY FIFTH REPORT, SAFEGUARDING PATIENTS, LESSONS FROM THE PAST - PROPOSALS FOR THE FUTURE, 2004, Cm. 6394-I/II/III (UK).

208 *See* Sarah Boseley, *Shipman Struck Off GMC Doctors' Register for "Undermining Trust,"* THE GUARDIAN, Feb. 12, 2000, at 3; *Shipman Jailed for 15 Murders*, BBC NEWS (Jan. 31, 2000, 7:22 PM GMT), http://news.bbc.co.uk/2/hi/uk_news/616692.stm [https://perma.cc/8MZL-6KX4].

The government's subsequent Shipman Inquiry described the procedural failures at the GMC that had enabled someone like Dr. Shipman to stay in practice.[209] The Shipman report concluded that wherever the GMC's disciplinary process provided for discretion, the system consistently placed a higher premium on the fair treatment of the doctor than on the protection of patients.[210] The report recommended that disciplinary decision-makers be given clear and explicit standards to be applied at each stage of the process and that disciplinary adjudication be handled by an agency independent of the GMC itself.[211] Following the Shipman Inquiry, and in the face of "highly organized and deeply wounded families and patients, relentless media pressure, and a multiplicity of voices demanding action,"[212] the government was forced to implement reforms that effectively ended the era of medical self-regulation in the UK.[213]

B. *General Medical Council: Balanced*

Reforms following the Shipman report have made medical regulation in the UK more balanced, structured, and unbiased.

1. Membership

The first important change made following the Shipman report was to the overall membership of the GMC. Today, lay and professional members each get half the seats on the arm of the GMC that sets practice and ethics rules (the violation of which will form the basis of professional discipline) and that sets the priorities for disciplinary enforcement.[214] In contrast, very few medical boards in America

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209 *See generally* JANET SMITH, *supra* note 207.

210 *See* HOME SECRETARY AND THE SECRETARY OF STATE FOR HEALTH, LEARNING FROM TRAGEDY, KEEPING PATIENTS SAFE: OVERVIEW OF THE GOVERNMENT'S ACTION PROGRAMME IN RESPONSE TO THE RECOMMENDATIONS OF THE SHIPMAN INQUIRY, 2007, Cm. 7014, ¶ 2.17 (UK).

211 *Id.*

212 Dixon-Woods, Yeung & Bosk, *supra* note 201, at 1457.

213 SECRETARY OF STATE FOR HEALTH, TRUST, ASSURANCE AND SAFETY – THE REGULATION OF HEALTH PROFESSIONALS IN THE 21ST CENTURY, 2017, Cm. 7013, at 23–31 (UK).

214 *See* GEN. MED. COUNCIL, OUR ANNUAL REPORT 2019, at 54 (2020); GEN. MED. COUNCIL, SANCTIONS GUIDANCE FOR MEMBERS OF MEDICAL PRACTITIONERS TRIBUNALS AND FOR THE GENERAL MEDICAL COUNCIL'S DECISION MAKERS ¶ 13 (2020) [hereinafter GMC, SANCTIONS GUIDANCE]; Medical Act 1983, c. 54, § 1(1B)(c) (UK).

have achieved parity between lay and physician members, and most other professional licensing boards are also dominated by professionals.[215]

The post-Shipman reforms also changed how these members were selected. Prior to 2003, they were elected by members of the profession,[216] not unlike the process in the United States where professional associations hold sway over the appointment process. Today, appointments to the GMC are made by the Privy Council, a formal body of advisers made up of current and former members of the House of Commons and House of Lords,[217] through open competition and based on objective criteria.[218] Importantly, and in contrast to licensing board members in the United States, members of the GMC are not volunteers, but rather are paid a salary for their full-time work.[219]

2. Complaints and Investigations

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215 *See* Allensworth, *supra* note 9, at 1572; YOUNG, *supra* note 38, at 87–89; FED'N OF STATE MED. BDS., BOARD MEMBERSHIP COMPOSITION (2024), https://www.fsmb.org/siteassets/advocacy/regulatory/board-structure/board-membership-composition.pdf.

216 *See Our History*, GEN. MED. COUNCIL, https://www.gmc-uk.org/about/who-we-are/our-history [https://perma.cc/5WKU-7XQN].

217 The Privy Council of the United Kingdom holds the delegated authority to issue Orders of Council, which are used to regulate certain public institutions, including healthcare regulators. In the UK, the Privy Council is further guided in its member selection process by the oversight body for healthcare regulators: the Professional Standards Authority for Health and Social Care (PSA). There is a degree of uniformity across the fitness to practice processes of all healthcare regulators in the UK, which are guided by an oversight body – the PSA –which must review all fitness to practice cases by each regulator and may appeal decisions through the courts. In addition, the PSA carry out annual performance reviews against its Standards of Good Regulation to assess how well the regulators are carrying out their fitness to practice functions. *See* PRO. STANDARDS AUTH., GOOD PRACTICE IN MAKING COUNCIL APPOINTMENTS: PRINCIPLES, GUIDANCE AND THE SCRUTINY PROCESS FOR REGULATORS MAKING APPOINTMENTS WHICH ARE SUBJECT TO SECTION 25C SCRUTINY (2022), https://www.professionalstandards.org.uk/what-we-do/our-work-with-regulators/appointments-to-councils [https://perma.cc/HW87-FXV3].

218 GEN. MED. COUNCIL, REQUIREMENTS FOR COUNCIL MEMBER APPOINTMENTS AND REAPPOINTMENTS 2016, at 2, 4 (2016).

219 *Salaries and Expenses*, GEN. MED. COUNCIL, https://www.gmc-uk.org/about/how-we-work/governance/executive-board/salaries-and-expenses (last visited Aug. 19, 2024).

GMC's disciplinary procedure is, like its American counterpart, complaint-based,[220] and for this reason may have some of the same problems in identifying professionals for discipline whose misconduct is unlikely to result in complaints. But once a credible complaint is investigated, the system begins to depart in important ways from that of a state licensing board. At the end of the investigation, evidence is considered by two case examiners employed by the GMC, only one of whom may be a physician, and both must agree on the next step.[221] The GMC case examiners have three options at this stage of the case. First, if there is little reason to believe the physician violated a rule of practice or ethics, they can close the case.[222] Second, if the violation is minor, they may issue a warning or ask the doctor to change his or her practice in a specific way (called an "undertaking").[223] Finally, if the case is sufficiently serious, however, the case examiners will refer the case to the Medical Practitioners Tribunal Service (MPTS) for a hearing and final determination of discipline.[224] Of the complaints that British regulators take seriously, less than a third are handled privately as a matter between the regulator and the physician (the second option);[225] in America that figure may be as high as ninety percent.[226] Also unlike the American system, the GMC publishes and

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220 The GMC must investigate if a doctor appears to have failed to maintain the required standards. General Medical Council (Fitness to Practise) Rules 2004, SI 2004/2608, ¶¶ 4,7 (UK). In addition to deviating from GMC guidance, such concerns may include misconduct, poor performance, a criminal conviction or caution, physical or mental ill-health that may impact the ability to practise medicine, or a determination of impaired fitness to practice by another regulatory body, including determinations by medical regulators from other jurisdictions and by other professional regulators in the UK. Medical Act 1983, c. 54, § 35C(2) (UK).

221 General Medical Council (Fitness to Practise) Rules 2004, SI 2004/2608, ¶ 2 (UK) (requiring one "medical" and one "lay" case examiner); *id.* ¶ 8 (setting out role of case examiners). The use of case examiners was introduced as a resource-saving step, which allows straightforward or "clear-cut" cases to be disposed of without the need to convene a meeting of the Investigation Committee. *See* Cathal Gallagher et al., *The Legal Underpinnings of Medical Discipline in Common Law Jurisdictions*, 39 J. LEGAL MED. 1, 15-34 (2019).

