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CONSUMERS, COMPLAINTS, AND PROFESSIONAL DISCIPLINE: A LOOK AT MEDICAL LICENSURE BOARDS

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I. INTRODUCTION

STATE MEDICAL LICENSURE boards perform the important functions of investigating allegations that physicians are incompetent or have behaved unprofessionally and of taking disciplinary action where such allegations are substantiated. Given the importance of these tasks, it is surprising that very little is known about how well boards are able to perform them. Most discussion about the effectiveness of medical boards has been based on counts of dis-

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ciplinary actions (e.g., number of revocations, suspensions and probations imposed per one thousand physicians), which do not give us a full picture of board activity. Very little is known about who complains to medical boards, how allegations of incompetence or unprofessional conduct are investigated, and how boards react once a problem has been confirmed.

This article begins to examine this hitherto unexplored process. It concentrates on two main issues. First, it attempts to understand more about those who complain to boards. Treating persons who complain as an example of an aggrieved population, we present a profile of complainants and discuss what might have motivated them to complain and what the objectives of their complaints might be. We also consider the extent to which those who complain are a distinct population, especially focusing on whether or not there is an overlap between complainants and claimants, i.e., those persons who sue for medical malpractice. Second, this article explores the response of one state medical licensure board to public complaints. It examines the process of complaint investigation and the types of action taken by boards against physicians as a result of complaints. Data concerning these processes are considered in the context of the larger question of what functions licensure boards can be expected to perform with respect to identification and disciplining of incompetent physicians.

II. THE FUNCTION OF THE STATE MEDICAL BOARD.

Each state in the United States has a medical licensure board responsible for controlling entry into the medical profession by means of licensure and for disciplining physicians who are incompetent or who engage in "unprofessional" conduct. These boards vary considerably in their approach to these tasks and in the extent to which their activities are facilitated by state legislation. They all, however, have a variety of disciplinary powers including, most commonly, the power to revoke or suspend licenses and to place physicians on probation.[1]

State boards initiate investigations of physicians primarily on the basis of information received from two main categories of sources.[2] First, there are *public complaints*: letters or phone calls

1. OFFICE OF INSPECTOR GENERAL, DEP'T OF HEALTH & HUMAN SERVS., OFFICE OF EVALUATION AND INSPECTIONS, STATE MEDICAL BOARDS AND MEDICAL DISCIPLINE: A STATE-BY-STATE REVIEW 12 (1990) (hereinafter OIG, STATE BY STATE REVIEW).

2. *See* OFFICE OF INSPECTOR GENERAL, U.S. DEP'T OF HEALTH AND HUMAN SERVS,

alleging mismanaged care or inappropriate behavior received from patients, their relatives or friends, or professionals involved immediately in their care. Second, there are *reports and referrals* from other individuals or entities, including referrals from boards within the state that license other professionals or institutions or from the medical licensure boards of other states; reports of disciplinary actions taken by hospitals, of malpractice payments by insurers, of criminal convictions by the courts, and of sanctions imposed at the instance of Medicare Peer Review Organizations; and reports of questionable conduct of licensees submitted by physicians, pharmacists, or other professionals. Under the recently adopted federal Health Care Quality Improvement Act[3] and the laws of many states, certain referrals or reports are mandatory.

In recent years, the number of reports, referrals or complaints received by medical licensure boards have been increasing.[4] In California, for example, the number of complaints against physicians almost doubled in eight years, from around 4,000 complaints a year in 1983 to over 7,000 in 1990.[5] In New York, the number of complaints increased from 1699 in 1985 to over 5000 in 1989.[6] The cause of this increase is not immediately obvious. While one explanation is that the quality of care and services has declined, equally plausible explanations are that societal norms inhibiting complaining behavior have decreased, or that changes in operation of the boards have facilitated complaining. Whatever the explanation, the phenomena of public complaints is worthy of consideration.

III. CHARACTERISTICS OF THE BOARD SELECTED FOR STUDY

The study described herein reviewed complaints closed by the Ohio State Medical Board during 1990. It analyzed a random sample of case files including both complaints, referrals, and reports made to the Board together with the records of the Board's investigations and responses to those complaints, reports and referrals.

OFFICE OF EVALUATIONS AND INSPECTIONS, STATE MEDICAL BOARDS AND MEDICAL DISCIPLINE 3-6 (1990) (hereinafter OIG, STATE MEDICAL BOARDS).

3. 42 U.S.C.A. §§ 1131-1137 (West Supp. 1992).

4. OIG, STATE MEDICAL BOARDS, *supra* note 2, at 5.

5. KENNETH J. WAGSTAFF, CALIFORNIA'S CENTRAL COMPLAINTS AND INVESTIGATIONS UNIT, FED. BULL., Nov. 1991, at 331 (1991). Federation Bulletin. In this context complaint is used to refer generically to what otherwise are referred to in this article as complaints, reports and referrals.

6. OIG, STATE MEDICAL BOARDS, *supra* note 2, at 5.

The Ohio State Medical Board licenses medical doctors, osteopaths, podiatrists, physicians assistants and massage therapists. In 1990 the Board had 22,706 physicians under its jurisdiction, ranking it seventh among State Boards in the number of licensees.[7] The Board has twelve members, including nine physicians and three members appointed to represent consumer interests. In 1989 the Ohio Board had twelve full-time investigators. Only the California licensure board had more.[8] As is true with other state medical licensure boards, the number of complaints and reports and referrals received by the Ohio Board has been increasing. Table 1 show the number and source of complaints, reports, and referrals made to the Board during the year studied here and the two preceding years. During 1990 the Ohio Board imposed 91 serious disciplinary ac-

TABLE 1

Table to show the number and source of complaints and referrals made to the Ohio State Medical Board 1988-1990

Source of Complaint or Referral	1988	1989	1990
Public complaints	36%	36%	38%
Medical Board/Staff	26%	24%	23%
Mandatory reports	8%	<1%	8%
Anonymous	5%	3%	6%
Other Boards/Agencies	5%	3%	2%
Drug wholesalers	4%	<1%	—
Auditor	4%	12%	8%
Physicians	4%	8%	8%
Peer Review Organizations	—	—	2%
Pharmacists	3%	<1%	1%
Professional associations	2%	2%	1%
Other (media, police, etc)	2%	7%	1%
Insurance companies	<1%	<1%	<1%
Hospitals	<1%	1%	<1%
Total Received	*1100*	*1152*	*1654*

tions (license revocations, suspensions and probations) ranking it eleventh among State Boards in number of formal actions taken.[9]

Though it would perhaps have been preferable to conduct a comparative study of several medical licensure Boards, problems of access to confidential data make such a study difficult. Access to

7. INGRID VANTUINEN & SIDNEY WOLFE, STATE MEDICAL LICENSING BOARD SERIOUS DISCIPLINARY ACTIONS IN 1990 27 (1991).

8. OIG, STATE BY STATE REVIEW, *supra* note 1, at 11.

9. VANTUINEN AND WOLFE, *supra* note 7, at Table 2.

the Ohio Board complaint files was only possible because one of the investigators was a member of the Board, and thus had access to the Board files.[10] As the Ohio Board is in many respects typical of large medical board, however,[11] the examination of its complaints and complaint processing, presented herein, is a useful starting point for considering broader questions of complainant and board behavior.

