State Medical Boards: Are the Regulators Regulated?

David Segal[*]

Disclaimer: The author was a practicing neurosurgeon in private practice for 20 years, and in Iowa since 2009. The author completed neurosurgical training at the Mount Sinai Medical Center in 1997, and has numerous publications and presentations in the field of neurosurgery. The Iowa Board of Medicine charged the author in May 2015 with specific violations of the Iowa Administrative Code regarding his neurosurgical practice. The board alleged the author had improperly used epidural blood patches for postoperative spinal fluid leaks and that some patients developed infections following neurostimulator placement. The author denied the allegations and prepared for litigation. Before a hearing date was set, the author developed a medical illness that impacted his surgical proficiency. He retired from clinical practice in May 2016 and was admitted to the Iowa College of Law, with a JD granted in 2019. The author then settled with the Iowa Board of Medicine to avoid the burdens of continued litigation. The author's experiences with the Iowa Board of Medicine motivated him to produce this legal analysis.

Thus, this perspective is from a practicing physician, which are the ones who are under scrutiny by this administrative agency.

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[*] Juris Doctor, University of Iowa College of Law, 2019. The views expressed in this Note are solely those of the author. They do not reflect the views of the Journal of Corporation Law, the University of Iowa College of Law, the University of Iowa generally, or any affiliated institution.

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I. ARE THE REGULATORS REGULATED?

In the United States, high-impact professions such as law and medicine are monitored by statutorily empowered regulation.[1] In both the legal and medical regulatory realms, a board composed of a majority of professionals in that specific field enforce quality care standards through professional discipline, with the goal of protecting the public from substandard practice. However, as noble a cause as this may be, the system as it stands now does not work because it fails to adequately protect the public from poor medical treatment standards. The system as is also encourages and rewards reporting of frivolous and false charges against quality professionals—who are in short supply—and provides these accused professionals with little legal protection or recourse when they are faced with such false charges. This can result in the careers of quality practitioners being ruined, and the populace's options in quality medical care shrinking dangerously.

A. Excessive Action by the Iowa Board of Medicine

This Note will examine the harm that can result from a government agency wielding its administrative power over the careers and livelihood of public citizens, many of whom have little in the way of protections for substantive or procedural due process.[2] Many states, like Iowa, have critical physician shortages, and need a public policy that attracts and retains competent physicians to the state.[3] Looking specifically at the Iowa Board of Medicine, current practices do not accomplish this. A medical board investigation into any physician, even those who provide competent care, can be devastating professionally and

1. *See, e.g.*, Iowa Administrative Procedure Act, IOWA CODE § 17A (2008) (setting minimum standards for regulation by state agencies).

2. *See generally* Leigh Page, *What Really Happens When the Medical Board Investigates?*, DOCTORNEWS (Dec. 25, 2015), https://www.doctornews.com/article/what-really-happens-when-medical-board-investigates [hereinafter Page, *When the Medical Board Investigates*].

3. Michaela Ramm, *Recruit, Retain, Repeat: Iowa Faces Doctor Shortage*, GAZETTE (May 10, 2018), https://www.thegazette.com/iowaideas/stories/health-care/recruit-retain-repeat-iowa-faces-doctor-shortage-20180426.

personally, especially if the charges are public.[4]

The consumer advocacy group, Public Citizen, grades state medical boards. Each state has been ranked by the number of medical board disciplinary actions per 1000 physicians. The top rank is the most punitive—the state taking the most such actions. As displayed by their ranking system, Public Citizen considers such harsh punishments desirable; and, between the years 2003 and 2011, Iowa ranked between seventh and fifteenth most punitive, with Alaska averaging the most punitive and Minnesota the least punitive through that time period.[5] Analyzing the statistics further, in 2012 the IBOM disciplined 30% of physicians they investigated; in 2015 that number rose to 43%.[6] In contrast, Ohio, which was ranked by Public Citizen as the third most punitive state in 2011,[7] disciplined 28% of the physicians investigated in 2015.[8] Ohio ranks 14 in physicians per capita, compared with Iowa's ranking of 42.[9] The higher rate of discipline in Iowa indicates the state's haste to act on complaints against physicians, despite the state's public policy interests in attracting such physicians.

One example of excessive IBOM discipline is exhibited in *Glowacki v. IBOM*, where an anesthesiologist was charged with fraudulent billing.[10] Testimony portrayed this physician as honest, respected, competent, and caring.[11] The evidence showed that the alleged violation concerned the definition of billable "anesthesia time," for which there was no agreement or clear accepted practice.[12] Despite this ambiguity, the IBOM suspended this physician's medical license, charging him with "knowingly making fraudulent representations."[13] The IBOM reasoned that though this physician had not intended to mislead, this physician knew that he was billing, and the fact that his records could have been misleading was sufficient.[14] The Iowa Supreme Court overturned the IBOM ruling, holding that there was not substantial evidence to support it.[15]

Legislators and organized medicine have made no attempt to correct the state medical board's misapplication of the law or its lack of oversight, accountability, or constraints on its authority. This is mostly due to political pressures from consumer advocacy groups,

4. *Enforcement*, IOWA BD. OF MED., https://medicalboard.iowa.gov/physicians/enforcement (last visited Mar. 3, 2019) (complaints may be closed, continued, reopened, result in sending of a confidential letter of warning, or public charges) [hereinafter *Enforcement*].

5. SIDNEY WOLFE ET AL., PUB. CITIZEN, PUBLIC CITIZEN'S HEALTH RESEARCH GROUP RANKING OF THE RATE OF STATE MEDICAL BOARDS' SERIOUS DISCIPLINARY ACTIONS, 2009-2011 2–3, 9 (2012), https://www.citizen.org/sites/default/files/2034.pdf (ranking the states exclusively by the number of disciplinary actions they take per 1000 doctors in the state).

6. IOWA BD. OF MED., 2015 ANNUAL REPORT 10 (2015), https://medicalboard.iowa.gov/sites/default/files/documents/2017/11/2015_annual_report.pdf [hereinafter IBOM, 2015 ANNUAL REPORT].

7. WOLFE ET AL., *supra* note 5.

8. STATE MED. BD. OF OHIO, FY15 ANNUAL REPORT JULY 1, 2014-JUNE 30, 2015 12–13 (2015), http://www.med.ohio.gov/Portals/0/DNN/PDF-FOLDERS/Publications/Annual-Reports/2015-annual-report.pdf [hereinafter OHIO FY15 ANNUAL REPORT].

9. ASS'N AM. MED. COLLS., OHIO PHYSICIAN WORKFORCE PROFILE (2013), https://www.aamc.org/system/files/2019-08/ohio-2013.pdf; IBOM, 2015 ANNUAL REPORT, *supra* note 6, at 18.

10. Glowacki v. State Bd. Of Med. Exam'rs, 516 N.W.2d 881, 883–84 (Iowa 1994).

11. *Id.* at 886.

12. *Id.* at 883.

13. *Id.* at 886.

14. *Id.* at 883.

15. *Glowacki*, 516 N.W.2d at 887. The IBOM's application of "knowingly" also contradicted the definition used by the Eighth Circuit, which requires some level of intent for a violation to be "knowing." United States v. Enochs, 857 F.2d 491, 493 (8th Cir. 1988).

such as Public Citizen,[16] and state medical boards, along with distorted public policy motives disguised within the abstraction of protecting the public. While the government has a duty to protect the public, this duty is not a license for abuse of power, especially when the issues do not directly involve public safety, as seen in *Glowacki*.[17] This lack of oversight, coupled with overzealousness, can result in decreased access to medical care for patients if their competent physicians are unfortunate enough to be singled out for heightened scrutiny by the state medical board.[18] The seemingly unjust practices of Iowa's professional boards were the subject of a recent report from the Iowa Ombudsman office that highlighted the secrecy and lack of oversight.[19] In that report, the Iowa Ombudsman office found that incomplete investigations that lacked oversight led to false charges, poor documentation, unprofessional behavior, conflicts of interest, and a lack of transparency.[20] Physicians should be subject to a high bar for professional conduct, as well as high levels of scrutiny and oversight. Medical boards should exist with reliable mechanisms for identifying and correcting physicians who do not comply with a national standard of care. However, the current process of the IBOM does not fairly or accurately judge physicians and does not protect the public.[21]

B. Iowa's Physician Shortage

The future course of healthcare reform in our country is uncertain. The escalating physician shortage is an under-appreciated obstacle toward reforming the current healthcare delivery system.[22] States that have the worst physician shortages will find it increasingly difficult to implement expanded Medicaid or Affordable Care Act (ACA) exchanges, because the limited physician supply will allow physicians to selectively treat patients with higher reimbursing commercial insurance.[23] As mentioned above, Iowa

16. *Ranking of State Medical Boards' Disciplinary Actions: 2009-2011*, PUB. CITIZEN, https://www.citizen.org/article/ranking-of-state-medical-boards-disciplinary-actions-2009-2011/ (last visited May 17, 2019).

17. *See generally Glowacki*, 516 N.W.2d 881 (revolving around the definition of "anesthesia time" as related to billing procedures).

18. *AAPS News January 2018 - A Right to Work*, ASS'N AM. PHYSICIANS & SURGEONS (Dec. 27, 2017), https://aapsonline.org/aaps-news-january-2018-right-work/ ("Physicians who have served on medical boards report that actions often appear arbitrary. Dangerous doctors escape unscathed despite patient complaints; others are pursued relentlessly on questionable pretexts, even if patient outcomes are exemplary."); Mark Crane, *Surviving a Medical Board Investigation*, MEDSCAPE (Apr. 13, 2016), http://www.medscape.com/viewarticle/857744 (discussing medical boards' unrealistic standards "the boards can be relentless and their expectations about medical care sometimes exceed reality").

19. *See generally* KRISTIE HIRSCHMAN, IOWA OFF. OF OMBUDSMAN, A SYSTEM UNACCOUNTABLE: A SPECIAL REPORT ON IOWA'S PROFESSIONAL LICENSING BOARDS (2017), http://publications.iowa.gov/23532/1/A%20SYSTEM%20UNACCOUNTABLE.pdf (finding that Iowa's licensing boards tend to value secrecy over transparency).

20. *Id.* at 1, 13 (critiquing Iowa's licensing boards, saying "We strongly believe that the environment in which these boards have been allowed to exist—behind closed doors—has fostered uninspired work and unprofessional conduct. It has been easy for these boards to do less than their best because, for years, no one has been in a position to evaluate their work. In short, it has been a system unaccountable.").

21. For critiques of these investigations generally, see Neil Chesanow, *Medical Board Investigations: Legitimate or Kangaroo Courts?*, MEDSCAPE (Mar. 15, 2016), www.medscape.com/viewarticle/857598.