222 General Medical Council (Fitness to Practise) Rules 2004, SI 2004/2608, ¶ 8(2)(a) (UK).

223 *Id.* ¶ 8(2)(b), 8(3).

224 *Id.* ¶ 8(2)(d); Gallagher et al., *supra* note 221, at 20–21.

225 *See*, *e.g.*, GEN. MED. COUNCIL, FITNESS TO PRACTISE STATISTICS 2023 (2024), where of 842 total cases progressing past triage, 632 were concluded in private versus 210 in public.

226 Because private board discipline is by its nature difficult to study, we only have the figure for one state, Georgia, where if the medical board takes any action at all on a complaint, there's a 90% chance it will be with a private letter of concern. *See, e.g.*, GEORGIA AUDIT, *supra* note 33.

adheres to guidance detailing the criteria and elements for every stage of a complaint from initial receipt to referral to for discipline. These dozens of documents can be easily viewed on the GMC's website.[227]

C. *Medical Practitioners Tribunal Service: Independent*

Thus, when a case is sufficiently serious, the GMC transfers responsibility for adjudicating professional discipline for physicians to an independent body in the form of the MPTS.[228] The MPTS achieves even greater representation than the GMC of non-physicians in its decision-making procedures, and although the MPTS is funded by the GMC and reports to its governing council twice a year, it is accountable directly only to Parliament.[229] Also in contrast to the American system, MPTS proceedings (called "tribunals," equivalent to "contested cases" in the US) are fully adversarial and their decision rules are highly structured to ensure public-regarding disciplinary decisions.[230] Perhaps most crucially, the cases are decided by panels that are typically *not* dominated by the profession.

1. Membership and Training

The MPTS adjudicates disciplinary cases through three-member panels, drawn from a pool of about 300 members.[231] Members of this pool are, like the governing council of the GMC, appointed based on specific criteria and not by a system of political patronage.[232] Criteria include "intellectual and analytical ability

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227 *How We Make Decisions*, GEN. MED. COUNCIL, https://www.gmc-uk.org/concerns/information-for-doctors-under-investigation/how-we-make-decisions (last visited Aug. 19, 2024).

228 *See* JANET SMITH, *supra* note 207, ¶¶ 27.204–.210.

229 Cathal T. Gallagher & C.L. Foster, *Impairment and Sanction in Medical Practitioners Tribunal Service Fitness to Practise Proceedings*, 83 MEDICO-LEGAL J. 15, 16 (2015).

230 *See id.*

231 On January 22, 2021, there were a total of 247 panelists of whom 120 were medically qualified and 127 were lay members. Tribunal members, chairs and legal assessors are all known as MPTS associates, who are not directly employed by the MPTS. Rather, they are self-employed contractors. Current information on tribunal members is available at *Who Makes the Decisions?*, MED. PRACS. TRIBUNAL SERV., https://www.mpts-uk.org/hearings-and-decisions/who-makes-the-decisions (last visited Jan. 12, 2025).

232 MED. PRACS. TRIBUNAL SERV., CRITERIA FOR THE APPOINTMENT OF TRIBUNAL MEMBERS (2018) [hereinafter MPTS, APPOINTMENT CRITERIA]; MED. PRACS. TRIBUNAL SERV,

… decision-making and sound judgment … [and] fairness, equality and diversity," "demonstrable integrity" and a commitment "to follow the Principles of Public Life as drawn up by the Committee on Standards in Public Life."[233] They are paid pro-rata for their part-time work, adding to the competitive nature of the selection process.[234] All new tribunal members attend several days of in-depth training, which emphasizes the legislation and rules that govern the process for hearings—the key skills required for hearing disciplinary cases.[235] Tribunal members are required to keep their skills and knowledge up to date via regular circulars, updates to guidance, e-learning modules, videos, and webinars. Furthermore, all MPTS tribunal members attend an annual training day.[236]

Once a case has been referred to the MPTS, the doctor will receive a public tribunal as a matter of course; there is no opportunity, as there is in the United States, for the doctor to negotiate a settlement privately.[237] Tribunals are heard by a three-member panel drawn from the larger body of MPTS panelists, ordinarily consisting of a chair, who is usually legally qualified (in American terms, a lawyer),[238] one lay member and one member of the medical profession.[239] Thus, most MPTS panels maintain a two-thirds majority of non-physician members.[240]

CRITERIA FOR THE APPOINTMENT OF CHAIRS OF A TRIBUNAL (2016); MED. PRACS. TRIBUNAL SERV., CRITERIA FOR THE APPOINTMENT OF LEGALLY QUALIFIED CHAIRS OF A TRIBUNAL (2015). A member or officer of the GMC, or a committee of the GMC, cannot serve on the MPTS. General Medical Council (Constitution of Panels Tribunals and Investigation Committee) Rules 2015, SI 2015/1965, art. 2, ¶ 4(3) (UK). Nor can any person who has been the subject of fitness to practise proceedings that resulted in their registration being suspended or made conditional upon compliance with any requirement, or who has been erased from the medical register. General Medical Council (Constitution of the Medical Practitioners Tribunal Service) Rules 2015, SI 2015/1967, art. 2, ¶ 7 (UK).

233 MPTS, APPOINTMENT CRITERIA, *supra* note 232. The Seven Principles of Public Life (also known as the Nolan Principles) are: selflessness; integrity; objectivity; accountability; openness; honesty; and leadership. *See* COMM. ON STANDARDS IN PUB. LIFE, STANDARDS IN PUBLIC LIFE, 1995, Cm. 2850-I, at 14 (UK).

234 MEDICAL PRACS. TRIBUNAL SERV., SCHEDULE FOR SERVICES (2023).

235 MEDICAL PRACS. TRIBUNAL SERV., REPORT TO PARLIAMENT 2020, at 24 (2021).

236 *Id*. at 25.

237 *See* Gallagher & Foster, *supra* note 229, at 16.

238 *Legal assessors and legally qualified chairs*, MEDICAL. PRACS. TRIBUNAL SERV., https://www.mpts-uk.org/about/how-we-work/legal-assessors-and-legally-qualified-chairs (last visited Feb. 4, 2025).

239 General Medical Council (Constitution of Panels Tribunals and Investigation Committee) Rules 2015, SI 2015/1965, art. 2, ¶ 7 (UK).

240 *Id.* ¶ 27. In some cases, the panel may be constituted with a chair who is not a lawyer, in which case the physician members may outnumber the lay member 2:1, but this is less

Again, this is in contrast to the American system which, for the most part, uses physician-dominated panels to decide contested cases.[241]

2. Rules of decision

The MPTS's disciplinary trials are designed to assess whether a physician is a safe and ethical provider, in light of evidence found during a GMC investigation. The Medical Act of 1983, the statute that established the GMC and outlined its authority, advances a theory of professional discipline and identifies its three related goals: to protect the public, to send the message to the public that misconduct is unacceptable, and to send that same message to the profession.[242] The Medical Act thus calls for discipline for doctors whose "fitness to practice" is "impaired" . The term "impairment" is not used as it is in the American system for a doctor who suffers from drug or alcohol use disorder. Rather, "impaired" doctors are those who have put or are likely to put patients at "unwarranted risk," have brought or are likely to bring the "medical profession into disrepute," or have breached or are likely to breach "one of the fundamental tenets of the profession."[243]

In contrast to the typical licensing board hearing, the tribunal's cases are highly structured, with a three-stage adversarial hearing prosecuted by a lawyer from the GMC. Stage 1 focuses on the past (was there misconduct?), Stage 2 on the present (is the physician unable to safely practice?), and Stage 3 on the future (what sanction, if any, shall be imposed?).[244]

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common. Of the 152 first-instance cases heard by the MPTS in the six months immediately preceding the national lockdown on 23 March 2020, 108 (71%) were constituted with a majority of lay panelists and 42 (29%) had a majority of medical panelists.

