IN THE PUBLIC INTEREST

MEDICAL LICENSING AND THE DISCIPLINARY PROCESS

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Chapter 1

The Genesis of a Project

My position as a board member evolved over time. I started as a citizen doing my civic duty, a member of society who happened to be a sociologist, invited to serve first on Board A, then Board B. With the passage of time, my role as a committed intellectual made itself felt, and I slowly became an organic public sociologist in dialogue with public advocacy groups and medical professionals.¹ As my roles merged, the multiple vantage points fed back and forth, providing me a richer understanding. I was also in a position to cultivate a heightened reflexivity in understanding the social world and my place in it. Each position raised a special set of issues.

Working for an organization educating public members thrust me into the role of organic public sociologist and underscored the need to think more systematically, which in turn also activated my skills as a professional social scientist on Boards C and D. While navigating my various roles and engaging in dialogues with board members, I saw the connection between routine board deliberations and general procedures of deliberative democracies and the need to understand the changes that were occurring. The fact that I had to juggle multiple identities sensitized me to the meaning of committed citizenship in a democratic community and the difficulties we all face while trying to live up to the ideals of democratic participation.

As a Public Member

I faced different realities when I joined first Board A and then, more than ten years later, Board B, each one reflecting different board setups, institutional history, and my own experience. Officially under the aegis of a state bureaucracy, Board A was actually quite independent from the state, except that a deputy attorney general was required to prosecute its disciplinary cases. At the time of my appointment in the late 1980s, the board had only a part-time secretary and offered no formal training for its members. I spent eight years serving on this board, which licensed about two thousand physicians. The state’s medical practice act generally followed the Federation of State Medical Boards (FSMB) Model Practice Act of the 1960s, and yet it was far from being an exemplary modern board and sometimes seemed to resemble the boards from the 1950s and 1960s.²

Board B worked within a state bureaucracy, and its well-trained staff tried valiantly to improve board performance, educate members, and live up to its mission of protecting the public. It had state-employed staff lawyers and investigators to develop and prosecute cases, but it was difficult to ascertain what happened to reports dismissed by staff and unseen by board members. This state licensed more than fifty thousand physicians.

By the time I was appointed to Board B, I was an experienced public member who had participated in several national committees of the FSMB and had some reputation. The difference between Boards A and B was significant, manifested in their structures, interactions between the participants, and general philosophy. No two boards are quite alike, yet some problems boards face and the solutions they work out are common. Board A can serve as an example of an underfunded, traditional board without strong ties to a state bureaucracy, whose members often catered chiefly to the medical community and did all the work. What they seemed to be doing was peer review. Board B was reasonably well-funded, had a large staff, and was deeply embedded in the state bureaucracy with staff who had some decision-making authority and handled much of the regulatory work. The second board had three foci—the medical community, the state bureaucracy, and the public. This board’s work did not seem like peer review; there were too many lawyers present.

Degrees of Being an Outsider

When I first received a call from the governor’s appointment secretary asking me to become a public member of Board A, I had little idea what the board did or who the members were. The appointment secretary had no information about board activities or time commitment. I contacted the public member who told me the work was interesting and entailed a monthly board meeting that started at 4 P.M. and often stretched until 11 P.M. Each member conducted investigations of doctors who were singled out by various parties (patients, health-care personnel, or insurance companies) as deficient in some respect...
and under investigation for violations of the practice act. If the charges were seen as warranted, board members sat on panels of three, advised by a deputy attorney general, to hear the cases. Once the hearing was completed, the entire board discussed the sanction.

I accepted the invitation, even though I was unsure about the time I would need to invest in learning about the board and actively participating and had little understanding of what was going on with the board or what the state’s medical practice act was. I did not realize that members did all board work, which included typing letters to complainants, persuading the attorney general to get a subpoena, visiting a doctor’s office to get records, interviewing doctors and complainants, and holding hearings that lasted anywhere from one to seventeen days. Many policy issues required additional time and skills, as we had to communicate with other health professions, the medical society, public-interest groups, the media, and the legislature.

When I arrived at my first meeting, ten of the thirteen members were already seated, and the board president asked who I was. I told him I was the new public member, and he handed me an agenda and introduced me to the others, most of whom were significantly older than I. The other women present were a senior physician board member and a part-time secretary who reviewed licensure applications and took notes at meetings. Robert Derbyshire found few women on the boards in the late 1960s.3 The president suggested I come to his office before the next meeting so he could explain what the board did.

That first meeting began with a waiver hearing of a foreign-trained physician denied a license after failing to obtain the state-defined requisite of seventy-five points on the basic science section of the three-part national FLEX exam.4 His overall average was well above seventy-five. I knew nothing about FLEX or what score was required. I learned later that foreign medical school graduates had to meet different requirements than U.S.-trained doctors and that passing scores varied among the states. Most states required an average of seventy-five, but the state required seventy-five on each section. The physician appeared well qualified to me as he had trained, after practicing for about fifteen years abroad, in several prestigious U.S. university hospitals and was on the faculty of a nationally renowned hospital. He had a job waiting for him in our state in a subspecialty. After he made his plea and several board members asked questions about his qualifications, we went into executive session to discuss the case. I thought his training and a faculty appointment overcame his deficiency of less than one point on one part of an exam, but since I had no idea about the standards at the time, I felt too intimidated to express my opinion.

It appeared that the board was ready to vote against him. The deputy attorney general, who advised the board, reminded us that the law provided an exemption only if the doctor practiced in an “underserved” locality. I felt conflicted and, not knowing what to say, abstained when others voted against his licensure. After the meeting I asked whether doctors out of medical school for many years could pass the basic science section. Several admitted the were rusty. After several such cases we brought our standards in line with the majority of states.

Board members often rejected the “majority of states do it this way” argument, relying instead on the “we do it this way” or “when I was in med school language of personal experience. The logic made little sense to me and made even less sense when, several meetings later, someone made an argument that a doctor who seemed to be far less educated than the first doctor should be granted a waiver because he was planning to practice in an “underserved” area. Why should some people get less-qualified doctors, I wondered? And why would stop them from moving around the state once they secured a license? The answer to this last question was that nothing would stop them from moving. If exams measured minimum required competency, why would an state accept lower scores, why did the exemption apply only to “underserved areas,” and why were extra training, demonstrated good practice, or outstanding educational credentials not legitimate justifications for an exemption?

Thanks to my talk with the board president, I got a better sense of board’s agenda by our second meeting, but it took time to fathom some of the less obvious rules. Members relied heavily on medical jargon and dropped references to medical diagnoses or treatment options that I could not follow even if I was not sure how important it was for me to understand the particular medical diagnosis or terms. It was hard to figure out who made more sense.

The board president gave me my first case to investigate during the second meeting. Many cases under review, I discovered, involved patients’ concerns over billing, poor physician communication skills, using or selling drugs, or sexual boundary issues, but the case I received had a clear medical component which I could not evaluate. The board president suggested that I call the physician to obtain patient records and take them to a specialist. I called and, using my title, “Doctor,” asked for the charts of the complainant. He yelled “Never,” “Call my lawyer,” and hung up the phone. I shuddered as I held the phone, partly from anger, partly from fear. There was nothing in the statutes that protected patients from an offensive physician, even not a private letter of warning. I felt sympathy for the patient’s frustration. For a hearing, the doctor’s behavior had to rise to the level of gross negligence or incompetence.
I obtained the charts from a second doctor seeing the patient and asked a specialist to help me assess whether the doctor met the standard of care. He claimed the technical care was excellent, and with no way to second-guess him, I had to go along. The case was closed, and I informed the complainant. This first investigation took me more than two full days; the investigation from the time the report was filed until it was resolved took about five months. Neither fellow board members nor I had ever been trained to do our job—constructing cases so they could be heard by a panel.

My third meeting remains vivid in my memory. I could not find my colleagues in the room where we were usually scheduled at 4 P.M. Half an hour later, when nobody showed up, I ran around the capital looking in the state office buildings where I thought the board might be. Something pushed me to check the restaurant where we adjourned after brief public sessions following our first meetings. Perhaps no public sessions or licensure hearings were scheduled, and everyone went directly to the restaurant. As it turned out, the board members had ordered their dinners and drinks in that restaurant. No one had bothered to explain that if no public sessions were held, the entire meeting would be conducted at a restaurant. While we discussed the cases before us, we sat balancing a five-inch-thick packet on our laps containing the meeting agenda, the reports of misconduct, and the summary of licensing actions. It was difficult to read some of the complainant reports, for many were handwritten, and the copy machine was of poor quality. Every month the board president assigned board members new cases to investigate, and all reported on the progress made on open cases. Each doctor applying for licensure was interviewed by two physician board members, which was then discussed and voted on by the entire board. We each paid for our dinners and drinks. I later learned that we were paid fifty dollars for each of ten meetings a year, but that I would be spending fifteen to twenty-five days per year conducting board-related business. We saw everything that came to the board, yet it was apparent that no one could keep track of it all.

When I left that first board, it still did not have a toll-free telephone number to receive complaints, a computer system, an Internet site, or a full-time lawyer assigned to assist the review process. I thought I was done with licensing boards once I moved, but when the call came to join a new board, I changed my mind. It was by comparing Board B with Board A that I realized how lacking in resources Board A was and how much difference the presence of lawyers, outside experts, and professional investigators could make. Board B had excellent support staff and administrative systems—trained investigators (medical and others), staff medical experts, probation supervisors, computerized systems of complaint tracking, staff attorneys (prosecutors), and administrative law judges (ALJs). Located within a reasonably well-funded state agency, a nonphysician administrator with substantial statutory authority dealt with supervising impaired physicians, investigations, case construction, probation, and the board unit. The board unit had a president, an advisory group (appointed by the president), and investigatory and hearing committees made up of three, one of whom had to be a public member.

My introduction to the second board was in sharp contrast to my earlier experience. At the annual meeting of the FSMB, I met several board members who told me they wanted experienced public members. The staff worried when they discovered that I had registered as a member of a different political party than the governor, but that was no different from the situation in the other state. Some governors tend to favor public representatives from their own party, and several public members I met at national meetings were not reappointed when a new governor with a different political affiliation was elected. Board staff invited nominated members to their annual two-day training marathon. We received a well-organized packet explaining how the board operated and what we were expected to do at the meeting. When my appointment came through several months later, I was put on a disciplinary hearing panel immediately. Before the hearing, staff provided packets with the charges. I received specific instructions on how to find the meeting and found a sign with my name on the table and a comfortable chair, unlike the metal folding chair I grew accustomed to on Board A.