IV. METHODOLOGY

This study analyzed cases closed during 1990 by the Ohio Board that were generated by complaints, reports, and referrals. We randomly selected 200 closed cases initiated by public complaints and 200 closed cases initiated by referrals and reports for analysis. These amounted to 48.5% of the cases closed during 1990 initiated by public complaints and 34.6% of the closed cases generated by other reports and referrals.

Analysis of the complaints drew on research instruments developed by Lloyd-Bostock and Mulcahy at the Centre for Socio-Legal Studies of Oxford University as part of an ongoing study of the socio-legal dynamics of complaining behavior in the British National Health Service.[12] The schedule developed by these researchers was shortened and modified for use in an American setting. In order to establish its content validity, drafts were reviewed by several experts familiar with consumer complaints and pretested on a pilot sample.

Because of the confidentiality restrictions noted above, it was not possible to have Board case files reviewed by researchers other than the principal investigator, a Board member and author. Intra-rater reliability was established for survey items used for analysis, however, by having the principal investigator recode a 15% random sample of coded surveys following a six-month lag, minimizing memory effects. An 80% decision rule on agreement was used for determining intra-rater reliability. Of the 68 items on the survey, 52 (76%) passed the 80% test. Of the 18 that did not, additional reliability validation was done using the Kappa statistic, which controls for the marginal distribution of the response set. Items with Kap-

10. *See* OHIO REV. CODE ANN. § 4731.22(C)(1) (Baldwin 1992) (rendering complaints and other information uncovered through a complaint investigation strictly confidential).

11. *See* R. John Kinkel & Norma C. Josef, *Disciplining Doctors: How Medical Boards are Dealing with Problem Physicians in the Midwest*, 9 RES. IN THE SOC. OF HEALTH CARE 207 (1991); OIG, STATE BY STATE REVIEW, *supra* note 1 (generally showing that the characteristics of the Ohio Board are similar to those of other medical boards).

12. This study is funded by the Economic and Social Research Council.

pas lower than .67 were deleted from the analysis and deemed unreliable. In total, 7 of the 18 items in question generated unreliable results using this test, and were not used in the analysis.

It can be seen from Table 1, that in 1990 the Board received 1654 complaints, 38% of which originated with the public. Because of our particular interest in expression of grievance and in the dynamics of disputing behaviour, we concentrated on analyzing public complaints. In addition some analysis was done of another 200 referrals and comparisons are made between the two when appropriate. Table 2 shows the breakdown of sources of referrals and reports in the sample studied.

V. WHO COMPLAINS?

It is clear from recent research that few people who have a grievance voice it by complaining or instituting a legal claim.[13] Most people choose to "lump" their grievance (i.e., put up with it or ignore it) or to avoid expressing it by "exiting" (abandoning or limiting) the troublesome relationship.[14] In the medical context there is evidence that the vast majority of patients do not sue for negligently caused injuries.[15] Most recently, the Harvard Medical Practice Study has demonstrated that the gap between negligent injuries and claims is substantial. That study concluded that less than one out of twenty-four injuries resulting from medical treatment, and one in nine negligently caused injuries, results in litigation or request for payment.[16] Studies of complaining and claiming behaviour are, therefore, studies of atypical behavior.

Our study concentrated on a variety of characteristics of persons who complained to the State Board. We collected data on whether complainants were also patients, the sex and age of complainants, what complainants said they wanted to achieve by complaining and

13. *See* DONALD HARRIS ET AL., COMPENSATION AND SUPPORT FOR ILLNESS AND INJURY 46 (1984) (finding that only 14% of all accident victims consulted an attorney).

14. *See, e.g.*, William L. F. Felstiner, *Influences of Social Organizations on Dispute Processing*, 9 LAW & SOC'Y REV. 63, 70, 81 (1974) (explaining outcome of lumping and avoidance behavior); Laura Nader & Harry F. Todd, Jr., *Introduction: The Disputing Process*, *in* THE DISPUTING PROCESS 9 (Laura Nader & Harry F. Todd Jr. eds., 1978) (pointing to economic and social reasons for lumping and avoidance).

15. *See, e.g.*, PATRICIA M. DANZON, MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY 20-25 (1985) (detailing results of CMA study); Patricia M. Danzon, *Medical Malpractice Liability*, *in* LIABILITY PERSPECTIVES AND POLICY 102-05 (Robert E. Litan & Clifford Winston eds., 1988) (analyzing factors that may affect claim frequency).

16. HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK 7-28 (1990).

whether or not complainants displayed any of the characteristics of those persons who file malpractice suits.

TABLE 2

Table to show sources of reports and referrals analyzed

Source of Referral	Number of Cases
License applications' — problems identified by OMB Staff	33
Other state medical board action	32
Malpractice insurer report	26
Report by another licensee	18
Ohio Medical Board Staff	15
Police or law enforcement	13
Continuing education audit problems identified by OMB staff	9
Pharmacist	8
Medicare Pro	7
Medical society	5
Anonymous	3
Report of criminal conviction	2
Hospital	1
Other	28
Total	*200*

A. Are All Complainants Patients?

Complainants are not limited to those who have received or are receiving care. Indeed, some research suggests that relatives are likely to rate care more negatively than patients rate it.[17] Our study showed that relatives and friends of patients play an active role in voicing concerns to the Medical Board. In our sample of 200 public complaints, 112 (56%) were received from patients and 81 (40.5%) from non-patient complainants on behalf of a patient.[18] In addition, 17 (18.5%) patients who had complained said in their letter to the Board that they had been advised to complain by others. Identi-

17. *See, e.g.*, Ann H. Walker, & Joseph D. Restuccia, *Obtaining Information on Patient Satisfaction With Hospital Care: Mail Versus Telephone*, 19 HEALTH SERVICES RES. 291, 300 (1984); STEPHEN STRASSER & SHARON SCWEIKHART, WHO IS MORE SATISFIED WITH MEDICAL CARE? PATIENTS, FAMILY MEMBERS & FRIENDS 2 (The Ohio State University College of Medicine, Division of Hospital and Health Services Administration Working Paper #94-5631, 1992).

18. An additional seven public complaints (five of which were anonymous) were not specific to the care of any particular patient but were rather about issues that touched the patient population in a more general sense.

fied sources of this advice included physicians, nurses, medical societies, lawyers and police. Relatives were mentioned in just one case.

The relationship of non-patient complainants to patients is illustrated in Table 3. It can be seen from this that children and parents of a patient were most likely to complain on their behalf.

TABLE 3

Table to show the relationship of non-patient complaints to the patient on whose behalf they complained

Non-Patient Complainant	Number of Cases
Parent	
Mother	14
Father	5
Both Father and Mother	1
Total Parent	*20*
Child	
Daughter	20
Son	2
Both Son and Daughter	1
Total Child	*23*
Other non-relative	15
Other relative	6
Spouse	19
Total	*81*

(Two complaints were initiated by complainants from more than one category.)