241 *See supra* note 215.

242 *See* Medical Act 1983, c. 54, § 1(1B) (UK). Before imposing a sanction, it is common for an MPTS chair to read the following statement into the record: "The purpose of any sanction that we impose is threefold: firstly, it is to ensure the safety of the public; secondly, it is to maintain standards in the profession; and, thirdly, it is to maintain public confidence in the profession." *See,* e.g., Burton, No. 3539187, at 123 (Med. Pracs. Tribunal Serv. July 31, 2023) (record of determination).

243 The High Court has emphasized the importance of bearing in mind the need to protect the public and maintain public confidence in the profession when determining the issue of impairment of fitness to practice. *See* Council for Healthcare Regulatory Excellence v. Nursing & Midwifery Council [2011] EWHC (Admin) 927.

244 General Medical Council (Fitness to Practise) Rules 2004, SI 2004/2608, ¶ 17 (UK).

Stage 1 resembles the fact-finding phase of an American trial. As in a civil case in America (and, at least nominally, contested cases before licensing board hearings in states like Tennessee) the tribunal uses a relatively low standard of proof; the GMC must prove "on the balance of probabilities" that misconduct occurred.[245] If so, the case proceeds to Stage 2, where the tribunal evaluates the physician's present fitness to practice. Here, the tribunal will consider remedial measures like substance use disorder treatment or further education that the physician has taken since the misconduct only to the extent they imply present fitness to practice.[246] Finally, at Stage 3, the tribunal will take evidence about the proper sanction. If the doctor is found to have taken sufficient remedial steps as to be presently competent, the doctor can return to practice, with or without an official warning. If not, the tribunal must decide whether to impose conditions (like probation in the American system), suspend the physician from the register (precluding practice for up to one year) or erase the doctor from the register, which is effectively permanent.[247]

Crucially, unlike in the American context, the tribunal must follow the GMC's *Sanctions Guidance for Members of Medical Practitioners Tribunals and for the General Medical Council's Decision Makers* ("Sanctions Guidance"),[248] which is extensive, specific, and public. Ignoring or misapplying these rules may result in the tribunal's decision being thrown out on appeal.[249] Sanctions Guidance identifies mitigating and aggravating factors that focus on fitness to practice, not on the doctor's character or blameworthiness.[250] The guidance also sets default

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245 Gallagher & Foster, *supra* note 229, at 16.

246 *Id.*

247 *Id.* If a doctor wishes to return to the register after being erased for disciplinary reasons, they must wait at least five years before submitting an application for restoration to the Registrar of the GMC and pleading their case to a tribunal. *See* GEN. MED. COUNCIL, GUIDANCE FOR MEDICAL PRACTITIONERS TRIBUNALS ON RESTORATION FOLLOWING DISCIPLINARY ERASURE ¶ A1 (2019). These attempts rarely succeed. Of 13 who applied in 2019 only two were successful, and in 2018 only four of 14 applications were granted. *See* Clare Dyer, *Doctors Who Was Struck Off for Misconduct Is Restored to the Register After Changing His Ways,* 368 BRIT. MED. J. m723 (2020), https://www.bmj.com/content/368/bmj.m723.

248 GMC, SANCTIONS GUIDANCE, *supra* note 214.

249 *See, e.g.,* Cohen v General Medical Council [2008] EWHC 581(Admin) (in which Justice Silber ruled that Dr Cohen's fitness to practise should not have been regarded as impaired and the sanctions imposed by the Tribunal should be substituted for a warning).

250 GMC, SANCTIONS GUIDANCE, *supra* note 214, ¶¶ 24–60.

sanctions for specific categories of misconduct; for example, erasure for possession of child pornography.[251]

The Sanctions Guidance is supplemented with over forty additional guidance documents, which provide tribunals with direction on subjects such as the interpretation of statutory rules,[252] the role of the chairperson,[253] the use of expert witnesses,[254] voluntary erasure applications,[255] and considerations relevant to each available sanction.[256] All this guidance is public, transparent, and easily found on the MPTS's website.[257]

For example, in its Sanctions Guidance for physicians, the MPTS unambiguously spells out its approach to sexual misconduct, promoting uniformity of purpose and outcomes. Sexual misconduct is defined as encompassing "a wide range of conduct from criminal convictions for sexual assault. . . to sexual misconduct with patients, colleagues, patients' relatives or others."[258] Panelists are directed to consider precursor acts, which may not involve any sexual contact, as equally serious: "If a doctor has demonstrated predatory behaviour, motivated by a desire to establish a sexual or inappropriate emotional relationship with a patient, there is a significant risk to patient safety…. [and m]ore serious action is likely to be appropriate."[259] In deciding upon an appropriate sanction, panelists are guided away from warnings or conditions on practice and towards suspension and erasure from the medical register.[260]

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251 *Id.* ¶ 151.

252 GEN. MED. COUNCIL, GUIDANCE TO THE GMC'S FITNESS TO PRACTISE RULES 2004 (AS AMENDED) (2012).

253 MED. PRACS. TRIBUNAL SERV., MANAGING MEDICAL PRACTITIONERS TRIBUNAL HEARINGS: GUIDANCE FOR TRIBUNAL CHAIRS (2012).

254 MED. PRACS. TRIBUNAL SERV., EXPERT WITNESSES: PROTOCOL FOR THE INSTRUCTION OF EXPERTS TO GIVE EVIDENCE IN MEDICAL PRACTITIONERS TRIBUNAL HEARINGS (2015).

255 GEN. MED. COUNCIL, GUIDANCE ON MAKING DECISIONS ON VOLUNTARY ERASURE APPLICATIONS AND ADVISING ON ADMINISTRATIVE ERASURE (2015).

256 MED. PRACS. TRIBUNAL SERV., IMPOSING CONDITIONS ON A DOCTOR'S REGISTRATION (2019); GEN. MED. COUNCIL, GUIDANCE FOR DECISION MAKERS ON AGREEING, VARYING AND REVOKING UNDERTAKINGS (2012); GEN. MED. COUNCIL, GUIDANCE ON WARNINGS (2018); MED. PRACS. TRIBUNAL SERV., UNDERTAKINGS AT MEDICAL PRACTITIONERS TRIBUNAL HEARINGS (2016).

257 *Resources for Parties and Representatives*, MED. PRACS. TRIBUNAL SERV., https://www.mpts-uk.org/doctors-and-representatives (last visited Jan. 12, 2025).

258 GMC, SANCTIONS GUIDANCE, *supra* note 214, ¶ 149.

259 *Id.* ¶¶ 55, 109, 147.

260 *Id.* ¶¶ 62, 81, 92–94, 107–109.

The MPTS's decisions are subject to a robust review system, both internal and external. The agency's "Quality Assurance Group" meets monthly to review a portion of written tribunal determinations and the Professional Standards Authority (PSA) must review all fitness to practice determinations made by the MPTS (the PSA may appeal a case if they believe the imposed sanction is too lenient).[261] Tribunal decisions can be appealed outside of the medical regulatory system to the High Court.[262] The GMC and the MPTS are bound by decisions by this court and must revise their guidance to fit these decisions.

V. THE UK: BETTER, FASTER, SAFER?

In September 2020, Dr. Katie McAllister appeared before a disciplinary panel of the UK's medical licensing authority.[263] Much like Dr. Lapaglia, it was not for the first time. But the result in Dr. McAllister's case—the product of adequate investigation, unbiased decision-making, and a structured, adversarial trial—was a far cry from the decision made by the Tennessee medical board in Dr. Lapaglia's case.[264]

In May 2015, Dr. McAllister supplied a friend with an opioid pain killer and a benzodiazepine (which had been prescribed to the doctor herself) to help her with anxiety she was suffering in advance of getting a tattoo.[265] Later that same evening, her friend died of a suspected drug overdose and it was alleged that she had obtained the drugs from Dr. McAllister.[266] When the police searched Dr. McAllister's home, they found drugs of the type that led to the overdose as well as some vials of midazolam, another benzodiazepine used in surgery.[267] She claimed at the time that she had inadvertently taken the vials home from work.[268]

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261 Medical Act 1983, c. 54, §§ 40A & 40B (UK).