22. Logan Albright, *How Government Helped Create the Coming Physician Shortage*, MISES INSTIT. (Feb. 3, 2015), https://mises.org/library/how-government-helped-create-coming-doctor-shortage.

23. *See* Matthew J. Belvedere, *Doctors 'Reluctant' to Take Obamacare Patients: Hospital CEO*, CNBC

ranked 42 in the US for the number of physicians per population and last in some important subspecialties.[24]

On May 5, 2017, former Iowa Governor Terry Branstad signed the Iowa Tort Reform bill into law in an effort to retain and attract more physicians to Iowa.[25] This law enacts a $250,000 cap on noneconomic damages (i.e., pain and suffering), expands expert witness requirements, and requires a certificate of merit[26] in medical liability suits.[27] Opponents of the Iowa Tort Reform bill, mainly consumer advocate groups and plaintiff's malpractice counsel, highlighted that Iowa is not a litigation-heavy state for physicians.[28] Data shows that medical malpractice lawsuits substantially decreased in Iowa in the last decade.[29]

However, the Iowa Tort Reform bill did not address the harshness of the state medical board disciplinary process. The manner and fairness with which a state medical board punishes its physicians is another prominent metric (and weighed as being as important as malpractice climate) for ranking a state's ability to attract and retain physicians.[30] Experiences in other states show that when tort reform is enacted, complaints to medical boards rise.[31] This may reasonably result in an exodus of competent and qualified physicians from that state.

Iowa was overall ranked best state for physicians in 2017 by WalletHub and fourth best by Medscape for a variety of economic and lifestyle metrics.[32] However, Medscape

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(May 15, 2015), https://www.cnbc.com/2015/05/15/doctors-reluctant-to-take-obamacare-patients-hospital-ceo.html.

24. *New Iowa Physician Workforce Data Shows Critical Shortages Persist*, IOWA MED. SOC'Y (Sept. 23, 2015), https://www.iowamedical.org/Iowa/Iowa_Public/Public_Affairs/News/2015/New_Iowa_Physician_Workforce_Data_Shows_Critical_Shortages_Persist.aspx (the important subspecialties are Emergency Medicine and Obstetrics & Gynecology).

25. Brianne Pfannenstiel, *Branstad Signs into Law Medical Malpractice Reforms*, DES MOINES REG. (May 5, 2017), https://www.desmoinesregister.com/story/news/politics/2017/05/05/branstad-signs-into-law-medical-malpractice-reforms/311848001/.

26. To commence a medical malpractice lawsuit, a plaintiff will need to file an expert witness affidavit endorsing merit of the case. IOWA CODE § 147.140.

27. *Governor Signs Tort Reform into Law*, IOWA MED. SOC. (May 5, 2017), https://www.iowamedical.org/Iowa/Iowa_Public/Public_Affairs/News/2017/Governor-Signs-Tort-Reform-Into-Law.aspx.

28. *E.g.*, *Iowa Enacts Hurtful Medical Malpractice Tort Reform Law*, MED. MALPRACTICE LAW. (May 7, 2017), https://www.medicalmalpracticelawyers.com/iowa-medical-malpractice-2/iowa-enacts-medical-malpractice-tort-reform-law/.

29. *Id.* (click second source then click "*Iowa Medical Errors Fact Sheet*"); *see also* IOWA INS. DIV., IOWA MEDICAL MALPRACTICE ANNUAL REPORT FOR CALENDAR YEAR 2015 (Dec. 2016), https://iid.iowa.gov/documents/2015-medical-malpractice-report; IOWA INS. DIV., IOWA MEDICAL MALPRACTICE ANNUAL REPORT FOR CALENDAR YEAR 2006 (Dec. 2007), https://iid.iowa.gov/documents/2006-medical-malpractice-report.

30. Leigh Page, *Best and Worst Places to Practice Medicine 2017*, MEDSCAPE (May 10, 2017), https://www.medscape.com/slideshow/best-places-to-practice-2017-6008688#5.

31. CYNTHIA S. GOOSEN, COPING WITH A STATE BOARD INVESTIGATION: ADDRESS AT 8TH ANNUAL FORUM ON HEALTH CARE LIABILITY 3 (Oct. 17, 2008), http://www.cooperscully.com/uploads/seminars/Goosen-StateBoard.pdf ("With no legal forum available to the potential medical malpractice plaintiff, many patients may instead turn to the [medical board] as the only available avenue to air their grievances."); *see also Doctors Sue Texas Medical Board for Misconduct - Cites Institutional Culture of Retaliation & Intimidation*, ASS'N. AM. PHYSICIANS & SURGEONS (Dec. 21, 2007), https://aapsonline.org/doctors-sue-texas-medical-board-for-misconduct-cites-institutional-culture-of-retaliation-intimidation/ [hereinafter *Doctors Sue Texas Medical Board*].

32. *Best and Worst States for Doctors in 2017: See How Your State Stacks Up*, THE DO (Mar. 29, 2017), https://thedo.osteopathic.org/2017/03/best-and-worst-states-for-doctors-in-2017-see-how-your-state-stacks-up/; Page, *supra* note 30.

noted that Iowa had "a fairly harsh medical board."[33] The IBOM's harsh tactics and actions may have negative and far reaching effects. Competent and qualified physicians may become familiar with aggressive IBOM actions and choose to practice elsewhere. Physicians who consider leaving Iowa may weigh personal experiences or observed accounts of IBOM harshness as a factor in their decision to move out of state. Any disadvantage Iowa faces in attracting or retaining physicians needs to be remedied.

This Note will discuss how the current process of broad IBOM discretion can punish and devastate the careers of competent, qualified physicians when physicians are in short supply in Iowa. The current practices of the IBOM will be examined with a focus on the processes of filing complaints, investigating those complaints, and charging physicians based on those complaints. This Note will examine how the current procedures lack sufficient due process protections relative to the risks faced by physicians. This analysis will focus on the problem of the IBOM acting as prosecutor, judge, and jury, how the all-important peer review process is fatally biased, and how the IBOM requires a low burden of proof relative to the risk of erroneous deprivation. The current system grants the IBOM too much power at the expense of the medical profession and those they serve. These flaws in the system result in arbitrary and irreversible damage to the careers of competent physicians. To remedy the current flawed process, the state should increase protections for practicing physicians and reform the IBOM's administrative procedures.[34]

II. BACKGROUND

The Iowa General Assembly created the State Board of Medical Examiners in 1886 with the charge of regulating the practice of medicine.[35] The earliest court cases addressed practicing medicine without a license in an age when medical education and licensure were novel concepts.[36] The board now regulates allopathic and osteopathic physicians, as well as acupuncturists. The board members meet about every eight weeks to review and finalize board business and the many disciplinary decisions.[37]

A. Process of Policing Physicians in Iowa

All board investigations begin with complaints, which can originate from any source, including active competitors and anonymous individuals.[38]

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33. Page, *supra* note 30.

34. Page, *supra* note 30, at 34 (listing medical board action first among the factors that contribute to burnout).

35. *Board Overview*, IOWA BD. OF MED., https://medicalboard.iowa.gov/board-overview (last visited Feb. 4, 2019); IOWA ADMIN. CODE r. 653-1.1 ("'The practice of medicine and surgery' shall mean holding one's self out as being able to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity or physical or mental condition . . . .").

36. State v. Bonham, 65 N.W. 154, 155 (Iowa 1895) (holding an "itinerant vendor" of any drug shall require a medical license); Coll. Physicians & Surgeons of Keokuk v. Guilbert, 69 N.W. 453, 454 (Iowa 1896) (members of the State Board of Medical Examiners were held in contempt for refusing to grant a license upon presentation of medical diploma per Iowa law).

37. *Enforcement*, *supra* note 4. The Board receives around 700 complaints a year, leaving incredibly limited time to review any given complaint.

38. *Id.* For an alleged example of this, see *Surgeon Says Allegations Just Plot by Rivals*, DISPATCH-ARGUS (July 16, 2001), https://qconline.com/news/iowa/surgeon-says-allegations-just-plot-by-rivals/article_7e596bd2-0ab8-558e-862e-e4623ff45086.html (citing a surgeon who had an emergency revocation of his license in Iowa to be restored in California).

The goal of a state medical board is to prosecute and punish bad actors in the medical field.[39] The medical board receives few complaints, relative to the number of practicing physicians in the State of Iowa.[40] The Board investigates many physicians,[41] though few physicians are punished in a way that affects their ability practice.[42] Once investigated, even physicians who have done no wrong can face negative consequences in the court of public opinion. The current process can allow a physician's competitors to create baseless investigations and can overlook actual instances of wrongdoing. Meanwhile, physicians who actually need oversight can continue practicing unnoticed.[43]

An example of the flawed process from a different state is *Mishler v. State Board of Medical Examiners*.[44] Dr. Mishler was a neurosurgeon who discovered fraudulent billing and poor patient care by other surgeons in his city and tried to remedy the problem.[45] His competitors, successfully, used the Nevada Medical Board to ruin Dr. Mishler's career. The board took away his license. Dr. Mishler was unable to practice anywhere in the country and was forced to declare bankruptcy. The Nevada Supreme Court found that the

> Board's power was not exercised for the proper and commendable purpose of protecting the public from incompetent and negligent physicians. Instead, the Board wielded its power to ruin the career of an outspoken physician while simultaneously protecting a possibly negligent or incompetent practitioner who had questionable billing procedures. Although only one patient had complained about Dr. Mishler, and that complaint was subsequently found to be unjustified, the Board purposely scrutinized Dr. Mishler's charts to find evidence with which to discipline Dr. Mishler.[46]

Despite this ruling, Dr. Mishler never recovered damages because his attorney failed

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39. Michelman & Bricker, *Physicians Investigated by State Medical Board*, HG, https://www.hg.org/legal-articles/physicians-investigated-by-state-medical-board-35192 (last visited Apr. 1, 2019) (describing the goal of state medical boards as investigation, prosecution, and conviction of physicians).

40. IBOM, 2015 ANNUAL REPORT, *supra* note 6, at 5 (showing there were close to 12,000 licensed physicians, but only 712 complaints).

41. Crane, *supra* note 18, at 1 (noting in 2012, 4479 doctors were disciplined, but the scope of medical board inquiries has expanded).

42. John Fauber & Matt Wynn, *7 Takeaways from Our Year-Long Investigation into the Country's Broken Medical License System*, USA TODAY (Nov. 30, 2018), https://www.usatoday.com/story/news/2018/11/30/medical-board-license-discipline-failures-7-takeaways-investigation/2092321002/; Chesanow, *supra* note 21, ("However, a small percentage of complaint investigations can get quite aggressive, according to attorneys who represent physicians in board cases, the article noted. Over the course of the investigation, the allegation against the physician can completely change, and in some cases, the board can summarily remove the doctor's license without a hearing. The board's final decision has ripple effects, such as a permanent mark on their records, loss of hospital privileges, and potentially being dropped by health insurance carriers.").

