

Report on a Flawed “Report Card”: The Public Citizens Ranking of Medical Licensing Boards

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Introduction

Each year the Public Citizens Health Research Group (HRG), led by Sidney Wolfe, MD, issues a “report card” ranking physician discipline rates, state by state. And each year, newspapers run stories about the “anemic” performance of the Wisconsin Medical Examining Board, using the HRG report as their source.

In its 2002 report, the HRG makes some rather sweeping charges, raising “serious questions about the extent to which patients in many states with poorer records of serious doctor discipline are being protected from physicians who might be barred from practice in states with boards that are doing a better job of disciplining physicians. **It is extremely likely that patients are being injured or killed more often in states with poor doctor disciplinary records than in states with consistent top performance.**”¹ The HRG ranked Wisconsin 49th among the 50 states and the District of Columbia in meting out physician discipline.

This is a grave allegation with serious implications regarding patient care and safety.

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The report continues: “Given the importance of medical boards in protecting patients in a state from doctors who are **not practicing medicine in the best manner** and are **endangering the lives and health** of the residents of those states, most states are not living up to this obligation. Serious attention must be given to finding out which of the above variables are deficient in each state and action, legislatively and through pressure on the medical boards, to **increase the amount of discipline and, thus, the amount of patient protection.**”

This paper examines the HRG “report card” and the far-reaching consequences HRG alleges may stem from poor medical licensing board performance.

If HRG is correct in its assertion that its survey results raise serious questions regarding “doctors who are not practicing medicine in the best manner” thereby “endangering the lives and health” of patients because of inadequate “patient protection,” then these findings should be similarly reflected in other “report cards” measuring patient care as well. This article outlines the method employed by HRG to create its ranking system and the problems with that methodology. It then seeks to document whether the HRG rankings are consistent with, and parallel to, several other reports on patient care in the various states.

A Flawed Reporting System

There are a number of serious problems with the HRG report. First, HRG does not generate any of its own data, but instead uses the 2002 Federation of State Medical Examining Boards (FSMB) Summary of Board Actions as the resource for its report.²

The problem is that HRG uses only portions of the FSMB report—choosing data arbitrarily—for its state rankings. Yet page one of the 2002 FSMB report states explicitly: “Each state has differing structures and statutory authority influencing outcomes. The information contained herein should not be used to compare the performance between boards but rather as a tool to review an individual board’s activity over time.” In the 2003 FSMB report, Chief Executive Officer James N. Thompson underscores that caution by stating, “The report is not useful for state-to-state comparisons. Each board operates under different state laws and completely different circumstances.”³ Nevertheless HRG uses the FSMB report to do just that.

FSMB Report

The FSMB report divides disciplinary actions into three categories: A—Loss of License, B—Restriction of License, and C—Other prejudicial actions. Category C includes reprimands and other license modifications. The HRG does not consider category C actions “serious” and excludes them in its annual rating.

However, the Wisconsin Medical Examining Board intentionally uses category C actions, when appropriate, for its goals of protection of the public and physician discipline. For example, in the 2002 FSMB report, Wisconsin had 16 A actions, 4 B actions, and 52 C actions, which is a much higher use of C actions than most states.

The HRG report does not consider the following examples of C actions to be “serious”:

- A formal, written reprimand.
- The requirement that, because of a surgical error, a surgeon must complete a risk management course and undergo an on-site assessment of the physician’s practice and procedures.
- A doctor with an alcohol or drug dependency issue, by agreement, stipulates to an order suspending the license for 5 years, with a stay of suspension so long as the doctor complies with random drug and alcohol screens, attends AA or NA meetings and AODA counseling as prescribed by an addiction specialist, and that he or she agrees to a practice mentor or supervisor.

These are “serious” disciplinary actions and should be considered as such. To rate them not “serious” because they do not involve actual revocation or suspension for a definite period of time ignores the very tools and actions the Wisconsin Medical Examining Board most often—appropriately and effectively—uses for physician discipline and protection of the public.