262 Medical Act 1983, c. 54, § 40 (UK). In Scotland, cases are appealed to the Court of Session; in Northern Ireland, to the High Court of Justice. *Id.* § 40(5).

263 McAllister, No. 7042366 (Med. Pracs. Tribunal Serv. Sept. 8, 2020) (record of determination).

264 *See supra* Part II.

265 McAllister, No. 7042366, at 36–39 (Med. Pracs. Tribunal Serv. Sept. 8, 2020) (record of determination).

266 *Id.*

267 *Id.* at 11, 18.

268 *Id.* at 15.

The MPTS immediately imposed an interim order, akin to a summary suspension in the United States, that precluded her from working as a physician.[269] Dr. McAllister was charged with culpable homicide, supplying a controlled drug outside of medical practice (to her friend) and illegally possessing a controlled drug (the midazolam); she was acquitted on the homicide charge and convicted of the others in June 2017.[270] She was called in front of the MPTS based on these convictions in November 2017.[271] That disciplinary panel credited her testimony that her possession of the midazolam was inadvertent, and that she accepted full responsibility and understood the gravity of her mistake in taking the vials home.[272] Even with these mitigating facts, however, they still suspended her license and placed the burden on her to prove her fitness to practice when she wished to return.[273]

After this decision, additional facts came to light. The GMC learned that Dr. McAllister had left the drugs at her home for her friend with instructions to take them in combination and "help [her]self to the rest of the white wine that's left in the fridge," and that later, at the tattoo parlour, Dr. McAllister gave her friend more opioid painkillers.[274] The GMC also learned that the concentrations and batch

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269 *Id*. at 41.; McAllister*,* No. 7042366, at 13 (Med. Pracs. Tribunal Serv. Nov. 15, 2017) (record of determination). At any stage of an investigation, a doctor may be referred to the MPTS for an Interim Order Tribunal hearing. The IOT can suspend or restrict a doctor's practice while the investigation continues if it is necessary for the protection of the public, or otherwise be in the public interest or in the interests of the doctor. *See* General Medical Council (Fitness to Practise) Rules 2004, SI 2004/2608, ¶ 6 (UK).

270 *See* James Mulholland, *Tattoo Parlour Doctor Acquitted of Killing Friend,* THE TIMES (May 27, 2017), https://www.thetimes.co.uk/article/tattoo-parlour-doctor-acquitted-of-killing-friend-33tdc9pvs [https://perma.cc/ZSV4-XAJ6].

271 McAllister*,* No. 7042366, at 2 (Med. Pracs. Tribunal Serv. Nov. 15, 2017) (record of determination).

272 *Id.* at 6–7. Evidence that the doctor understands the problem, has insight, and has made attempts to address or remediate it is considered a mitigating factor by the MPTS. *See* GMC, SANCTIONS GUIDANCE, *supra* note 214, ¶¶ 25, 46.

273 McAllister*,* No. 7042366, at 11–13 (Med. Pracs. Tribunal Serv. Nov. 15, 2017) (record of determination). In determining that a period of suspension was the appropriate sanction, the tribunal quoted directly from the Sanctions Guidance, which reads, "Suspension will be an appropriate response to misconduct that is so serious that action must be taken to … maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration." GMC, SANCTIONS GUIDANCE, *supra* note 214, ¶ 91.

274 McAllister*,* No. 7042366, at 19–20 (Med. Pracs. Tribunal Serv. Sept. 8, 2020) (record of determination).

numbers of the vials of midazolam Dr. McAllister had removed from her place of work suggested she had taken them on multiple occasions.[275]

The GMC referred these new facts to the MPTS, who convened that second tribunal in 2020 to consider these new allegations and decide whether Dr. McAllister could ever return to practice. The proceeding was, like all MPTS tribunals, heavily structured. At Stage 1, the tribunal applied the civil standard of proof and found most of the new facts proved.[276] At Stage 2, when the MPTS panel considered her present fitness to practice, they were able to hear not only about the 2017 round of discipline but also her criminal history, which included the conviction for possession and distribution and a 2019 DUI.[277] The panel found her to be, at present, an unsafe provider. And while the 2017 panel found her to have understood the gravity of her actions, the new facts demonstrating the lie convinced the 2020 panel that the doctor had not accepted responsibility nor shown insight.[278]

When the panel turned to Stage 3, to ask whether there were any circumstances under which Dr. McAllister could safely return to practice, they found the possibility of the doctor reoffending too great to justify a path back to licensure.[279] In doing so, they quoted the guidance and considered the factors within it that support erasure from the register.[280] They noted that even one of these factors may point towards erasure; Dr. McAllister's case involved five.[281] She was erased from the register in October 2020.[282]

A. *Lapaglia and McAllister: A Tale of Two Doctors*

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275 *Id.* at 12.

276 *Id.* at 35–41. The panel noted that "[t]he standard of proof is that applicable to civil proceedings, namely the balance of probabilities, i.e. whether it is more likely than not that the events occurred as alleged." *Id.* at 10.

277 *Id.* at 44, 46–48, 55–58.

278 *Id.* at 64, 66–67.

279 *Id.* at 67–69.

280 *Id.* The tribunal stated that "[s]uspension may be appropriate . . . where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated." *Id.* at 66. *See also* GMC, SANCTIONS GUIDANCE, *supra* note 214, ¶ 93.

281 McAllister, No. 7042366, at 67–68 (Med. Pracs. Tribunal Serv. Sept. 8, 2020) (record of determination); *see* GMC, SANCTIONS GUIDANCE, *supra* note 214, ¶ 109.

282 *Katy McAllister, GMC. Ref. No. 7042366,* GEN. MED. COUNCIL, https://www.gmc-uk.org/doctors/7042366 (last visited Jan. 12, 2024) (select "Registrant history" tab).

At each stage of the McAllister case, the GMC's disciplinary system used a better balance of physician and non-physician perspectives, included more and more reliable information and facts, and applied clear decision rules aimed at public protection. The result was harsher, which is not in itself proof that the UK system works better than that in the United States, but it does suggest that a doctor like Lapaglia—whose conduct was in some ways more disturbing from a public protection standpoint—would not have been allowed back into medical practice by a system designed like the GMC.

First, Dr. McAllister was not immediately given a second chance to practice after criminal charges for illegally distributing drugs, as Dr. Lapaglia was in his first round of board discipline in 2014.[283] Rather, she was given the opportunity, and the burden, to prove her fitness at a later date, which she consequently was unable to do.[284] Then, when new facts came to light, Dr. McAllister's case was reopened so the panel could be sure it was working with full information.[285] Facts relevant to Dr. Lapaglia's fitness to practice—his inappropriate relationship with the sixteen-year-old patient and his forced paralyzations and rectal searches[286]—were never presented to a disciplinary panel at all.

Next, in 2020, Dr. McAllister's panel carefully considered whether the removal of midazolam vials amounted to dishonesty; Dr. Lapaglia's 2019 panel either did not notice or did not put any weight on the doctor lying about the prior accusations of drug trafficking made against him.[287] Then, in considering present and future fitness (Stages 2 and 3), the MPTS panel considered McAllister's whole history with the GMC and the criminal system.[288] In Dr. Lapaglia's case, his 2014 misdeeds were hardly mentioned in his 2019 hearing.[289] Finally, in considering Dr. McAllister's possible return to practice, the tribunal engaged in a forward-looking

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283 *Compare* McAllister, No. 7042366, at 12 (Med. Pracs. Tribunal Serv. Sept. 8, 2020), *with* Discussion *supra* notes 88–91.