Looking back, I realized that Board A was still transitioning to a framework that would be dominated by disciplinary review. Its structure resembled that of many other boards in the late 1980s when boards struggled to understand how to manage disciplinary cases and obtain and use legal tools. Board A used legal procedures for disciplinary hearings, but cases rarely made it that far. Board members had to do everything themselves, despite lack of training and varied enthusiasm. Board B had staff members who did all the leg work and had the final say on some of what was done. The entire disciplinary process was framed by law.

Investigations: Medical Language and Voice

Most cases under review are dismissed, or an informal disciplinary outcome is reached, or a settlement is achieved in the course of investigations and investigatory meetings, which is why the investigative phase of the process is so important. When I first joined Board A, it was reasonably easy to see the cases about which I could form an independent opinion and others where I could
only say, "I feel something is going on." In cases of sexual abuse, alcohol or drug dependency, or illegal sales, I felt confident I could analyze the information and frame an argument that might resonate with other members. When it came to medical quality-of-care cases, I had a hard time framing sensible questions. At the investigatory stage, we generally relied on the expertise of board members. If the case involved a specialty far outside the specialties of board members, the physicians on the board would ask a friend or colleague to volunteer as an expert. That was how my first case was handled. Reliance on a member's impressions made it difficult for a public member to ask informed questions when the board members would say something like, "Well, those things happen."

In my experience on Board A, informal interactions sometimes created a space for potential influence, but it was difficult to affect the trajectory of disciplinary cases. During investigatory discussions, I was asked if I understood an issue or found explanations satisfactory. This might have been my colleagues' way of handling situations with which they were not completely comfortable, or it might have been a way to co-opt me, but such solicitations gave me an opening to express my views, especially when I found explanations less than persuasive. I noted that investigations sometimes took a new turn when I raised questions and expressed unease about decisions to drop cases without further investigation. After my querying, the assigned investigator went back to do more work. I felt that my concerns were taken seriously, even though in the end the complaint was usually judged lacking in merit. My limited knowledge was insufficient to counter a doctor's assessment of cases of questionable medical skills. My markedly different experience on Board B helped me understand what was going on; some organizational and discursive practices encouraged public members' participation.

Before my first investigatory committee meeting on Board B, I spent about eight hours reading the thick files of the twenty-five physicians whose cases were coming up for discussion. Each case included medical charts, interview summaries, expert evaluations, and a summary by staff. We had to decide which should go to hearings, receive a private administrative warning, or be dismissed. When the committee voted a case to a hearing, it recommended parameters to the head administrator so that staff lawyers could negotiate a settlement to avoid a hearing. A few of the cases were the staff's petitions for a "CMR." I had to ask what that meant and was told "comprehensive medical review." In cases that concerned a doctor's office practice and the board had a simple case of negligence and some evidence of more systematic problems, the investigatory committee decided if it had sufficient evidence to ask for a sample of the physician's cases. In a hospital, printouts could be made of all of a physician's cases that list outcomes and complications.

As a nonmedically trained member, I found reading the cases difficult; they were complex and often required medical knowledge. I did not count the number of acronyms I came across in various documents, but my guess is that each packet contained at least thirty abbreviations and medical terms. When I arrived a few minutes before the meeting, I asked if the board would provide me with a medical dictionary. Public members had served on investigatory committees for more than ten years, but no one had asked for one before. Without a basic understanding acquired prior to a meeting, it would be difficult for a public member to raise questions as everyone jumps into the discussion and assumes that others understand technical terms. Some bought medical dictionaries on their own. I jotted down questions to ask or discuss on the front page of each case packet, which I noticed physicians did as well. I was no more medically sophisticated than before, yet with enough information provided beforehand, I felt I could ask specific, sensible questions, with people listening to my queries and comments on negligence and incompetence cases and not just to questions dealing with fraud, drugs, or sexual misconduct.

Senior staff attending investigatory meetings were well prepared to argue the cases and often disagreed among themselves over both medical and legal points. Many arguments about the gravity of the offense considered were heated, with members discussing whether sufficient evidence was available to put it before a hearing panel. Discussions about what the defense would say in a case and whether a panel would accept the evidence were inevitable. At other times the discussion revolved around the medical facts of the cases or a disagreement over the desirable outcome. Several staff had law degrees, and others had medical or nursing degrees. The medical staff and investigators clarified points.

Despite lack of medical training, public members could aid discussion, provided they had enough description of the diagnosis or treatment. Thus I pushed for an administrative warning in a case that did not rise to the level of medical misconduct in the eyes of the other panel members and most of the staff. I was uneasy about the expert who said the doctor's actions remained above the level of minimally acceptable practice on the cases he evaluated, even though the physician under review was cited repeatedly in the past for sloppy work and had to leave one specialty after a number of malpractice cases went against him. The lawyers told the panel that, since this was a new case, we could not overturn an expert's claim that the questionable performance did not rise to the level of misconduct. I left the meeting with a heavy
heart, thinking that the doctor was a danger to the public and that we should have given him a private administrative warning. But I could begin to see the importance of legal argument.

Hearings: Similarity of Legal Practices, Variation in Topics

In my eight years on Board A, we very rarely had cases where negligence or incompetence was the central issue. We had diet doctor cases, sexual misconduct cases, and impairment cases, but diagnoses and treatments were never the central issue. On Board B many of my cases involved negligence or incompetence. My first case on Board A took four days spread over about three months—it was hard to reconcile ten people’s schedules. Testimony was wrenching; several of the patients cried profusely. Hearings took place in various venues, most of which were not set up as hearing rooms. We sat on folding chairs, often with only a small narrow table separating the panel from the defense team. The prosecutor, who was in the same office as the deputy attorney general advising the panel, sat to one side; the witnesses, straining to face the panel, sat next to the prosecutor. The panel deliberations that followed the hearing gave me confidence I could make independent assessments, as this case required little knowledge of medicine. I organized the evidence before the panel met to make the decision, persuading both doctors to follow my lead. We had no money for transcripts, so the construction of facts was based on our notes. The panel voted that the doctor committed misconduct, recommending revocation of his license.

On Board A the findings of fact by the panel bind the board, but the full board can vote to change the conclusions of law and the panel’s recommendation. Although the board did not contest the recommendations in this case, it discussed the facts for an extended period while the hearing panel waited in the hall. I worried that those most sympathetic to the perspective of protecting the public were on the panel and the board would not be sufficiently tough; they voted to revoke.

The typical Board B member sat on one to three cases (normally one to eight days per case) each year. Although an administrative law judge made the legal decisions, rather than the board with the advice of a deputy attorney general, the hearing was similar. But Board B had transcripts, made very detailed findings of fact and conclusions of law, and decided the sanction. I found I had plenty of information with which to form an opinion, even on highly technical medical cases. Not only was I in a position to question witnesses and query the doctors on the panel, I could also ask the panel members to justify the decision to say one expert was more persuasive than the other. I began to see the importance of legal discourses and practices for public participation. These variations became the focus of my analysis.

State Commitment to Public Protection

The lack of resources of Board A suggested a weak state interest in public protection and democracy, as adequate funding and transparency is necessary. Doctors were happy with the low licensure fees, and state government still kept some of the fees, a national complaint. With limited staff and no money for expert witnesses, trained investigators, transcripts, or travel to national meetings, the board remained parochial. It was difficult to ascertain whether this was the result of a legislature that subscribed to a “small government" philosophy, a by-product of the medical society’s interest in having an inactive board, or the board’s relative invisibility. However, this clearly underscored the importance of the relationship the board had with the state and medical society. How resources affected the public voice became another focus of my research.

Board B had decent offices and hearing rooms, but it had its share of financial and space problems. There was no place for the hearing panel and defense counsel to talk separately, and some of the hearing rooms had glass doors, so anyone could peek through. But at least the chairs were comfortable and the rooms large enough. Most important, Board B had funds to pay for outside experts and investigators with special skills; it takes different skills to investigate sexual misconduct and negligence/incompetence cases. The availability of and performance by outside experts became one aspect of my research. But with a shrinking state budget, training for board members ended.

Lack of state government interest can affect board transparency. About a year after I joined Board A, the local newspaper pointed out that under the sunshine law, public boards should not do business in a private venue. But the state bureaucracy did not make sunshine work. While we moved our meetings from the restaurant to a state building, the room on the second floor was barely large enough for a table to seat the board, the secretary, and the deputy attorney general. Whenever the public and the media attended, the room was overcrowded and sometimes overheated. Dinner arrangements became problematic. If we went out, our deputy attorney general advised, others might suspect we were discussing board business. We ordered pizza. Someone had to lean out the window to wait for the delivery because a state rule dictated the door downstairs had to be locked at five-thirty (no doorsbel)!
We scrounged for cash for pizza and turned out pockets for change for soda machine.
Meeting in a public place was intended to open the proceedings to the public, but the facilities were inadequate for the purpose, generating frustration and solidarity among board members. Meanwhile, the locked door made it difficult for the public to attend the “open” meeting. On one occasion, before the general use of cell phones, a physician member, late for the meeting, was unable to enter using conventional means (knocking loudly and yelling). Suddenly, a shower of pebbles hit the second-floor window. Below, the board member waited. Should members of the public wish to attend and arrived after five-thirty, they might not want to throw stones at windows. How to make board meetings more open to the public was an obvious question, yet no one was asking. It was up to the media and public-interest groups to raise the issue, which they did; eventually a new location was found.

The failure to send Board A members to national meetings undermined prospects for reform and deprived members of a chance to learn. National meetings were helpful to me to shape my identity as an active public member. After two years on Board A, I attended the second annual meeting of Citizen Advocacy Center’s (CAC) educational training conference, where I discovered that my state had fewer resources and staff than others and that many states had private sanctions in place to warn physicians. As a sociologist, I recognized that private sanctions are a double-edged sword with regard to public protection: a private sanction is less costly and is viewed by some as rehabilitative, and the board can put a doctor on notice, but this action may thereby avoid a more serious and warranted action that would better protect the public. In discussion with other public members at meetings, they began to see the dilemmas of private reprimands. That was encouraging, for I saw that an active stance could promote change.