Other problems

There are other statistical problems with the HRG report as well. The HRG ranking is derived by dividing the number of “serious” disciplines (Groups A and B) by the total number of physicians practicing in the state. To be accurate, a uniform classification for “physicians practicing”

is necessary among the states being compared. No such uniform classification exists. Some states have a category for “retired” physicians; others do not. Many physicians have licenses in several states, but are in active practice in only one. While the FSMB report separates the total number of licensed physicians in the state from the total number of physicians actually in practice, the HRG report does not. For example, the 2002 FSMB report shows that Wisconsin has 19,868 licensed physicians but only 13,222 practicing in-state, a difference of 6646 (over 30%). Which numbers are used when dividing licensure actions by number of practitioners makes a considerable difference in final ratings since some states are more likely to have more out-of-state license holders than others.

But, the HRG report does not use FSMB figures **at all**. Instead, it substitutes “American Medical Association data on nonfederal MDs as of December 2000 and adding to this number osteopathic physicians if the board is a combined MD/DO board.”

The number used for Wisconsin physicians in the 2002 HRG report is 14,241. However, the actual number of physicians practicing in-state, according to the FSMB 2002 report, is 13,222—about 1000 less than HRG’s number. Using the smaller, correct number would give Wisconsin a higher performance ranking than the HRG reports. The difference between the number of physicians licensed in a state compared to total physicians actually in practice in that state creates an even larger discrepancy when looking at a state like New York. The HRG report uses the figure of 80,134 physicians compared to the FSMB figure of 56,995 of physicians who are actually in practice in-state.

HRG offers no explanation as to why it relies on FSMB physician

discipline numbers but does not use corresponding FSMB figures for physicians in practice.

An additional statistical problem is that the FSMB report acknowledges that discipline rates in states with the fewest doctors need to be interpreted with particular caution. In fact, it states that in the case of Wyoming, ranked #1 in the 2002 HRG report, “validity is limited as total in-state licensee population is less than 1000.” In fact, the three top-rated states in the 2002 HRG report—Wyoming, North Dakota, and Alaska—each have less than 2000 licensees. In 2003 the FSMB report began listing those states with fewer than 2000 doctors as a separate section in an acknowledgment that the lower number of doctors tends to skew the ranking upward.

Since the HRG report depends on FSMB data, it is worth mentioning why FSMB collects that data in the first place. It is **not** to compare performances by the various medical examining boards state by state. The preface to the FSMB report states, “It is a tool to review an individual board’s activity over time” and “should not be used to compare performance between boards.”

The FSMB does assign a Composite Action Index (CAI) number to each board, which gives a weighted value to data collected from each board as a “useful and interesting measure of activity within a jurisdiction.” But the FSMB states, “it is not statistically valid to use the CAI to compare one board’s activity level with that of another in any given year.” Instead the CAI allows each board to measure its own progress over time to see how changes the board implements might affect its CAI number. “If a medical board’s CAI fluctuates, it’s a good indication something has happened to impact the board’s level of disciplinary action. That board may have experienced an increase in funding, new leadership, changes in structure, or changes in the state laws

that govern its priorities. The report gives them a context to see that impact.” The CAI provides a chart for each individual board to look at its own performance on this index over the previous 10 years.

Faulty premises

Finally, beyond those serious definitional and statistical problems, there are other faulty premises in the HRG report. First, there is no solid evidence that the number of physician discipline actions somehow translates directly to quality of patient care or “practicing medicine in the best manner.” To validate any such correlation would involve a much more sophisticated equation than simply dividing Group A and B disciplines by the number of doctors in the state. Second, one would have to consider numbers from the complaint process itself. Perhaps some states simply have fewer complaints filed by patients per physician than some other states. That would seem to translate into better care, rather than poorer care. And third, perhaps those states with fewer disciplinary actions, and hence a “poor” HRG score—such as Wisconsin—are more careful up front in the licensing process and do a better job in keeping out problem physicians in the first place.

The assumption that “more is better” with respect to physician discipline, when assessing quality of care, is mere conjecture. If physician discipline translates directly into better patient care, as HRG asserts, then there should be similarities and consistency between its rating system and other systems that evaluate and rank quality of medical and health care in some manner. There is no such consistency. The following examples will demonstrate that.