284 McAllister, No. 7042366 at 13 (Med. Pracs. Tribunal Serv. Nov. 15, 2017) (record of determination).

285 McAllister, No. 7042366 at 1, 2, 8–10 (Med. Pracs. Tribunal Serv. Sept. 8, 2020) (record of determination).

286 *See supra* notes 100–05.

287 *See supra* notes 94–95.

288 McAllister, No. 7042366, at 44, 46–48, 55–58 (Med. Pracs. Tribunal Serv. Sept. 8, 2020) (record of determination).

289 *See generally* Hearing Before the Tenn. Bd. of Med. Exam'rs, Lapaglia, No. 17.18-157362A (Tenn. Bd. of Med. Exam'rs July 31, 2019), https://tdh.streamingvideo.tn.gov/Mediasite/Channel/98fe21d561e9489487745f0c7da678b25f/watch/ee17b74a7fa640d994571f4a5fee42261d.

inquiry about patient protection guided by specific factors.[290] The panel in Dr. Lapaglia's case engaged in a loose analysis of the doctor's personal character, finding him fit to practice because he "has a good heart."[291]

The identity of the decision-makers in the McAllister case likely played a role in these differences. Six panels were convened over the course of her case.[292] Three of these panels were comprised of two lay people (one of whom was a lawyer) and one doctor, while the other three were made up of one lay person (again, a lawyer) and two doctors.[293] These members were trained and paid for their regulatory work.[294] They were vetted by a rigorous process designed to select for fair, impartial decision-makers, not by a process of political patronage designed to appease a professional association.[295]

B. *The TBME and the GMC: A Tale of Two Regulators*

To show that the two systems perform differently in a more systematic way, we coded five years of disciplinary data from Tennessee and two years of disciplinary data from the GMC. We compared the overall activity of the disciplinary systems, as well as their responsiveness to certain kinds of conduct. We found that the empirics support the intuition suggested by juxtaposing the McAllister and Lapaglia cases: the system in the UK is more protective of the public.

1. Data collection and coding

Disciplinary information from the Tennessee Board of Medical Examiners was obtained from the state Department of Health's Disciplinary Action Reports (DARs), available online.[296] These reports provide the names of doctors receiving

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290 McAllister, No. 7042366, at 63–68 (Med. Pracs. Tribunal Serv. Sept. 8, 2020) (record of determination).

291 See *supra* note 99 and accompanying text.

292 *Katy McAllister, GMC. Ref. No. 7042366,* GEN. MED. COUNCIL, https://www.gmc-uk.org/doctors/7042366 (last visited Aug. 20, 2024) (select "Registrant history" tab).

293 *Id.* (this information is compiled from the six records of determination spanning Nov. 15, 2017 to Sept. 8, 2020).

294 *See* text accompanying *supra* note 234.

295 *See* MPTS, APPOINTMENT CRITERIA, *supra* note 232.

296 *See Public Use Data File*, NAT'L PRAC. DATA BANK, https://www.npdb.hrsa.gov/resources/publicData.jsp (last visited Aug. 19, 2024).

public discipline and some bare information about the disciplinary action. We then looked up each doctor's profile in the Department of Health's online database, also publicly available online, which has copies of disciplinary orders.[297] Each case was coded according to the nature of the allegation made against the doctor: criminal conviction, habitual intoxication or personal misuse of drugs, malpractice, fraud, improper prescribing, and sexual misconduct. These categories were not mutually exclusive so, for example, a case about trading sex for prescriptions would be categorized as involving both sexual misconduct and improper prescribing. In Tennessee, the sanctions included mandated education, fines, reprimand, probation with conditions, suspension of licensure, revocation (permanent or with leave to reapply), voluntary surrender, or retirement.[298] Retirement and voluntary surrender are only used in consent orders; they are not imposed after a contested case hearing.[299]

Disciplinary cases of the MPTS are also available online by reference to a doctor's entry on the GMC's Medical Register. We obtained a list of all MPTS determinations made against doctors between January 1, 2019 and December 31, 2020, using powers granted by Section 8 of the Freedom of Information Act 2000.[300] The list of determinations was then cross-referenced with the Medical Register, from which the determination notices for the listed cases were collected, collated, and coded according to the nature of the offense and the penalty imposed.

In contrast to Tennessee's nine possible penalties, the MPTS may impose only four sanctions: public warning, conditional practice, suspension and erasure.[301] To compare these two jurisdictions, it is first necessary to align their respective penalties (**Table 1**). Private letters of warning, very common in the United States, are not used at all in the UK.[302] A reprimand in Tennessee is equivalent to a warning in the UK (as all UK warnings are public). There is no

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297 *License Verification*, TENN. DEP'T OF HEALTH, https://apps.health.tn.gov/Licensure/ [https://perma.cc/KW2Q-H82Y] (last visited Aug. 19, 2024).

298 McPheeters & Bratton, *supra* note 14, at 1332; TENN. CODE ANN. § 63-6-214(a) (2024)

299 TENN. COMP. R. & REGS. § 0880-02-.10 to -.12 (2024); *see, e.g.*, TENN. BD. OF MED. EXAM'RS, REGULAR BOARD MEETING TUESDAY, MAY 16, 2023 MINUTES, at 11, 22 (2023) (documenting consent orders voluntarily surrendering registrants' medical licenses).

300 Freedom of Information Act 2000, c. 36, § 8 (UK).

301 Medical Act 1983, c. 54, § 35D(2) (UK).

302 Decisions from Case Examiners' reports, Investigation Committee hearings and MPTS tribunals that conclude in a warning are published on the GMC website for a period of one year. *See* GEN. MED. COUNCIL, PUBLICATION AND DISCLOSURE POLICY: FITNESS TO PRACTISE (2022).

distinction between revocation with leave to re-apply and permanent revocation in the UK, so penalties 6 and 7 from Tennessee are combined to align with the UK sanction of erasure. Probation with conditions in the Tennessee Code is functionally equivalent to the British sanction of conditions, though it is not called "probation." This allows the BME and GMC/MPTS to be directly compared over four categories (C, D, E and F): however, there is no equivalent of education or a fine in the UK (Penalties 1 and 2) and one cannot voluntarily remove oneself or retire to avoid a hearing (Penalties 8 and 9).[303]

Table 1: *Initial alignment of the Tennessee BME's penalties with MPTS sanctions.*

Tennessee penalty		**Combined category**		**UK sanction**	
1	Education	A	Education		
2	Fine	B	Fine		
3	Reprimand	C	Warning	1	Warning
4	Probation (with conditions)	D	Conditions	2	Conditions
5	Suspension	E	Suspension	3	Suspension
6	Revocation (re-apply)	F	Erasure	4	Erasure
7	Revocation (permanent)				
8	Voluntary surrender	G	Voluntary surrender		
9	Retirement	H	Retirement		

The new combined categories of penalty were further refined into binomial groups based on severity (**Table 2**). Those categories (A-D), which allow a doctor to continue practicing medicine were categorized as *modest*, while those that prevented them from doing so (E-H) were categorized as *severe*. Voluntary surrender of licensure and retirement have the same effect on a doctor's ability to practice as erasure (i.e., that the doctor may not continue to practice medicine) and were therefore categorized as severe.

Table 2: *Binomial classification of the new combined categories for comparison based on severity.*

303 General Medical Council (Voluntary Erasure and Restoration following Voluntary Erasure) Regulations 2004, SI 2004/2609, § 3(8) (UK) (in cases where the applicant has an outstanding fitness to practice issue, the application must be referred to the MPTS to be determined accordingly).