43. *A Right to Work*, *supra* note 18 (discussing how good physicians may be "pursued relentlessly," while dangerous physicians are not punished); *see generally* Eric A. Dover, *Ch. 9, Functioning as a Physician in a Regulatory Environment, in* RISK MANAGEMENT, LIABILITY INSURANCE, AND ASSET PROTECTION STRATEGIES FOR DOCTORS AND ADVISORS: BEST PRACTICES FROM LEADING CONSULTANTS AND CERTIFIED MEDICAL PLANNERS (David E. Marcinko & Hope R. Hetico eds., 2015), http://harbr-usa.org/wp-content/uploads/2017/05/HARBR-Web-Copy-Functioning-as-a-Physician-in-a-Regulatory-Environment-by-Eric.pdf; *see also infra* Part III.C.4.

44. Mishler v. St. Bd. of Med. Exam'rs, 849 P.2d 291 (Nev. 1993).

45. *Id* at 292.

46. *Id*. at 296–97.

to join the correct defendant in a timely manner.[47]

1. The Investigative Process

The IBOM employs seven to ten investigators[48] whose job it is to amass evidence about complaints against physicians by gathering records, interviewing parties, and question the accused physician to determine the veracity of the complaints.[49] The investigators need not have medical training.[50] When faced with an issue of medical complexity and potentially lacking medical experience, the investigators rely on the opinions of physician peer reviewers, including physicians who are competitors of the physician under investigation.[51] Although the board investigates physicians only after it receives a complaint, once the investigation begins, the investigation is not limited to the issues raised in the complaint—anything is fair game.[52] The final report of the investigator, including the opinion of the peer reviewer, is given great weight by the IBOM in arriving at its decision. Although peer reviewers, by definition, practice in the same field as the accused physician, peer reviewers need not have credentials or recognition as leaders or authorities within that field of medicine or be versed in the national standards of care that bestows legitimacy to judge the accused physician.[53]

2. Pseudo-Criminal Charges and Disproportionate Punishment

In the face of medical board charges, many physicians quickly settle by agreeing to a fine and sanctions to avoid further publicity, risk, and expense.[54] Physicians who choose to fight the charges will have a hearing with the same board members who charged them with the violation, who then act as judge and jury.[55] These board members not only have

47. Roy G. Spece, Jr. & John J. Marchalonis, *Sound Constitutional Analysis, Moral Principle, and Wise Policy Judgment Require a Clear and Convincing Evidence Standard of Proof in Physician Disciplinary Proceedings*, 3 IND. HEALTH L. REV. 107, 116 (2006).

48. *Board and Staff Members*, IOWA BD. OF MED., https://medicalboard.iowa.gov/board-and-staff-members (last visited Feb. 2, 2019) (listing the eight current investigators).

49. Crane, *supra* note 18.

50. *See generally* IOWA ADMIN. CODE r. 653 (listing no requirement that the IBOM hire full-time investigators, and, therefore, no minimum hiring standards for these investigator positions).

51. *See* Carolyn R. Cody, Note, *Professional Licenses and Substantive Due Process: Can States Compel Physicians to Provide Their Services*, 22 WM. & MARY BILL RTS. J. 941 (2014) (discussing how state medical boards may abuse due process in an attempt to assert control over physicians).

52. *See Enforcement*, *supra* note 4 (stating there is no statutory limitation on investigators scope of inquiry); IOWA ADMIN. CODE r. 653-24.2.

53. *See* IOWA BD. OF MED., PEER REVIEW MANUAL 3 (2018), https://medicalboard.iowa.gov/sites/default/files/documents/2018/12/peer_review_manual.pdf (stating that peer reviewers are *usually* selected from the same field as the physician under investigation) [hereinafter IBOM, PEER REVIEW MANUAL].

54. *See* Dover, *supra* note 43, at 225 ("With the threat of license revocation, the physician, under duress, will sign almost any document in the hope of placating the Medical Board and keeping their license."); Leigh Page, *The Black Cloud of a Medical Board Investigation*, MEDSCAPE (Dec. 23, 2015), https://www.medscape.com/viewarticle/853911_1 ("Often, physicians initially aren't told much about the complaint, and even if they think the charges are overblown, they may plead guilty because they fear worse consequences if they insist on a full hearing."); Joel Bruce Douglas & Peter R. Osinoff, *What to Do When the Medical Board Comes Knocking - An Overview of Licensing Board Procedures*, MARTINDALE LEGAL LIBRARY (July 1, 2009), https://www.martindale.com/health-care-law/article_Bonne-Bridges-Mueller-OKeefe-Nichols_734038.htm; Chesanow, *supra* note 21.

55. IOWA ADMIN. CODE r. 653-25.18; Spece, Jr. & Marchalonis, *supra* note 47, at 125.

approved the charges, they have reviewed and have access to all information collected on the accused physician compiled by the investigator—any of which might be unproven—further compromising impartiality.[56] An assistant attorney general prosecutes the case,[57] and an administrative law judge (ALJ) is assigned to the case.[58]

The medical board uses the preponderance of evidence standard for a finding of guilt of a physician accused of misconduct.[59] Possible sanctions include fines up to $10,000, public reprimand, license probation with restricted practice,[60] license suspension, license revocation, or any combination of these.[61] Legal fees associated with representing the accused physician can be astronomical, and must be borne by the physician, even if there are no findings of wrongdoing.[62]

Public discipline on a physician's record creates a domino effect of consequences,[63] each of which can be a career-ender resulting in penalties that are vastly disproportionate to the alleged wrongdoing.[64] Before charges are adjudicated or substantiated, the IBOM issues a press release.[65] The consequences of public citations and sanctions can be as severe as criminal punishment.[66] If a state licensing board imposes license restrictions and public sanctions,[67] it can result in loss of hospital privileges, and loss of malpractice insurance coverage on which hospital privileges depend. Additionally, the physician can lose their credentials with insurance companies and would be barred from receiving reimbursement

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56. Spece, Jr. & Marchalonis, *supra* note 47.

57. IOWA ADMIN. CODE r. 653-25.18.

58. *Enforcement*, *supra* note 4. The ALJ "rules on matters of law and *assists* the board in preparing the Findings of Fact, Conclusions of Law, and Decision and Order of the board." *Id.* (emphasis added). As such, the ALJ does not control the ultimate outcome of a proceeding unless it turns on a strict issue of law.

59. Spece, Jr. & Marchalonis, *supra* note 47, at 108.

60. Restrictions may vary both in length of time and severity, but any restriction will trigger the consequences listed.

61. *Enforcement*, *supra* note 4.

62. *How Much Will It Cost Me to Have a Lawyer Defend Me Against the Charges?*, IOWA PERS. INJ. L., https://www.lombardilaw.com/blog/how-much-will-it-cost-me-to-have-a-lawyer-defend-me-against-the-charges.cfm (last visited Mar. 31, 2019) ("You're going to spend between $10,000 and $50,000 to defend your reputation and medical license.").

63. Page, *supra* note 54, at 3 ("The charges are announced to the public, which 'puts insurance carriers and hospitals . . . in a difficult position,' she says. They don't want to look like they are protecting physicians who might lose their licenses. So even without a hearing, 'you may be dropped by certain insurance plans, and your hospital privileges may also be affected.'").

64. *See* DeLouis v. Iowa Bd. of Med., No. 13-1623, 2014 WL 4230219, at *1 (Iowa Ct. App. 2014) (consequences of IBOM discipline caused physician to be unable to practice after signing settlement agreement for prescribing diet pills to her family); *see also* Spece, Jr. & Marchalonis, *supra* note 47, at 115–16 (describing the case of Dr. Alan Mishler and the stigma he received after being sanctioned for an unjustified complaint).

65. *See, e.g.*, Press Release, Iowa Board of Medicine (Aug. 1, 2018), https://medicalboard.iowa.gov/sites/default/files/documents/2018/08/08_01_2018.pdf (including a notice that disciplinary charges had been filed against a physician five days prior to the press release date)..

66. Spece, Jr. & Marchalonis, *supra* note 47, at 113 ("The impact of disciplinary sanctions is similar to that of criminal punishment.").

67. *See DeLouis*, No. 13-1623, 2014 WL 4230219, at *1 (describing consequences of IBOM discipline for prescribing diet pills to her family: "Dr. DeLouis was dropped from coverage by her medical malpractice insurance carrier and because she did not have insurance coverage she was no longer able to practice medicine with her employer."); *see also* Spece, Jr. & Marchalonis, *supra* note 47, at 115–16 ("The board's final decision has ripple effects, such as a permanent mark on their records, loss of hospital privileges, and potentially being dropped by health insurance carriers.").

for any patient with that insurance.[68] Additionally, a physician with formal sanctions against him or her from a state medical board could be impeached as an expert witness,[69] be an easy target for malpractice suits, and be subjected to loss of patients as referring physicians refer elsewhere due to fear of their own malpractice liability.[70]

An example of this disproportionate punishment is *Leo v. Board of Medical Examiners*, where the IBOM sanctioned a physician for not signing hospital medical records.[71] Although not best practice, this is a common misdeed.[72] The IBOM then reported him to the National Practitioner Data Bank (NPDB).[73] As a result, this doctor had limitations imposed by his malpractice carrier and third-party payors harming his career.[74] The physician appealed, also citing derogatory statements made against him by the board members who imposed the sanctions as well as lack of notice that denied him due process rights. The Iowa Court of Appeals ultimately denied his appeal because he did not exhaust administrative remedies.[75]

III. ANALYSIS

A governmental agency directed by non-physician agents who are immune from review is not the best way to regulate physicians. The risk of prejudicial, arbitrary, and overly severe punishments under the umbrella rationale of protecting the public is simply too high.[76] Those concerns, it seems, have been justified by several inappropriately pursued cases.

A. Illustrative Case that Represents IBOM Procedure

On January 18, 2001, the IBOM filed a statement of charges and an Emergency Adjudicative Order against Daniel Miulli, a neurosurgeon practicing in Des Moines, alleging professional incompetency and practice harmful or detrimental to the public, and

68. *See* Paul K. Ho, *HCQIA Does Not Provide Adequate Due Process Protection, Improve Healthcare Quality and Is Outdated Under "Obama Care,"* 11 IND. HEALTH L. REV. 303, 303–05 (explaining an illustration of a surgeon victimized by sham peer review that ended his career).