The HRG Report Card and Quality of Care to Medicare Beneficiaries Report Card

The January 15, 2001 issue of the

Table 1.

	HRG ranking of 10 “Best” States For Physician Discipline	Rank In the Medicare Beneficiary Report
Wyoming	1	21
North Dakota	2	4
Arkansas	3	33
Kentucky	4	40
Oklahoma	5	45
Arizona	6	29
Ohio	7	36
Colorado	8	7
Montana	9	13
Utah	10	5

Table 2.

	Medicare Beneficiary Report of 10 “Best” States for Quality of Care	Rank in the HRG report
New Hampshire	1	30
Vermont	2	32
Maine	3	22
North Dakota	4	2
Utah	5	10
Iowa	6	15
Colorado	7	9
Wisconsin	8	49
Connecticut	9	38
Minnesota	10	42

Journal of the American Medical Association (JAMA) contains an article titled “The Change in the Quality of Care Delivered to Medicare Beneficiaries 1998-1999 to 2000-2001.”⁴ The report describes 22 quality-of-care indicators: six for patients with acute myocardial infarction, two for congestive heart failure, three for stroke, five for inpatients with pneumonia, and six for any setting relating to immunizations, breast cancer, and diabetes mellitus. It then rates the 50 states and the District of Columbia on quality of care on those 22 variables, giving each state a final ranking. If the HRG is correct in its assertion that its ranking of states from those with best doctor discipline rates to those with worst doctor discipline rates is commensurate with quality of care and “patient protection,” then it follows that there should be some similarity and parallels between the HRG “report card” and the Medicare “report card.” However,

that is not the case (Tables 1 and 2.) For example, Wyoming is ranked number 1 by HRG, but is 21st in the Medicare data. (See appendix for complete listing.) If one then ranks the 10 “best states” according to the Medicare Beneficiary Report alongside the HRG report, the rankings are disparate (Table 2).

The rankings differ widely between these reports. The Medicare Beneficiary Report, analyzing 22 elements of direct patient care, would seem to be a much more reliable measure of quality of medical care than the HRG physician discipline report, and on such a scale Wisconsin ranks 8th—not 49th—nationally.

The HRG Report Card and HealthGrades Hospital Quality in America

If one looks at a second measure of quality of care—The HealthGrades Hospital Quality in America Study—the same inconsistencies

Table 3.

	HRG "Best States" for Physician Discipline	HealthGrades Hospital Quality Report
Wyoming	1	43
North Dakota	2	1
Arkansas	3	39
Kentucky	4	34
Oklahoma	5	45
Arizona	6	13
Ohio	7	3
Colorado	8	6
Montana	9	14
Utah	10	9

Table 4.

	HealthGrades Hospital Quality Report Best States	HRG Report Ranking
North Dakota	1	2
Florida	2	44
Ohio	3	7
Michigan	4	37
Maryland	5	46
Colorado	6	8
Pennsylvania	7	43
Connecticut	8	38
Utah	9	10
South Dakota	10	39

appear.⁵ For this report, researchers ranked each of the country's nearly 5000 hospitals based on 26 common procedures and conditions. While perhaps measuring physician performance less directly than the Medicare Quality Study, one would expect there to be some similarity in rankings between the quality of care that HRG purports to measure and the hospital quality report. And yet that is not the case (Tables 3 and 4). For example, while HRG ranks Wyoming at the top, it ranks 43rd in the HealthGrades Hospital Quality in America Study. Conversely, Maryland is ranked 43rd by HRG, but is 5th in the Health Grades Hospital Quality Study.

As with the Quality of Care to Medicare Beneficiaries Report, there is simply no consistent relationship among the ranking of states between the Hospital Quality of Care report and the HRG report (Tables 3 and 4).