Combined category		Binomial	
A	Education	1	Modest
B	Fine		
C	Warning		
D	Conditions		
E	Suspension	2	Severe
F	Erasure		
G	Voluntary surrender		
H	Retirement		

These choices, made to facilitate comparison between the typical American licensing board and the system of medical regulation in the UK, *understate* the leniency of the American system. First, because conditional probation is far more common in the United States than suspension or probation, the average "severe" sanction in Tennessee is lighter than that imposed in the UK, where erasure accounts for a higher percentage of "severe" sanctions.[304] Second, we coded voluntary surrenders and retirements in Tennessee—negotiated quietly and out of the public eye—as equivalent to the UK's "erasure" determination, which necessarily comes after an adversarial and public airing of the doctor's misdeeds. The former—which far outnumber revocations in contested case hearings in Tennessee—should be seen as less harsh than the latter. Finally, "revocation" in the United States is almost always temporary, and in the UK, it is effectively permanent;[305] coding them as equivalent understates the relative harshness of the British system.

2. Methodology and empirical results

304 For the five-year period from 2016 to 2020, 4.8% of hearings (18/378) heard by the Tennessee BME resulted in license revocation, compared to 27.5% (295/1071) of MPTS tribunals.

305 *See, e.g.*, *Regaining Certification*, THE AM. BD. OF PREVENTIVE MED., https://www.theabpm.org/continuing-certification-program-ccp/regaining-certification/ [https://perma.cc/R6AM-9W35] (last visited Jan. 12, 2025) (outlining steps for regaining certification after revocation); Allaina M. Murphy, *Preponderance, Plus: The Procedure Due to Professional Licensees in State Revocation Hearings*, 52 Conn. L. Rev. 943, 966 (2020); *supra* note 247.

In comparing the relative seriousness of each regulator's penalties, Fisher's Exact Test was used to detect a variation from the distribution of data that should be expected.[306] In total, 482 cases were included in the analysis, of which 264 (54.8%) occurred in Tennessee and 218 (45.2%) in the UK (**Table 3**). Of the 264 cases heard in Tennessee, only fifty-six percent of cases resulted in a serious sanction compared to eighty-eight percent in the UK. This represents a statistically significant difference in outcomes between the two jurisdictions ($p < 0.0005$).

Table 3: *Numbers of cases from Tennessee and the United Kingdom resulting in the imposition of modest and severe penalties/sanctions.*

	Modest	**Severe**	**Total**
US	115	149	*264*
UK	26	192	*218*
Total	*141*	*341*	***482***

Analysis of the complete data demonstrates that UK penalties are more severe than those in Tennessee overall. The picture is the same when the data are broken down by offense category, except for misuse of drugs or alcohol, for which a greater percentage of severe penalties was imposed by the BME than the MPTS. Given the outsized role that Physician Health Programs play in the disciplinary system in the United States, it is perhaps unsurprising that all eight BME cases involving the personal misuse of drugs or alcohol that concluded during the period of the study resulted in conditioning doctor's practice on participation in the state's PHP. In contrast, only 57% (four out of seven) of UK cases involving the personal misuse of drugs or alcohol led to severe sanctions, although the difference between the two countries was not statistically significant ($p = 0.077$).

When examining sexual misconduct ($n = 50$) and fraud ($n = 150$), the Tennessee BME imposed severe penalties in only 67% and 63% of cases, respectively. Compare this to 95% and 89% of severe sanctions in the equivalent UK cases ($p_{sexual} = 0.035$; $p_{fraud} = 0.007$). Temporary or permanent revocation of a doctor's licensure was the outcome in just 33% of cases involving sexual misconduct in Tennessee, compared to the 95% rate of erasure or suspension in the UK for of doctors found to have engaged in this type of egregious conduct.

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306 R.A. Fisher, *On the Interpretation of X^2 from Contingency Tables, and the Calculation of P*, 85 J. ROYAL STAT. SOC'Y 87, 88 (1922).

We compared our findings in Tennessee to the available national data on physician discipline. The National Practitioner Databank (NPDB) allows researchers to download anonymized nationwide disciplinary data.[307] The NPDB data for Tennessee is inferior to our own, which was obtained directly from the Tennessee BME and coded for our purposes to include data missing from the national database, such as fine-grained and reliable data on types of offences. Nevertheless, using the information that is available from NPDB, we were able to find yet more confirmation that Tennessee is typical among U.S. states,[308] and that the American system as a whole imposes "serious" sanctions in disciplinary cases at a rate far lower than in the UK (39% as compared to 88%).

Our data strongly supports the conclusion that the UK system is harsher on doctors *who have been found by a tribunal to have engaged in serious misconduct*. However, our data also shows that the Tennessee took serious public action against a higher percentage of its total licensed physicians than did the MPTS against physicians in the UK (about 0.02% for the year 2018 in Tennessee compared to 0.008% in the UK).[309] This might challenge our conclusion that the UK system is harsher and more protective of the public if the base rate of physician misconduct is the same in both jurisdictions, but there is good reason to believe that there is more physician misconduct in Tennessee than in England, and perhaps dramatically more. In a nationalized system as in the UK, there is little incentive to practice

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307 *See Public Use Data File*, NAT'L PRAC. DATA BANK, https://www.npdb.hrsa.gov/resources/publicData.jsp (last visited Aug. 19, 2024).

308 In 2019-2020, the NPDB recorded 5,357 penalties issued by US State Boards of Medicine, of which 2,084 (39%) were severe (i.e. involved the restriction of a doctor's ability to practice medicine). Of these penalties, 69 were issued by the Tennessee BME, with 22 (32%) being severe. This small difference is not statistically significant ($X^2 = 1.413$; $p = 0.235$).

309 In 2018, which was the last pre-COVID calendar year for which both Tennessean and British data are available, there were 17,133 doctors practising in the state of Tennessee, compared with 250,210 in the UK. ASS'N OF AM. MED. COLLS., 2019 STATE PHYSICIAN WORKFORCE REPORT 8 (2019); GEN. MED. COUNCIL, ANNUAL REPORT 2018, at 29 (2018). In that year, the BME received one complaint for every seven licensed doctors. The corresponding rate at the GMC was approximately one complaint per 30 registered doctors. Approximately one in every 1 in 535 registered doctors in Tennessee received a serious penalty in 2018: in the UK, this figure was 1 in 1,300. So, while the BME had higher absolute rates of both complaints and serious penalties than the GMC/MPTS, it received complaints against doctors at approximately four times the per doctor rate of the GMC but issued serious penalties at a rate only two-and-half-times that of its UK counterpart. That is to say, it issued fewer serious penalties relative to the number of complaints it received (1.3%) than the MPTS (2.3%).

medicine in ways to increase profits (selling prescriptions, performing unnecessary surgeries to pad insurance billing). Perhaps not unrelatedly, the United States, and not the UK, is suffering from an opioid crisis driven by physician prescribing.[310] A large portion of American disciplinary cases that we coded allege misprescribing; in the UK that number is close to zero. Without knowing the actual rate of physician misconduct in each jurisdiction, we should hesitate to use a higher overall rate of discipline in Tennessee to question the idea that the UK system is more effective in bringing doctors to heel.

VI. FIXING THE AMERICAN SYSTEM

The American system of professional discipline should use the UK system, as it was revised after the Shipman Inquiry, as a model for reform. State boards should be reconstituted to eliminate professional dominance, as was the GMC. And like the GMC, they should be subject to more and stricter state governmental oversight and their members should be merit-selected, paid a professional wage, and fully trained in their regulatory role of protecting the public. Most importantly for this article's arguments, these boards should not be responsible for hearing disciplinary cases. Rather, discipline should be administered by a body separate in membership and interests from the board that decides the admission, practice and ethics rules that govern professionals. A sketch of how this might be achieved is set out below.