69. *State Laws Chart II: Liability Reforms*, AMA ADVOC. RESOURCE CTR., https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/arc/state-laws-chart-2_0.pdf (last visited Mar. 31, 2019) (see Mississippi and West Virginia); Christopher K. Jones, *Court Refuses to Exclude Evidence of Disciplinary History of Plaintiff's Expert*, RISK MGMT. SANDS ANDERSON (Jan. 10, 2018), https://www.sandsanderson.com/news/2018/01/10/court-refuses-exclude-evidence-disciplinary-history-plaintiffs-expert/ (discussing an instance where an expert witness was questioned about prior discipline).

70. *See* Spece, Jr. & Marchalonis, *supra* note 47, at 114–15 (exemplifying repercussions after a disciplinary proceeding).

71. Leo v. Bd. of Med. Exam'rs, 586 N.W.2d 530, 531 (Iowa Ct. App. 1998).

72. *Case Study: One Hospital Monitors its H&Ps to Set Benchmarks, Significantly Reduce the Delinquency Rate*, MED. RECORDS BRIEFING (Feb. 2008), http://hcpro.com/content/203960.pdf (discussing doctor delinquencies in history and physical medical recording).

73. *Id. See* 45 C.F.R. § 60.1 (2013) (explaining the National Practitioner Data Bank (NPDB) regulations). NPDB is a Federal Government program that the collects and discloses negative information on health care practitioners. NAT'L PRACTITIONER DATA BANK, https://www.npdb.hrsa.gov/ (last visited Feb. 3, 2019).

74. *Leo*, 586 N.W.2d at 532.

75. *Id*. at 531.

76. Dover, *supra* note 43, at 226 (criticizing the "broad latitude" and "little, if any, effective oversight" of state medical boards).

forcing him to immediately stop the practice of medicine.[77] In 1997, this board-certified neurosurgeon had been recruited to join another neurosurgeon in Des Moines. The IBOM stipulated that there was animosity between the busy practice Miulli had just joined and the larger competing neurosurgery practice in town.[78] The competing neurosurgeons arbitrarily reviewed a year of surgeries of the accused neurosurgeon and out of the many hundreds of surgeries,[79] they identified 18 that, in their opinion, had medical care concerns.[80] At the same time, one of the competing neurosurgeons applied for, and was appointed to, a membership on the Iowa Board of Medicine.[81]

The competitors registered a formal complaint against Miulli in 1999.[82] At that time, no patient or family member had complained about the accused neurosurgeon.[83] The competitor neurosurgeons talked with the IBOM investigator to show where, in their subjective opinion, Miulli allegedly deviated from the standard of care.[84] The IBOM contracted three peer review physicians, who were chosen by consulting with the accused's competitor on the board.[85] These peer reviewers found substantial, willful, or repeated breaches of the standard of care with five patients and had serious concerns with five others.[86] Dr. Miulli asked four different surgeons to complete a peer review, and their opinions were the opposite of the three peer reviewers selected by the IBOM.[87]

At the administrative hearing, the three peer reviewers were the IBOM witnesses.[88] The accused brought four board-certified neurosurgeons and one orthopedic surgeon as witnesses who testified that the standard of care had not been violated. The testimony of the head of the peer review committee was scrutinized due to biased statements he had made against the accused.[89] The accused's main witness, an internationally renowned

77. IOWA BD. OF MED. EXAM'RS, PRESS RELEASE (Jan. 22, 2001), https://medicalboard.iowa.gov/discipline-press-releases-and-board-news-releases (stating that Daniel E. Miulli, D.O., was charged with professional incompetence).

78. Findings of Fact, Conclusions of Law, Decision and Order at 11, In the Matter of Statement of Charges Against Daniel E. Miulli, File No. 03-99-055, DIA No.01DPHMB005 (Oct. 19, 2001), https://eservices.iowa.gov/PublicPortal/Iowa/IBM/licenseQuery/LicenseQuery.jsp?Profession=Physician (search "Miulli", double click "Daniel Miulli" record, download "Legal Documents - Miulli,Daniel E.,D.O.-03-1999-055.pdf" and scroll down to the docket number in question).

79. This practice is not a valid form of review. The practice of scrutinizing every patient under a physician's care will always reveal marginal cases where decisions were difficult. Patient care is complex, and a patient's presentation does not always follow the textbook. Any physician subjected to such scrutiny would reveal many questionable decisions. *See* GREGORY R. PICHÉ, SHAM PEER REVIEW: THE POWER OF IMMUNITY AND THE ABUSE OF TRUST 9–13 (2012) (discussing various professional and personal factors that drive sham peer reviewed).

80. Findings of Fact, Conclusion of Law, Decision and Order, *supra* note 78, at 13.

81. *Id.* at 14. This neurosurgeon denied that his decision to join the board was related to this case, but he resigned from the IBOM when the investigation was complete. *Id*. He recused himself from voting on this case, but was involved in the investigation and the choice of peer reviewers and expert witnesses. *Id*.

82. *Id.* at 13.

83. *Id.*

84. *Id.* at 14.

85. Findings of Fact, Conclusion of Law, Decision and Order, *supra* note 78, at 14–15.

86. *Id.* at 15, item 9.

87. *Id.* at 16. (The peer reviewers were chosen by Dr. Miulli's competitors, specifically Dr. Winston, and were local Iowa ortho/neurosurgeons, while Dr. Miulli's experts were from outside Iowa with less potential conflict of interest and were noted to have "impressive resumes and well trained" including Dr. Fred Geissler, a nationally renowned neurosurgeon).

88. *Id.* at 15–16.

89. *Id.* at 16.

neurosurgeon, was given less weight—the findings of fact noted the quality of the sound on his testimony was poor and they were not able to ask him further questions.[90]

The IBOM believed their three witnesses based their opinions on the accused's chosen treatment options, which differed from the decisions they would have made.[91] The state's peer reviewers also based their opinions on postoperative patient complications (although those complications were known and accepted by the patients, given the types of surgeries performed). The board determined Miulli had violated the Iowa Administrative Code, and Miulli was indefinitely prohibited from practicing surgery on the central nervous system and spine.[92] He was later ordered to undergo extensive retraining and reevaluation by the Iowa Board of Medicine before petitioning to practice again, subject to restrictions.[93]

1. Appeal and Aftermath

Miulli sought judicial review of the IBOM decision. The district court held that substantial evidence supported the IBOM decision, and the Court of Appeals affirmed.[94] The court did not review the details of the medical decisions nor the weight given to the experts, because "[t]he Board relied extensively on its medical expertise to evaluate the patient records and the testimony of the treating physicians and expert witnesses. It is exactly this kind of expertise to which the Iowa Supreme Court repeatedly urges deference."[95] The court decided the only requirement for an emergency order and the revocation of a license was that the IBOM request and obtain a peer review, but the peer review itself was not evaluated for possible defects because of administrative judicial deference on questions of fact.[96] Because "the factual issues [were] complex and highly technical,"[97] the court did not review any medical evidence, and gave deference to the IBOM's expertise.[98]

Miulli sued his competitors and members of the IBOM for tortious conduct, alleging bias and conspiracy to destroy his practice. A district court found no evidence to support Miulli's allegations against his competitors, particularly given the evidence the IBOM had against him.[99] The court noted that if the neurosurgeon had proven his charges, by definition, the administrative punishment would need to be overturned—and this was an "impermissible result."[100]

While the proceedings were still in progress, Miulli applied for a medical license in California, and was granted a license with a five-year probation period requiring practice under direct supervision of other neurosurgeons.[101] Within a residency teaching program,

90. Findings of Fact, Conclusion of Law, Decision and Order, *supra* note 78, at 17.

91. *See id.* at 15–39.

92. *Id.* at 47.

93. *Id.*

94. Miulli v. Iowa Bd. of Med. Exam'rs, No. 03-0319, 2004 WL 893934, at *2 (Iowa Ct. App. 2004).

95. *Id.*

96. *See* Schutjer v. Algona Manor Care Ctr., 780 N.W.2d 549, 557 (Iowa 2010).

97. *Miulli*, 2004 WL 893934, at *2.

98. *Id.* at *4–5 (finding the Board's decision to be supported by substantial evidence). Most physicians do not understand complex issues such as surgical procedure choice outside their specialty. Bryan C. Ramos, *Deciphering Medical Specialties*, 24 GPSOLO 26, 27 (2007) (providing an example that orthopedic surgeons "will likely consult with another specialist" if "the patient's pathology strays too far from the bone or muscle arena").

99. Miulli v. Iowa Clinic, P.C., 725 N.W.2d 658, 658 (Iowa Ct. App. 2006).

100. *Id.*

101. Before the Osteopathic Medical Board of California, In the Matter of the Petitioner for Termination of

the Iowa neurosurgeon was closely evaluated.[102] After one year, the Chair and Vice Chair of that neurosurgery program wrote the following to the California Medical Board:

> Dr. Miulli has demonstrated uniformly excellent clinical and surgical skills, and most importantly, he has proven to have very clear and rational judgment regarding his indications for when to operate, and when not to do so. At no time have I found Dr. Miulli overly aggressive about recommending surgical intervention for cases, which did not justify operation. . . . I have no hesitation in concluding that this is a truly gifted Neurosurgeon, whom I have observed operate, and with whom I have operated. I found Dr. Miulli to be a highly compassionate and empathetic physician, whose personal and professional integrity is self-evident to all around him. . . . I frankly see no areas of concern with this Neurosurgeon.[103]

Upon review of this evaluation, the California Board of Medicine granted Dr. Miulli a full unrestricted medical license and terminated the probation four years early.[104] This neurosurgeon is now the Director of a residency training program in California, teaching residents how to be neurosurgeons.[105]

A physician deemed a danger to the public in Iowa by the IBOM was fully restored to practice after review in California, and now teaches residents.[106] IBOM may argue this physician did a better job in California; however, it is not possible to change an entire manner of practice in such a short time.[107] IBOM did not rule that this neurosurgeon needed to correct a few deficiencies; it ruled that his entire practice method was a danger to the public.[108]

The plausible explanation for the contradictory determination in California compared to Iowa is that California evaluated this physician's overall competency to care for and treat patients.[109] Iowa selected this physician's most difficult cases (every physician practicing has difficult and marginal cases) as representative of this physician's overall care in what the accused physician claimed was a politically motivated and taxpayer-

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Probation of: Dan Edmund Miulli, DO, OAH No. L-2005030155, at 1 (June 7, 2005), https://search.dca.ca.gov/details/9001/20A/8153/1153a84ef3bca74566e1b63f1ac8599e.

102. *Id*. at 2.

103. *Id.*

104. *Id.*

105. *Neurosurgery Program*, ARROWHEAD REG'L MED. CTR., https://www.arrowheadmedcenter.org/resNeurosurgery.aspx (last visited Aug. 1, 2019).