Encouraged by public members at the CAC meeting, I asked to attend a Federation (FSMB) meeting. I paid for the plane ticket and stayed with relatives but persuaded the state to pay for registration. As a voting delegate, I had a special ribbon on my name tag, and each candidate running for office came up to me and tried to convince me to vote for him or her (mostly “him,” for only one candidate was a woman that year). Candidates gave me their handouts and a symbolic gift—a tiny bottle of hot sauce or maple syrup, a packet of wild rice, or a small emblem of the state symbol that could be fastened to the badge. States with candidates brought many board members. One board, funded directly by licensing fees, gave a cocktail party with an open bar and elaborate hors d’oeuvres. The event was attended by the entire board and their wives (there were no women on that board), who greeted each person entering the room. Tales circulated of many parties in the past.

Meetings were well attended for two and a half days. Delegates from each board vote on acceptance of committee reports, issues, and officers, then attend a black-tie dinner with the Bierring Lecture, which was given by the president of the American Medical Association (AMA) when I first attended. I was invited to several private parties, and I felt like one of the team. Attending this meeting alerted me to the connections among medical organizations.

Multiple Vantage Points for Understanding

Multiple vantage points are useful for thinking about boards. As I show in this book, media stories about board problems spurred reforms, but seeing them from a member’s perspective, I construed the press attacks differently. The media provided the public with information about boards, thus increasing transparency and the potential for a more active public. Nevertheless, as a board member under attack, I felt uneasy in the spotlight. In some cases, especially vociferous and one-sided coverage created solidarity among members, pushing me to over identify with the doctors. Even when Board A was ranked quite highly by Public Citizen, a Ralph Nader public-interest group, the headline in the local paper was negative, compelling the legislature to increase public membership to one-third, which prompted some board members to observe that this was more than in other states.

I was surprised by how much relationships with members on Board A mattered to me when a reporter questioned me about board actions after I attended only three meetings; I certainly had no informed thoughts about the process. She asked my views on how the board protected the public from physicians with AIDS. I had not formed a position on the subject, nor had the board spoken of the issue. The reporter then asked what I thought about the handling of a sexual misconduct case that was in civil court, which was dismissed by the board before my appointment. I did not have a sufficient understanding to answer the questions intelligently, and, had I criticized the board’s actions publicly, I would have had a hard time building rapport. I kept answering the reporter with “I don’t know.”

The reporter did not write about our conversation, but during the following weeks, the newspaper began a series on the sexual misconduct case that the board had dismissed and that, according to the press, it mishandled. This attack led me to identify strongly with the board members and take the critique personally, though it was dismissed before I was appointed. I had to find the right balance between building rapport with the board and being able to maintain independent judgment as a public member. Looking back at the press coverage, I can see that sometimes reporters got it right; other times I wondered...
if the journalist and I had attended the same meeting. As an analyst, I strive to present multiple sides.

Trust and Deliberative Democracy

As a member, a public sociologist, and researcher, I saw the fine line between trust and co-optation. Board members need to have confidence in each other, but too much trust can undermine willingness to question. Deliberative democracy is known to stumble when people take for granted that their leaders will always do “what is right.” Rigorous questions, persuasive arguments, and careful monitoring strengthen democratic institutions. Medical board deliberations are an example of deliberative democracy in action, and as such, they thrive on the ability to voice criticism and monitor outcomes, and they wilt when board members—especially appointed to defend the public good—think that doctors always know best. The profession has a powerful voice in defining what patients want and need, and they influence public members’ perspectives. Doctors use their expertise to define what the practice of medicine is, what makes a good physician, and what constitutes the safe practice of medicine. Often what they say goes unchallenged. Some trends counteract this excessive trust. Although Americans trust their personal physicians, they are apt to question physician leaders and organizations today. It also matters that patients and patient rights groups have learned some of the language of medicine and have begun to challenge doctors and medicine’s definition of illness and treatments.

Some cases and issues require medical knowledge, and committee work necessitates relying on others’ judgments. Respect as a basis for trust helps to ensure that deliberations can work among people with unequal resources. By respect, I mean evaluation of the willingness of others to listen, explain clearly, make sensible arguments, stay open to others’ arguments, and explore issues from a variety of perspectives. In the discussion that follows, I use my experience as a board member, a public sociologist, and a researcher to unravel the relationship between social skills, respect, and trust. My argument is that, while trust in others is essential to board work, it must grow from respect and not derive from social skills or status.

Boards depend on committees to do much of the work, and some members are more knowledgeable in specific areas. Boards should not need to rehash an entire case when asked to decide the sanction because those who heard it have provided sufficient evidence for their findings and have a history of backing their decisions with sensible rationales. Too little trust may lead to overzealous questioning of every decision made by others. It is not uncommon after a committee has made the findings of fact by which the board is bound by statute that other members want to rehash the case and decide the facts for themselves. When a full board changed a panel’s recommended disciplinary action, the panel complained. Boards are sometimes reluctant to reaffirm disciplinary actions taken by other states on locally licensed physicians without rehearing a case. I heard members from many states explain that they needed to rehash cases because they did not trust others’ opinions. In states where judges heard cases and boards were not bound by judges’ findings of fact, board members and administrators told me that boards often changed the findings of fact as members did not trust lawyers. Sometimes physician members did not trust a particular doctor’s expertise because they did not know him personally. Conversely, they were at times eager to place their trust in doctors they knew.

Earning respect is difficult and figuring out who to respect is problematic. When I sent back cases for more investigation on Board A, I believed I had a valid point, but nothing changed the outcome. I knew no one and had little idea whose judgment I could trust. I wanted some knowledge of others. When I was driving home close to midnight, two pick-up trucks with gun racks (and guns) surrounded my car and tried to force me off the road. The next month, when one of the physicians asked me to join the carpool, I accepted. Getting to know several members allowed me to feel like I belonged, but I realized I was more likely to accept my carpool buddies’ opinion than before. It took me a long time and several national training meetings to see it was their social skills influencing me.

Attendance at the annual FSMB meetings co-opted me at first with all the party invitations. But public members, including myself, tested the Federation waters by asking for a public member’s session. We got our wish but were given a room during the lunch hour on Saturday—when everyone either takes off for the afternoon or is enmeshed in politicking for votes. The session was hard to find on the program and the room difficult to locate. The lawyers and executive directors set up programs, but the public members had few resources, and only a handful of public members attended for more than two consecutive years. I began to wonder if I was invited to parties in part because few women attended at that point.

I continued to attend Federation and CAC meetings and often heard, “We trust our doctors.” I began to notice how social skills facilitated the development of trust. It was rather common for me to hear from some public members who socialized with physicians that doctors knew what was best for patients. A public member informed me at a Federation meeting of public members that “we like our doctors.” She said this to support another public member who
complained that the CAC meeting was antidocor. Another public member added, “Our members are ethical and we never disagree. All board members think alike.” A third added, “There is no tension between public members and doctors—they help us out.” These public members tend to rely heavily on physicians in decision making. Trust may blind an individual to the need to ask for and make clear arguments necessary for reasoned assessments of cases and issues. It is possible that some public members are easily swayed by “expert” opinions that they are meant to be guarding against. My experience taught me that the confidence these public members expressed in the physicians had something to do with the physicians’ social skills. One told me how pleasantly surprised she was when a doctor invited her to travel with him so he could tell her more about the board. Feeling included and being treated courteously are important, but the danger is to mistake social skills for a commitment to protecting the public interest.10

At Federation meetings I dined with boards that brought several members. The conversation was lively, and the board members knew each others’ interests outside board activities. It was only after I began to pay systematic attention to board social interactions that I concluded that the ability to schmooze could be conflated with the ability to take a critical stance on problem, a problem I was having. Some boards spend several days together, as many as six times a year, and stay together in a hotel. Sometimes spouses accompanied them and spent the day together, joining the group for dinner. During meals, discussions rapidly evolved into discussions of family, travel, movies, or current events, just like a dinner party among friends. Such gatherings provided the opportunities for trust to develop, but such trust was not always conducive to democratic deliberations and mutual criticism.

I faced a moment of truth on Board A when I realized it was virtually impossible for me to persuade my colleagues to hear incompetency and negligence cases, unlike sex or drug cases, and I was developing too chummy relations with physicians, not unlike the ones I observed at meetings where I heard people take for granted the infallibility of doctors’ judgments. But, after a very long argument with a medical member, whom I respected, over pending legislation, I felt confident enough about the issue to alert a state legislator. We had several meetings with the legislative subcommittee and compromised, but on cases that involved technical issues where I had to rely on someone else’s judgment, I simply did not have the knowledge to ask the right questions that might change the evaluations of the cases. The doctors were probably humoring me by waiting to dismiss the cases where I requested more investigation.

I am not sure when exactly I became a “public” sociologist rather than just a “citizen,” but at that moment, I consciously set out to improve my board. I started questioning public members at national meetings when I heard them say “we like our doctors.”11 Few people showed any interest in the fact that I was a sociologist. I was a public member who had been around longer than some, took pains to learn about board work across the country, and tried to be reflexive about the complexities of the role public members play on medical boards. I had the sociological tools to do that, and I began to use them. If I was a public sociologist when I was pushing some public members to think twice about their trust in physicians, then I was also using my public sociology role to analyze the dangers of putting unrestrained trust in physicians’ expertise and selflessness.

I asked public members attending the Federation public members’ meeting what they thought about my writing a book on boards, and I was relieved to learn that they approved of my agenda and offered help. For several years the Federation provided me with address labels so I could send letters to public members encouraging them to attend Federation meetings and the public members’ session. After several years of few resources, the Federation began to provide lunch and programming.

To be sure, many public members are not victims of “blind trust.” Some talk about developing respect for certain members rather than blanket trust. “It is never ‘us against them’ in a vote,” a public member told me. “Some relations are stronger than others, and I listen to some more than others. I have one doctor to whom I turn for advice whom I really respect.” She distinguished among the medical members but learned to see things from the physicians’ perspectives too: “They make mistakes and are not gods. They don’t have all the answers. People [the public] also have a great sense of entitlement. Public members need to enter into the language of doctors, and that takes education and training, I take it seriously.”