A. *Separation of governance and discipline*

Due process requires adjudication by an impartial tribunal. Although state administrative law holds that the impartiality requirement is not violated when a board combines rule-making with adjudicative functions,[311] having a single entity set and apply the rules without any separation of roles leads to conflicts of interest. As discussed in Part III, it permits boards to sound tough at the rule-making stage,

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310 *Cf.* Vicki Osborne, *Is the UK Facing its Own Opioid Crisis?,* DRUG SAFETY RSCH. UNIT, https://www.dsru.org/blog/is-the-uk-facing-its-own-opioid-crisis/ [https://perma.cc/FKX8-VXNL] ("In the UK, we have generally not seen the same levels of [opioid] use [as in the US] which would cause concern in past years.").

311 *See* Martin v. Sizemore, 78 S.W.3d 249, 265–66 (Tenn. Ct. App. 2001).

and then refuse to bring the hammer down in individual cases. It also encourages boards to make vague or no rules about discipline through a public rule-making process. If an independent entity were delegated authority to apply the rules, boards would likely feel obligated to promulgate, after public input, theories and specifics about when and how a professional should be disciplined. At least one state does this for physicians—New York uses one board to govern physician licensure (the New York State Board for Medicine) and another to handle discipline (the Board for Professional Medical Conduct).[312]

Disciplinary tribunals should not only be independent from the licensing boards creating the rules, but as independent from the professions as possible, so that discipline can vindicate public interests, not focus on the well-being of the accused, as under the current system. The UK achieves this in medicine with a panel of between 250 and 300 hearing officers, only approximately one-third to two-fifths of which are physicians;[313] in the United States, disciplinary decisions are made by professionally-dominated panels.[314] The "independent" medical disciplinary board in New York is not an exception to this—it hears cases in panels dominated by its physician members.[315] A truly independent adjudicatory body would not be dominated by members of the very profession it must discipline.

B. *Legal expertise, competency appointment, and training*

American states should follow the example of the UK and ensure that there is at least one legally qualified member (a lawyer) on every disciplinary panel. This will help ensure that a professional's case is heard by someone with at least a basic understanding of due process, regulation, and the adversarial system. Having a lawyer as one of the decision-makers may bring a measure of skepticism to professionals' self-serving claims of being well-intentioned and perhaps provide some realism that in adversarial hearings, sometimes parties lie. Each panel should

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312 *See Physician and Physician Assistants Disciplinary and Other Actions*, N.Y. STATE DEP'T OF HEALTH, https://www.health.ny.gov/professionals/doctors/conduct/ (last visited Aug. 19, 2024); Milton Heumann et. al., *Bad Medicine: On Disciplining Physician Felons*, 11 CARDOZO J. CONFLICT RESOL. 501, 512–13 (2009).

313 *See supra* note 231.

314 *See supra* notes 9–10 and accompanying text.

315 *See Understanding New York's Medical Conduct Program - Physician Discipline,* N.Y. STATE DEP'T OF HEALTH, https://www.health.ny.gov/publications/1445/ [https://perma.cc/4Y5P-FJUL] (last visited Nov. 8, 2024).

also include a member from the professional in question, to advise on the facts of the case from a practitioner's perspective (not to self-police the profession). Finally, every panel should have one lay member to provide an understanding of what matters most for people using professional services.

Thus, the pool of possible panelists should be roughly one-third lawyers, one-third professionals, and one-third lay members. All members of this pool should be adequately trained on the theories of discipline and the proper role for each sanction—restricted practice, suspension, and revocation—and when second chances are and are not appropriate. They should also be trained on the statutes, rules, and guidelines they will be asked to apply, trial procedure, public health, and other issues related to professional regulation. They should be paid a part-time salary that incentivizes the work, which will be a significant expense given that the pay rate will need to be sufficient to attract good lawyers and professionals whose time is valuable.

C. *Guidance and procedure*

Good guidance can steer a path aimed at the public-regarding objectives of our model of professional discipline, instead of the status quo—unbounded discretion allows panelists' feelings of empathy and professional identity to influence decision-making. Ideally, these guidelines should track our theory of discipline and be detailed and specific, yet they fall short of mandatory consequences for certain conduct, or, like the Federal Sentencing Guidelines, break cases down in rigid and complicated matrices.[316] Rather they should establish clear aims, suggest outcomes in typical cases, and express policies on measures like mandated chaperones or practice monitoring. These guidelines should be created by the board in a formal administrative rule-making process that allows for sunshine and public input.[317]

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316 *See* Michael Tonry, *The Functions of Sentencing and Sentencing Reform*, 58 STAN. L. REV. 37, 51 (2005) (observing that "overly rigid, overly detailed guidelines do not work well" in the context of the federal sentencing guidelines).

317 Some states already go further in providing specific guidance to board members about discipline (although none match the specificity and rigidity of the British system). For example, Delaware codifies sanction ranges for specific conduct. *See* 24 DEL. ADMIN. CODE § 1700-17.0 to -17.16 (2013). The states should expand on Delaware's model to make it as robust as the English.

Contested cases should also follow the "stages" approach in the UK,[318] but with some modifications. In the UK, there are three separate stages to a tribunal (past, present and future). Although this clarifies the fact-finder's thinking about what question is relevant at each stage, it is cumbersome to have three different stages and stages one and two, especially, risk redundancy. Therefore, we suggest a separating the guilt and the sanction phases into two different proceedings, as is common in the American criminal system. The first stage would establish the facts of the allegation under a preponderance of the evidence standard and ask the panel to decide if there was a violation of the rules of practice and ethics. At this stage, something akin to the rules of evidence would apply, and formal adjudicative procedures followed as in the guilt or liability phase of an American trial.

Then, if the panel finds a violation of the practice act, a new proceeding would begin that resembles a criminal sentencing hearing. Here, the question would be about the appropriate sanction required to protect the public. It would, like Phase 3 in a MPTS tribunal, be largely forward-looking. The accused professional would be allowed to be present and give a statement; other witnesses could be called as well, but the rules of evidence would be relaxed, and a fuller picture of the professional, including past misdeeds, criminal convictions, or prior board discipline that might have been excluded at the fact-finding stage under the prohibition on prior bad acts evidence, could be presented. At the close of this hearing, the panel would deliberate (again, they should do so in private) with clear guidance as to which of the four disciplinary paths best protects the public and its confidence in the profession.

These contested cases should replace all negotiated settlements, as orders hashed out behind the scenes defeats the purpose of professional discipline that we described in Part II: public protection and confidence in the professions. Plea-bargaining with professionals about the appropriate sanction serves expediency, the interests of the professional in keeping things quiet, and little else.[319] There is a significant cost to the public by not learning about the full range of misconduct (professionals negotiate the statement of facts in agreed orders along with the sanction). It also contributes to the appearance of a regulatory system by and for the profession. A respondent's cooperation should be expected and not rewarded with a lighter "punishment;" failure to cooperate should invite a separate charge of

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318 *See* General Medical Council (Fitness to Practise) Rules 2004, SI 2004/2608, ¶ 17 (UK).

319 For a discussion of the problems with opacity in lawyer discipline, in particular, see Levin, *Less Secrecy*, *supra* note 4.

misconduct.[320] When board prosecutors compromise with professionals at the settlement phase, they are playing with other people's money: namely, the public's safety.

D. *Putting it together: The Professional Disciplinary Tribunal*

The professions will argue that a UK-style tribunal sacrifices professional expertise.[321] This criticism is misguided for several reasons. First, every panel would have a professional expert, and where a case required especially detailed or specialized professional knowledge, both parties would be free to call expert witnesses. Second, it improperly privileges one kind of expertise over another. One way of understanding how professional discipline has gone so wrong in America is recognizing that the people deciding the cases are inexpert in what really matters—regulation, adjudication, broader public health issues, patient or client expectations and fears—not the narrow professional expertise of a working provider. Third, most cases of discipline involve either non-technical misconduct, like trading sex for legal services or selling controlled substance prescriptions for profit, or such dramatic lapses in professional judgment (like fusing the wrong vertebrae)[322] that highly technical medical knowledge is not necessary.