106. *Id.*

107. *See* John Saunders, *The Practice of Clinical Medicine as an Art and as a Science*, 26 J. MED. ETHICS: MED. HUMAN. 18, 22 (2000), *available at* https://mh.bmj.com/content/26/1/18 ("'Doctor factors' such as emotions, bias, prejudice, risk-aversion, tolerance of uncertainty, and personal knowledge of the patient also influence clinical judgment. The practice of clinical medicine with its daily judgments is both science and art. It is impossible to make explicit all aspects of professional competence."); *What Is the Job Description for a Surgeon?*, AM. COLL. OF SURGEONS, https://www.facs.org/education/resources/medical-students/faq/job-description (last visited Feb. 24, 2019) (listing complexities and many facets of surgery practice).

108. Findings of Fact, Conclusion of Law, Decision and Order, *supra* note 78, at 43–45.

109. *See generally* Mary C. Politi et al., *Supporting Shared Decisions when Clinical Evidence is Low*, 70 MED. CARE RES. REV. 113S–28S (2013) (discussing the many clinical situations where there is not evidence to one clear course of action); *see generally* Findings of Fact, Conclusion of Law, Decision and Order, *supra* note 78 (discussing how specific patients were selected for increased scrutiny).

funded proceeding that was pre-decided to end his career.[110] Miulli's Iowa competitors pushed him out of the market, the IBOM declared this was in the interest of public safety, and now California has another compassionate and competent neurosurgeon. But Iowa taxpayers,[111] Iowa patients, and a physician were caught in the crosshairs, and all suffered for it.

B. Broad Discretion

A state board of medicine, in its regulatory capacity, is a prosecutorial government agency.[112] Under the current system, a physician who is investigated for any complaint—even insignificant or unmeritorious complaints targeting blameless physicians—can be found guilty due to the low burden of proof requirements and weak due process protections in administrative procedures.[113]

This predilection toward finding guilt promotes punishment of those physicians who are not politically connected and who are targeted by rivals. An example of this is illustrated above in *Miulli v. Iowa Board of Medical Examiners*, where competitors with influence in the IBOM orchestrated charges and prosecution.[114]

Other physicians have argued that they were charged merely to justify a lengthy investigation. In *Schaaf v. Iowa Board of Medicine*, the Iowa Court of Appeals reversed IBOM sanctions and a license restriction that punished a physician for an incident that allegedly occurred 42 years prior to the statement of charges.[115] In *Miller v. Board of Medical Examiners of the State of Iowa*, a physician was investigated for prescribing practices that allegedly occurred three years prior, with charges only coming after three years of investigation.[116]

Another example of a good physician's career being irreversibly harmed by the IBOM is *Poole v. Iowa Board of Medical Examiners*, in which the Iowa Court of Appeals reversed an IBOM ruling of professional incompetency.[117] In *Poole*, a physician missed an incorrect IV fluid order that was ordered by another physician, which the Board deemed to be professional incompetence. The Iowa Court of Appeals reversed, saying IBOM inappropriately defined legislative intent of the word "willful" to mean general intent to provide care and one incident of ordinary negligence.[118] In this case the IBOM used three

110. Miulli v. Iowa Bd. of Med. Exam'rs, No. 03-0319, 2004 WL 893934, at *3 (Iowa Ct. App. Apr. 28, 2004).

111. While there is not cost attributed for each case, in 2015 expenditures were as follows: $61,000 for professional services and peer reviews, $132,000 for attorney general counsel, $530,959 for board operations within a total expenditure of $4,497,612. IOWA BD. OF MED., 2017 ANNUAL REPORT 5 (2018), https://medicalboard.iowa.gov/sites/default/files/documents/2018/05/2017_annual_report_-_final.pdf.

112. Dover, *supra* note 43, at 228; Alex J. Keoskey, *Will I Lose My License? Representing Physician Clients before the State Board of Medical Examiners*, MARTINDALE LEGAL LIBRARY (Apr. 14, 2015), https://www.martindale.com/professional-liability-law/article_DeCotiis-FitzPatrick-Cole-LLP_2201266.htm.

113. PICHÉ, *supra* note 79, at 2 (2012) ("There are very few, if any, professionals who could withstand a comprehensive review of performance without someone raising an issue of whether the service might have been enhanced through a different procedure or approach.").

114. *See Miulli*, 2004 WL 893934, at *1.

115. Schaaf v. Iowa Bd. of Med., No. 09-0721, 2009 WL 5126252 (Iowa Ct. App. Dec. 30, 2009).

116. Miller v. Bd. of Med. Exam'rs, 609 N.W.2d 478, 482 (Iowa 1991).

117. Poole v. Iowa Bd. of Med. Exam'rs, Nos. 1999-403, 9-656, 99-0074, 2000 WL 193612 (Iowa Ct. App. Jan. 26, 2000).

118. *Id.* at *5.

sets of peer reviewers until the IBOM received the expert opinion it was seeking.[119]

Another example of disproportionate punishment is *DeLouis v. Iowa Board of Medicine*, in which a physician prescribed diet pills to a family member.[120] The physician entered into a settlement agreement with the IBOM.[121] The IBOM did not disclose to her that she would be reported to the National Practitioner Data Bank (NPDB) for unprofessional conduct.[122] Because of the NPDB reporting, this physician was dropped from her malpractice insurance, was unable to obtain other coverage, and, therefore, could no longer practice.[123] Her requests for rescission of the settlement agreement were denied.[124] This physician's career ended because she prescribed to a family member, a practice that is not uncommon for physicians, and was not informed on full extent of her settlement with the IBOM.[125]

C. Lack of Procedural Due Process

The principles of due process require the government to treat citizens fairly, even when the issues involve matters of public safety.[126] Every state must balance the need to discipline physicians whose conduct or practice represents a danger to the public with the due process rights of those physicians. The power assigned to medical boards needs to be regulated to prevent overly aggressive and unrealistic judgment criteria that can lead to erroneous deprivation of physicians' careers and due process violations.[127]

There are also weak evidentiary rules in administrative disciplinary hearings; for example, hearsay is admissible. This further dilutes a physician's constitutional protection, as virtually anything said by anyone can be used against the accused physician. The administrative agency can admit testimony or documents if there is a degree of relevance and reliability.[128] Because the physician is confronted with evidence that should not be admissible under federal and state rules of evidence, there is not a fair hearing with an impartial tribunal, resulting in the denial of their right to due process. There are basic procedural elements that all Americans deserve in both criminal and civil proceedings. These include: an unbiased tribunal, the right to know opposing evidence, the right to cross examine adverse witnesses, and the right to have the decision based solely on the evidence presented.[129]

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119. *Id.*

120. DeLouis v. Iowa Bd. of Med., No. 13-1623, 2014 WL 4230219 (Iowa Ct. App. Aug. 27, 2014).

121. *Id.* at *1.

122. *Id.* at *2.

123. *Id.* at *1.

124. *Id.* at *2.

125. Edward Krall, *Doctors Who Doctor Self, Family, and Colleagues*, 107 WIS. MED. J. 279, 279 (2008) (discussing up to 90% of physicians have prescribed for themselves).

126. *See generally* Cody, *supra* note 51, at 945 ("this liberty [guaranteed by the Due Process Clause] may not be interfered with, under the guise of protecting the public interest").

127. *See e.g.*, Smoker v. Iowa Bd. of Med., No. 12-1216, 2013 WL 1760185, at *7–8 (Iowa Ct. App. Apr. 24, 2013) (holding the Board did not have substantial evidence to find against Dr. Smoker but not reaching the constitutional due process question); *Falsely Accused MD Wins Claim Against Medical Board*, OFF. MED. & SCI. JUSTICE (Sept. 22, 2012), https://www.omsj.org/issues/health-care/falsely-accused-md-wins-claim-against-medical-board.

128. IOWA ADMIN. CODE r. 7.21, https://www.legis.iowa.gov/docs/iac/agency/07-19-2017.11.pdf; IOWA CODE § 17a.14; State v. Wright 465 N.W.2d 661, 663 (Iowa 1990).

129. Peter Strauss, *Due Process*, LEGAL INFO. INST., https://www.law.cornell.edu/wex/due_process (last

An example of how the lack of due process protection can harm innocent physicians is seen in *Smoker v. Iowa Board of Medicine*. There, the medical license of a nationally renowned neuroradiologist was placed on five-year probation because of hearsay evidence that she had a glass of alcohol, not while working, but in violation of a prior IBOM agreement.[130] The Iowa Court of Appeals found that "a reasonable mind would find the facts and circumstances presented in this proceeding to be inadequate to reach the conclusion reached by the Board."[131] The court added that the IBOM conducted a "blatantly sub-par investigation."[132]

1. All in One Accuser, Judge, and Jury

At the very essence of this system, the IBOM is acting as accuser, judge, and jury. This means it cannot be impartial due to the conflict between making objective decisions and upholding accusations. This lack of impartiality is magnified by the lack of oversight and accountability. The Pennsylvania Supreme Court ruled in *Lyness v. Commonwealth* on this combination of prosecutorial and judicial powers, stating "the potential for bias and the appearance of non-objectivity is sufficient to create a fatal defect under the Pennsylvania Constitution."[133] The court added, "[t]he accused is forced to face the same body which heard allegations and formed prosecutorial judgments concerning probable cause (some of it perhaps inadmissible as formal evidence), now dressed in the robe of impartial jurist."[134] However, the Supreme Court of Iowa held that political appointees are presumed to be above the suspicion of partiality when it stated that "[t]here is a 'presumption of regularity that attaches to the decisions of administrative agencies' that protects them against inquiry into how they reach their decisions based upon mere suspicion."[135]

In *Collison v. Iowa Board of Medicine*, the accused physician argued his procedural due process rights were violated because the same people were both accusing him and judging him.[136] The Iowa Court of Appeals ruled that, while the same people were involved in both the investigative and adjudicative process, this double role is not enough "to satisfy the high burden of overcoming the presumption of honesty and integrity" of the board members and does not violate due process.[137]

However, judicial review of many disciplinary outcomes shows board members are not immune to the inherent bias of being accuser, judge, and jury. This includes judicial review of many cases that are discussed in this Note. For instance, in *Smoker*, the court overturned a board decision for a blatantly subpar investigation.[138] In *Poole*, the board's decision was overturned because it defined "willful" improperly.[139] In *Schaaf*, the Iowa

visited May 15, 2019).

130. *Smoker*, 2013 WL 1760185, at *8–9.

131. *Id.* at *21.

132. *Id.* at *19.