These figures prompt further questions as to why non-patients complain on behalf of patients in instances where the patient does not complain. This was not always obvious from examination of letters of complaint although there were some indications of why patients had not complained for themselves. In 11 cases the patient was dead and in a further 22 cases the patient was a minor.[19] In 16 of the cases involving a patient over 65 the complaint was made by a person other than the patient, including 9 complaints filed by their children.

19. In ten of the 22 cases the child was aged between two and 11 years of age, four were teenagers, one was a baby and in a further seven cases it was not possible to determine the exact age of the minor. Overall very little data was available from the complaints as to the exact age of complainants.

B. Networks of Complaints

The data also suggest that the act of complaining to the State Medical Board should not be seen in isolation. We looked for indications that the complainant had made a complaint to another person or agency at the same time as making a complaint to the Board. In 21 (10.5%) of cases the complainant had either sent a copy of the complaint made to the Board to another agency or had sent the Board a copy of a complaint made to another person or agency. Moreover in a further 99 (40.5%) of cases, there were indications that the complainant had already complained elsewhere before complaining to the Board. Of the 120 cases where another person or agency was contacted, the complainant had contacted a medical society in 32 cases; a hospital in 19; another licensee in 15; other state agencies such as another licensing or the Attorney General in 12; and Medicare or insurance companies in 11.

These data have implications for understanding the satisfaction of complainants with the various channels through which complaints can be expressed, since a complainant's assessment of one avenue may well be dependent on overall satisfaction with all avenues used. Moreover, it is also clear that there may be a substantial duplication of effort by the various entities that receive complaints, and that a more efficient use of resources might call for a more integrated approach to investigations.

C. Is One Sex More Likely To Complain Than The Other?

Research into patient dissatisfaction has suggested that females are somewhat more likely to be satisfied with health care than males.[20] In this context a remarkable finding of the study was that women complained to the Board far more often than men. It would seem then that although women are less likely to be unhappy with care, women who are dissatisfied are much more likely to complain than their male counterparts. Overall 129 (71%) of gender identifiable complainants were women. Of the 72 non-patient complainants where gender was identifiable, 49 (68%) were women.[21] Of the 110 patients complaints where gender could be determined, 80 (73%) of the complainants were women.

The fact that more complaints are from women than men may be partially explained by the fact that women have more contacts

20. *See, e.g.*, Lea Aharony & Stephen Strasser, *Patient Satisfaction: What We Know About and What We Still Need to Explore*, 50 MED. CARE REV., Spring 1992, at 49, 59.

21. These data exclude five joint complaints made by both a male and a female.

TABLE 4

Table to show frequency and percentages of gender of patient complainants (N=110 where gender identifiable) and of non-patient complainants (N=72 where gender identifiable)

Gender of Patient Complainants	Frequency	Percent
Male	30	16.5%
Female	80	44%
Gender of Non-Patient Complainants		
Male	23	12.7%
Female	49	27%
Total	*182*	*100%*

(This table excludes five joint complaints initiated by both a male and a female.)

with physicians than men. In 1990 women in the United States had 6.1 contacts with physicians annually compared with 4.7 for men, 30% more.[22] The disproportionate number of women among non-patient complainants is also no doubt attributable in part to the care-giving role that women tend to play in American families. The fact that 91% of child complainants were daughters and 73.7% of parent complainants were mothers illustrates this tendency.

Nevertheless, the problem remains that comparing complainants to the patient or caregiving population as a whole assumes that complainants are evenly distributed among patients or caregivers.[23] A more relevant population with which to compare complainants is that of the dissatisfied or disputing population, where women seem underrepresented.[24] Thus, the disproportionate number of women among the complaining population deserves further study.

VI. WHAT DO COMPLAINANTS COMPLAIN ABOUT?

One of the most interesting aspects of examining the complaining process is analysis of the subject matter of complaints. Analysis of allegations provides an important indication of which

22. *See* U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, HEALTH UNITED STATES 219 (1991) (indicating in Table 76, 6.1 physician contacts per year for women compared with 4.7 for men for 1989) (hereinafter HHS, HEALTH UNITED STATES).

23. *See* Linda Mulcahy & Sally Lloyd-Bostock, *Complaining - What's the Use?*, *in* QUALITY AND REGULATION IN HEALTH CARE 51, 60-65 (Robert Dingwall & Paul Fenn eds. 1992).

24. *See* Ahrony & Strasser, *supra* note 20 (reviewing the available literature on patient satisfaction).

types of medical procedures or behaviour are most likely to form the basis of a complaint to the state medical board.

Any one complaint may include several allegations of various types, and the research framework used had to allow for this. We developed a detailed system for the study which classified allegations according to eighty-nine categories, though, in the end, these categories were reaggregated into broader classifications for purposes of analysis. Table 5 presents the details of all allegations made about licensees.

It can be seen from this table that the range of complaints was extremely wide and varied. It is also evident that while a substantial proportion of complaints raised allegations related to clinical care, a significant number alleged problems unrelated to clinical care, such as behavior (58) and billing problems (46).

A. Who Was Complained About?

Most of the complaints (189) related to professionals licensed by the Board.[25] Of these 162 were directed at medical doctors, 23 at osteopaths, 2 at podiatrists and 2 at massage therapists. It was most common for complaints to be made against just one practitioner (169). Where more than one was named, the complaint tended to be directed at a partnership or group practice as a whole. Practitioners cited in complaints were most likely to be practicing primary care (including pediatrics) (87) followed by surgery (28); psychiatry (15); Obstetrics and gynecology (13) and emergency medicine (13). By contrast, a 1981 General Accounting Office study of malpractice claims, found that 12% of claims were against obstetricians and gynecologists, 34% against surgeons, and only 23% against primary care physicians and 4.6% against emergency medicine specialists.[26]

As termination of the physician/patient relationship has been shown to be significantly related to the propensity to complain, we looked at whether or not patients whose care was complained of were still being treated by the professional complained of at the time of the complaint. Our data confirmed expectations that in the majority of cases the patient's relationship with the licensee had terminated at the time the complaint was made. Of the 165 (82.5%)

25. Fifty-two of the complaints (26%) contained allegations concerning non-licensees such as office staff, nurses, pharmacists or the hospital or nursing home as a whole, in addition to or instead of allegations directed at licensees.