Unlike trust based on social skills, respect is derived more from public displays of reasoning skills and sensibilities at meetings, including informal gatherings. Respect has to be earned—both by physicians and public members. As boards are ongoing organizations, members develop reputations. Within a span of several meetings, people can see which members explore several sides of an issue, offer detailed explanations, and are reliable. Members take a measured look at each other and evaluate each others’ stances, manners of carrying out a discussion, voting patterns, and so on. When doubts persist as to the merit of the case, members decide whom to tap for advice and information, and this is where trust and judgment play a major, sometimes decisive, part. Both public members and doctors use their impressions of others in determining
who should be questioned carefully and to whom one should particularly listen. In discussing how she works on a board, one public member explained to me how she thinks carefully before challenging someone’s opinion: “I will look at a specific member of the board and say to them ‘maybe I’ve missed something’—I don’t need to be harsh. So that’s another thing I use to determine the fine gray area, but I’ll point to someone personally because you know the members.” A new member of a different board explained her situation: “I’m a virgin at this. At one meeting I felt that this physician should be disciplined very harshly in this case and none of the doctors agreed with me, but the other public member . . . is a very successful businesswoman and they really respect her. She took the lead and she got what she wanted because they really respect her—that’s the dynamics.” Another added that reasonable arguments are necessary to get the respect of others, “not to make any wild statements . . . then people pay attention.”

According to several public members they gain the respect of doctors by making sensible arguments. One explained to the group: “I received a compliment about how I talked about a case in the full board. One time we were discussing a case at the board meeting, and one doctor asked who was on it. I said I was and he replied—Oh, then it’s ok.” Failure to speak up and take a stance can prevent respect. Physicians do not value public members who remain silent as they do not advance board work. Most encourage questions, but on some boards, members learn to be careful about expressing views contradicting others.

Administrators’ observations provide another perspective on trust and respect, and several administrators jotted down opinions of public member participation when I asked them when public members were first appointed in each state and how many times the legislation had changed. Some expressed pessimism about the independence of public members because of limited training, support, and encouragement. Others were more optimistic and saw neither interest-group voting nor public members as dominated by physicians. One wrote, “Our public members represent a broad range of professional and personal backgrounds. They consistently vote their own viewpoints or those of their constituencies, if any. In eighteen years of ‘Board watching’ I’ve never seen any sign of P.M. [public members] v. M.D. bloc-voting. If P.M.s take the same side on an issue it is because that is what they believe.” This administrator saw the board members as coming to their decisions through independent assessments. A second thought that some public members were even more independent than others and wrote that public members did not vote as a block because of “different backgrounds and training, level of preparation for meetings, bringing in different perspectives, level of understanding or issues.” A third explained, “They [public members] are of very different minds. Two of the three have had training through the Consumer [Citizen Advocacy Center in Washington, D.C. They are both strong voices on the board for consumers, though they sometimes disagree on particular issues. The third consumer member always casts her vote in accordance with the vote of physicians on the board that she respects.” Public members are never the majority; they need respect based on their reasonable questions and persuasive skills.

Doctors also make assessments of each other; one said he imitated the types of questions asked by a physician he admired. After a doctor on one board declared that no licenses should be revoked, he was ostracized and, after failing to attend several meetings, was asked to resign. Failure to make sensible arguments and ask reasonable questions may lead to the ineffectiveness of any member.

Staff members, too, need to respect each other to establish trust. One state agency head decided not to issue an emergency license suspension when advised to do so by a board lawyer. The case concerned a doctor’s failure to notify a patient of a serious illness. Dizzy, the patient went to the emergency room, where doctors found the patient had been given a toxic dose of medication. The lawyer felt that the agency head would respect her advice the next time she made a recommendation. Respect is necessary, as persuasion is the tool for influencing others’ views.

My experiences taught me that the need to develop trust to depend on others’ judgments was related in part to the resources available to board members. In the case of Board B, members had few opportunities to develop relationships based on social relations or respect for fellow board members. Although it did not make it easy for public members to feel a part of the board, I felt less need to rely on trust. I listened carefully to arguments during investigatory committee meetings and hearings and developed respect for the opinions of some physician board members, but I did not have to depend heavily on them, as I did on Board A, even for the technical issues. We had experts who were not board members and contested hearings with two sides articulated and case details presented. I could listen to arguments and ask questions. I did not have to confront a board member’s judgment as on Board A without enough information to ask a reasonable question. I used this insight both in talking with other public members and in developing my analysis of the different board discourses. I wasn’t a doctor and could not make an independent assessment on incompetence or negligence cases without an expert. “Something smells fishy” is not a strong enough argument to carry the day.
Independent experts were critical to the process, but Board A did not use them often. Board B did, and I was able to ask much more informed questions. What created the differences among boards? Members were not that different.

**As a Researcher**

I also interacted with two additional boards that I anticipated to be different from Boards A and B. I hypothesized that the degree of independence from a state bureaucracy mattered for public-member participation, but I was unsure why, except that I thought that independent boards were likely to be closer to the medical societies. Board C was an independent board; it collected its own fees, hired its own staff, and operated outside a state bureaucracy. Board D was located in a small underfunded state, and while linked to a state bureaucracy, it worked more independently than Board B and less independently than Board A. Board D was responsible for about the same number of physicians as Board A and worked hard to be innovative. Invited to attend Boards C and D, I had a chance to talk casually to their members between public meetings. Both were “hands-on” boards with members involved in almost all aspects of the process. Board members saw most of the reports that came in and followed them through the disciplinary process.

Board C hired its own staff and had better resources than many others—advanced computer systems and a senior staff member sat with new board members during first meetings to explain what was going on. They met for several days in a row, and committees met during months when the board did not. The investigatory committees heard the presentation of many cases, and a constant parade of doctors arrived for interviews. The full board sat for several hearings, directed by the board president, during a single day in a public session and decided the outcomes the next day. Coffee and cookies were always available, and lunch was served. In the evening board members dined together, often with spouses. The board covered the members’ dinners, travel, honoraria, and hotel.

The small state staff of Board D played multiple roles and had tiny offices with state-issued furniture and worn carpets. Senior staff spent a good deal of time delivering papers. The board met once a month. Investigatory and licensing committees met at least one other day per month. The investigatory panel decided which cases involved unprofessional conduct, if proven in a formal hearing. Medical staff presented cases, outside experts were seldom involved, and a committee often interviewed the accused physician. When the investigatory panel found misconduct and no settlement was achieved, a panel of three board members heard the case over several days to assess the evidence and make a finding of unprofessional conduct. The entire board decided the sanction. Board D members received no compensation; staff made coffee for the long meetings, and training was limited. I followed each of these boards for about a year.

As a researcher, I was trained to stand back; as a public sociologist an public member, I learned to take a stance and weigh in. It was difficult not to form opinions on cases when I was in the audience. As a participant I often jotted notes to keep track of the discussion for purposes of persuasion and decision making. I could only summarize at the end of the day. As an observer of public meetings I was able to concentrate on note taking as well as observing subtler communication patterns. Sometimes it was hard to keep up with the fast flow of board interactions.

**As a Researcher, Board Member, and Public Sociologist**

While I can now categorize my position as public member, public sociologist or researcher, my role was constantly changing depending upon the place, the people, and what was going on while observing and participating in board work. Keeping apart my identities as public member, expert, public sociologist, and researcher was difficult. The identity that was most salient depended on the situation, and sometimes I had to negotiate the identity in question. Is not like one can entirely turn off one’s sociological perspective while acting as a board member. Whatever identity I envisioned for myself, others were likely to see me differently at times. By the time I began as a researcher I had a reputation as a board expert. Interestingly, I was often asked for my opinion as someone with extensive experience serving on and working with various boards. What physicians seemed to want was a “public sociologist.” I certainly could not play the naïve observer, as I had in research projects in the past; everyone had questions to ask me, and as a public sociologist I felt free to share my thoughts on policy issues and organizational matters. We talked about the pros and cons of national licensure requirements, of the structures of review processes, of problems and opportunities public participation creates for boards, and of the limits of transparency. But then the ability to play multiple roles and place oneself in the shoes of others is critical to a deliberative democracy.

My experiences as a board member, public sociologist, and researcher led me to ask a variety of questions. Both as a board member and as a researcher I needed to understand what was going on, but for different reasons. As member, I wanted to be the best public member I could be, which first and foremost meant understanding the board. This led me to ask about why
my role should be. When was the right time to take a stand against the entrenched majority opinion, engage the legislature, or talk to the media? How could I, as a public member, untrained in medicine, take an independent position on complex medical issues? What should I do to help a board reach an informed decision on where the public interest lies? As a sociologist, I needed to stand back and look at the way decisions were made on different boards and whose voices were heard at the table.

My intuition when I switched boards was that I could participate more fully on Board B than on Board A. But until I stepped back as a researcher and sociologist, I did not realize how different the talk was in the deliberative process depending upon the board. Professional groups coalesce around their members' need to control their work environment, maximize income opportunities, and secure their members' status in society. To achieve these objectives, professionals develop a form of talk or professional discourse highlighting their members' specialized knowledge that only highly trained practitioners possess. The more successful professionals are in developing their own language, the more they are able to maintain self-regulation and determine the public interest for others. Barriers to public members' effective participation have been high, a formidable one being the medical talk that dominates board deliberations and often intimidates nonprofessionals. The medical/professional discourse is not the only one structuring board discussion. With disciplinary cases emerging at the center of board work, the legal-administrative discourse gained a foothold in some board deliberations, often providing an important counterbalance to the once-dominant medical reasoning on disciplinary cases, as was the case on Board B.

The civic/public discourse is one more form of talk increasingly heard on medical boards that helped refocus the discussion on the patient and public protection. Compared to medical and legal reasoning, public discourse is less organized. Its natural constituency—the general public—is hard to mobilize, its interests are underarticulated, and its representatives are often hampered by lack of training. I began to ask how the three forms of discourse developed and how they affected board disciplinary processes.

I realized that I needed to focus on the interplay among three groups of players shaping board deliberations, each one championing a particular kind of discourse—medical, legal, or public. My discussion is based on the premise that modern board work is a form of democratic deliberation that produces a legitimate outcome, acceptable to the community, when all parties involved manage to transcend their immediate interests, take the role of the other, and effectively articulate their points of view.