133. Lyness v. Commonwealth, 605 A.2d 1204, 1210 (Pa. 1992).

134. *Id* at 1211.

135. Martin Marietta Materials, Inc. v. Dallas Cty., 675 N.W.2d 544, 553 (Iowa 2004) (citing Wright v. Indus. Comm'n, 103 N.W.2d 531, 535 (Wis. 1960)).

136. *See generally* Collison v. Iowa Bd. of Med., No. 13-0477, 2014 WL 69535 (Iowa Ct. App. Jan. 9, 2014).

137. *Id.* at *6.

138. Smoker v. Iowa Bd. of Med., No. 12-1216, 2013 WL 1760185 (Iowa Ct. App. Apr. 24, 2013).

139. Poole v. Iowa Bd. of Med. Exam'rs, Nos. 1999-403, 9-656, 99-0074, 2000 WL 193612 (Iowa Ct. App. Jan. 26, 2000).

Court of Appeals reversed a punishment set by the IBOM when the alleged incident occurred 42 years prior to the charges.[140] Finally, in *Mishler*, the Nevada Supreme Court reversed board punishments which the court found were an obvious and baseless attempt to ruin a particular physician's career.[141] In short, such a presumption seems unearned, especially in light of specific and egregious instances of bias and broad discretion.

2. Immunity of Peer Reviewers and Sham Peer Review

In 1986, Congress enacted The Health Care Quality Improvement Act (HCQIA)[142] "to encourage the peer review of physicians."[143] This law provides immunity for any physician acting as a peer reviewer as long as the prosecuting agency complies with reasonable standards in the overall prosecution of the case against the accused physician.[144] The current HCQIA law is considered by some to be "too vague to protect physicians' interests and too overbroad to justify the immunity granted by federal and state legislation."[145] However, case law indicates there is essentially absolute immunity because HCQIA presumes that a state medical board has met all reasonableness standards in its processes.[146] With this presumption, HCQIA renders irrelevant the motivation of adversarial competitors, and disregards anticompetitive[147] or malicious motives.[148]

In *Poliner v. Texas Health Systems*, the Fifth Circuit reversed a large jury award to a physician whose hospital privileges were rescinded based on what the physician alleged was sham peer review for anticompetitive motives.[149] Although the jury was convinced and granted $360 million in damages, the appellate court ruled that subjective anticompetitive or bad motives do not overcome HCQIA's immunity.[150]

A serious flaw with peer review, which can come out during litigation, is a physician can testify that his or her subjective opinion is the standard of care.[151] Physician opinions range along the spectrum of medical care and knowledge. With this array of opinions, a medical board can choose a peer reviewer whose opinion can be predetermined because of

140. Schaaf v. Iowa Bd. Of Med., No. 09-0721, 2009 WL 5126252 (Iowa Ct. App. Dec. 30, 2009).

141. Mishler v. State Bd. of Med. Exam'rs, 849 P.2d 291, 291 (Nev. 1993).

142. 42 U.S.C. § 11112(a)(4) (2019). This statute protects peer reviewers with the presumption that they "have met the preceding standards necessary for the protection set out in section . . . 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence." *Id.*

143. Katharine Van Tassel, *Hospital Peer Review Standards and Due Process: Moving from Tort Doctrine Toward Contract Principles Based on Clinical Practice Guidelines*, 36 SETON HALL L. REV. 1179, 1194 (2006).

144. *See id.* at 1209 ("Under HCQIA, in order for the participants in the peer review process to be granted immunity, the physician must have received adequate notice.").

145. *Id*. at 1194–95 ("Acting on this belief, Congress passed HCQIA, which grants qualified immunity from suit for those who participate in the peer review process, while at the same time conditioning this immunity upon the provision of adequate notice and fair process to the physician.").

146. *See* Ho, *supra* note 68, at 321 (noting that HCQIA requires only reasonable effort to obtain facts, but opinions and conclusions do not need to be correct and bad faith is irrelevant).

147. *See id*. at 322 ("Legal scholars, the physician community as well as the media have expressed concerns about the antitrust immunity afforded peer review under HCQIA as well as associated abuses.").

148. *See generally* Poliner v. Tex. Health Sys., 537 F.3d 368 (5th Cir. 2008).

149. *See generally id.*

150. *Id.* at 380.

151. *See* Robert I. Simon, *Standard of Care Testimony*, 33 J. AM. ACAD. PSYCHIATRY & LAW 8, 10 (2005) ("Core biases in standard-of-care testimony may be the result of a lack of expertise, the application of personal, subjective standards and hindsight bias."); *see also* Van Tassel, *supra* note 143, at 1183 ("[T]he validity of the process may be jeopardized by employing vague and ambiguous standard of care rules ex post facto.").

an established relationship.[152] As a result, peer reviewers can feel pressure to misrepresent the standard of care, literature, and data to support medical board allegations and have immunity when doing so.[153]

Many motivations may drive the physician to become what can reasonably be called a sham peer reviewer.[154] Some physicians may believe their way is the only way, and the right way; and, with sham peer review, that warped notion becomes reality, though only for the isolated setting of the disciplinary hearing.[155] Some physicians may have business and personal relationships either with the board or with the physicians who lodged the complaints being investigated, and still others may feel they could benefit if a competitor is removed from the market. Even without these bad motivations, peer reviewers may still provide wrong testimony due to lack of knowledge, failure to review relevant documents, or simple human error.

3. The Problem with Preponderance of Evidence

In Iowa, as in 42 of the states and territories, the burden of proof in medical board hearings is the preponderance of evidence.[156] With this standard in mind, the Board spends much time and expense on the investigation. They then approve the charges to be brought against the physician and proceed to act as judge and jury.[157] In contrast, a physician appealing an IBOM ruling has a high burden of proof with deference given to the licensing board;[158] the accused physician would need to prove that the board's decision was "irrational, illogical, or wholly unjustifiable."[159]

External factors place the accused physician at a substantial disadvantage even if the IBOM theoretically bears the burden of proof: (1) external pressures on the IBOM, like other state medical boards, to find against the physician,[160] (2) vague and arbitrary standards of conduct and practice,[161] (3) acting as both as judge and jury, the IBOM is not experienced and does not have the knowledge to judge both normative and technical

152. *See* Van Tassel, *supra* note 143, at 1184–85 ("Moreover, peer review decision-makers may feel pressure to bow to the wishes of the executive committee . . . .").

153. *See id*. at 1198 ("[T]he substantive standards being used to measure physician competence in peer review do not properly protect the interests of all of the stakeholders, rendering the process fundamentally unfair.").

154. *See* Ron A. Virmani, *Abuse of Peer Review Is Widespread*, CTR. FOR PEER REVIEW JUSTICE, www.peerreview.org/articles/abuse.htm (last visited Feb. 4, 2019) (explaining physician's involvement in sham peer review).

155. PICHÉ, *supra* note 79, at 5–7.

156. *Standard of Proof*, FED'N OF STATE MED. BDS., http://www.fsmb.org/siteassets/advocacy/key-issues/standard-of-proof-by-state.pdf (last visited Sept. 13, 2019); *see also* Johnson v. Bd. of Governors of Registered Dentists, 913 P.2d 1339, 1353 (Okla. 1996) (listing 39 states that have upheld the preponderance standard); Eaves v. Iowa Bd. of Med. Exam'rs, 467 N.W.2d 234, 237 (Iowa 1991) (determining that preponderance of evidence is used in medical disciplinary cases in Iowa).

157. *See* Spece, Jr. & Marchalonis, *supra* note 47, at 125 (suggesting a conflict of interest exists when medical boards are involved in multiple stages of the disciplinary process).

158. *See* Abbas v. Iowa Ins. Div., 893 N.W.2d 879, 886 (Iowa 2017) ("When the legislature has clearly vested an agency with interpretive authority, we will reverse the agency's ruling only when its interpretation of a statutory provision is 'irrational, illogical, or wholly unjustifiable.'").

159. *Id.*

160. *See* Peter Eisler & Barbara Hansen, *Thousands of Doctors Practicing Despite Errors, Misconduct*, USA TODAY (Aug. 20, 2013), https://www.usatoday.com/story/news/nation/2013/08/20/doctors-licenses-medical-boards/2655513/ (suggesting that medical boards are too lenient with physicians).

161. Spece, Jr. & Marchalonis, *supra* note 47, at 125.

specialty-specific standards,[162] (4) there are no evidentiary safeguards, such as the rules against hearsay,[163] and (5) the degree of review exercised by appellate courts is very limited.[164]

Many appellate courts in reviewing board proceedings do not review the merits of the charges.[165] Rather, they tend to assume that the IBOM's goal of protecting the public trumps any violation of a physician's constitutional right to due process.[166] The Wisconsin Court of Appeals wrote that "[p]rotecting citizens is one of the fundamental reasons for a government's existence. This obligation of the state is superior to the privilege of any individual to practice his or her profession."[167] However, in *Nguyen*, the Washington Supreme Court ruled that the U.S. Constitution's Due Process Clause requires proof by clear and convincing evidence in a medical disciplinary proceeding and that a physician's license is a property right per the Fourteenth Amendment.[168]

The U.S. Supreme Court has further ruled that due process protection applies to adverse license actions by the state.[169] When a state medical board damages a physician's license using procedures that afford limited due process, it violates the substantive property rights afforded to the physician by the U.S. Constitution.[170] The counterpoint that may be argued by the IBOM is that protecting public safety in life and death matters supports the insufficiency of due process and low burdens of proof. Balancing the conflicting interests of substantive property rights and legitimate public protection is appropriate, but should be weighed with the true risk to public safety.[171]

4. Risk of Erroneous Deprivation of Livelihood

In state medical board proceedings, the risk of erroneous deprivation of a private citizen's career is great; and, as such, greater due process is required based on the *Matthews* test.[172] The United States Supreme Court, in *Matthews v. Eldridge*, outlined a three-part

162. *Id.* at 125–26.

163. *Id.* at 126–27.

164. BARRY R. FURROW ET AL., HEALTH LAW 5 (2015).

165. Skaufle v. Iowa Bd. of Med. Exam'rs, No. 07-0875, 2008 WL 942290, at *2 (Iowa Ct. App. Apr. 9, 2008).

166. Miller v. Bd. of Med. Exam'rs, 609 N.W.2d 478, 482 (Iowa 1991) ("The State is free to deal with different professions differently without violating the equal protection guarantees established under the federal and state constitutions."); Eaves v. Bd. of Med. Exam'rs, 467 N.W.2d 234, 237 (Iowa 1991) ("That same observation holds true here. Medical board decisions involve important issues of public health and safety.").