26. UNITED STATES GENERAL ACCOUNTING OFFICE, MEDICAL MALPRACTICE: CHARACTERISTICS OF CLAIMS CLOSED IN 1984 54 (1987).

TABLE 5

Frequency of complained of behavior. (See note 1)

Complained of Behavior	Frequency	Percent
Office and appointments (e.g. waiting times, cancellations).	9	4.5
Subminimal or incompetent (e.g. failure to diagnose or treat, improper diagnosis, treatment, or medication).	120	60
Professional/patient relationship problems (e.g. sexual misconduct, records access, failure to obtain informed consent).	87	43.5
Behavior and attitude problems (e.g. rudeness).	58	29
Problems with billing.	46	23
Licensee impairment	4	2
Improper use of controlled substances.	11	5.5
Employment evaluation (e.g. disability, sick leave).	5	2.5
Other consultation.	3	1.5
Other grounds for discipline.	13	6.5

Note 1: Complaints of behavior exceeds 200 cases because complaints may raise more than one problem.

cases where the situation was clear from the file, 83 (50.3% of the 165) involved one-time encounters and a further 66 (40%) involved cases where the physician/patient relationship had been terminated. In only 16 (9.7%) cases was the relationship clearly ongoing. The prevalence of complaints involving single episodes of care also illustrates the greater risk of a complaint faced by professionals who treat patients with whom they do not have a long-term relationship.

B. Setting Of Complaintworthy Event Or Circumstance

Patients are much more likely to see physicians in their offices than to receive care in hospitals. The average American patient had three office visits in 1990, but only about one in ten were hospitalized.[27] Correspondingly, a high proportion of complaints, 107

27. DHHS, HEALTH UNITED STATES, *supra* note 22, at Tables 76 & 84. Since a single hospitalization usually involves multiple physician contacts, the relationship between these statistics is not straightforward, though they indicate that patients see physicians more often in physician's offices than in the hospital.

(54%), concerned physicians' office-based care. Just over a quarter of complaints, 55, involved hospital care. The most frequent location of unsatisfactory hospital care was the operating theater (19), followed by the ward (15) and emergency department (13). The remaining complaints were based on care received in such places as nursing homes, urgicenters, mental hospitals, and prisons. The preponderance of complaints involving office-based care underscores the importance of the medical board's role in overseeing the quality of medical care in an office setting, as most other quality assurance mechanisms - Medicare Peer Review Organizations, Joint Commission accreditation and hospital risk management and quality assurance programs only evaluate institution-based care.

VII. WHY DO COMPLAINANTS SAY THAT THEY COMPLAIN?

We were also interested in trying to understand the motivations of those who complained. In our attempts to gauge why certain patients and relatives decide to make a complaint, our analysis was necessarily limited to explanations of complaining behavior contained in complaints to the Board. Many of the complainants did not explicitly state in their complaint why they were complaining. Where a reason was given, one of the most common was expression of a desire to protect others from suffering the same fate in the future. In the words of one complainant: "This is not just for my mother but for some little old lady that has no family or no one in the medical field that can recognize gross professional behavior that may fall victim [to this doctor]" and again, "I would hate for anyone to be extremely ill and have her do the same thing to them that she has done to me."

Most often the letter of complaint gave no reason for complaining beyond simply stating, "I am writing to complain about . . ."

One factor that distinguished the study proceeding in England from that conducted in Ohio was the fact that the English study examined complaints in the context of a public health care system where patients are not charged for the treatment they received while the Ohio study involved a system where the patient was responsible for the cost of treatment. The researchers on both projects were interested to know whether in the American system a complaint was likely to be precipitated by receipt of a bill. Our data illustrate the importance of the issue. It can be seen from Table 5

above that 46 (23%) of the complaints contained allegations of billing problems. Further, 27 (13.5%) of complainants stated that the complaint was precipitated by receipt of a bill and in 20 cases bills were actually attached to the complainant's letter.

VIII. WHAT DO COMPLAINANTS HOPE TO ACHIEVE?

Linked closely to the issue of the motivation of complaints is that of what complainants hope to achieve by making complaints. We were interested in knowing whether complainants articulate specific goals in writing to the Board and, if so, what these goals were. Understanding the objectives of complainants is key to understanding the match between expectations of those who complain to the Board and the tasks it is able and willing to perform. It is also a way of testing whether the objectives of those who complain might be satisfied by means other than those currently employed by the Board.

There are undoubtedly a number of objectives that complainants hope to achieve, not all of which will be evident from their letter of complaint. In some cases it is possible to assume that the complainant wants something to be corrected despite the fact that this has not been specifically mentioned. Where the complaint is, for instance, about incorrect billing, it might be assumed that the complainant wants the bill to be corrected. Significantly only 122, or 61%, of the consumer complainants stated explicitly in their complaint what they specifically wanted or expected the Board to do. These are shown in Table 6.

It is clear from this that the majority of complaints were not obviously instrumental in the sense that they requested something specific. Our findings reflect Lloyd-Bostock's suggestion that many complaints can be seen as ends in themselves, the main purpose being to express dissatisfaction: "Some complainants do specifically state that they want an apology, an explanation, compensation or their appointment sorted out. Others may wish primarily for their complaint to be acknowledged and taken seriously."[28]

The most common request was for the Board to "investigate" the complaint. Other common requests included that the Board offer "help"; protect the public from bad doctors; do "something"; or provide an answer or explanation. Typical comments included,

28. Sally Lloyd-Bostock, *Attributions and Apologies in Letters of Complaint to Hospitals and Letters of Response, in* ATTRIBUTIONS, ACCOUNTS AND CLOSE RELATIONSHIPS 217 (J.H. Harvey et al. ed., 1992).

TABLE 6

(Complaints may contain more than one stated goal)

What the Complainant Said They Wanted	Number of Cases	Percentage of Sample
An investigation	40	20%
"Help"	17	8.5%
Protect the public or preventing recurrence	16	8%
To get Records	15	7.5%
Fee waived or reduced	14	7%
"Something done"	10	5%
To get an answer	8	4%
To get an explanation	8	4%
Licensee reprimanded	5	2.5%
Compensation	3	1.5%
License revoked or suspended	3	1.5%
Apology	2	1%
Teach licensee a lesson	2	1%
Other miscellaneous	22	11%

"Look into this situation and do whatever you deem necessary to see that this situation does not recur"; "I wish in the name of God that someone could help me with this problem. . .Please answer this letter and tell me what could be done"; "We would be grateful for any help the Board could give us in this matter." Often it also appeared that the complainant lacked a clear notion of the powers the Board had at its disposal to discipline physicians. Thus, only 3 (2%) of the complainants asked that the physician's license be revoked or suspended.

These findings have implications for the debate on the malpractice "crisis," which tends to emphasize the potential for complaints to evolve into claims, to see complaints as the first stage of a process that may end in a claim.[29] But, do public complaints to the Board express grievances that could form the basis of a legal claim against the doctor?

IX. THE COMPLAINING AND CLAIMING POPULATIONS

The disciplinary functions of the State Board are associated with

29. *See, e.g.*, JOHN CARRIER & IAN KENDALL, MEDICAL NEGLIGENCE: COMPLAINTS AND COMPENSATION IN THE SERIES OCCASIONAL PAPERS ON SOCIAL ADMINISTRATION 1-2 (1990).

malpractice concerns insofar as the Board provides mechanisms parallel to the litigation system for expressing grievances on the one hand, and for the identification of and sanctioning of errant physicians on the other. But is there any evidence that complainants to the Board are also potential litigants or do the two channels service essentially different populations? One of the difficulties in determining the potential overlap between the two populations is that complainants do not always provide as specific information concerning alleged fault, causation, and damages suffered as litigants are compelled to provide when initiating legal proceedings. Nonetheless, we were able to glean from the complaint investigation files useful information for delineating the relationship between complaints and claims.