John Dewey, George Herbert Mead, and Jürgen Habermas are among the modern thinkers who have highlighted the centrality of public discourse to democratic society. According to their views, democratic deliberation achieves its end when (1) all participants have a voice, (2) everyone says what he or she believes, (3) no relevant issue is left out, (4) participants use persuasion rather than authority to win an argument, (5) every issue is examined from multiple perspectives, and (6) deliberation remains civil even when it is emotionally charged. The deliberative process presupposes the freedom to ask questions and the right to receive relevant information. Those partaking in this process must try to persuade as well as remain open to being persuaded. The theory of deliberative democracy predicates its success on the equality of all participants, yet in practice, the participants rarely come to the table with equal resources allowing them to make a forceful argument.

I invite readers to join me in exploring how occupational regulatory boards evolved to understand how they work today, how we can improve their performance, and how complex relationships between the state and civil society are structured and structure board interactions. One paramount concern drives my work as a member and an analyst—protecting the public. That is the issue I always keep in the back of my mind. What protecting the public requires is rarely obvious, nor is there only one sound answer. "Protecting the public" is a complex reference frame, often ambiguous, and sometimes requiring contradictory strategies. What is the best strategy for a nonexpert member debating specialists? When should public members defer to the profession, and when should they question its assumptions? But first, we need to understand how medicine came to dominate state boards and the origin of the public voice.
While general public transparency is important to democratic legitimacy and accountability, how much information should be provided to the public is a matter of debate. The right to privacy is the value that has to be assessed against transparency. Court hearings are generally open to the public, and some are even televised, but jury deliberations proceed outside of public view, even though juries can in some states discuss their positions publicly after a verdict. The news media generally does not publish rape victims’ names, even if the victims are expected to testify in public. Transparency also implies that information must be available to deciders so they can understand the case and assess what a reasonable outcome should be. Transparency varies in terms of what information decision-making groups have at their disposal and what will be made available to general public. Debating board matters openly keeps the community informed, but the presence of a public audience changes discussion, sometimes leaving “real reasons” buried under a pile of platitudes. “Public” does not necessarily mean transparent. Transparency and public discussions need to be balanced to ensure that the discussion does not lose its effectiveness, that board legitimacy is preserved, and that the right to privacy is honored.

Democratic Deliberation and the Public Interest

For decades critics have wondered if letting professions police themselves was like allowing foxes to guard the chicken coop. The licensure movement unfolded under the banner of ensuring quality of service and weeding out bad apples within the profession—a public-minded rationale, to be sure, yet as this book has sought to demonstrate, community interests have not always prevailed in the course of self-regulation. While social closure greatly improved the practice of medicine, professional autonomy also helped solidify physicians’ vested interests, which have not automatically aligned with the public good. The realization that doctors are propelled by self-interest as much as by community spirit has brought into the fray new actors—state legislatures, the federal government, public-interest groups, and the press; these new actors took it upon themselves to monitor the medical profession in the interest of the public. With new public and state agents in play, social control over the profession exercised by medical licensing and disciplinary boards has begun to resemble democratic politics in general, where outcomes depend on the skills, resources, and organizational assets of the participants. In this chapter, I argue that a deliberative democracy model of professional self-regulation offers a fruitful avenue for evaluation research and policy analysis and as a model for boards. The key issue this model addresses is how experts and nonexperts on medical boards can work together to safeguard the public good without compromising the quality of physician services.

In spite of claims of commitment to professionalism, doctors do sometimes act inappropriately. We know from numerous accounts that some use unnecessary procedures, regularly provide wrong diagnoses and treatments,
commit fraud, abuse substances, commit acts of sexual misconduct, and
decline to step in when they witness their colleagues’ unprofessional conduct.
Even today, some disciplinary boards see their role primarily in terms of reha-
bilitating errant doctors rather than guarding the public good. In the last few
decades, however, the focus of social control in the medical profession signifi-
cantly shifted from licensing and rehabilitation to discipline and protecting
the public. In the last decade licensing has again emerged as a public protec-
tion issue. A broad range of public-interest groups and government agencies
are now involved in national discussions on how to ensure physicians’ com-
petency over the life course for patients’ health and safety. To articulate the
deliberative democracy model, we need to start with the alternative formu-
lations of social control over professions that sociologists have used.

According to Eliot Freidson, a prominent theorist in the sociology of pro-
fessions, there are three common solutions to establishing control over profes-
sional work: (1) client control through market choices, (2) bureaucratic control
with rules and regulations, and (3) professional self-regulation. Freidson is par-
tial to the third model emphasizing professionalism, even though he readily
acknowledges that professionals have often been self-serving; that professional
standards have been challenged in recent decades under the pressure of mar-
ket forces, consumerism, and bureaucratic control; and professionals have lost
some sensitivity to being responsive to public interests. This is where a delib-
erative democracy model offers an improvement on the traditional model of
professionalism by encouraging various publics to be involved with medical
boards and other medical organizations that can speak on behalf of patients
and forcefully advocate for public interests without turning the profession over
to much more bureaucratic control or market forces.4

As our historical overview has shown, there were once voices opposed to
licensure in the name of letting consumers and market forces decide who was
fit to practice medicine. While we do not hear this argument repeated in its
original form today—no one is advocating abolishing medical licensure—
neoliberals frown on state regulation and are more content to let the market
place weed out bad physicians. According to this ideology, a consumer is
smart enough to choose a health-care provider for the price he or she is willing
to pay (with some additional information) and to settle on one, including a
provider who falls outside the realm of what is considered conventional medici-
today. Radical consumerism also places choice in the hands of the con-
sumer, who is trusted to shop around for sound information necessary to make
an informed choice. Such claims are based on the notion that complexity is not
an insurmountable barrier to patient choice, that intelligent consumers can

glean relevant information from sources like Consumer Reports, and that forms
of health-care that are not legitimized by the medical profession have merit.3
Such optimism can be misguided; economists have doubts about information
asymmetries and the consequences of poor choices in health care that can
saddle patients unlucky with their health providers.4 Even Adam Smith
thought that some closure of professions was necessary to assure minimum
competency among practitioners in a given trade.5

What undermines professionalism today, according to Freidson, is con-
sumerism and bureaucratic control of health care, which manifests itself in the
proliferation of guidelines, protocols, peer reviews, practice standards, and the
emergence of rigid hierarchies in health-care management. For Freidson, these
changes weaken a doctor’s discretion and, thus, undermine professionalism.
Any rational person, in his view, would look for ways to get around the rules.
Economic incentives encourage doctors to milk either the payer or the patient
by ordering unnecessary tests, using their own equipment that needs to be paid
off, and making other commercial arrangements that can compromise the
physician’s judgment. Economic competition undermines professional social
relations, which once promoted trust and goaded practitioners toward a norma-
tive consensus. Freidson leaves room for bureaucratic control and market
forces in modern health-care delivery but only as a means “to reduce cost and
control performance” and only insofar as these forms of social control “do not
destroy or seriously weaken what is desirable in professionalism.”6

The third logic, professionalism, is predicated on occupational control
over one’s work which, Freidson argues, requires social closure—licensure.7
Such closure is not necessarily exploitative or conducive to domination.
It allows professions to create educational and supportive institutions, career
paths, ethical codes, common talk, and a service ethic, and it allows profes-
sions to develop and spread common knowledge. Professionals need to learn,
practice, and identify with the community. According to Freidson, “The ide-
ology of professionalism asserts above all else devotion to the use of disci-
plined knowledge and skill for the public good.”8 Freidson’s sympathies are
with this third pathway, even though his own research shows that doctors and
patients sometimes have competing interests,9 and doctors are hobbled by
what he calls “clinical mentality” that encourages responsibility for one’s own
patients but not for patients treated by other doctors.10 Professionals have not
always used their discretion wisely despite codes of ethics, and yet repairing
professional logic is the only way to control occupations where the work is
exceedingly complicated, autonomous decisions are necessary, and expert
knowledge is gained through long training. These hallmarks of professionalism
require closure provided by licensure and a service ethic attuning professionals to public good. As Freidson states, “Practitioners and their associations have the duty to appraise what they do in light of that larger good, a duty which licenses them to be more than passive servants of the state, of capital, of the firm, of the client or even of the immediate general public.” Even the fact that closure promotes monopoly is not necessarily inimical to public good, Freidson maintains, for it decreases competition among colleagues and provides disciplinary coherence. In a democracy, he argues, people should be able to regulate themselves—especially if they are expected to perform highly technical work like that associated with the medical profession.

Autonomous professionals guided by a professional code of conduct may indeed act as public trustees, but they are also likely to develop blind spots as they are enveloped within a network of strong institutions where they are trained, where they work, and that regulate them. In this traditional model of professionalism, the physician is the ultimate judge of what is in the patient’s best interest, while the patient is more or less excluded from the deliberation process. And the profession decides what is in the public interest.

My approach draws its intellectual ammunition from the model of deliberative democratic process articulated by philosophers and sociologists like John Dewey and George Herbert Mead. These American pragmatists stipulated that the public good is best articulated when all the relevant publics are brought into play and when those participating in the deliberative process learn to place themselves in the shoes of their adversaries or, as Mead put it, “take the role of the other”:

The control of the action of the individual in a cooperative process can take place in the conduct of the individual himself if he can take the role of the other. . . . [This] makes it possible for him to take the attitudes of other individuals, and the attitudes of the organized social group of which he and they are members . . . so that he is thereby able to govern and direct his conduct consciously and critically. . . . Thus he becomes not only self-conscious but also self-critical; and thus, through self-criticism, social control over individual behavior. . . . The development of this process . . . is dependent upon getting the attitude of the group as distinct from that of a separate individual—getting what I termed a ‘generalized other’.

Thus, by seeing his behavior as others do, the individual will control his own actions. This requires physicians to see themselves as the public does, and the reverse.