167. Gandhi v. State Med. Examining Bd., 483 N.W.2d 295, 299 (Wis. Ct. App. 1992).

168. Nguyen v. State, 29 P.3d 689 (Wash. 2001) (holding that the Due Process Clause requires proof by clear and convincing evidence in medical disciplinary hearings in Washington).

169. *In re* Ruffalo, 390 U.S. 544 (1968) (reversing disbarment decision where state did not afford due process to a lawyer); Withrow v. Larkin, 421 U.S. 35, 42 (1975) (discussing due process needed for state to suspend medical license); Goldberg v. Kelly, 397 U.S. 254, 262 n.8 (1970).

170. J. Bruce Bennett, *The Rights of Licensed Professionals to Notice and Hearing in Agency Enforcement Actions*, 7 TEX. TECH. ADMIN. L.J. 205, 208 (2006) (discussing property interests protected by the Due Process Clauses).

171. Maxine A. Papadakis et al., *Disciplinary Action by Medical Boards and Prior Behavior in Medical School*, 353 N. ENG. J. MED. 2673, tbl. 1 (2005) (while many disciplinary violations potentially involve public welfare, others include failure to meet CME requirements, medical records, and billing irregularities); Cody, *supra* note 51, at 959.

172. Ho, *supra* note 68, at 340; Spece, Jr. & Marchalonis, *supra* note 47, at 123 ("The Supreme Court has found that the individual's interests in avoiding adverse action and stigma, especially that associated with a finding of misconduct, along with the moral principle of avoiding erroneous serious deprivations outweigh the

test to determine the amount of due process required based on the potential consequences of an error.[173] The *Matthews* test requires weighing: (1) whether and how severe the private interest will be affected by official actions, (2) the risk of erroneous deprivation of private interest through procedures used and if additional safeguards would protect those interests, and (3) the burden on the government in following procedural requirements.[174]

In considering the *Matthews* test as applied to physicians before a medical board, higher due process protections are justified. Charges can be brought based solely on probable cause,[175] which is defined as better than a 50-50 chance that the wrongdoing occurred.[176] This low burden is based on the investigator's fact gathering and report. As Roy Spece notes, the proceedings of a medical board "involve complex medical or scientific matters that can be impossible to prove beyond a reasonable doubt . . . are *quasi* criminal, but not criminal in nature . . . [and] the substantive definition of 'unprofessional conduct' varies among the states."[177] The complex nature of medical licensure hearings increases the risk of government error. Physicians before the board are at risk of losing their career and, therefore, their livelihood. Higher due process protections should be afforded via a higher standard of proof requirement, such as clear and convincing evidence.

5. Secrecy and Lack of Transparency

The IBOM disciplinary process is shrouded in secrecy. This secrecy is beneficial to physicians while they are under investigation, because the process is initially confidential. However, the accused physician does not have access to the accusations, the identity of the accusers (especially if the complaints are anonymous), the deliberations, or the evidence.[178] If the IBOM files formal charges, only then are selected materials released to the accused physician.[179]

An example highlighting this secrecy is *Kholeif v. IBOM*, where the IBOM revoked a physician's license and he attempted to compel in-camera judicial review of the IBOM's private deliberations regarding his case.[180] The physician alleged that board members and peer-review experts were biased, and that proceedings were prejudiced by a competing

government's interest in proving by a mere preponderance of the evidence, as opposed to an intermediate standard, that a person is dangerous."); Telang v. Bureau of Prof'l & Occupational Affairs, 751 A.2d 1147, 1151–52 (Pa. 2000) (discussing that limiting a physician's due process in medical board actions risks erroneous deprivation of his license).

173. Mathews v. Eldridge, 424 U.S. 319, 321 (1976) (defining due process against erroneous deprivation based on the Fifth and Fourteenth Amendments).

174. *Id.* at 335–36.

175. Spece, Jr. & Marchalonis, *supra* note 47 (examining how the burden of proof, typically preponderance of evidence, is often misunderstood and unjustly used to discipline physicians for arbitrary and political motivation).

176. *Enforcement*, *supra* note 4; *Probable Cause for a Prosecution*, *in* BALLENTINE'S LAW DICTIONARY (3d ed. 2010).

177. Nguyen v. Dep't of Health, 29 P.3d 689, 692 (Wash. 2001) ("It is difficult to imagine a more subjective and relative standard than that applied in a medical discipline proceeding where the minimum standard of care is often determined by opinion, and necessarily so."); Spece, Jr. & Marchalonis, *supra* note 47, at 133–34.

178. Kholeif v. Bd. of Med. Exam'rs, 497 N.W.2d 804, 806–07 (Iowa 1993) ("[I]nquiry into the mental processes of administrative decisionmakers is usually to be avoided. And where there are administrative findings that were made at the same time as the decision . . . there must be a strong showing of bad faith or improper behavior before such inquiry may be made. . . .").

179. *Enforcement*, *supra* note 4 ("The public may know only when the board files charges against a licensee. Only then is the investigative file shared with the physician or licensed acupuncturist who is charged.").

180. *Kholeif*, 497 N.W.2d at 805.

medical group.[181] The Iowa Supreme Court denied the request and held that that board is allowed to have confidential ex parte hearings after charging a physician, and the accused physician did not have rights to transcripts of those closed sessions regarding his case per the Iowa Administrative Code.[182]

D. Unrealistic Standards and Standard of Care

Medical decision-making is multifactorial and requires consideration of a patient's history, treatment tolerance, resource availability, treatment goals, the physician's training and experience, and the dynamics of the physician-patient relationship. The appropriate standard to evaluate a physician is based on accepted medical literature and national guidelines.[183] When a medical board performs a retrospective review of a physician's clinical decision using another physician's personal standard, or from information gathered by a non-medical investigator from his or her internet readings, a valid conclusion is not possible. There are many ways of treating disease and most physicians can easily find fault when judging the decisions of other physicians, given that any two physicians might choose to treat someone differently.[184]

The legal application of the medical standard-of-care for medical malpractice litigation analyzes how the ordinary prudent professional, having the same training as a defendant physician, would practice under the same or similar circumstances.[185] For the IBOM, the criteria for judging standard-of-care is much stricter. Under the Iowa Code, to prove a decision is professionally incompetent, the IBOM must show that a medical decision was less than what the "average physician or surgeon" in Iowa would choose to do.[186] An Iowa physician choosing to perform a less popular procedure is professionally incompetent by this standard.[187] Additionally, a physician who employs a new technique that is performed in most of the country, but not in Iowa, could be considered incompetent.[188] This deviation from the national standard-of-care can prevent Iowa physicians from using new, and innovative, techniques that may help their patients. As such, the Iowa Code should adopt the appropriate standard of care definition that is based

181. *Id.*

182. *Id.* at 807; IOWA ADMIN. CODE r. 653-25.21 (2016).

183. *See* Cheryl L. Damberg et al., *An Evaluation of the Use of Performance Measures in Health Care*, RAND CORP. (2012), https://www.rand.org/pubs/periodicals/health-quarterly/issues/v1/n4/03.html (evaluating the effectiveness of health care standards propagated by the National Quality Forum).

184. Van Tassel, *supra* note 143, at 1219 ("In most states, some hospitals provided [a] treatment one-hundred percent of the time, while other hospitals in the same community provided it only fifty percent of the time.").

185. *See* Peter Moffett & Gregory Moore, *The Standard of Care: Legal History and Definitions: The Bad and Good News*, 12 W.J. EMERGENCY MED. 109 (2011).

186. IOWA ADMIN. CODE r. 653-23.1(2)e (2019) (the average physician would perform a procedure according to a majority of like physicians, a less popular method, even if within standard of care, is outside what the average Iowa physician would do, implying that for any given procedure or medical decision, a physician performing a procedure different than the majority would be incompetent).

187. IOWA ADMIN. CODE r. 653-23.1(2)e (2019) ("A failure by a physician or surgeon to exercise in a substantial respect that degree of care which is ordinarily exercised by the average physician or surgeon in the state of Iowa acting in the same or similar circumstances."); *see also* Van Tassel, *supra* note 143, at 1224–25 ("In spite of the choice in malpractice cases by state courts to move away from a narrow locality rule in favor of either a similar community rule or a national rule . . . a standard in peer review that is even more limited in scope than the locality rule.").

188. *See* IOWA CODE § 653-23.1(2)d (2013) (establishing that deviation from the standard of care followed in Iowa is grounds for discipline).

on accepted medical literature and national guidelines.

The IBOM disciplines physicians based on a small number of incidents, sometimes even one.[189] If a physician's overall practice is proficient, the practice on a whole is not evaluated; the individual actions or incidents alone are investigated.[190] A physician can be charged with global incompetency based on the individual incident investigated, even though there is evidence that, on the whole, the physician's practice is competent.[191] All that is needed for a finding of professional incompetence is for the investigator to locate another same-field physician willing to claim that any decision of the physician in question was below average,[192] even with decisions made following nationally recognized medical principles.[193]

IV. RECOMMENDATIONS

The legislature should adopt a policy that affords physicians the same protections society grants to any individual at risk of liberty or property loss.[194] This Note is not suggesting that physician oversight should be eliminated, but that discipline by an oversight board should depend on actual wrongdoing and, in the process, promote justice. The Iowa Code should be revised to protect against biased proceedings that lack oversight, especially when the board is directed by non-medical administrators, and the proceedings have a high-risk of due process violations.

A. Public Policy Pendulum Shift

A public policy reversal is needed to remedy the flawed system that disciplines physicians in Iowa. Public safety is better served by constraining aggressive medical boards than by removing physicians through arbitrary and selective prosecution.[195] HCQIA immunity fosters a system where guilt is likely to be found any time a physician is in the

189. Lyons v. Iowa Bd. of Med., 772 N.W.2d 16, 17 (Iowa Ct. App. 2009) (IBOM revoked physician's license over one incident); Poole v. Iowa Bd. Of Med. Exam'rs, Nos. 1999-403, 9-656, 99-0074, 2000 WL 193612, at *7 (IBOM suspended license for one incident which Court reversed suspension because "[t]he record shows no evidence of a willful or substantial departure from the applicable standard of care by Dr. Poole in this case").

190. Glowacki v. St. Bd. Med. Exam'rs, 516 N.W.2d 881, 886 (Iowa 1994) ("The board expressly acknowledged Glowacki's reputation as a "competent, caring and respected physician," and acknowledged that remedial steps had been taken so that the challenged billing practices were no longer occurring. The suspension thus is entirely punitive; no present threat to the public is implicated.").

191. *Id.*

192. Bruce E. Landon et al., *Personal, Organizational, and Market Level Influences on Physician Practice Patterns: Results of a National Survey of Primary Care Physicians*, 39 MED. CARE 889, 889 (2001) (discussing reporting "significant variability" between physicians in making clinical decisions).