We looked for two indications of a relationship between complaints and legal claims. First, we looked for suggestions in the letter of complaint that the allegations could also form the basis of a medical negligence claim. Here we focused on whether allegations in the complaint related to clinical care, whether the complainant alleged that the complained of conduct had caused harm sufficiently serious to ground a malpractice claim, and whether the complainant was seeking compensation. Second, we looked for indications as to whether the complainant had independently filed a malpractice claim.

A. Allegations Made

It can be seen from Table 5 that the majority of complaints contained allegations of mismanaged care. These included charges of refusal or failure to test, misdiagnosis or delay in diagnosis, failure to treat or improper choice or performance of treatment, and failure to medicate or prescription of improper medication. All of these allegations could have grounded a claim for medical malpractice if they resulted in injury. In addition, complaints of sexual misconduct, abandonment, or failure to obtain informed consent, which were classified in the patient-provider relationship category, could also have grounded lawsuits. Thus a substantial majority of the complainants made allegations that could have also been expressed in tort litigation, if sufficient severity and injury were present.

B. Injuries Suffered

The complaints examined frequently alleged that significant in-

juries were caused by licensees.[30] Evidence of physical harm is one of the most important indicators of a potential malpractice claim. In 116 (58%) of the cases examined, complainants alleged that they had suffered harm caused by the actions complained of. This included 9 allegations of pain from the procedure at issue, 39 allegations of physical harm other than just pain (e.g., addiction caused by improper prescribing, deterioration in condition caused by delay in diagnosis or treatment, blindness caused by improper surgery), 32 complaints of mental or emotional harm, and 11 charges of death caused by mismanaged care. In a further 32 cases (16%) the complainant alleged that the allegation resulted in mental or emotional harm to the patient. Forty-two complaints alleged other losses that might also have been compensable, such as the denial of worker's compensation, loss of employment, or financial loss attributable to the complained-of conduct.

C. Taking Further Action

It would seem then that there are indications from the data that a number of cases might also have formed the basis of a legal claim. Despite this, just three complainants mentioned the issue of compensation in their letter of complaint. Moreover, only one complainant mentioned having also filed a lawsuit prior to the time of filing the complaint. In spite of the fact that 16 complainants mentioned contacting an attorney prior to filing the complaint, and that 11 threatened a lawsuit, it could only be determined from the files examined that 1 complainant actually filed a lawsuit against the licensee subsequent to complaining to the Board.

The most reliable method of determining whether an overlap exists between claimants and complainants would be to search the indices of each of the courts in each of the counties of the state for the names of each complainant. This task was beyond the scope of this study. Nevertheless, because Medical Board investigators interviewed the licensee concerning the incident at issue in most cases, interviewed the complainant or patient in many cases, and often in fact reviewed relevant malpractice indices to determine if the licensee had been sued on other occasions, it seems likely that any additional lawsuits filed against licensees by complainants would have come to light.

Nonetheless, to confirm the lack of significant overlap between

30. Data is only presented where a direct causal link is made by the complainant between the allegation and the harm caused.

claims and complaints we also examined malpractice settlements and judgments reported to the Board under state and federal mandatory reporting requirements to determine how many involved conduct that had resulted in separate public complaints to the Board. Twenty six (13%) of the 200 complaints in our non-public report and referral sample were generated by malpractice reports. In none of these had the plaintiff independently complained to the Board about the incident that generated the suit. Moreover, a review of an additional randomly selected sample of 100 of the 472 lawsuit settlements and judgments reported to the Board under state and federal reporting requirements in 1990 also failed to reveal a single instance where the plaintiff had independently complained to the Board.

X. RESPONSE OF THE BOARD TO THE COMPLAINTS

The second major focus of our study involved an examination of how the Medical Board responded to complaints. Very little is known about the handling of complaints by boards other than figures on the number of public disciplinary actions that boards impose in response to unprofessional or incompetent behavior that complaints reveal. To put these figures in context, however, we need to know much more about the procedures for receiving and investigating complaints, the standards used to judge what is acceptable and unacceptable behavior, and the constraints boards face on taking formal action.

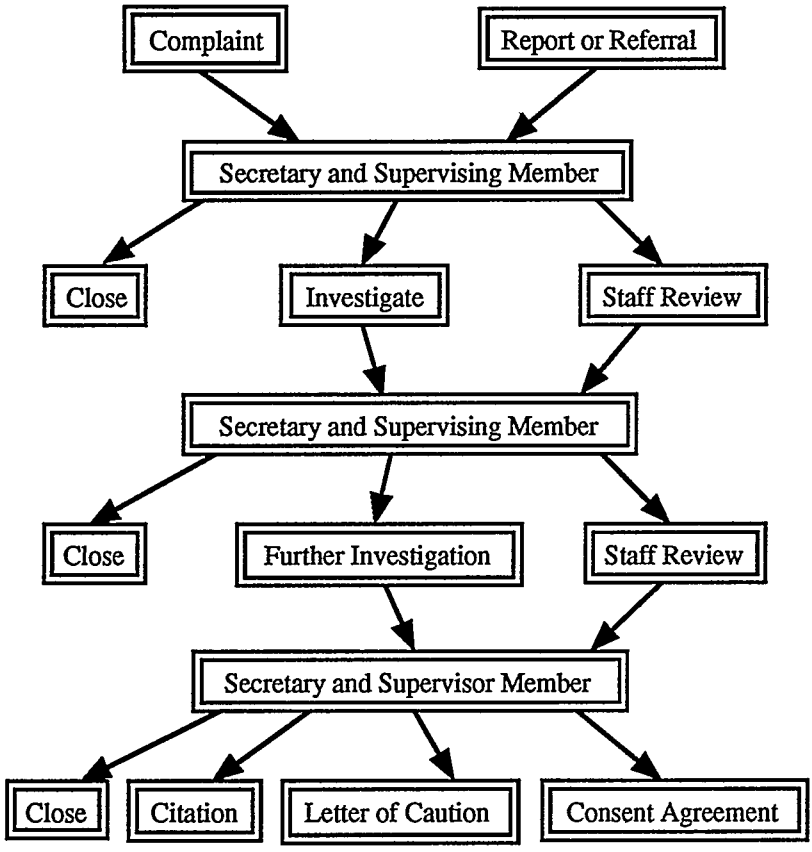
In our study we examined procedures used for receiving and investigating complaints, the reasons why certain complaints were filtered out, and the actions taken as a result of complaints. Because our data were based on analysis of files we were unable to explore in detail the ways in which the various investigators and members of the State Board made their decisions about how a complaint was to be handled. Future research could usefully pursue this further.

A. The Procedure - Receipt And Investigation

Once complaints are received at the Board they are logged in, given a complaint number and attached to a "complaint routing form." The form is then sent to the Secretary, who is a physician, and the Supervising Member of the Board, who is a member but usually not a medical doctor. Non-public reports and referrals are, with few exceptions[31] handled in the same way. Diagram 1 shows

31. Malpractice Reports are cumulated and presented to the Secretary and Supervising

Diagram 1



how complaints were processed by the Board.