Although Freidson sees “consumerism and managerialism” as undermining professionalism, my research shows that social closure itself narrows professionals’ perspective on public good and hampers their capacity “to take the role of the generalized other.” Pragmatists are keenly aware of the barriers to adopting a public perspective in a modern society where groups are engaged in adversarial relations. Elite training and expert ideology endemic to professionalism differ from the exclusionary practices found in societies rigidly structured by class or caste, but the ideology of professionalism and expert knowledge may also discourage taking into account other perspectives and reaching a decision benefiting various publics. When professionals look largely to each other for guidance, they are more apt to confuse professional interests with public ones. Dewey and Mead clearly saw the dangers inherent in professional insulation, in setting up one’s community apart and vigorously policing the borders from outsiders wishing to be part of the monitoring process. A strong medical community encourages members to treat each other with respect and follow local ethics, but this model of social control cannot escape the tension between self-interest and public interest, between collegiality achieved within the professional community and indifference and patronizing attitude toward outsiders. For example, collegiality has been invoked by doctors to justify not testifying in malpractice cases against their brethren. The mantra of “improving training standards” led to shutting down rival medical schools, impeding minorities, women, and financially strapped individuals from obtaining medical degrees and licenses, and limiting access of minorities and rural residents to medical services. Social closure has institutionalized a medical discourse that has inhibited intergroup communication and discouraged broadening the range of participants engaged in deciding the public good.

The decision-making process is going to be truncated when the parties involved fail to take each other’s perspectives, and such a process is going to backfire, as evidenced by the proliferation of patients’ complaints, malpractice suits, and bad press besetting the medical profession.

Adding nonphysicians to the process of medical board decision making is a step in the right direction. Ensuring parity in deliberations involving professionals and nonprofessionals moves the process further ahead. Difficult as this task might be, it is not impossible. As I have shown in this book, there are ways to ensure that more voices are heard and heeded in the deliberations on medical boards. Adding nonphysicians improves the odds that public interests will receive a fair hearing. Interweaving legal discourse with medical discourse helps redress the imbalance of power. Challenging the ideology of professionalism that urges “independence of judgment and freedom of action,” extols
"collective devotion to that transcendent value," and demands "the right to serve it independently when the practical demands of patrons and clients stifle it" will, in due course, make room for a more equitable and democratic method of delivering medical services and safeguarding the public good.\(^8\)

Professional codes legitimize the doctor’s autonomy and freedom of action,\(^7\) but they also discourage physicians from paying close attention to patients’ wishes and discourage the profession from paying close attention to the public interest. Institutions that have developed to protect patients’ interests are now coming into their own, but they still have difficulties achieving their stated goal. We need to keep asking ourselves what encourages doctors to question and listen to their patients. Can one make reasonable decisions for others without effective communication with parties coming from different cultural and economic backgrounds? How can the profession decide what the public interests are when physicians tend to look largely toward each other? Does the fact that professionals sometimes act out of self-interest mean that the old-school professionalism is no longer tenable?

For a solution, we can turn to theorists of democracy, notably to Dewey and Mead. According to their theory, a society regulates itself though the discussion of issues by a diverse group of people who struggle to keep a common good in sight without disregarding the interests of parties involved. What this means is that we must put into place a framework for democratic deliberation that encourages all stakeholders to be part of the process.\(^8\) Such a framework requires not only that diverse voices are given a chance to be heard but also that parties have adequate resources to make their case. Within such a framework participants learn to see themselves from multiple perspectives, think about their spouses, children, and parents in decision making, and take into account the needs of the poor, of rural dwellers, of diverse ethnic and racial groups. Encouraged to participate, people will be able to see others’ views and take them into account when they are ready to vote and act. In the case of medical boards, this means including public members and inquiring how any decision will affect the various publics. For example, should a doctor who has been touching patients inappropriately and who happens to be a skillful physician be placed on probation, required to have a chaperone, suspended for a period of time, or have his license revoked? If the decision is not to revoke, is the probation system working? Can the board enforce provisions for chaperones? Or, for another example, will facilitated licenses for doctors practicing medicine over the Internet benefit the public? Is it open to abuse? What about granting additional privileges to nurse practitioners—is it a threat to patients’ safety or to doctors’ incomes? Will medical testing kits sold directly to nonphysicians through the Internet help or harm? These are the questions that implicate the public interest and that cannot be left solely to the discretion of professionals who may have financial stakes in the outcome.

Traditional peer review makes little room for the public voice, as was the case on medical boards. Courts and state legislatures pushed law and lawyers into the process, as public opinion demanded more action. Legal procedures challenge the medical discursive domain and provide additional resources for public members advocating public protection. It is partially this competition that permits public members to evaluate more fully what is going on and widens the range of stories allowed to be heard.\(^9\) Competition, in turn, broadens power bases that affect the outcome and puts pressure on doctors to go beyond thinking that they are deciding purely technical questions and to consider a broader range of issues and values.

Of paramount importance, also, is that the public today is more educated and knowledgeable about its rights. Some patients no longer do a fair amount of homework before they decide where to get health care, which doctor to select, and what type of treatment to follow. Medicine practiced in two hospitals in the same town can differ substantially, with one physician counseling chemotherapy, the other taking exception to this approach. Who should the patient follow? Health care requires that patients be involved in making decisions. Greater transparency and wider information dissemination have increased patients’ activism. The public is also getting more involved in new governance issues: discussions of continued competency, maintenance of licensure, and standards for reentry when a doctor has been out of active practice. Patients know there are doctors who fail to keep up, lose their skills, or violate the ethics of doctor-patient trust. That is why it is important for some of the public to be involved in decision making and for all to understand how cases are decided on medical boards.

As medical boards decide whether professional work has been done appropriately, they rely on knowledge that is both nontechnical and technical, making it possible for the general public to understand much but also requiring evaluation by specialist physicians. According to Charles Bosk, "Moral failure is more often the subject of serious social control efforts than errors in technique.\(^2\) Health care is a complicated process, and past failures are too significant and too important to let medicine be governed exclusively by the profession.

**Democratic Deliberation**

The democratic ideal envisions informed citizens with personal stakes in governance, deliberating on issues facing society, then voting on the alternatives
and implementing the decisions embodying the will of the public. This lofty vision is hard to implement, especially in a modern society where knowledge required for informed decision making often exceeds the expertise individual participants bring to democratic deliberation. Group interests and private biases driving public debates further complicate the matter by fanning factional politics, benefiting some segments of society at the expense of others. Representative democracies tackle these problems by delegating deliberative responsibilities to elected representatives and establishing constitutional frameworks to ensure equal access to governance. To function smoothly, a representative democracy requires bureaucracy to service democratic machinery and enforce public will. Yet these bureaucracies "professionalize" and develop missions of their own, as happened with prisons in the first part of the twentieth century until they began to be challenged in the 1960s, when their powers and independence were gradually curtailed.  

The greater the reliance on public servants, the greater the danger that bureaucrats will develop their own interests, thwarting the public's sovereignty. The challenge modern democracies face is to expand the room for public participation in a society dependent on civil servants and expert knowledge. It is in response to this challenge that civil society has spawned juries, school boards, community health councils, occupational regulatory boards, police/citizen review panels, liquor control boards, and parent-teacher associations promoting the public's involvement in governance. These civic institutions promote public participation in the decision-making process.

A substantial body of work highlights the critical role that democratic deliberation plays in sustaining modern society. As John Dewey, a pragmatist philosopher and public intellectual, pointed out, "Democracy must begin at home, and its home is the neighborly community." His colleague, George Herbert Mead, agreed; democracies can sustain their vitality only by "passing... the functions which are supposed to inhere in the government into activities that belong to the community."  

The spirit of Jeffersonian democracy informing these precepts is as uplifting as it is impractical in a society where administrators, professionals, and volunteers come to oversee and implement policy. The realities of the market and interest-group politics make state involvement in democratic governance necessary. These bureaucratic forms of control led some commentators to doubt the effectiveness of public involvement in a modern industrial society. Thus for Michel Foucault, public participation was little more than window dressing, a welcome opportunity for those in power to legitimize their control. Pierre Bourdieu grew equally disillusioned with democratic deliberation, which he came to see as something of a distraction from the political struggle led by the intellectual elite fighting to secure a bigger share of the public pie for the disadvantaged. Still, many theorists of democracy inspired by American pragmatism remain alive to the possibilities of public participation and deliberative democracy.  

Democratic deliberation is central to the operation of medical board activities, yet balancing community involvement, professional self-governance, and state regulations has proved a daunting task. History shows that left, to their own devices, doctors tend to police themselves in a manner that does not always coincide with the public good. The creation of Medicare and Medicaid prompted federal agencies and then state legislators to step up their regulatory oversight to ensure medical care standards and to keep costs down, with community members brought on board at this point. At first resistant, medical professionals on boards came to view public-member participation as benign, even beneficial, insofar as community representatives could be readily co-opted and used to legitimize their enterprise. It took time for public members to discover their voice, to take a critical stance. Lacking the technical expertise needed to challenge physicians, public members sometimes took the backseat and let physicians set agendas and lead discussions. Many today play active roles, but some lack the communication skills necessary for defending their positions, lack proper training to do effective public advocacy, and, invariably, are outnumbered by physicians. While some of these problems have been addressed in recent years, there are still barriers to public representatives' effective participation. The onus is not just on public representatives to learn proper deliberative skills; doctors also have to shed their blinders as functionaries in the medical domain and heed their community identities as patients, spouses, and guardians of the public good. This is why the query, "Would you send your child to this doctor?" can be effective, as it prompts a medical professional to don a different hat and exercise sociological imagination. Bringing legal experts into the disciplining process helps as well. Legal discourse allows different versions of the story to emerge, encourages the separation of documented facts from hearsay and a focus on what happened, and promotes due process. Legal inquiry may sensitize participants to the suffering of patients, present and absent—but not necessarily.

A central issue of deliberative democracy is how to get the public involved in the governance process. Electing representatives and voting in referendums on major policy initiatives leave the citizenry far too removed from daily politics, according to Carole Pateman. The participatory democracy model, she argues, has to reach beyond government institutions and elective politics; it has to empower citizens in the workplace as well, bring them into self-governance,
board members or deciding what constitutes a proper mix of experts and lay persons serving on a board.