193. *Poole*, 2000 WL 193612, at *2 (allowing decisions made in good faith to serve as a basis for incompetence as only one "failure to conform to the minimum standards of acceptable and prevailing practice of medicine in Iowa").

194. Cody, *supra* note 51, at 959 ("It has been firmly established that medical licenses are subject to state regulation, and some hold this decision as barring a finding that such a license could be a fundamental right.").

195. Kristy Taylor, *Increased Doctor Burnout Rates Lead to Decreased Patient Safety*, HUFFPOST (July 26, 2017), https://www.huffpost.com/entry/increased-doctor-burnout-rates-lead-to-decreased-patient_b_59794e3de4b09982b7376222 (a major cause of burnout is when physicians do not feel in control of their environment and ability to treat); John Noseworthy et al., *Physician Burnout Is A Public Health Crisis: A Message to Our Fellow Health Care CEOs*, HEALTH AFFAIRS (Mar. 28, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170328.059397/full/.

crosshairs of a state medical board. The attitude that a government appointee on a medical board is the best person to judge an accused physician is based on an outdated fantasy.[196]

Legislation is needed to fix the current system and to redefine due process rights for medical board proceedings. Legislation should also rescind the essentially absolute immunity of peer review. Legislators' first need to realize there is a problem that needs correcting.[197] That may be the most difficult hurdle, as medical boards are powerful in the state bureaucracy, and have large budgets and the resources to lobby for their continued power.[198] As discussed below, there are fair systems that can police physicians, protect the public, and attract more physicians to Iowa.

B. Restructuring of Current System

To fix the current system, Iowa should require higher due process protections for any medical disciplinary hearings. All states have boards of medicine, but many states have more protective processes than Iowa, including 17 states and territories that use the clear and convincing burden of proof.[199]

1. Ensuring Due Process

Currently, administrative due process consists of notice and a chance to be heard. This is not sufficient in cases of governmental deprivation of career and livelihood of a U.S. citizen.[200] The process should include increased privacy protection during investigations, hearings before an impartial and competent tribunal, an increased burden of proof for the state board, and stricter standards for peer review.[201] Additionally, appeals should be reviewed de novo.

This Note proposes that the IBOM can receive complaints, but only investigate to the point where the complaint is attributed to a reliable source and worthy of further investigation. If the complaint involves clinical competence issues, then the issue should be referred to the corresponding national medical specialty board for consideration.[202] There would be no need for hiring peer reviewers because, as opposed to the IBOM, the specialty board consists of impartial peers with acknowledged expertise in their field.[203]

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196. *See* Mishler v. State Bd. of Med. Exam'rs, 849 P.2d 291, 291 (Nev. 1993).

197. The American Association of Physician and Surgeons (AAPS) sued the Texas Medical Board in 2008 alleging that the board president "arranged for her husband to file anonymous complaints against other physicians, including her competitors in Abilene . . . ." *Doctors Sue Texas Medical Board*, *supra* note 31. In 2011 the Texas Legislature ended anonymous complaints. *Id.*

198. Oklahoma State Legislature-House Bill 1412 passed unanimously out of the State Government Operations Committee on Feb 18, 2015. Quoting Rep. Morrissette, "This bill will end the days of the 'Chamber of Horrors', what has been the State Board of Medical Licensure . . . [g]one will be the days of the 'good ole' boy' agreements, persecution from a government agency or a system lacking in fundamental fairness." H.B. 1412, 2015 Leg., Reg. Sess. (Okla. 2015), https://okhouse.gov/Media/PrintStory.aspx?NewsID=4996.

199. *Standard of Proof*, *supra* note 156 (fifteen states and two territories); Spece, Jr. & Marchalonis, *supra* note 47, at 110 ("[O]nly fifteen states utilized the clear and convincing standard.").

200. Snyder v. Massachusetts, 291 U.S. 97, 105 (1934); *see supra* Part II.A.1.

201. Goldberg v. Kelly, 397 U.S. 254, 267 (1970).

202. This process does not currently exist but can be implemented with agreement of the specialty boards. This is a feasible proposal, as national medical boards also have a stake in maintaining quality in their respective specialties.

203. John R. Combes & Elisa Arespacochaga, *Physician Competencies for a 21st Century Health Care System*, 4 J. GRAD. MED. EDUC. 401 (2012).

This would still be peer review, but fair and unbiased peer review that can properly judge the merits of the issues at hand. The IBOM would need to pay for this service, but it would cost less than the multiple expert witnesses at an IBOM hearing. The specialty board could recommend appropriate corrective measures to be administered by the IBOM.[204] If the complaint involves inappropriate behavior, such as substance abuse issues or relations with patients, the state police would investigate the charge with procedures and protections similar to criminal charges. In this way, protections guaranteed by the Constitution would be respected.[205] Such a system would not compromise the state's duty to protect the public, only employ competent decision makers to further the goal of protecting the public.

2. Professional Competency Review by an Independent Tribunal

The court rulings which support the IBOM merging of investigative, prosecutorial, and adjudicative processes by the same individuals,[206] although within limits of the administrative code,[207] are a stretch of our country's legal principles. Many of the appellate reviews of these proceedings apply the legal and medical fiction that it is impossible for governor-appointed board members to be biased or swayed by any other pressures than justice and fairness, even though their medical knowledge in general is fallible, not to mention their command of specialty-specific medical issues of which they have no knowledge or experience.[208] Due to all of these concerns, this Note strongly recommends establishing a tribunal independent of the IBOM to hear the cases brought against physicians. This may be simply establishing that these charges should be heard in state district courts, or it might involve establishing an entirely new tribunal for these hearings. Either method would resolve the need for impartiality, though the latter might be better as the decision-maker could be chosen so that they have more specialized medical knowledge.

3. Heightened Standard for Peer Review Liability

Peer reviewers should have to meet higher standards than the current system provides to prove they are in a position to judge a colleague with similar credentials. The opinions of a peer reviewer need to be based on medical and scientific evidence, not subjective thought or individual experience.[209] Peer reviewers should be liable for negligence or a wrongful review claim if their testimony was not based on medical evidence. The *Daubert*

204. Tom Bourne et al., *The Impact of Complaints Procedures on the Welfare, Health and Clinical Practice of 7926 Physicians in the UK: A Cross-Sectional Survey*, 5 BMJ OPEN 1 (2015).

205. *Id.*

206. Collison v. Iowa Bd. of Med., No. 13-0477, 2014 WL 69535, at *6 (Iowa Ct. App. Jan. 9, 2014) (ruling there is no due process violation if the state attorney or IBOM members are involved in both the investigative and adjudicative process); Tobin v. Iowa Bd. of Med., 843 N.W.2d 476, No. 13-0294, 2014 WL 69514, at *7 (Iowa Ct. App. 2014) (Iowa Administrative Code allows individuals to be involved in the investigative and adjudicative proceedings unless they "personally investigated" the issue. The Court defines personally investigated as interviewing witnesses and directly obtaining documents.).

207. IOWA ADMIN. CODE r. 653 (2019).

208. *See supra* Part III.C.1.

209. B. Sonny Bal, *The Expert Witness in Medical Malpractice Litigation*, 467 CLIN. ORTHOP. RES. 383, 388–89 (2009).

criteria[210] should be used as a guideline,[211] which would lead to fewer peer reviewers rendering arbitrary opinions not supported by the literature.[212] Lastly, the IBOM should levy mandatory sanctions against a peer reviewer who offered false testimony after applying the *Daubert* standards.

4. Clear and Convincing Burden of Proof

Potentially the easiest, and most impactful, remedy to this system is to revise the burden of proof to one of clear and convincing evidence. By changing the burden of proof alone, complaints, and charges based on those complaints, will merit greater scrutiny before the board undertakes a full investigation.[213] With a heightened evidence standard, a medical board would be reluctant to initiate a full investigation for an issue that is insignificant or has weak evidence. This is because they will have to work harder to prove any allegations they decide merit bringing charges over, and the evidentiary weight of a peer reviewer's opinion will be reduced. Under the preponderance of evidence standard, an accused physician can be found guilty because the IBOM favored its own witness more than the witness of the accused physician. If the burden of proof is heightened, this preference of one expert's testimony over another will not be sufficient to sustain a verdict of guilt on appeal. The clear and convincing burden of proof would serve to mitigate the harmful effects of sham peer review because opinions would need to be supported by evidence.

Because of the devastating professional effects of IBOM sanctions and the inherent unfairness of IBOM hearings as explained above, the preponderance of the evidence standard is insufficient to protect a physician's constitutional due process rights. This was the ruling in *Painter v. Abel*, where the Supreme Court of Wyoming held that the preponderance of the evidence standard for Board disciplinary proceedings violated the physician's due process and equal protection rights.[214] In this country, when the government challenges a private citizen's basic rights, at least the clear and convincing standard needs to be applied.[215] A medical license is a property right,[216]and the standard for deprivation of profession, property, and happiness should be the clear and convincing standard.

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210. *See* Daubert v. Merrell Dow Pharms., Inc., 509 U.S. 579, 580 (1993) ("Many considerations will bear on the inquiry, including whether the theory or technique in question can be (and has been) tested, whether it has been subjected to peer review and publication, its known or potential error rate and the existence and maintenance of standards controlling its operation, and whether it has attracted widespread acceptance within a relevant scientific community.").

211. David Parker, *Peer Review: How HCQIA Due Process is a Fiction*, LILES PARKER (Sept. 3, 2014), https://www.lilesparker.com/2014/09/03/hcqia-due-process-fails/.

212. Moffet & Moore, *supra* note 185, at 11 ("The mere fact that the plaintiff's expert may use a different approach is not considered a deviation from the recognized standard of medical care. Nor is the standard violated because the expert disagrees with a defendant as to what is the best or better approach in treating a patient.").

213. George F. Indest, III, *What is Clear and Convincing Evidence in Administrative Hearings?*, THOMPSON REUTERS: LEGAL SOLUTIONS BLOG (Aug. 6, 2013), http://blog.legalsolutions.thomsonreuters.com/practice-of-law/what-is-clear-and-convincing-evidence-in-administrative-hearings/.

214. Painter v. Abels, 998 P.2d 931, 940–48 (Wyo. 2000).

215. Nguyen v. Dep't of Health, 29 P.3d 689, 692 (Wash. 2001).

216. Van Tassel, *supra* note 143; Cody, *supra* note 51, at 942 ("The grant of a license is considered to be a vested property interest of the individual, which is protected by due process").

V. CONCLUSION

The legislature should propose and pass the above statutory changes and advertise these changes as evidence of a statewide program to attract and keep physicians, to enhance the quality of medical care, to reduce physician burnout, and to encourage just and fair legal processes for all Iowans.