Upon receipt of a complaint the Secretary and Supervising Member make a joint decision as to how the complaint should be handled. The vast majority of cases generated from public complaints go on to be investigated. In our sample of complaints from the public, 184 (92%) cases were referred by the Secretary and Supervising Member for review by Board staff or for investigation by Board investigators. Most of the complaints that we closed without investigation or review were complaints over which the Board

member once or twice a year by way of computer generated one page reports including reported malpractice judgments and settlements and other information about the licensee. After reviewing these the Secretary and Supervising member decide which to open as "complaints" Auditor reports covering Medicaid fraud and overcharges are reviewed by the Executive Director who makes a recommendation to the Secretary and Supervising Member as to which to pursue further.

lacked jurisdiction, usually because the complaint did not involve a licensee or was concerned solely with the amount of a fee. Only three (1.5%) of the complaints were closed because the complaints raised problems not worthy of investigation. For example, one concerned conduct that had happened over a decade previously, another conduct that had already been investigated.

The remainder of complaints were referred to Board investigators for review or investigation. Four (2.2%) of these cases were referred directly to Board staff attorneys for internal appraisal. Cases sent for review typically involved complex and important allegations (involving, for example, an alleged Medicaid fraud scheme or sexual misconduct) where further guidance was necessary before the case could be assigned for investigation.

In the vast majority of cases, complaints were referred directly to investigators. Occasionally the referral was accompanied by specific instructions about how the complaint was to be handled. Where the complaint raised very serious allegations which needed to be checked immediately it was marked "ASAP." There were 12 complaints that qualified for this treatment, including 5 where the licensee was accused of sexual misconduct with a patient, 2 where the licensee was alleged to be mentally impaired, and two where the licensee was alleged to be maintaining the addiction of a patient. The most common instruction was "check with doctor," which occurred in 58 (29%) of the cases. This instruction indicated the opinion of the Secretary and Supervising Member that the complaint warranted an explanatory response from the doctor, but would probably not require further investigation if this response was satisfactory to the Secretary and Supervising Member. An allegation that a physician had refused to issue a prescription for a minor viral infection in a child might warrant such a response. In these cases the investigator normally reviewed the complaint and perhaps the medical record with the practitioner being criticized. All but one of these cases was closed upon receipt of the initial investigatory report. In a further 10 (5%) of cases the form was annotated, "get record," in most cases indicating that the investigator should secure records for a patient whose records were wrongfully being withheld.

Where specific instructions were not given, the investigator had the discretion to conduct an inquiry as he or she saw fit within the scope of the specific protocols provided by the Board for guidance in investigating particular categories of cases. While these protocols are confidential investigatory materials, they can be generally de-

scribed. Allegations of incompetent provision of care, for example, are generally investigated by interviewing the patient or complainant, discussing the case with the treating physician, checking the reputation of the physician in the medical community, checking the local courts for malpractice filings, checking with Medicare Peer Review Organizations for quality interventions and perhaps obtaining relevant medical records. Allegations of improper prescribing might involve checking with local pharmacists or perhaps obtaining records of all controlled substance prescribed by the doctor in local pharmacies or purchasing and dispensing records. Complaints about rudeness might involve interviewing the patient, the doctor, or office staff. Where physicians were visited by the investigator, this was often done without prior warning.

Complaint investigations demand the dedication of substantial resources by the board. Investigators personally interviewed licensees who were the subject of the complaint in 164 (89.1%) of the 184 cases investigated or reviewed by the Board. In 80 (43.4%) of the investigated cases the investigator interviewed the complainant, patient or both. Moreover, although 50 (25% of the total of 200) cases took less than 3 months to close (including cases that were not investigated), 80 (40%) took up to 6 months, 42 (21%) up to a year and 28 (14%) over a year. Investigators spent between 2 and 96 hours conducting the initial investigation of complaints, with the average time per investigation being just over 10 hours.

At the close of the investigation the investigator submitted a report to the Secretary and Supervising Member. Their documents varied considerably in length ranging from less than a page to over ten pages in length. The Reviewers examined the report and decided whether to close the complaint or to assign the case for further action. The report occasionally included a recommendation as to disposition from the investigator, particularly where the issue was one that does not involve medical judgment. In a case, for example, in which a patient complained that a doctor had been rude, but the investigator upon interviewing both the complainant and the doctor found the doctor mild-mannered and easy-going and the patient loud and obnoxious, the investigator might have, based on these impressions, recommended that the case be closed without further action. Further review by the Board resulted in 19 referrals back to investigators, 12 referrals for internal board review for recommendations on action to be taken, 5 referrals to staff with a view to official citation, and 11 other referrals for miscellaneous further actions, such as summoning the licensee for an office conference.

Three quarters of the cases investigated or reviewed, 138, were closed after review of the initial investigative report.

B. Action Taken After Investigation

The legislation establishing and empowering the Board gives it broad authority to discipline its licensees for a wide variety of offenses, including "The violation of any provision of a code of ethics of a national professional organization . . ."[32] or "A departure from, or the failure to conform to minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established."[33] It also authorizes the Board to impose various disciplinary sanctions, ranging from revocation to reprimand.[34] Formal disciplinary processes must be initiated, however, by citation. Once a medical board decides to cite a physician, the process becomes public. Regardless of whether the physician's license is ultimately taken or restricted, therefore, citation puts the reputation of the physician in jeopardy. Citations are normally contested vigorously, and the Board bears the burden of proof. The decision to cite, therefore, is a serious step and an indication that the offenses of a particular physician are sufficiently grave to warrant the commitment of substantial public resources.

Only 5 (2.5%) complaints in the sample of 200 public complaints resulted in formal disciplinary action by citation. These 5 citations, together with 2 additional consent orders whereby the doctors agreed to disciplinary action by consent in lieu of proceeding through a contested hearing, were the only actions in our sample stemming from the public complaints that would show up in reported disciplinary statistics of the Board. They are thus the output statistics on which the Board would normally be judged. Our research has revealed however, that these actions only account for a fraction of Board interventions. Total formal and informal Board interventions are represented in Table 7.

It can be seen from the table that of the 193 total complaints closed without formal action being taken, 10 resulted in "informal" letters of caution being sent to the physician expressing the Board's disapproval of the physician's behavior. Moreover, of the 138 complaints closed after the investigator's report, 38 (19%) resulted in other informal actions. In 7 cases the patient's bill was written off

32. OHIO REV. CODE ANN. § 4731.22(B)(18) (Baldwin 1992).
33. OHIO REV. CODE ANN. § 4731.22(B)(6) (Baldwin 1992).
34. OHIO REV. CODE ANN. § 4731.22(B) (Baldwin 1992).