Pateman’s approach to creating citizenship is consistent with Dewey’s and Mead’s views of community involvement but is silent on how we should go about identifying eligible members. Even when membership criteria are clearly articulated, we encounter the difficulty of pressing citizens into service. Physicians join boards out of professional pride, duty, or self-interest; a citizen must be convinced to spend personal resources and volunteer for board work. Even when the selection process has been successful, we still have to see if participants are “free” and “truthful” in their deliberations. The model of civic identity implicit in many democratic theories do not readily accom with the organizations like medical boards, which are made up of professionals, administrators, and public representatives. Autonomous, self-interested individuals claiming a place at the table as a matter of right are not always best suited for board work. Nor can we expect boards to represent all segments of the public or all medical specialties in equal measure. Some interests may be overlooked in a small group with limited resources and also commit efficiency. Civic identity embedded in a small community within a larger one whose members pursue their own agenda is ill-suited for disentangling public from private agendas. And the problem is not just with the doctors pitted against public representatives—there are many “publics” with different perspectives and priorities.

We have to start by acknowledging that, in a diverse society, good is likely to be partial, that there is room for honest differences of opinion on matters of policy, and that each participant in a deliberative process must listen to various constituencies, cultivate multiple identities, and “take the role of the other.” The more pronounced the ability to take the role of the other, the broader will be the “generalized other” that emerges in deliberations and th greater the likelihood will be that the outcome will be acceptable to stakeholders. Participation in public discussion creates competent citizens capable of inhabiting alternative perspectives and articulating an inclusive notion of common good. A key to this achievement is sensitizing all board members to the problems that the deliberative process poses for board members.

Inequalities are endemic and difficult to overcome. Even with citizens trained in assuming the role of the other and listening to multiple constituencies, some groups gain advantage by using well-honed discourse, while others find themselves at a deliberative disadvantage because they lack communication skills and a well-articulated discursive framework to back up their positions. Members of the public are particularly vulnerable in this respect.
for their interests tend to be underarticulated compared to those of physicians, administrators, and lawyers. Wielding a powerful paradigm gives deliberants an advantage. Many theorists acknowledge that the ideal of discussion free from coercion and open to all with a stake in the outcome is just that—a worthy ideal that is hard to achieve. Insufficient research exists on how to equalize the power of the deliberants and specifically how to empower public representatives in their struggle to get their concerns across without being overwhelmed by experts. We need a better understanding of how experts marginalize outsiders and what can be done to give nonexperts a proper say in the deliberative process. Broader public participation is part of the revitalization of the citizen role in governance, and it requires minimizing the power asymmetry that threatens to distort the deliberative process. Strengthening the discursive domain of law is one way we can begin to realize this goal.

There is no bright line separating civil society and the state; many hybrid institutions resist conceptualization. Thus we have prisons run for profit, federally funded welfare programs administered by private organizations, and a huge private security sector contracted by the military. Whereas medical professionals are adept at harnessing state powers to their advantage, they now have to contend with the increasingly assertive representatives of civil society who have learned to play the game and deploy legal arguments to ensure greater deliberative fairness. Nevertheless, there is little discussion of participation and deliberation in hybrid institutions such as medical boards, which straddle the domains of government and civil society. Government plays a key role in medical board change, as it lays out a statutory framework that provides disciplinary tools and procedures, ensures some transparency, maintains membership diversity, and achieves court oversight. A strong civil society also needs a reasonably strong state; civil society needs the support of robust political institutions to fulfill its agenda and to balance the power of professionals, administrators, and the public. This is a precarious balance at best. When boards are too embedded in civil society, it becomes easy for the profession to determine outcomes without other voices. However, when the balance of power shifts too much to the state, bureaucrats are apt to make decisions without much input from others and subordinate ethical concerns to the needs of efficiency and are subject to major funding cuts in times of state budget crises.

Deliberative democracy models offer few guidelines for balancing legitimacy, transparency, and public deliberation. This is a major gap in existing theory, for board legitimacy depends in large measure on the coverage its work receives in the local press and the publicity generated by public-interest groups. A critical issue is disentangling transparency from deliberation in public. Would more public deliberation increase legitimacy in the eyes of the profession or the public? Does increasing information flow increase legitimacy? As we have seen, deliberating in public has serious drawbacks in disciplinary cases where deliberants may hedge their bets, play to the media, or yield to the pressure from the party that did the best job mobilizing its supporters. Still, more information could be made available to enhance transparency and improve legitimacy of board actions both in the eyes of the profession and the public.

It is a challenge for a modern democracy to articulate and legitimize the common good. Media stories of physicians' misconduct and conflicts of interests have made the wisdom of second-guessing professionals clear. State licensing statutes and government inactivity that permitted self-regulation failed both patients and doctors. The era of complete self-regulation for the medical profession is over.

**Overhauling the Medical Board System**

The medical board system has been evolving for decades, yet the need for systemic reforms has not lost its urgency. Licensure and disciplinary practices continue to differ among states, making it difficult for doctors to obtain multiple licenses necessary for innovative strategies of delivering health care. The current system does little to assure patients that similar protective measures are taken everywhere. A physician whose license is revoked in one state sometimes can continue to practice in another state with a different set of rules. Many boards hold on to obsolete procedures, with legislators slow to make necessary changes. Board members still get insufficient training, little guidance exists on collecting data, and there are few clear standards for securing transparency and resolving conflicts of interests. The following recommendations are based on my conviction that effective boards require a diverse body of participants, improved data collection, formal training of board members, transparency balanced with privacy concerns, effective relationships between national and local organizations, and strong leadership from the FSMB in highlighting best practices and involving a broad diversity of groups in their discussions and activities.

**Selecting Board Members**

In most jurisdictions, the statutes establishing medical boards offer little guidance for choosing board members. States designate who is able to nominate board members, and some mandate a geographic distribution. It is left to the governors or their surrogates to figure out the eligibility criteria and the desired skill mix. Board physicians tend to be selected from medical society designees.
Sometimes the selected physicians had appeared before the board for discipline action. It is troublesome that public representatives may be affiliated with medical institutions, may work for medical industries, may be closely related to medical professionals, or might have been parties to multiple malpractice suits. It is the matter of concern, also, that states differ greatly on the ratio of medical professionals and public representatives serving on boards. In many states, boards lack policies designed to ensure that different groups have a foothold (with so few public members on boards, however, such a balance may be impossible to achieve). Few guidelines exist concerning desirable personal skills or qualifications. Often it is not a governor’s priority; the resulting board composition may appear unbalanced, and the quality of membership uneven.

The need to ensure fairness and the general goal of strengthening deliberative democracy suggest the following imperatives and criteria for selecting board members:

1. highlight diversity, including regional, ethnic, and gender diversity, and various medical specialties among board members;
2. balance the ratio of medical professionals and public representatives on the board, with no less than one third from the community at large;
3. carefully explain the nature of board work and provide nominees with a realistic estimate of time they will have to devote to it;
4. vet all nominees carefully while weeding out unnecessary documentation that burdens board candidates; make sure to eliminate public members who are too close to the profession or have a narrow vested interest in a particular cause, physicians with multiple problems before the board, or doctors saddled with more than the average number of malpractice settlements for their specialty;
5. ensure that all nominations can be made from any source and that the nomination process is well known to the public;
6. specify the need for rotation among board members while ensuring continuity; and
7. educate governors and their appointment secretaries about the board agenda, membership needs, and the vital role public members play in protecting patients’ interests.

Training Board Members

Boards are too small to be more than marginally representative, which makes it necessary for all members to think broadly as citizens and take the perspectives of various communities affected by board actions. With multiple communities and deep involvement in their own enclaves, all board members need training as citizens responsible for seeing issues from multiple perspectives. Training board members helps ensure that boards properly dispense with their deliberative responsibilities, that they are not beholden to a parochial perspective, that they partake in what Mead saw as the ever-growing democratic community committed to empowering individuals and groups previously excluded from deliberations. Board training will help its members develop a critical sell that transcends the limitations of the present order. According to Mead,

The only way in which we can react against the disapproval of the entire community is by setting up a higher sort of community which in a certain sense outvotes the one we are in. A person may reach a point of going against the whole world about him: he may stand out by himself against it. But to do that, he has to speak the voice of reason to himself. He has to comprehend the voices of the past and of the future. That is the only way in which the self can get a voice which is more than the voice of the community.

Training should sensitize all board members to the diverse interests they serve, the ever-present possibility of succumbing to a bias, and the need to advance the community well-being as the ultimate good. Board members must be encouraged to cultivate multiple identities and develop diverse skills. A well-designed curriculum would outline common communication problems, the negative consequences of stereotyping, and the high toll prejudices inflict. Both medical professionals and public members should be instructed on the limitations and strengths that each side brings to the deliberation process. All boards benefit from careful evaluation and articulation of its practices. Here are my recommendations for training a board:

1. designate a staff member to facilitate the learning process and outline the board mission, structure, procedures, responsibilities, division of labor, and lines of authority;
2. institute formal training sessions for all board members that include presentations, educational video shows, and simulation games modeling typical problems and situations;
3. bring new and established board members together to make sure the newcomers feel welcome and assign mentors;
4. periodically invite outside experts to update board members on best practices, latest legal developments in the field, and new challenges facing medical boards;
5. emphasize that the quality and effectiveness of deliberations improve when multiple voices are heard, when members with diverse expertise weigh in on a decision, when members listen carefully to others, and when each member learns to take the role of others; and
6. send board members and staff to Federation and CAC meetings, where they can learn and debate.

Data Gathering

Data help improve board functioning and transparency. In some instances board members do not have sufficient data to improve board functioning or even to make good decisions on cases. Board members dependent on administrators for the case-selection process are often troubled by lack of knowledge about the criteria used for choosing cases for review. Without enough data, the public has insufficient information to make decisions about which doctor to use or to understand what needs improvement in the process. To alleviate problems, boards need to develop data-gathering and data-reporting mechanisms. For example, boards should make a point of finding out who supervises doctors on probation and how to evaluate the probation process. Boards need to know who reports cases, particularly those likely to require investigation and hearings. Data gathering also allows boards to evaluate whether organizations that are required to report are doing so. Boards have to do more to encourage hospitals and other medical entities to report and explain to the public when the board can take action if few patient reports become fully investigated complaints. The following measures will help medical boards turn their decision making into a more data-driven process:

1. keep a log of reports that become complaints, break down the cases into categories (e.g., negligence, incompetence, ethical infractions, impairment issues, sexual improprieties, criminal violations, etc.), track changes, and look for patterns in reporting by different agencies and people (health-care organizations, government agencies, court holdings, patients, etc.);
2. inform board members about selection criteria for investigations, give reasons for excluding cases from consideration, encourage board members to go over closed cases;
3. match cases with resources needed to process them, balance the likelihood of prevailing in cases against seriousness;
4. track sanction patterns with an eye to increasing their overall consistency; and
5. make data and information public, but before doing so, engage in a discussion with the community about what it would like to know about board activities.