Discussion

The Public Citizens Health Research Group report that uses physician discipline rates in the various states as a measure of patient health, safety and/or quality of care is flawed. It uses self-selected numbers (A and B disciplinary actions only) from the Federation of Medical Examining Board data to rank the 50 states and the District of Columbia from best to worst—a ranking the FSMB explicitly states is not valid because of differences in definitions, administrative procedures, and other circumstances among the various state boards. The HRG report then substitutes AMA figures, rather than FSMB numbers, to compute the number of physicians (nonfederal) in each state without separating out doctors with state licenses who are not actually in practice in that state. Using that data to rate the states, the HRG report ties its problematic rankings directly to patient

safety with speculation that in those states rated "worst," it is "extremely likely" that more patients are being "injured or killed" than in those states at the top of the list.

The 2002 HRG report ranks Wisconsin 49th out of the 50 states and the District of Columbia in physician discipline and, by extension, in patient safety. The principle defect in such a rating for Wisconsin is that HRG excludes class C actions, which the Wisconsin Medical Examining Board uses frequently to accomplish its purposes of public protection and physician discipline. While the FSMB cautions that its data are not to be used for ranking the states, if one puts that caution aside for the moment and accepts the HRG method of ranking states but includes, rather than excludes class C violations as "serious" actions, Wisconsin rises from 49th to 24th.

The most serious concern regarding the HRG report is the sweeping allegation that its rating of the various states is tied directly to quality of patient care in terms of "not practicing medicine in the best manner" and "endangering the lives and health" of those residents of the states with poor performance rankings. However, when states are ranked on an actual Quality of Care Scale using Medicare performance data that measures 22 elements of medical care, and then compared to HRG rankings, there is no consistency. Likewise, a comparison of HRG state rankings with state rankings in the Health Grades Hospital Quality report, based on 26 common procedures and conditions, fails to show any consistent parallels. These two examples demonstrate that, in these instances at least, HRG's allegation of a direct relationship between physician discipline rates and patient health, quality of care, and safety is an unsupported one.

The National Practitioner Data Bank Summary report provides an

ongoing cumulative total, state by state and profession by profession, of instances (adverse actions) where malpractice reports, licensure, clinical privilege and society membership reports, or Medicare/Medicaid exclusion reports have been sent to NPDB beginning in September, 1990. It is of interest that Wisconsin has the fewest adverse actions per 1000 physicians of any state reported in the 14-year period from September 1990 to June 2004. The NPDB Summary reports 154 adverse actions per 1000 Wisconsin physicians (HRG's 49th state) as opposed to 457 such actions per 1000 Wyoming physicians (HRG's 1st state) during that same time period. Similarly, Minnesota had 165 adverse actions per 1000 physicians (HRG's 42nd) compared to North Dakota (HRG's 2nd), which had 388 adverse actions per 1000 physicians practicing in that state. The dissonance between these findings and those of HRG lends further weight to the data from the Medicare Beneficiary Report and the HealthGrades Hospital Quality Study. The NPDB findings also run counter to what one might predict: that those states "lax" on physician discipline would, as a result, be expected to have more malpractice reports, clinical privilege curtailments and professional society sanctions, and Medicare/Medicaid exclusions, as a reflection of such "dangerous" practices.

Of course not all Medical Examining Boards are working perfectly, and there is always room for improvement. But based on the authors' first-hand experience of serving on the Wisconsin Medical Examining Board for 8 years each, we feel the Board carries out its public protection and physician discipline activities in a very capable, responsible, and accountable manner. The Wisconsin MEB is continually studying, and has successfully revised, the disciplinary process to

reduce the time from complaint to resolution, along with providing easier access for the public to the complaint process itself. And the Medical Examining Board portion of the Department of Regulation and Licensing Web site (www.drl.state.wi.us) is continually upgraded so the public can more easily access an individual physician's licensure status and disciplinary history.

Summary

Any global ranking of states with respect to the health and safety of its citizens using specific, singular scales is fraught with difficulty and all such efforts should be interpreted with caution. It becomes even more problematic when one attempts to link physician discipline rates directly to either quality of care or injury and deaths of patients, as the Health Resource Group alleges. Any bona fide ranking of states with respect to health care or patient safety overall, whatever its source or its attempted correlations, would require a very complex, sophisticated equation with multiple, defined, distinct, quantifiable variables.