A more serious objection to our suggestion is that it would be prohibitively expensive. First, our system would pay panel members a market rate to do things that members of the profession now do for free. It would also dramatically increase the number of cases heard. Money to pay for the pool members' time and other trial expenses must come from somewhere. Such an elaborate disciplinary system, repeated nearly 2,000 times over in the United States, could not achieve economies of scale.

Economies of scale need to be found somewhere. We propose that states create one disciplinary tribunal that hears cases from all the professions. This tribunal would draw from a pool with diverse professional membership, allowing

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320 *See* GMC, SANCTIONS GUIDANCE, *supra* note 214, ¶ 26(d).

321 *Cf.* Cruess & Cruess, *supra* note 18, at 322–23.

322 *See, e.g.*, Velez, No. 2011-004642 (Mo. Bd. of Registration for the Healing Arts Nov. 12, 2019) (final order), https://pr.mo.gov/boards/healingarts/orders/MED-2007038367.pdf (lifting previous disciplinary order for nine botched spinal surgeries including misplaced screws and incorrectly fused vertebrae). Velez' practitioner profile can be accessed through the *Licensee Search & Downloads*, MO. DIV. OF PRO. REGISTRATION, https://pr.mo.gov/healingarts-online.asp (search for license number "2007038367").

there to be one member from the profession in question for each panel. In larger states, it may be feasible to have two tribunals—one for the health care professions and another for the rest. New York uses a system akin to this, by hearing all professional disciplinary cases (except those against doctors) through a single agency: the New York Board of Education.[323] But whereas in New York, panels for disciplinary hearings are comprised of one lay member from a pool and two professional members of the relevant state board[324] (recreating the problem of professional dominance we are trying to solve), our proposed panel would constitute one professional with the relevant expertise (not a board member), one lawyer (perhaps an ALJ), and one lay member, all drawn from a pool of merit-selected, paid, trained regulators.

In the end, financial objections to our proposal should not win the day anyway. Failing to discipline lawyers who have fanned the flames of the current crisis of democracy,[325] or doctors who sexually abuse dozens or hundreds of patients[326] may be pennywise but it is pound foolish. So far, professional self-regulation has been popular at state legislatures because it is cheap. But you get what you pay for.

Implementing these reforms will face significant political headwinds. Professional associations can be expected to resist any reforms that reduce the self-regulatory nature of licensing. For example, the American Medical Association has fought hard for state-by-state licensure, and resisted attempts at licensure reform that would reduce physician influence.[327] The legal profession has reacted similarly

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323 *See* N.Y. STATE DEP'T OF HEALTH, *supra* note 315.

324 *See* N.Y. STATE DEP'T OF HEALTH, *supra* note 315.

325 *See* Green, *supra* note 51, at, 180 (discussing the possibility of professional discipline for lawyers' frivolous lawsuits contesting the results of the 2020 election).

326 *See Former USC Doctor Charged with Sexual Abuse of Students Dies Before Going to Trial*, PBS News (Oct. 5, 2023 4:55 PM), https://www.pbs.org/newshour/nation/former-usc-doctor-charged-with-sexual-abuse-of-students-dies-before-going-to-trial (describing the case of George Tyndall who abused more than 700 patients); Connor, *supra* note 48 (describing the case of Larry Nassar who abused over one hundred patients).

327 In stressing the avowed importance of self-regulation, the AMA's Council on Ethical and Judicial Affairs has insisted of physicians that: "No other party in the health care system is charged with the responsibility of advocating for patients, and no other party can reasonably be expected to assume the responsibility conscientiously." CARL AMERINGER, STATE MEDICAL BOARDS AND THE POLITICS OF PUBLIC PROTECTION 113 (1999). As recently as 2023, the AMA "advised state medical boards that proposals for national or federal medical licenses should be opposed," and "laid out clear guidelines for state medical boards to oppose a national licensing registration scheme." Cara Smith, *Senate Approps Seek FTC*

to calls for reform away from self-regulation.[328] The fact of professional resistance is not, by itself, a reason to not try to fix a broken system. It does, however, underscore the importance of developing countervailing political will by documenting the dangers and dysfunction of the current system, one of the main contributions of this article and other work by one of its authors.[329]

Skeptics will also point out that real reform will involve not only pulling off reform against the headwinds of professional lobbying, but doing so fifty times, as each state has a different licensing regime. Yet in terms of achieving reform, the state-by-state nature of professional licensing may help the odds of making progress. A well-organized campaign in one state may face better prospects than a sweeping, national campaign for reform.[330] And if one state's experimenting with an accountable, guided, and balanced disciplinary tribunal is met with success, it can serve as a proof-of-concept for other states seeking reform.[331]

Study on Interstate Licensing Merits, As AMA Poses Hurdles, INSIDE TELEHEALTH (July 25, 2023, 03:38 PM), https://insidehealthpolicy.com/inside-telehealth-daily-news/senate-approps-seek-ftc-study-interstate-licensing-merits-ama-poses.

[328] Marsha Griggs, *Outsourcing Self-Regulation*, 80 WASH. & LEE L. REV. 1807, 1815 (2024) ("[T]he ABA staunchly insists on an autonomous, self-regulated legal profession that is free from external interference."). The preamble to the ABA's Model Rules of Professional Conduct states: "An independent legal profession is an important force in preserving government under law, for abuse of legal authority is more readily challenged by a profession whose members are not dependent on government for the right to practice." DEBORAH L. RHODE, IN THE INTERESTS OF JUSTICE 145–46 (2000). Despite the willingness of American courts to "permit some regulation of attorneys by legislatures and administrative agencies . . . lawyers retain considerable control over their own regulation," particularly with respect to the promulgation, recommendation, and approval of bar codes of conduct, as well as the make-up of disciplinary committees. *Id.*

[329] *See* ALLENSWORTH, *supra* note 5.

[330] In the same way that lobbying *for* professional regulation has proved easier to accomplish state-by-state, lobbying for reform and change may be more effective at the state level than nationally. *See* YOUNG, *supra* note 38, at 24–25. More effective local political organization may make it easier to counteract the political influence of practitioners, who "have a greater interest in licensing and may be better able to influence policy through their active professional associations." MARGIE CASTRO, OCCUPATIONAL LICENSING: BENEFITS, COSTS, AND ISSUES 22 (2016). For example, in the area of tort reform, despite efforts to nationalize tort law, "[t]he majority of . . . reform measures that have managed to succeed have occurred in state legislatures, whereas reforms at the federal level have—at least until 2005—encountered more obstacles." John T. Nockleby & Shannon Curreri, *100 Years of Conflict: The Past and Future of Tort Retrenchment*, 38 LOY. L.A. L. REV. 1021, 1032 (2005).

[331] *See* New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) ("[A] single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.").

CONCLUSION

The professions will always be self-regulatory to some degree— indeed autonomy is part of what it means to be a "profession."[332] But it does not follow that professional autonomy needs to be taken to the current extreme observed in professional discipline, where accused professionals are judged by their literal peers. While it is sociologically, historically, and culturally ingrained that professionals will govern themselves, it does not need to be accepted as an immovable object, especially with mounting evidence that in the bargain struck between the professions and the public, the professions have not held up their end. In the UK, a similar crisis of confidence in the professional discipline emerged two decades ago, and the solution was to reduce and temper professional influence over the regulatory process, and to provide clear, public-regarding guidelines for how to address unethical, incompetent, and dangerous practice. State licensing boards in the United States should follow suit.

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332 *See, e.g.*, ELIOT FREIDSON, PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE 185, 368 (1970) (observing that in their quest for professional status, "[a]utonomy is the prize sought by virtually all occupational groups").