Balancing Transparency and Privacy

We expect democratic deliberation to be accessible to all interested parties, and with outcomes publicly reported. This ideal is hard to implement in cases of medical board deliberations. Increased transparency has its drawbacks. The reasons for that are similar to those requiring jury deliberations to be removed from public scrutiny (but in some states they can do talk afterward). Deliberating in the media glare can distort the proc when members of the public misbehave or when board members feel intimated by television cameras, but it does eliminate discussions of defendar professional or private lives not on the record and makes reasoning public the public can understand the process. Sensational cases tend to put extra burden on deliberaants who may be swayed by biased media coverage or become afraid to speak. With free access to the disciplinary decision, there is a dan that one party may bring along supporters who intimidate others and dism the discussion. However, all should know how the deliberaants reached these positions. Posting lengthy disciplinary opinions may pose fewer probles while improving an understanding of why doctors were disciplined a avoiding the public to choose whether to use a doctor, for example, who is probation. The board’s visibility also may attract quality participants a alert legislators about its needs.

More and higher-quality information and resources must be available members about how similar cases were disposed of in the past, what membe and staff reasoning is, and what the facts (technical and moral) of the cases a. This is transparency in a broad sense. Cases need to be transparent to all bo members to allow them to make reasonable decisions.

But what is made available to the public varies widely from board to boa Cases where sufficient evidence is available to hold a hearing for license action can be brought to public attention, for the public has a right to know there is enough evidence to charge a doctor as dangerous to patients, as is do in some states. At this stage, boards need to be able to alert other states whe the doctor is licensed that they may have a licensed doctor working who l been charged. Open hearings are less clear. Victims of sexual abuse might less willing to testify in public, but the public and physicians might und stand the process better after witnessing hearings, and doctors would becom more aware of acts that might get them into trouble. Discussing sanctions
public may improve the quality of outcomes by curtailing references to what is not on the record. At the same time, such discussions can produce formal and cursory deliberations that make it difficult even for board members to understand each other’s reasoning.

With these general considerations in mind, here are my recommendations related to board transparency:

1. select venues for meetings that can accommodate members of the board and the general public;
2. provide clear instructions on the code of behavior for those attending meetings;
3. hold well-advertised public meetings with discussion times posted and resources publicly available about new issues, such as scope of practice and maintenance of licensure (post publications, data, and summaries of the issues on the board website); personally invite groups who may be interested;
4. give the media as much information as possible to educate all;
5. respond to each report of a problem physician, and when the case is resolved, send a letter; tell complainants why their cases were not pursued or why doctors’ cases were dismissed without discipline;
6. post detailed decisions on the Internet and send releases to the media;
7. make sure at each stage of the disciplinary process that the group has sufficient information, understanding, and reasons to make sensible decisions;
8. post statistical information on the website concerning the number of reports and their sources and the type and sources of cases that require hearings, in addition to how long the process takes;
9. make disciplinary cases public early to protect the state’s residents and to protect patients in other states where a doctor is also licensed; and
10. educate both the public and medical groups about board activities and importance of community involvement in board policy deliberations and changing procedures.

Strengthening a Legal Framework
Boards operate under the statutory authority of a state. A state agency or, at other times, the board itself provides the administrative personnel, lawyers, and other resources that facilitate board deliberations. Board work is circumscribed by a legal framework that gives specified authority to its members and strengthens particular discursive domains at the expense of other discursive frameworks. In states with a strong legal structure, board members may be limited in the choice of cases that come for review or in what they can decide. However, a well-designed legal framework offers opportunities for deploying legal discourse, which offers not only due-process safeguards but also a way to talk about cases that may be lacking when medical discourse dominates board deliberations.

Board members are required to make judgments on different kinds of issues, from licensing and disciplinary cases to policy issues. People with different training and experiences bring to the table their own favorite ways of talking and deciding issues. Entrenched habits can be assets as well as liabilities. Doctors tend to focus on their peer’s history and character, and only after they have gotten a feel for the problem physician do they shift attention to the incidents. Public members have to break some habits as well. They must learn to see beyond their own social group, pay heed to special needs of publics other than their own. The expertise all members acquired in the course of life and work may come handy in deliberations, and they should be encouraged to flex their expert muscles where it is prudent. All participants need to learn that they are not autonomous actors; everyone has to cultivate a civic identity attuned to a public culture and common good in addition to their particular identity as members of a parochial group.

Board members with different backgrounds and discursive preferences must operate within a common framework that draws out their civic virtues and improves the fairness of the deliberative process. To facilitate this objective, boards will need to do the following:

1. review the statutory framework governing board work, identify the procedures that are given precedence in a given state, and work to empower the discourses that tend to be shortchanged;
2. use legal counsel broadly and consult medical experts other than board members to write reports; describe what happened and what should have happened (standard of care) in cases of possible negligence or incompetence; implement due-process safeguards and limit the use of professional reputation in deciding what happened;
3. at the earliest stages of the investigation, focus on what happened rather than on the doctor’s history and reputation;
4. advise all parties about the legal framework governing hearings, spell out the rights and obligations of all participants;
5. identify shortcomings in existing statutes and communicate board recommendations to the state legislature;
6. open and work to sustain lines of communication between board members and legislators; and

7. make sure that all the board members provide justifications for their decisions and understand the elementary rules of evidence and due-process requirements.

Strengthening Relations between Boards and National Organizations

In every field one finds organizations operating on the cutting edge and showing consistently good results, as well as those plagued by dissension, poor case management, and staff turnover. Improving coordination between the local and national organizations is one way we can improve the quality of medical board work. While too much bureaucracy and standardization may stifle local initiative and innovation, greater similarity of standards and procedures can benefit physicians and patients alike. Acceptance of one licensure standard and the use of a common application for licensing developed by FSMB would be beneficial. More standardization of disciplinary language and practices would make the assessment of best practices easier. Comparisons across state lines are complicated by a patchwork of incompatible laws and practices. The percentage of local doctors sanctioned by medical boards may reflect, among other things, the number or types of legally defined categories of misconduct; budget constraints; state involvement; disciplinary processes; the quality of local doctors; the quantity and quality of reporting by health-care providers; health entities and the public; standards of proof; the number or quality of investigators; or the number or percent of public members. Given this variability, one should proceed gingerly in comparing boards across state lines.

National issues and ideas need to be adapted to local environments, just as local wisdom should inform national models. Active participation of boards in the national debates with the FSMB and the CAC facilitates local acceptance and adoption of national models. Following the logic of Theda Skocpol’s argument that the decline of associational structures linking local and national engagement created a decrease in citizen involvement, I suggest that boards encourage and fund members and staff to participate actively in national meetings. This facilitates the exchange of ideas and presses local boards to align their work with best practices and national standards. The more understanding and trust boards have in each other, the more likely they are to develop consistent strategies to deal with doctors who have been disciplined in other states. Strong communications among organizations—both local and national—are necessary. Three groups are critical in this respect: the state, the profession, and the public. They can be at odds, but they can work together to improve board and professional practices.

Local autonomy makes it difficult to move smoothly through the twenty-first century. States need to look beyond their borders to coordinate standards and deploy research findings obtained by national organizations. Although a new credentialing service of the FSMB facilitates licensure, it is still cumbersome, as states maintain different criteria particularly for physicians trained outside the United States and Canada. Perhaps licensure standards should be the same, which would permit recognition of licenses of other states. Maintaining multiple licenses may become increasingly complicated as some states begin to establish new relicensure requirements.

As we strive to improve the lines of communication between local and national organizations, we might want to consider the following recommendations:

1. define categories of disciplinary actions that all states could use;
2. create a list of the most important aspects of board actions, structure, and process; develop and administer a short survey to allow board members to express their ideas;
3. invite experts in board development to assess the performance of a given medical board; identify the resources needed for the board to improve its work;
4. spell out best practices in medical board work, summarize the achievements of high-performance organizations, and use national organizations to disseminate knowledge about successful operations;
5. bring board members to the regional and national events sponsored by the FSMB and the CAC; provide resource-poor boards with subsidies for its members; and
6. work to make it possible to use similar standards to ensure continued physician competency through the life course.

Many of these suggestions have been implemented in some states as board members, public-interest groups, and legislators struggle to improve board practices. Boards evolve from legislative changes but also from new staff and members as they make sense out of their work.

Democracy thrives on active citizenship. It requires competent agents familiar with their rights and willing to exercise these rights. The state plays a part in creating an intelligent democracy by bridging a gap between isolated groups.
Placing citizens on the boards that regulate professions is one way it can achieve that goal. The state cannot stop there, however. It must do more to improve the board member selection process, encourage the training of participants, gather data, set up a viable legal framework, and coordinate the work of local and national organizations. All of these measures will ultimately promote democratic deliberations and improve the quality of life in our communities.

Conclusion

An Exercise in Democratic Governance

While bringing this project to a close, I did the paperwork required for my board reappointment. The process has grown more complicated in recent years, with extra forms and documents to produce. The change was made in the name of “good government,” but it reminds us how difficult achieving the intended outcome is and how far we still have to go to achieve democratic governance worthy of its name.

Traditionally, board members invited to renew their appointments would submit letters of intent and update their vita. This time, attachments and forms sent to us were so massive they crashed my e-mail program. We were asked to supply high school, college, and graduate school diplomas, divorce papers where applicable, a complete list of publications and speeches, and all sorts of financial information. A state police officer, assigned to do a background check on every applicant, had to track down the diplomas that I could not find, even though there are no educational requirements for serving. It took me more than a day to fill out the forms and go to the governor’s office for fingerprinting. The whole process seemed costly, intrusive, time-consuming, and unwieldy.

While the state examined aspects of my life that had little to do with my volunteer work, it did not bother to check for possible conflicts of interest. State bureaucrats did not care to know whether I was married to a doctor, whether I had a physician in my immediate family, or whether I am presently or was in the past party to medical malpractice suits. Given the hassle, it is hardly surprising that several valuable board members decided to quit rather than go through this unduly complicated process. Good government, you might say, has taken its toll. Concurrently, with states’ deficits rising, many