The HRG report does not meet that high threshold. First, its report ranks states from best to worst using FSMB physician discipline action data despite the FSMB disclaimer that none of its numbers should be used to compare one state to another. Second, HRG sets up its own selective criteria for "seriousness" of discipline, and in so doing specifically excludes the category C disciplines, which Wisconsin uses often and responsibly in protecting the public and disciplining physicians. This arbitrary exclusion puts Wisconsin into an unwarranted "worst" state category. Third, HRG then links its worst states to practices that "injure or kill patients." However when one attempts to verify such allegations by comparing HRG

rankings to specific quality-of-care rankings, using such measurements as Medicare data or Hospital HealthGrade data, such a sweeping allegation is unsupported.

Finally, HRG's conclusion that "more is better" with respect to physician discipline rates needs to be examined and weighed very carefully. It may be, in fact, that in those states with lower rates of physician discipline ("worse" states by HRG standards) there are fewer complaints filed per capita in the first place, which would point toward a "better" level of practice in those states. Or it may be that a lower ("worse") record of disciplines is due to "better," more stringent screening of physicians in the initial licensing process, thus keeping out the problem physicians in the first place. Or those states with lower discipline rates may have more alternative programs and resources such as a voluntary impaired professional program, which has stringent monitoring but does not require formal discipline.

HRG's ranking of Wisconsin as 49th in physician discipline rates is flawed in process and in fact. The accusation that such a low rating results in danger to patients or "not practicing medicine in the best manner" is an unsupported one. Comparison of the HRG ranking system with two other measures of quality of care—the Medicare Beneficiaries Quality of Care Study and the HealthGrades Hospital Quality in America Study—shows little consistency between those rankings and the HRG study.

Overall, the Wisconsin Medical Examining Board continues to carry out its important mission of patient safety and physician licensing and discipline in a very responsible and accountable fashion, and a closer analysis of the Health Research Group report, which suggests otherwise, demonstrates it to be a flawed "report card."

Appendix. State Rankings of the Medicare Quality Improvement Study and the HRG Report

MQIS Rank		HRG Rank	MQIS Rank		HRG Rank
1	New Hampshire	30/31	27	Indiana	30/31
2	Vermont	32	28	Missouri	34
3	Maine	22	29	Arizona	6
4	North Dakota	2	30	Kansas	36
5	Utah	10	31	Pennsylvania	43
6	Iowa	15	32	South Carolina	47
7	Colorado	9	33	Alaska	3
8	Wisconsin	49	34	West Virginia	13
9	Connecticut	38	35	Nevada	40
10	Minnesota	42	36	Ohio	7
11	Oregon	16	37	District of Columbia	26
12	Nebraska	27	38	New Mexico	11
13	Montana	9	39	Tennessee	48
14	Delaware	50	40	Kentucky	4
15	Massachusetts	21	41	Florida	44
16	Hawaii	51	42	Alabama	12
17	Rhode Island	35	43	New Jersey	23
18	Virginia	28	44	California	24
19	Washington	41	45	Oklahoma	5
20	South Dakota	39	46	Illinois	29
21	Wyoming	1	47	Georgia	17
22	Idaho	14	48	Arkansas	33
23	North Carolina	45	49	Texas	25
24	New York	20	50	Mississippi	19
25	Maryland	46	51	Louisiana	18
26	Michigan	37			

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Wisconsin Medical Journal

The mission of the *Wisconsin Medical Journal* is to provide a vehicle for professional communication and continuing education of Wisconsin physicians.

The *Wisconsin Medical Journal* (ISSN 1098-1861) is the official publication of the Wisconsin Medical Society and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor is responsible for overseeing the production, business operation and contents of the *Wisconsin Medical Journal*. The editorial board, chaired by the medical editor, solicits and peer reviews all scientific articles; it does not screen public health, socioeconomic or organizational articles. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *Wisconsin Medical Journal* nor the Society take responsibility. The *Wisconsin Medical Journal* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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