TABLE 7

Table to show action taken by the Ohio Board as a result of public complaints

Formal Action Taken	Frequency
Citations	5
Consent agreement	2
Total formal actions	7
Informal Action Taken	
Letter of caution following initial investigation	10
Investigator's warning	6
Records obtained for complainant	7
Bill reduced	7
Informal agreement to alter practice	8
Total informal actions	*38*
Total number of formal and informal actions taken	*47*

or reduced[35] and in 7 more the patient was able to obtain previously withheld records because of Board intervention. In 8 cases the investigator's report noted that the licensee agreed to a change in his or her practice, usually related to non-clinical matters such as appointments or rudeness of staff. In 6 cases the investigator informally warned the licensee that continuation of complained- of practices might result in further complaints and possible disciplinary action. When allowance is made for cases in which more than one type of action was taken, there were 32 instances in which informal action was taken. Together with the 7 formal actions this represents much greater activity by the Board than has previously been realized.[36]

35. Though the Board has no jurisdiction over the amount that a licensee bills a patient, the Board does investigate cases where fraudulent billing is alleged such as cases where it is alleged that the licensee billed for services that in fact were never rendered. Bills also are written off or reduced in cases where the amount of the bill is not at issue, but the complainant believes that the service for which the licensee billed was unsatisfactory, and thus that billing for the service is inappropriate.

36. By way of contrast we also looked at how the 200 non-public referrals were handled. Less of them were investigated, 153 as compared with 184 public complaints, but they were more likely to result in formal disciplinary action and much less likely to result in informal action. Overall, disciplinary activity was markedly higher than was true with public complaints. The Board initiated disciplinary action in 24 (12%) of the 200 cases and entered into consent agreements in 16 (8%). In addition, informal action was taken in 18 cases. This included 8 letters of caution and 10 investigator's warnings. Since referrals and reports are frequently based on prior actions taken by the referring institution or agency, and since the Board is permitted by statute to take disciplinary action based solely on the prior action of specified entities (such as other state agencies or the federal Department of Health and

Despite a general belief that medical licensure boards should play a major role in assuring the clinical competence of physicians, it is clear from our data that most disciplinary actions do not focus directly on issues of clinical competence. In the 400 cases reviewed in this study, the Board took 29 formal disciplinary actions involving contested proceedings, entered into 18 consent agreements, and issued 18 letters of caution, a total of 65 formal and informal disciplinary interventions initiated by the Board.[37] Only 6 of these 65 actions were directly based on allegations of improper clinical practice not involving improper prescribing of controlled substances. By contrast, 11 were based in whole or in part on physical or mental impairment of the practitioner (usually substance abuse), 8 on violation of continuing medical education requirements, 7 on unlicensed practice or engaging in activity beyond the scope of practice, and 7 on convictions for criminal conduct. None of these grounds necessarily involved clinical incompetence. A number of other disciplinary actions were based on allegations that might have been related to clinical competence: 7 were based on disciplinary actions of other states, which may have included competency-based actions, and 15 (the largest number in any category) were based on misuse of controlled substances, which might involve competency but could alternatively involve simple drug pushing.

Disciplinary actions based on allegations of clinical incompetence generally require identifying and proving improper clinical practice in multiple instances. Effectively, they require work equivalent to investigating and then proving up several malpractice cases simultaneously. They require testimony from at least one and often several experts. Incompetence-based disciplinary actions are thus very expensive and time-consuming endeavors. It is not surprising, therefore, that boards do not discipline a doctor for clinical incompetence if they can alternatively discipline the doctor by bootstrapping on the action of another medical board or on a criminal conviction, or if they can establish a more easily proved controlled substance or CME violation. Nonetheless, the results of this study give pause to those who believe that medical licensure boards can play a major role in assuring clinical competence.

It is also clear from our research that where consumers raised

Human services), it is not surprising that non-public referrals and reports result in a higher level of disciplinary activity than public complaints.

37. This does not include informal interventions taken by investigators, such as obtaining improperly withheld medical records or securing informal agreements to change practice arrangements.

issues of physician competence, their complaints were seldom verified by Board investigation. One hundred and twenty (60%) of the public complaints included allegations of violation of minimal standards of care. In only two cases alleging violation of minimum standards and not involving allegations of misprescribing of controlled substances was a doctor cited, brought under agreement or sent a letter of caution.

XII. RESPONDING TO THE COMPLAINANT

Our study further calls into question the Board's responsiveness to the public who make complaints. Of the 200 public complaints studied, only 7 complainants received individualized letters from the Board responding to the specific allegations made in their complaint. A further 141 (70.5%) were sent a standard form letter drafted by the Board at the close of the case.[38] A staggering 26% (52) got no reply at all.[39]

There was no way for us to discover from the data on file how satisfied the complainants were with the way the Board handled their complaints. Only 7 complainants wrote a letter to the Board after their complaint was closed. They asked for more information than that which was provided initially; 3 repeated the information they had provided in their first communication; and 2 expressed anger at the letter received from the Board. Given the barriers which most dissatisfied users have in complaining about services, we cannot assume that this is the sum of dissatisfaction with the result. What is clear is that the Board has not put a priority on responding to complainants' particular concerns but rather uses the information consumers generate to perform its policing role. This attitude and lack of accountability to the very people who fund the Board may be increasingly difficult to justify.[40]

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38. This letter stated:

Dear "Complainant,"

Thank you for informing the Medical Board of your concern regarding "Name of Doctor"

Medical Board actions must be based upon violations of the State statutes which regulate the practice of medicine and surgery. After careful review and consideration, the Board's Secretary and Supervising Member have decided not to initiate disciplinary action on the basis of this complaint.

We appreciate your bringing this matter to our attention for review.

39. One complainant received both a standard form letter and an individualized reply.

40. One of the earliest responses of the Board to a preliminary report on this study was to develop a series of word-processed letters tailored to respond to various categories of complaints to be used in lieu of the standard form letter.

XIII. DISCUSSION

Our study attempted to discover more about who complains to medical boards, how allegations of incompetence are investigated and problem physicians identified by boards, and how boards react once a problem has been recognized. In many senses the study raises more issues than it is able to address and many of the questions it asks can best be seen as agenda for future research.

Our study of complainants indicates that family members play an important role in the expression of grievances; that women are much more likely to complain to the Board than men — both on their own behalf and on behalf of other people — and that a significant number of complainants use more than one formal channel to express their grievance. In addition it illustrates that the vast majority of complaints about physicians concern allegations connected with medical care, a significant number of which might form the basis of a medical negligence action. Despite this, it is clear that most complainants do not express an intention to sue, a desire for compensation or, indeed, a clearly articulated demand that the licensee complained of be disciplined. Moreover, complaints are most likely to be made about office-based physician care and only once treatment has been completed.

Our data on the response of the particular board that we studied illustrate that the majority of complaints were investigated. The data emphasize the pivotal role of the investigator in the handling of the complaints, in particular the power he or she exercises through his or her discretion to uphold a particular version of competing accounts of care received. It is clear that the investigator's exercise of discretion may be crucial to the outcome of the case. It is clear that the majority of complaints do not result in formal action being taken, and that where such action is taken, professional incompetence is not the primary focus of formal disciplinary actions. Most significantly, we discovered that boards are much more active than official statistics suggest.

What are the uses and implications of these findings? The profile of complainants might be of value in a variety of contexts. On its own, it provides indications of who is most likely to complain about physician care to a state board. This information might be of interest to licensed professional risk managers, and those involved in work involving patient satisfaction. In the context of understanding disputing behavior in health care, this study provides us with data on one dimension of a multi-faceted issue. Complaining

and claiming are increasingly being seen as atypical behavior, but we have no way of knowing how atypical they are until voiced grievances are compared with those that are not voiced through formal channels. The profile presented here is a small advancement in our understanding, which can be most fruitfully understood with reference to profiles of the patient population generally, the non-complaining but dissatisfied population, those who use different avenues to complain, and those who sue. Moreover, it is possible that not only is expression of grievance atypical behavior, but also that issues complained of may be unrepresentative of the actual universe of problems that result from medical care. It becomes clear then, that complaints, let alone the disciplinary actions of state licensure boards, may be nothing like the rational tools for evaluation of care which we often attempt to make them.

The study also suggests the importance of adopting a more global approach in the study of grievances involving medical care, an approach that puts priority on examining the activity of the complainant rather than the event or circumstances complained about. Complaints to state licensure boards are just one channel available to those dissatisfied with medical care. Our data show that a number of complainants do not restrict themselves to complaining through just one mechanism but rather complain to a number of agencies simultaneously or sequentially.[41] A complainant-based approach may provide us with a much more complex picture of complaining behavior than would be suggested by an approach that concentrates on one particular organizational perspective. In an era in which emphasis is increasingly being placed on the importance of concerted joint efforts between consumers, insurers, hospitals, physicians and regulators in the management of quality of care, this has important implications, suggesting that there may be at this time substantial duplication of effort among agencies.

Our data on the response of the Board to complaints also raises questions as to the ability of medical licensure boards to address problems concerning the clinical competence of their licensees (and thus ultimately the problem of medical error) through disciplinary interventions. It is often assumed that the primary function of li-

41. This may be because complainants approach a number of agencies simultaneously. Alternatively, it may indicate that complainants work in a linear fashion, asking one entity to resolve a problem, and then moving on to other entities looking for resolution/satisfaction if the first attempt does not succeed. Thus multiple complaints may be not so indicative of redundancy as they may be of inadequacy of discrete approaches. Our data, however, do not allow us to discern which of these explanations most fully explains complaining behavior.

censure boards is to assure clinical competence, and that the volume of their formal disciplinary actions is an appropriate measure for evaluating their success in accomplishing this task. Our study demonstrates that evaluating board success solely on the basis of formal disciplinary actions is inadequate because boards may be more active at the informal level than is commonly supposed. Indeed, given the resource constraints generally faced by licensure boards,[42] and the substantial commitment of resources required when formal action is taken, it may be that informal action is not just an alternative to formal disciplinary action, but a more rational strategy for boards to pursue in some cases.

Moreover, to evaluate the effectiveness of the board as a tool for addressing the problem of medical error by assuring clinical competency, we need to know much more both about the incidence of medical error and about the relationship between competence and medical error. The Harvard Medical Practice study has contributed much to our understanding of medical error and negligence, confirming the finding of earlier studies that injury caused by medical error, and in particular by negligent medical error, is distressingly common.[43] Research into the relationship between medical error and competence, or, more specifically, into the relationship between the incidence of malpractice litigation and competence, is less conclusive. While it appears that a relatively small number of practitioners account for a relatively large share of malpractice judgments, it is less clear that these practitioners are incompetent, or that they can be readily identified prospectively.[44] At this point, confidence that medical licensure boards are capable of systematically identifying incompetent practitioners, and that board interventions can address the problems caused by such practitioners, are probably misplaced.

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42. Kinkel & Josef, *supra* note 11, at 211-12 (1991); OIG, STATE MEDICAL BOARDS, *supra* note 2, at 7-8.

43. *See supra* notes 15 and 16.

44. A study of New Jersey malpractice claims concluded, for example, ". . . [W]e found little evidence that negligence claims were sufficiently concentrated, either in number or in kind, to permit negligence reduction strategies targeted at individuals. Our results . . . emphasize the difference between knowing that some practitioners must be more prone to incur claims than others . . . and being able to identify who they are." John E. Rolph et al., *Malpractice Claims Data as a Quality Improvement Tool, II. Is Targeting Effective?* 266 JAMA 2093, 2097-98 (1991). Another study of Florida claims concluded: "Empirical evidence available up to now, including our study, . . . does not demonstrate that claims experience is a valid indicator of physician quality, although it does correlate with future claims." Frank A. Sloan et al., *Medical Malpractice Experience of Physicians, Predictable or Haphazard?*, 262 JAMA 3291, 3297 (1989).

It is particularly clear from our study that public complaints, the form of information most commonly relied upon by boards for identifying disciplinary infractions, rarely lead to formal disciplinary actions. It is understandable that reports and referrals from other sources are more likely to result in disciplinary action, as they generally consist of reports by persons professionally trained to recognize a problem or referrals from entities that have already conducted their own investigation and concluded that a problem exists. Nevertheless, the question remains why so few of the public complaints in our study resulted in formal action being taken. It may be that complainants are not very proficient at identifying problems. Alternatively, it may be that the Board is not very adept at substantiating problems identified by the public. Finally, it may be that some complaints were in fact substantiated in part, but that it was concluded that standing alone the problem identified did not warrant formal disciplinary action, and the commitment of resources it would demand. Many of the 46 public complaint cases that were not closed upon initial investigation fall into this category. Whatever the case, the substantial resources committed by boards to investigation of public complaints are difficult to justify if boards are in fact primarily concerned with identifying incompetent practitioners, since public complaints so rarely achieve this result.

One could argue in the alternative, however, that another reason exists for medical licensure boards to be responsive to public complaints, even if these complaints rarely identify disciplinary offenses in general or incompetent physicians in particular. Though boards do not exist as adjudicatory bodies to determine the justness of the grievances that complainants bring to them, our study shows that important decisions are in fact made in the course of investigations as to the apparent rights and wrongs of a complaint. Our data further show that this information has rarely been passed on to public complainants in the past, raising the possibility that the grievance complainants experience because of the lack of responsiveness of physicians may be compounded by the lack of response they experience from the medical licensure board. Because boards are responsible to the public, they are justified in investing considerable resources in responding to public complaints. But this effort may be largely wasted if boards fail in turn to communicate to public complainants the message that their complaints are in fact taken seriously.

XIV. CONCLUSION

State medical licensure boards are widely, if dimly, perceived as the keepers of the gate of the medical profession. When patients or their advocates are aggrieved by physicians, they sometimes turn to medical boards for help. Medical boards respond, though not always in ways that are perceived, or appreciated, or effective. Who complains to boards, what they want, and how boards respond are issues until now little understood. If boards are to carry out their job effectively, more needs to be known about what that job is, and about how best it should be carried on. This study is an initial contribution to the understanding of these issues.